Utah

UNIFORM APPLICATION
FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 08/01/2019 4.02.24 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development
State Information

Plan Year
Start Year 2020
End Year 2021

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 Doug
Last Name Thomas
Agency Name Division of Substance Abuse and Mental Health
Mailing Address 195 North 1950 West
City Salt Lake City
Zip Code 84116
Telephone 801-538-4298
Fax 801-538-9892
Email Address dothomas@utah.gov

State CMHS DUNS Number
Number 878593383
Expiration Date 8/30/2013

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 Doug
Last Name Thomas
Agency Name Division of Substance Abuse and Mental Health
Mailing Address 195 North 1950 West
City Salt Lake City
Zip Code 84116
Telephone 801-538-4390
Fax 801-538-9892
Email Address dothomas@utah.gov

III. Third Party Administrator of Mental Health Services
Do you have a third party administrator?  ○ Yes  ○ No

First Name
Last Name
Agency Name
Mailing Address
City
Zip Code
Telephone
Fax
Email Address

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

From
To

V. Date Submitted
Submission Date
Revision Date

VI. Contact Person Responsible for Application Submission
First Name Shanel
Last Name Long
Telephone 801-538-4406
Fax 801-538-4696
Email Address shlong@utah.gov

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Title XIX, Part B, Subpart II of the Public Health Service Act

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1921</td>
<td>Formula Grants to States</td>
<td>42 USC § 300x-21</td>
</tr>
<tr>
<td>Section 1922</td>
<td>Certain Allocations</td>
<td>42 USC § 300x-22</td>
</tr>
<tr>
<td>Section 1923</td>
<td>Intravenous Substance Abuse</td>
<td>42 USC § 300x-23</td>
</tr>
<tr>
<td>Section 1924</td>
<td>Requirements Regarding Tuberculosis and Human Immunodeficiency Virus</td>
<td>42 USC § 300x-24</td>
</tr>
<tr>
<td>Section 1925</td>
<td>Group Homes for Recovering Substance Abusers</td>
<td>42 USC § 300x-25</td>
</tr>
<tr>
<td>Section 1926</td>
<td>State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18</td>
<td>42 USC § 300x-26</td>
</tr>
<tr>
<td>Section 1927</td>
<td>Treatment Services for Pregnant Women</td>
<td>42 USC § 300x-27</td>
</tr>
<tr>
<td>Section 1928</td>
<td>Additional Agreements</td>
<td>42 USC § 300x-28</td>
</tr>
<tr>
<td>Section 1929</td>
<td>Submission to Secretary of Statewide Assessment of Needs</td>
<td>42 USC § 300x-29</td>
</tr>
<tr>
<td>Section 1930</td>
<td>Maintenance of Effort Regarding State Expenditures</td>
<td>42 USC § 300x-30</td>
</tr>
<tr>
<td>Section 1931</td>
<td>Restrictions on Expenditure of Grant</td>
<td>42 USC § 300x-31</td>
</tr>
<tr>
<td>Section 1932</td>
<td>Application for Grant; Approval of State Plan</td>
<td>42 USC § 300x-32</td>
</tr>
<tr>
<td>Section 1935</td>
<td>Core Data Set</td>
<td>42 USC § 300x-35</td>
</tr>
</tbody>
</table>

Title XIX, Part B, Subpart III of the Public Health Service Act

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1941</td>
<td>Opportunity for Public Comment on State Plans</td>
<td>42 USC § 300x-51</td>
</tr>
<tr>
<td>Section 1942</td>
<td>Requirement of Reports and Audits by States</td>
<td>42 USC § 300x-52</td>
</tr>
<tr>
<td>Section 1943</td>
<td>Additional Requirements</td>
<td>42 USC § 300x-53</td>
</tr>
<tr>
<td>Section 1946</td>
<td>Prohibition Regarding Receipt of Funds</td>
<td>42 USC § 300x-56</td>
</tr>
<tr>
<td>Section 1947</td>
<td>Nondiscrimination</td>
<td>42 USC § 300x-57</td>
</tr>
<tr>
<td>Section 1953</td>
<td>Continuation of Certain Programs</td>
<td>42 USC § 300x-63</td>
</tr>
<tr>
<td>Section 1955</td>
<td>Services Provided by Nongovernmental Organizations</td>
<td>42 USC § 300x-65</td>
</tr>
<tr>
<td>Section 1956</td>
<td>Services for Individuals with Co-Occurring Disorders</td>
<td>42 USC § 300x-66</td>
</tr>
</tbody>
</table>
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.


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 Clean 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).


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.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of 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 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a “covered transaction” and verify each lower tier participant of a “covered transaction” under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

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 workplace in accordance with 2 CFR Part 182 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).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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) (31 U.S.C § 3801-3812)

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.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and
summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary
for the period covered by this agreement.

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

State: 

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

Signature of CEO or Designee: 

Title: Executive Director of Utah Dept. of Human Services Date Signed: 

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
State Information

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

Fiscal Year 2020

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1921</td>
<td>Formula Grants to States</td>
<td>42 USC § 300x-21</td>
</tr>
<tr>
<td>Section 1922</td>
<td>Certain Allocations</td>
<td>42 USC § 300x-22</td>
</tr>
<tr>
<td>Section 1923</td>
<td>Intravenous Substance Abuse</td>
<td>42 USC § 300x-23</td>
</tr>
<tr>
<td>Section 1924</td>
<td>Requirements Regarding Tuberculosis and Human Immunodeficiency Virus</td>
<td>42 USC § 300x-24</td>
</tr>
<tr>
<td>Section 1925</td>
<td>Group Homes for Recovering Substance Abusers</td>
<td>42 USC § 300x-25</td>
</tr>
<tr>
<td>Section 1926</td>
<td>State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18</td>
<td>42 USC § 300x-26</td>
</tr>
<tr>
<td>Section 1927</td>
<td>Treatment Services for Pregnant Women</td>
<td>42 USC § 300x-27</td>
</tr>
<tr>
<td>Section 1928</td>
<td>Additional Agreements</td>
<td>42 USC § 300x-28</td>
</tr>
<tr>
<td>Section 1929</td>
<td>Submission to Secretary of Statewide Assessment of Needs</td>
<td>42 USC § 300x-29</td>
</tr>
<tr>
<td>Section 1930</td>
<td>Maintenance of Effort Regarding State Expenditures</td>
<td>42 USC § 300x-30</td>
</tr>
<tr>
<td>Section 1931</td>
<td>Restrictions on Expenditure of Grant</td>
<td>42 USC § 300x-31</td>
</tr>
<tr>
<td>Section 1932</td>
<td>Application for Grant; Approval of State Plan</td>
<td>42 USC § 300x-32</td>
</tr>
<tr>
<td>Section 1935</td>
<td>Core Data Set</td>
<td>42 USC § 300x-35</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1941</td>
<td>Opportunity for Public Comment on State Plans</td>
<td>42 USC § 300x-51</td>
</tr>
<tr>
<td>Section 1942</td>
<td>Requirement of Reports and Audits by States</td>
<td>42 USC § 300x-52</td>
</tr>
<tr>
<td>Section 1943</td>
<td>Additional Requirements</td>
<td>42 USC § 300x-53</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Section 1946</td>
<td>Prohibition Regarding Receipt of Funds</td>
<td>42 USC § 300x-56</td>
</tr>
<tr>
<td>Section 1947</td>
<td>Nondiscrimination</td>
<td>42 USC § 300x-57</td>
</tr>
<tr>
<td>Section 1953</td>
<td>Continuation of Certain Programs</td>
<td>42 USC § 300x-63</td>
</tr>
<tr>
<td>Section 1955</td>
<td>Services Provided by Nongovernmental Organizations</td>
<td>42 USC § 300x-65</td>
</tr>
<tr>
<td>Section 1956</td>
<td>Services for Individuals with Co-Occurring Disorders</td>
<td>42 USC § 300x-66</td>
</tr>
</tbody>
</table>
ASSURANCES - NON-CONSTRUCTION PROGRAMS

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.


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 Clean 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


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.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of 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 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

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 2 CFR Part 182 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).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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) (31 U.S.C § 3801-3812)

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.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

State: ________________________________

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

Signature of CEO or Designee 1: ________________________________

Title: Executive Director of Utah Dept. of Human Services Date Signed: 7/12/2019

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
July 17, 2019

Grants Management Officer
Office of Financial Resources, Division of Grants Management Substance Abuse and Mental Health Services Administration 5600 Fishers Lane
Rockville, Maryland 20857

Dear Mr. Roger George,

Pursuant to Title V of the Public Health Act, I hereby certify that the state of Utah will assume responsibility for the implementation of the Community Mental Health and Substance Abuse Prevention and Treatment Block Programs for Fiscal year 2020–2021.

Utah Department of Human Services’ Division of Substance Abuse and Mental Health has been designated the state agency to carry out the policies and programs of the Block Grant. Accordingly, I delegate to Ann Williamson, Executive Director of the Utah Department of Human Services, the authority to sign the Assurances and Certifications and any documents related to the FY2020–2021 Substance Abuse Block Grant.

On the recommendation of SAMHSA, the grant application was written as a combined application, and it reflects the work of an interdisciplinary team of colleagues from the Division of Substance Abuse and Mental Health who are supported in their efforts by the State Mental Health Planning and Advisory Council. Their work reflects Utah’s commitment to provide a quality, community-based, locally managed and comprehensive community behavioral health system. Utah embraces hope and recovery, and our application contains several initiatives that will continue to build and transform our community behavioral health system focusing on person-centered services and outcome-based goals. Goals include an increased emphasis on prevention and early intervention, a Zero Suicide initiative, improved care for children and youth, recovery promotion, and health system integration. Utah is dedicated to the concepts of prevention, advocacy, treatment, education, and support.

I commend the Utah Behavioral Health Planning and Advisory Council and the many other citizens of Utah who have volunteered numerous hours to help develop and implement this state plan.

Sincerely,

Gary R. Herbert
Governor

Utah State Capitol, Suite 200 • P.O. Box 142220 • Salt Lake City, Utah 84114-2220 • Telephone (801) 538-1000
State Information

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

Fiscal Year 2020

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1911</td>
<td>Formula Grants to States</td>
<td>42 USC § 300x</td>
</tr>
<tr>
<td>Section 1912</td>
<td>State Plan for Comprehensive Community Mental Health Services for Certain Individuals</td>
<td>42 USC § 300x-1</td>
</tr>
<tr>
<td>Section 1913</td>
<td>Certain Agreements</td>
<td>42 USC § 300x-2</td>
</tr>
<tr>
<td>Section 1914</td>
<td>State Mental Health Planning Council</td>
<td>42 USC § 300x-3</td>
</tr>
<tr>
<td>Section 1915</td>
<td>Additional Provisions</td>
<td>42 USC § 300x-4</td>
</tr>
<tr>
<td>Section 1916</td>
<td>Restrictions on Use of Payments</td>
<td>42 USC § 300x-5</td>
</tr>
<tr>
<td>Section 1917</td>
<td>Application for Grant</td>
<td>42 USC § 300x-6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1941</td>
<td>Opportunity for Public Comment on State Plans</td>
<td>42 USC § 300x-51</td>
</tr>
<tr>
<td>Section 1942</td>
<td>Requirement of Reports and Audits by States</td>
<td>42 USC § 300x-52</td>
</tr>
<tr>
<td>Section 1943</td>
<td>Additional Requirements</td>
<td>42 USC § 300x-53</td>
</tr>
<tr>
<td>Section 1946</td>
<td>Prohibition Regarding Receipt of Funds</td>
<td>42 USC § 300x-56</td>
</tr>
<tr>
<td>Section 1947</td>
<td>Nondiscrimination</td>
<td>42 USC § 300x-57</td>
</tr>
<tr>
<td>Section 1953</td>
<td>Continuation of Certain Programs</td>
<td>42 USC § 300x-63</td>
</tr>
<tr>
<td>Section 1955</td>
<td>Services Provided by Nongovernmental Organizations</td>
<td>42 USC § 300x-65</td>
</tr>
<tr>
<td>Section 1956</td>
<td>Services for Individuals with Co-Occurring Disorders</td>
<td>42 USC § 300x-66</td>
</tr>
</tbody>
</table>
ASSURANCES - NON-CONSTRUCTION PROGRAMS

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.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to
State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (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).


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.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of 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 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a “covered transaction” and verify each lower tier participant of a “covered transaction” under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

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 workplace in accordance with 2 CFR Part 182 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 workplace 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).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

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) (31 U.S.C § 3801- 3812)

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.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. **Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

2. **Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

3. **Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.**

4. **The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

5. **Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.**

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

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

Signature of CEO or Designee 1:

Title: Executive Director of Utah Dept. of Human Services

Date Signed: 

mm/dd/yyyy

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

Footnotes:
State Information

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

Fiscal Year 2020

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1911</td>
<td>Formula Grants to States</td>
<td>42 USC § 300x</td>
</tr>
<tr>
<td>Section 1912</td>
<td>State Plan for Comprehensive Community Mental Health Services for Certain Individuals</td>
<td>42 USC § 300x-1</td>
</tr>
<tr>
<td>Section 1913</td>
<td>Certain Agreements</td>
<td>42 USC § 300x-2</td>
</tr>
<tr>
<td>Section 1914</td>
<td>State Mental Health Planning Council</td>
<td>42 USC § 300x-3</td>
</tr>
<tr>
<td>Section 1915</td>
<td>Additional Provisions</td>
<td>42 USC § 300x-4</td>
</tr>
<tr>
<td>Section 1916</td>
<td>Restrictions on Use of Payments</td>
<td>42 USC § 300x-5</td>
</tr>
<tr>
<td>Section 1917</td>
<td>Application for Grant</td>
<td>42 USC § 300x-6</td>
</tr>
</tbody>
</table>

Title XIX, Part B, Subpart III of the Public Health Service Act

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Chapter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section 1941</td>
<td>Opportunity for Public Comment on State Plans</td>
<td>42 USC § 300x-51</td>
</tr>
<tr>
<td>Section 1942</td>
<td>Requirement of Reports and Audits by States</td>
<td>42 USC § 300x-52</td>
</tr>
<tr>
<td>Section 1943</td>
<td>Additional Requirements</td>
<td>42 USC § 300x-53</td>
</tr>
<tr>
<td>Section 1946</td>
<td>Prohibition Regarding Receipt of Funds</td>
<td>42 USC § 300x-56</td>
</tr>
<tr>
<td>Section 1947</td>
<td>Nondiscrimination</td>
<td>42 USC § 300x-57</td>
</tr>
<tr>
<td>Section 1953</td>
<td>Continuation of Certain Programs</td>
<td>42 USC § 300x-63</td>
</tr>
<tr>
<td>Section 1955</td>
<td>Services Provided by Nongovernmental Organizations</td>
<td>42 USC § 300x-65</td>
</tr>
<tr>
<td>Section 1956</td>
<td>Services for Individuals with Co-Occurring Disorders</td>
<td>42 USC § 300x-66</td>
</tr>
</tbody>
</table>
ASSURANCES - NON-CONSTRUCTION PROGRAMS

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.


10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §1451 et seq.); (f) conformity of Federal actions to
State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (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).


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.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.
LIST of 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 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

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 2 CFR Part 182 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).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

Page 4 of 7
Printed: 8/1/2019 4:02 PM - Utah - OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
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.

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) (31 U.S.C § 3801- 3812)

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.

**HHS Assurances of Compliance (HHS 690)**


The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

**THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:**

1. **Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

2. **Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

3. **Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.**

4. **The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.**

5. **Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.**

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.
I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

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

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

Signature of CEO or Designee:\n
Title: Executive Director of Utah Dept. of Human Services

Date Signed: 7/17/2019

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
July 17, 2019

Grants Management Officer
Office of Financial Resources, Division of Grants Management Substance Abuse and Mental Health Services Administration 5600 Fishers Lane
Rockville, Maryland 20857

Dear Mr. Roger George,

Pursuant to Title V of the Public Health Act, I hereby certify that the state of Utah will assume responsibility for the implementation of the Community Mental Health and Substance Abuse Prevention and Treatment Block Programs for Fiscal year 2020–2021.

Utah Department of Human Services’ Division of Substance Abuse and Mental Health has been designated the state agency to carry out the policies and programs of the Block Grant. Accordingly, I delegate to Ann Williamson, Executive Director of the Utah Department of Human Services, the authority to sign the Assurances and Certifications and any documents related to the FY2020–2021 Substance Abuse Block Grant.

On the recommendation of SAMHSA, the grant application was written as a combined application, and it reflects the work of an interdisciplinary team of colleagues from the Division of Substance Abuse and Mental Health who are supported in their efforts by the State Mental Health Planning and Advisory Council. Their work reflects Utah’s commitment to provide a quality, community-based, locally managed and comprehensive community behavioral health system. Utah embraces hope and recovery, and our application contains several initiatives that will continue to build and transform our community behavioral health system focusing on person-centered services and outcome-based goals. Goals include an increased emphasis on prevention and early intervention, a Zero Suicide initiative, improved care for children and youth, recovery promotion, and health system integration. Utah is dedicated to the concepts of prevention, advocacy, treatment, education, and support.

I commend the Utah Behavioral Health Planning and Advisory Council and the many other citizens of Utah who have volunteered numerous hours to help develop and implement this state plan.

Sincerely,

Gary R. Herbert
Governor
### State Information

### Disclosure of Lobbying Activities

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

**Standard Form LLL (click here)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Ann Williamson</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Executive Director of Utah Dept. of Human Services</td>
</tr>
<tr>
<td>Organization</td>
<td>Utah State Department of Human Services</td>
</tr>
</tbody>
</table>

**Signature:**

**Date:**

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

Not Applicable- No activities reported
Planning Steps

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

Narrative Question:
Provide an overview of the state’s M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state’s Application. Describe how the public M/SUD 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD 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 and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
PLANNING STEP 1: Assess the strengths and organizational capacity

I. Overview of State Behavioral Health System

Organization of the Utah Public Behavioral Health System

a. State level organization—Utah Department of Human Services

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

- Division of Substance Abuse and Mental Health
- Division of Aging & Adult Services (programs supported under the Older Americans Act and
Adult Protective Services
- Division of Services for People with Disabilities (persons with developmental delays, intellectual disabilities 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)
- Office of Quality and Design

Coordination is a major emphasis in the Department of Human Services/Division of Substance Abuse and Mental Health (DHS/DSAMH), and is accomplished through several means. The various division and office directors meet monthly to discuss interagency issues and to resolve interdepartmental conflicts. Additionally, there are numerous workgroups and committees that meet regularly to resolve issues and to improve collaboration. For example, DHS has comprised a new interagency workgroup to address and advise on integrated service approaches addressing consistency and efficiency in key operations. The workgroup will address key issues and give input on barriers and opportunities that are collectively shared between all agencies.

There are currently multiple groups meeting to address Prescription Drug Abuse, Opioid Overdose Prevention, Suicide Prevention, Recovery Supports (Employment, Housing, Peer Supports) and Children/Youth Mobile Crisis Outreach and Follow up Care, all to ensure collaboration and to maximize the use of available resources.

An ongoing focus of the Department of Human Services, in conjunction with the Department of Health (DOH) is an ongoing effort to identify and enroll uninsured individuals either through the State’s Avenue H, private health insurance exchange, or if an individual qualifies as “medically frail”, with the option of enrolling in Medicaid.

In 2015, the Utah State Legislature passed a sweeping criminal justice reform bill. House Bill 348, Criminal Justice Amendments, sponsored by Representative Eric Hutchings, requires widespread collaboration between the Administrative Office of the Courts, the Departments of Corrections, Workforce Services, Human Services and the Department of Health, as well as collaboration at the Local Authority/county level. For FY18, additional legislative funding was allocated to enhance and support Justice Reinvestment Initiative (JRI).

Prevention

Utah’s State substance use disorder prevention system is similar to the mental health and
substance use disorder treatment systems’ organization. DSAMH provides oversight, technical assistance and support to the Local Substance Abuse Authority (LSAA) prevention staff. DSAMH also collaborates with other state agencies on statewide prevention strategies, including underage drinking prevention, opioid overdose prevention and suicide prevention.

DSAMH does not provide direct service, instead training on evidence based strategies, coalition efforts, and data collection. DSAMH contracts with our LSAs to provide direct services to their communities. Of the 13 LSAs, three contract with subcontractors (Davis, Utah and Salt Lake Counties), while the other 10 provide the direct services themselves. All 13 LSAs contract with coalitions in their respective communities to aid in providing appropriate evidence based services. Coalitions receiving SABG funding must use an evidence based coalition model.

The strengths of Utah’s substance use disorder prevention system are many. Utah uses the Strategic Prevention Framework to identify and assess the needs of individuals in need of primary substance use disorder prevention. Utah also uses a State Epidemiological Outcomes Workgroup (SEOW) to assist with data analysis and prioritization of issues and communities. DSAMH supports local coalition efforts throughout the state through a competitive grant process, matching funds and statewide training opportunities.

Utah’s substance use disorder prevention system still has room for improvement. At the state level, the DSAMH could strengthen the collaboration with the Utah Department of Health, State Board of Education and other non-traditional partners including the Utah State Chamber of Commerce. At the local level, a need is the increased adoption of tested and effective prevention science.

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

The Utah Division of Substance Abuse and Mental Health is authorized under Utah State Code Annotated §62A-15-103 as the single state authority for mental health and substance abuse in Utah. Utah Statutes require that the State Division of Substance Abuse and Mental Health to: “... set policy for its operation and for programs funded with state and federal money...establish, by rule, minimum standards for local substance abuse authorities and local mental health authorities...develop program policies, standards, rules, and fee schedules for DSAMH... ”(Utah Code Title 62A, Chapter 15, Section 105 “Authority and Responsibilities”) and that 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...” (Utah Code 62A-15-103. “Division -- Creation – Responsibilities”).
DSAMH carries out its statutory obligations by contracting with Local Substance Abuse and Mental Health Authorities for the delivery of Behavioral Health services. The DSAMH distributes federal and state funds through contracts, (Counties are required to provide matching funds) and monitors compliance by the Local Authorities to ensure compliance with statutory mandates and contracted services. Contracting requirements, monitoring and oversight, rule writing, interagency coordination, and technical assistance are used to influence and guide systems of care. The DSAMH also provides leadership and coordination with other state agencies, the state legislature and advocacy groups.

Local Prevention is organized through the LSAA system, meaning the designated authority is responsible for completing the Strategic Prevention Framework at the community level. The LSAA is responsible to provide prevention services throughout the entire LSAA. Each LSAA has a Prevention Coordinator that coaches community coalitions and may provide or contract direct service of evidence based strategies within the LSAA. As noted, DSAMH distributes federal and state funds to the LSAA for prevention services. The LSAA and local coalitions work together to get through the SPF process for the communities. The LSAAs collaborate with tribal entities where possible. Through the coalition efforts, the LSAAs work with local health departments, hospitals, mental health facilities, schools and businesses.

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

**DSAMH Vision** -- Healthy Individuals, Families, and Communities

**DSAMH Mission** -- Promote Health, Hope, and Healing from Mental Illness and Substance Use Disorders

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

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

Strategic Initiative #1 – Prevention and Early Intervention, Strategic Initiative #2 – Zero Suicides, Strategic Initiative #3 – Promote Recovery, Strategic Initiative #4 – Improve Care for Children and Youth, Strategic Initiative #5 – Health System Integration

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

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

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

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

DSAMH has implemented all of the mandates of this legislation and has increased its efforts to improve the uniform use of evidence based practices within the public behavioral health network. Improvements have included the development of active justice implementation committees on the local levels, that bring all the community players in the justice correctional and treatment fields together, with a common cause to improve outcomes for persons who are justice involved and have a high risk of recidivism due to a substance use or mental health disorder. All local authorities are now conducting or obtaining criminogenic screens and assessments on all of their justice involved clients, and are incorporating criminogenic need goals into treatment plans. Also, DSAMH has increased workforce competency through statewide training opportunities in Moral Reconation Therapy (MRT), Motivational Interviewing (MI), Level of Service/Risk, Need Responsivity (LSI/RNR) assessments and American Society of Addiction Medicine (ASAM) Criteria. Another exciting piece to this legislation is that it also involves private provider programs that assess and treat justice involved individuals. All of the requirements and training opportunities placed on the public behavioral network have been offered and received by the private providers that are justice certified, which currently includes 214 site and represents 173 community based treatment agencies. Also, DSAMH has recently
reviewed its Administrative Rule R523-4 and has made significant changes to that rule. It is expected that by the end of September 2019, the proposed rule changes will be made effective. DSAMH has made these changes to reduce the amount of unnecessary cost to private and publicly funded providers and to more accurately reflect current certification and service provision expectations.

Trauma-Informed: Most individuals with mental health and substance use disorders are also dealing with trauma issues. DSAMH recognizes the prevalence of trauma and takes a universal precautions position. Trauma affects all individuals involved, including staff and the local workforce. DSAMH is working to ensure that all aspects of its system recognize the impact of trauma and make every effort to avoid re-traumatization, as well as working on statewide trauma-informed initiatives with Resilient Utah (a Sub-Committee of the Lieutenant Governor’s Intergenerational Poverty Committee) and community partners. DSAMH will continue in its efforts to promote the use of trauma-informed care and trauma specific services through training and technical assistance for the local authorities and community partners.

Evidence-based Practices: Utah’s publicly funded behavioral health system is committed to providing the best possible services to individuals, families and communities. DSAMH provides training and consultation designed to promote evidence based practices. Evidence-based stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence. Sustainable: Utah’s Publicly funded system must be sustainable over time and be organized to provide a stable level of services. Culturally and Linguistically Competent: DSAMH believes all aspects of behavioral health services should recognize and adapt to reflect the diversity of Utah’s individuals, families, and communities. Individuals possess diverse cultural, economic, social backgrounds, values, beliefs, sexual orientations, ethnicity, religion, and languages. To be effective, behavioral health services need be gender responsive, trauma-informed, culturally and linguistically competent.

**Sub State Organization:** Utah State Statute specifically mandates the Local Substance Abuse Authorities (LSAA) provide a “continuum of services for Adolescents and Adults” aimed at substance use disorders, prevention and treatment; and requires Local Mental Health Authorities (LMHA) to provide ten mandatory services. Thus, Utah’s Local Mental Health Authorities are given the responsibility to provide mental health services to their citizens. Utah utilizes CMHS and SAPT Block Grant funds, along with State General Funds, other State and Federal appropriations and the Counties’ 20% funding match to fulfill these requirements to provide for services required by federal and state statutes. State and federal funds are allocated to Local Authorities through a formula which takes into account the percent of the state's population residing within the county's boundaries and a rural differential. Each county is required to
provide at least a 20% match on all state general funds. The majority of general and county funds allocated for mental health services are used to meet Medicaid match requirements.

In the 2019 Legislative session Senate bill 96 was passed that put Utah’s Medicaid Expansion bill into Law. This new law expands Medicaid to parents and adults without dependent children earning up to 100% federal poverty level (approximately $12,490 annual income for an individual). Approximately 70,000 – 90,000 Utah residents will become newly eligible for Medicaid. Approximately 40,000 individuals from 101-138% FPL will continue to receive services through the federal Marketplace. Enrollment eligibility started April 1, 2019. The State will also submit a new 1115 Waiver to CMS called the Per Capita Cap Plan. This plan will replace the plan implemented on April 1, 2019 and will be effective upon CMS approval. The Per Capita Plan covers adults up to 100% FPL and requests the following provisions: self-sufficiency requirement, enrollment cap, up to 12-month continuous eligibility, employer-sponsored insurance enrollment, lockout for program violation provision, and a per capita cap. This plan will also request 90% federal/10% state funding.

DSAMH overall budget was cut by 10 million dollars in the expectation that medicaid expansion would become the majority payor for behavioral health services. A percentage of these cuts were taken fourth quarter of FY19 and the remainder took effect for FY20. Currently the enrollment numbers have not met the anticipated enrollment numbers and we are anticipating clients served in the public system will decline as the medicaid expansion allows an all willing provider network.

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

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

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

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>% of Population</th>
<th>% of Land</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River</td>
<td>5.83%</td>
<td>9.70%</td>
</tr>
<tr>
<td>Weber</td>
<td>8.50%</td>
<td>1.40%</td>
</tr>
<tr>
<td>Salt Lake</td>
<td>36.61%</td>
<td>0.90%</td>
</tr>
<tr>
<td>Davis</td>
<td>11.21%</td>
<td>0.40%</td>
</tr>
<tr>
<td>Tooele</td>
<td>2.17%</td>
<td>8.40%</td>
</tr>
<tr>
<td>Wasatch</td>
<td>1.04%</td>
<td>1.40%</td>
</tr>
<tr>
<td>Utah</td>
<td>19.55%</td>
<td>2.40%</td>
</tr>
<tr>
<td>Summit</td>
<td>1.33%</td>
<td>2.30%</td>
</tr>
<tr>
<td>Central</td>
<td>2.57%</td>
<td>20.30%</td>
</tr>
<tr>
<td>Southwest</td>
<td>7.60%</td>
<td>21.30%</td>
</tr>
<tr>
<td>Northeastern</td>
<td>1.81%</td>
<td>10.20%</td>
</tr>
<tr>
<td>Four Corners</td>
<td>1.29%</td>
<td>11.70%</td>
</tr>
<tr>
<td>San Juan</td>
<td>0.50%</td>
<td>9.50%</td>
</tr>
</tbody>
</table>

The Utah State Hospital provides statewide inpatient mental health services, is a 24-hour psychiatric facility located in Provo, Utah and is organized as a part of the 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 be actively experiencing symptoms of severe and persistent mental illness to qualify for services, and are placed through a civil commitment or forensic commitment. The State Hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and certified for Medicare/Medicaid reimbursement by the Center for Medicare & Medicaid Services.

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

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

The greatest challenges faced in providing mental health, substance use disorder treatment and prevention services for residents of Utah are due to the distribution of the population and the decentralized nature of the system. Utah is 84,900 square miles with urban, rural and frontier communities, and is
Currently one of the fastest growing states in the nation with population by 1.64% in 2019. [http://worldpopulationreview.com/states/utah-population/] estimates to exceed 3,652,547 by 2020. The 2018 US Census estimates Utah’s population to be 3,161,105 an increase of 14.4% increase since 2010.

Since, as stated above, by Statute and rule, the Counties/Local Authorities are responsible for planning and providing services for their residents, this widely varied geography and population presents significant challenges in this area. An example of the diverse nature of the challenges facing authorities can be seen by comparing the following:

Salt Lake County                   1 county              36.96% of the state’s population 0.9% of state’s area
Weber Human Services         2 counties,           8.5% of the state’s population, 1.4% of the state's area,
Central Utah Counseling,      6 counties,           2.58% of the state’s population 20.3% of state’s area.

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

Utah and the Local Substance Abuse Authorities target all groups for substance use prevention services. Using the Strategic Prevention Framework, the LSAAs use the data to identify needs and gaps, including disparities among racial and ethnic groups. The LSAAs also use the data to identify existing resources, and then work with community partners to ensure that all populations in need are receiving the prevention services that best suit their needs.

The LSAA work with their local prevention coalition to recruit or reach all populations in their communities. The strategies selected for each population are culturally appropriate for each community.

Given the diverse nature of the various Local Authorities, geographically, culturally, economically and organizationally, the specifics of planning for services is left to the Counties and their Local Authorities, and monitored closely by the DSAMH during its annual audits, area plan reviews and technical assistance visits. Each County is responsible for preparing and submitting their “Area Plan” to DSAMH for approval each year, and then the implementation of those plans is monitored throughout the year.
Women and women with dependent children: Utah has focused on women with dependent children for several years including providing appropriate levels of services to include a full continuum of care. Local Authorities have been working with community partners to provide a network of providers that can provide gender responsive, trauma-informed services, medical
care, behavioral health, family support and recovery support services for not only the women but for the entire family. See Table below - The Table outlines all Pregnant and Parenting Women’s service providers providing services throughout the state. Services are located in all 13 Local Authorities. The Local Authorities also provide education and referral services to any woman that identifies as pregnant in which they provide intermittent services such as education, counseling and referrals to medical/prenatal care or community resources.

<table>
<thead>
<tr>
<th>County</th>
<th>Intermediary/MCO/ASO Name, Address, Telephone Number (if applicable)</th>
<th>Provider Name, Address, Telephone Number</th>
<th>Type of Program (e.g. PPW for PPW indicate if they accept children), OTP, Residential, Outpatient, Detox, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cache County</td>
<td>Director - Brock Alder</td>
<td>Bear River Health Department - 90 East 200 South, Logan, Utah 84321; (435) 752-0700</td>
<td>PPW Outpatient - Accept Children</td>
</tr>
<tr>
<td>Cabon County</td>
<td>Director - Karen Dolen</td>
<td>Four Corners Behavioral Health - 105 West 100 North, Price, UT 84501</td>
<td>PPW Outpatient - Accept Children</td>
</tr>
<tr>
<td>Central Utah</td>
<td>Director - Brian Whipple</td>
<td>Central Utah Counseling - 152 North 400 West, Ephraim, Utah 84677-5549; (435) 462-2416</td>
<td>PPW Outpatient - Accept Children</td>
</tr>
<tr>
<td>Davis County</td>
<td>Director - Brandon Hatch</td>
<td>Davis Behavioral Health - 934 South Main, Layton, Utah 84041; (801) 544-0585</td>
<td>PPW Outpatient - Accept Children</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>Director - Tim Whalen</td>
<td>Salt Lake County Behavioral Health - 2001 South State, Suite S2300, Salt Lake City, Utah 84190-2250; (801) 263-7100</td>
<td>PPW - Outpatient and Women and Children's Residential - Accepts Children (W&amp;G Residential Contracts: House of Hope Salt Lake, Odyssey House of Utah &amp; Valley Phoenix)</td>
</tr>
<tr>
<td>San Juan</td>
<td>Director - Tammy Squires</td>
<td>San Juan Counseling - 365 South Main, Blanding, Utah 84511; (435) 678-2992</td>
<td>PPW - Outpatient - Accepts Children</td>
</tr>
<tr>
<td>Washington County</td>
<td>Director - Mike Deal</td>
<td>Southwest Behavioral Health - 474 West 200 North, St. George, Utah 84770; (435) 634-5600</td>
<td>PPW - Outpatient and Women and Children's Residential - PPW Residential - Desert Haven - Accepts Children. Men's Residential Treatment - Does not accept children.</td>
</tr>
<tr>
<td>Summit County</td>
<td>Director - Dodi Wilson</td>
<td>Summit Valley Behavioral Health - 1753 Sidewinder Drive, Park City, Utah 84060; (435) 575-1216</td>
<td>PPW - Outpatient - Accepts Children</td>
</tr>
<tr>
<td>Tooele County</td>
<td>Director - Rebecca Brown (Adult); Randy Dow (Children/Youth)</td>
<td>Tooele Valley Behavioral Health - 100 South 1000 West, Tooele, Utah 84074; (435) 843-3520</td>
<td>PPW - Outpatient - Accepts Children</td>
</tr>
<tr>
<td>Uintah Basin - Tri County</td>
<td>Director - Kyle Snow</td>
<td>Northeastern Counseling - 285 West 800 South, Roosevelt, Utah 84078; (435) 789-6300</td>
<td>PPW - Outpatient - Accepts Children</td>
</tr>
<tr>
<td>Utah County</td>
<td>Director - Richard Nance</td>
<td>Utah County Department of Alcohol Prevention and Treatment - 151 South University Avenue, Suite 3200, Provo, Utah 84606; (801) 851-7127</td>
<td>PPW - Outpatient and Women and Children's Residential - Accepts Children. PPW Residential - House of Hope Provo. PPW Intensive Outpatient - Promise North and South</td>
</tr>
<tr>
<td>Wasatch County</td>
<td>Director - Richard Hatch</td>
<td>Wasatch County Family Clinic - 55 South 500 East, Heber City, Utah 84032; (801) 654-3003</td>
<td>PPW - Outpatient - Accepts Children</td>
</tr>
<tr>
<td>Weber County</td>
<td>Director - Kevin Eastman</td>
<td>Weber Human Services - 237 26th Street, Ogden, Utah 84401; (801) 626-3700</td>
<td>PPW - Outpatient and Women and Children's Residential - PPW Residential - Tranquility Home - Accepts Children</td>
</tr>
</tbody>
</table>
The use of Family Resource Facilitators and Certified peer support specialist to promote behavioral health services and recovery for all priority populations.

IV users: Local Authorities and contractors are required to screen and identify Intravenous Drug Users. Identified individuals are prioritized and provided screenings and assessments meeting Block Grant requirements. Individuals meeting priority standards are referred into appropriate levels of care. If admittance into identified levels are care are not available intermittence services are provided as indicated in Block Grant requirements. Yearly site visits and coordination efforts with Local Authorities have increased access to services for IV users including access to walk in assessments and same day crisis services.

Local Authorities report there are no waiting list for treatment services and services are provided to priority populations as required these are reviewed during yearly monitoring site visits at each Local Authority.

Local Authorities have been encouraged to reach out to community partners such as FQHC’s and Medical Clinics to provide additional wrap around services and referral opportunities to individuals needing such services including pregnant women, IV users, HIV/HEP C/TB, etc. Each Local Authority have developed relationships with their Local Health Departments in order to provide health screenings and treatment referrals. Some of the Local Authorities have created medical clinics within their agency to address medical concerns for clients which have shown to increase client retention, quicker access to care and better communication between physical and behavioral health care.

The Division has also encouraged the use of MAT services for Opiate users including those identified as IV opiate users in which the Division Directives has included language to support the use of MAT.

Funds allocated by DSAMH shall not be expended by any agency which would deny any eligible client, patient or individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monoprotect formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine).
See Table below: Table outlines a list of OTP providers throughout the State that have agreements with Local Authorities to provide MAT services.

<table>
<thead>
<tr>
<th>County</th>
<th>Director</th>
<th>OTP Provider Details</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salt Lake</td>
<td>Director - Tim Whaler; 2001 South State, Suite 52300, Salt Lake City, Utah 84190; (385) 468-4727</td>
<td>Metamorphosis Salt Lake - 169 East 5900 South #101, Salt Lake City, Utah 84123; Director - Debra Drabner - (801) 631-4835; CEO Shannon Terwedo - (530) 320-9220</td>
<td>Opioid Treatment Provider Program, which has an MOU with Valley Phoenix Women and Children’s Residential to provide MAT. Outpatient and PW services.</td>
</tr>
<tr>
<td>Salt Lake</td>
<td>Director - Tim Whaler; 2001 South State, Suite 52300, Salt Lake City, Utah 84190; (385) 468-4727</td>
<td>Project Reality - Salt Lake; 150 East 700 South, Salt Lake City, Utah 84111; (801) 364-8980; Director Linda Moore (801) 558-8496</td>
<td>Opioid Treatment Provider Program, which has a contract with Salt Lake County Behavioral Health to provide MAT. Outpatient and PW services.</td>
</tr>
<tr>
<td>Salt Lake</td>
<td>Director - Tim Whaler; 2001 South State, Suite 52300, Salt Lake City, Utah 84190; (385) 468-4727</td>
<td>Project Reality - Murray; 5280 South Commerce Drive, Suite D110, Murray, Utah 84107; (385) 881-0170; Director Linda Moore (801) 558-8496</td>
<td>Opioid Treatment Provider Program, which has a contract with Salt Lake County Behavioral Health to provide MAT. Outpatient and PW services.</td>
</tr>
<tr>
<td>Utah</td>
<td>Director - Richard Nance</td>
<td>Project Reality - Provo; 151 South University Avenue, Suite 1400, Provo, Utah 84606; Director - Linda Moore (801) 558-8496</td>
<td>Opioid Treatment Provider Program, which has a contract with Utah County Division of Substance Abuse to provide MAT. General Outpatient including WW services.</td>
</tr>
<tr>
<td>Weber</td>
<td>Director - Richard Nance</td>
<td>Discovery House - Orem; 714 South State Street, Orem, Utah 84058. (801) 426-6565; Director - Daniel Hymas (208) 313-7333.</td>
<td>Opioid Treatment Provider Program, which has a contract with Utah County Division of Substance Abuse to provide MAT. General Outpatient including PW services.</td>
</tr>
<tr>
<td>Weber</td>
<td>Director - Kevin Eastman</td>
<td>Metamorphosis - Ogden; 2557 Lincoln Avenue, Ogden, Utah 84401, (801) 622-5272. Director - Raquel Dee (801) 510-4758. CEO - Shannon Terwedo - (530) 320-9220</td>
<td>Opioid Treatment Provider Program, which has a contract with Weber Human Services. Outpatient and PW services.</td>
</tr>
<tr>
<td>Weber</td>
<td>Director - Kevin Eastman</td>
<td>Discovery House - Layton</td>
<td>Opioid Treatment Provider Program, which has a contract with Weber Human Services. Outpatient and PW services.</td>
</tr>
<tr>
<td>Carbon</td>
<td>Director - Karen</td>
<td>Operation Recovery - Price - 77 South 600 East, Suite C, Price, Utah 84501; (435) 613-6289; Director - Linda Moore - (801) 558-8496</td>
<td>Opioid Treatment Provider Program, which has a contract with Weber Human Services. Outpatient and PW services.</td>
</tr>
</tbody>
</table>
Disaster Plan: Utah Opioid Treatment Providers
Updated 1/10/19

**Purpose:** Describe the basic elements of the Disaster Response Plan for Opioid Treatment Providers in case of a major earthquake or similar natural disaster.

**Assumptions:** The following assumptions of the worst case scenario are listed below. If conditions are less critical then plans can be modified.

1) A significant earthquake has struck the Wasatch Front causing major damage to roads, communications and services. These include:

   a) Major Freeways may be blocked or impassable including I-80 in Parley’s Canyon, I-15 at point of the mountain and North Salt Lake.
   b) Major gas lines have broken in numerous places.
   c) The oil refineries near I-15 at North Salt Lake have major damage and possible fires and explosions.
   d) Cell phone towers are damaged and cell phone communication is unavailable or unreliable due to demand.
   e) Damage to roads, power lines and trees has made many roads impassable and travel difficult to impossible.
   f) Numerous buildings, especially older buildings may be damaged or unsafe.
   g) Power and water service will be out for up to a week. Longer in some places.
   h) The Airport may suffer significant damage meaning limited air traffic will be allowed or available.
   i) There will be significant casualties and widespread damage to homes and businesses resulting in emergency, medical and law enforcement agencies being overwhelmed.
   j) Significant shortages of food, water and medication could develop in a relatively short period of time.
   k) Individuals will be focused on family safety and survival ahead of other needs.
   l) Physicians and Prescribers will be pulled to serve emergency medical needs.

2) The resulting impact on Opioid Treatment Programs is assumed to be significant and will include:

   a) Up to 50% of OTPs will be damaged significantly
   b) Up to 50% of staff will be unable, or unwilling to travel to their work place.
   c) Communication with staff will be significantly impaired if not impossible.
   d) The OTPs in Northern Utah could be separated by transportation disruptions into three general groups:
      i) Ogden, Layton and Bountiful (Metamorphosis-Ogden, DH-Layton and Colonial-Bountiful)
      ii) Provo and Orem (Project Reality-UC, DH-Orem and True North)
      iii) Salt Lake (Metamorphosis-SL, DH-SL, DH-TV, Project Reality-SL, D
   e) Resupply of Methadone will be difficult if not impossible for up to two weeks.
f) Some methadone stocks will be damaged or destroyed by the damage to the buildings or resultant aftershocks.
g) Some individual who are addicted or dependent on opiates will be unable to find their regular suppliers and will look for alternative sources, increasing the security issues around the clinics.
h) No Prescribers will be available for at least the first two to four days due to emergency medical needs. Other medical/nursing staff will only be available for limited periods.

3) Concept of OTP Response:

a) Given the likely shortage of staff and equipment, as well as damage to existing clinics, the director of each clinic or his/her designee will coordinate with the SOTA or Alternate SOTA who will coordinate the consolidation of resources available in order to provide safe secure dosing of clients.
b) Clinics will consolidate staff, equipment and medication as directed, and ensure that notification about dosing locations and times is posted at their original facility.
c) DSAMH will coordinate with other emergency services to ensure they are aware of planned dosing locations and can assist in disseminating that information. DSAMH will also work to provide increased security and, where possible, additional medical capabilities at those sites.
d) As staffing, power and other utilities, resupply of medication and other supplies become available, a decision about admitting new clients will be made.
e) As outside support and assistance becomes available, the combined dosing will be discontinued when appropriate.
f) Patients may not have full identification available to them.
g) Most patients will not have resources to pay clinic fees.

4) Communication Plan:

a) As soon as possible after the disaster occurs, the DHS will open its communication net. DSAMH will be part of that net.
b) DSAMH will open its net and contact the local authorities and the SOTA.
c) The SOTA will coordinate with the OTPs with communications capabilities and direct them to the appropriate channel for ongoing communication. All OTP’s have radio communication capability.
d) OTPs without access to radios will establish contact by whatever means is available with the nearest clinic, or its parent clinic with radio capability.

5) Responsibilities:

a) DSAMH:
   i) Ensure DSAMH Disaster staff members and alternates are aware of the OTP disaster plan.
   ii) Operate the OTP portion of the DSAMH net
   iii) Consolidate reports from OTPs, and coordinate selection of dosing sites.
iv) Coordinate with other agencies to provide security, medical, and other emergency support as available.

v) Coordinate with law enforcement, medical providers, and other emergency service agencies about dosing locations and times.

vi) Keep clinics informed of changes as they occur and coordinate special requests with other agencies until other communication systems are restored.

vii) Coordinate the exchange of patient dosing records to allow for dosing at the nearest dosing location.

b) Clinics

i) Maintain an off site list of clients that is updated at least weekly which contains as a minimum the following information. This should be maintained by the senior individual who is most likely to be able to travel in case of a disaster.
   1. Patient number;
   2. Patient address or other identifier;
   3. Dose;
   4. Last date dosed;
   5. One additional identifier to ensure positive ID.
   6. Number of take homes the patient is authorized.

ii) Maintain an updated contact list of Clinic Staff with an emergency call down capability.

iii) Maintain an updated inventory of available medication with at least a two week reserve at all times, preferably of powdered methadone.

iv) Where possible, have back up power available. If not, have contingency plans for operating without power.

v) At least once monthly, have doses poured manually to ensure medical staff members are trained in the proper procedures and appropriate equipment is available and operable as well as accurate.

vi) Develop internal plans to notify and inform patients of likely dosing plans in case of an emergency.

6) Procedures:

a) As soon as safely possible after the onset of a disaster, the SOTA and OTPs will establish communications and each clinic will provide the information outlined in Tab A.

b) If clinic facilities are significantly damaged; if dosing equipment is inoperable; or if there is no back up power available, then Clinics will report that immediately to the SOTA or SOTA designee.

c) As soon as enough information is collected the SOTA or SOTA designee will determine if consolidated dosing is required and coordinate the consolidation of staff and equipment at the designated sites. If at all possible, these will be geographically spread out to make travel to one of the sites feasible for most clients.

d) All Clinics will disseminate by any and all available means the location of dosing sites.

e) DSAMH will make that information available to emergency services and public announcements if appropriate.
f) Priority will be to provide doses on a daily basis for the first two days and clinics will serve as an information center to provide information about additional emergency services. Clinics will also funnel information about needed services to the DHS net through the SOTA.

g) No new clients will be processed until regular medical staff is available.

h) Initially, facility security will have to be provided by staff and volunteers. The SOTA will ensure law enforcement is aware of dosing sites and the need for security assistance.

i) Each Dosing site will prepare a daily report with the information in Tab B.

7) Dosing Procedures:
   a) Patients can be dosed at any location and are not restricted to dosing only at “their” clinic.
   b) Drug Testing and counseling requirements are suspended until conditions improve and normal clinic operations can be reestablished.
   c) Prepayment of Fees will be suspended /waived until security and safety conditions permit resumption of normal operations.
   d) At minimum, dosing sites will record the following information for each patient dosed:
      i) Parent Clinic
      ii) Patient ID
      iii) Date Dosed
      iv) Dose
      v) Any take homes dispensed
      vi) Special requests or circumstances
   e) Every attempt to positively identify the client will be used including staff and peer identification. When positive identification is not possible, the dosing site manager is encouraged to dose the client if at all possible.
   f) When dosing records aren’t available, the client’s statement on dosing level will be used.
   g) Until ongoing supplies of medication are assured, take home doses will only be issued in extraordinary cases.

8) Using the UTAH Central Registry in the event of a disaster

Each of the above tasks assigned to Clinics can be completed using the Utah Central Registry operated by LHSS. While we have implemented the Lighthouse Central Registry System to help with Dual Enrollment verification, the system also provides a web-based platform to aid Utah Substance Abuse Patients during disasters. With this system, Patients can leave their home clinic that has been forced to close and receive accurate dosages at another clinic. The LHSS system will log any doses such patients receive to eliminate duplicate dosages to these patients. Patients can locate open clinics by viewing the Utah map at thecentralregistry.com Clinics can post messages to patients directly on this portal. The LHSS system also has a system to notify patients in the event their home clinic is forced to close. After obtaining the consent of the
patient for the Registry to contact them in an emergency, each clinic can send a text or email message to each patient affected by the clinic closure.

In a disaster, staff is often unable to access their clinic electronic data via normal means. The LHSS system is built to operate on any web enabled device, and screens render on cell phones and tablets.

Messages to patients can provide different levels of information, depending on the nature of the disaster. In a major disaster, the state can also broadcast messages to all patients who consent to receiving these notices. Any broadcast message sent between two clinics within the state is done without revealing patient identifying information. Patient HIPAA rights are protected, and no patient is contacted without providing consent to be notified. Those patients that do not wish to be contacted can still utilize the patient portal to find key information.

**How to use the Lighthouse Central Registry emergency module:**

Access the registry from any web enabled device:

https://thecentralregistry.com/utcr

Training material for preparing for disasters and caring for patients is attached to this document.

1. Prepare for an emergency in advance. Each Clinic should review the attached emergency checklist to insure they are ready to meet patient needs during a disaster. Staff should be trained on using the emergency closure and communication modules within the LHSS system.

2. Keep information in the https://thecentralregistry.com/utcr up to date. Patient safety depends on maintaining accurate information about your clinic, your staff, and your patients.

3. Run trial tests to prepare for an emergency closure twice per year. Make sure staff understands what will happen when you use the emergency closure option, and when you use the emergency communication module. Remember if you test these processes with actual messages everyone must be made aware that this is simply a test.

4. Emergency communication. In the event you have notice of a major storm or other calamity that might close your clinic, you can send patients instructions in advance through the LHSS system. For example, you can advise your patients of alternate treatment sites, changed hours, or availability of special exceptions for medication. Only patients who have consented to being contacted by the LHSS registry will receive these messages. To verify which patients will receive messages, print out a list of patients who have provided consent and contact information, and this list should be reviewed monthly.
5. Emergency closure. In the event of a disaster, and you should use the Emergency Clinic closure option in the LHSS registry. The closure process will send text and email messages to your State Opioid Treatment Authority, SAMHSA staff, and other treatment centers within your state. If your patients have provided a written consent form, a cell phone number and/or email address, the Central Registry will send a Reverse 911 Emergency Closure notice to each consenting patient. We suggest you inform your patients of the Emergency Closure website before you have a reason to close your clinic.

6. Emergency Dosing. In the event a patient is displaced by a disaster, or is otherwise unable to reach their home clinic, the patient can locate operating clinics by viewing a map at this url: www.thecentralregistry.com. From this map patients can see the status and hours of nearby clinics throughout the state. When a patient presents at a new clinic the Utah Registry system will allow that patient to access their dose records. You must identify the patient using standard means such as government issued ID. The Utah Registry also includes a picture of each patient to aid in the identification. Obtain consent from the patient to consult the Utah registry, and then enter the patient identifying information into the emergency dosing fields. If the patient’s home clinic has maintained dose information, you will find the patient’s current dose. Please do not rely solely on this dose, as you must follow clinic protocols before issuing any medication to a patient.

7. Record any emergency doses provided to displaced patients within the Utah Registry. A report can be printed showing each patient and medication. The system will also notify the patient’s home clinic of any emergency dose provided. Should the patient attempt to obtain a second medication at another clinic, your recorded emergency dose will alert about potential overdose issues.
TAB A: Clinic Status Report

This report is to be submitted to the DSAMH SOTA as soon as possible after a disaster occurs/is declared and will be updated each day by 5:00 PM. If Clinics are combined into consolidated Dosing Site Locations, then one report will be submitted for each Dosing Site.

A. Clinic Name: ___________________  B. Individual Reporting: ___________________

C. Condition of Clinic: Fully functional_____ Damaged but functional_____ Unusable:_____

D. Remarks

E. Staff Available: Administrative/Leadership: ________________________________

F. Medical Staff

G. Clinical Staff

H. Support Staff

I. Other Staff
   (Security, Volunteers, etc)

J. Medication Supplies:
   (Number of Days supply on hand) __________________________________________

   Dosing Equipment functional? Y _____ N_____

J. Utilities Available:
   J1. Power Y _____ N_____

   J2. Water: Y _____ N_____

K. Other Services available: ________________________________________________

L. Remarks:
TAB B  Dosing Site Report

This report should be submitted to the SOTA by 5:00 PM each day.

A. Clinic Name: ___________________  B. Individual Reporting: ________________

C. Number of individuals Dosed ____________

D. Patient Numbers: (attach list)

E. Problems or Incidents:

F. Requests for support or supplies.

Satellite cards for laptops…
Disaster Preparation Check List

We suggest you do the following steps to be prepared for disaster or emergency events. Staff should follow these steps as routine training, especially at the beginning of any foul weather season or when you have advanced notice of an incoming weather event. We recommend that this checklist is reviewed and acted upon at least once every four months.

- Review your Site Information including address, phone, program director name, making sure that the program director’s email is correct. This option is found on the Clinic Admin menu => Site tab.
- Review the Employee report to make sure only appropriate staff are listed.
- Make sure employees have updated their contact information. Be sure cell phone and carrier information is correct. This option is found on the Utilities menu => Profile tab.
- Review employee security levels to ensure staff have access to the options they need.
- Review the Patient report to make sure the census in the Central Registry is correct and that it matches your clinic census.
- Review both versions of the Emergency Consent report options to see which patients have approved to be contacted by the Central Registry in the event of a closure and which patients have not. These options are found on the Reports menu => Emergency Consent option. For safety reasons, we encourage you to suggest to patients to allow the registry to contact them. You don’t want patients driving to the clinic if they can’t get medicated.
- Review the Emergency Consent reports to make sure patient’s cell phones, carriers and email addresses are correct. Use the HTML version if you want direct access to make corrections. Use the PDF version if you are going to print the report and make corrections later.
- Review Dosing Info report and spot check patient medications and dosages to make sure they are correct.
- Review the No Dosing report to make sure there are no patients missing medication info.
- Make sure staff are familiar with both the Emergency Messages to Patients and Emergency Closure screens. Review training materials to understand the differences between the two systems.
- Make sure you have printed blank Consent to Release information forms for displaced patients to sign when they arrive at your MAT facility.
- Make sure staff are trained on how to use the Emergency Dosing screens should patients present from another clinic.
- Make and / or display posters for patients with reminders about emergency messages they will receive from the Central Registry and tell them how to access the web address of the patient portal for instructions:  www.centralreg.us
Using the Emergency Clinic Closure System

⚠️ WARNING: Do not “test” this process. The closure process will send a text and/or email to SAMHSA, your State Opioid Treatment Authority, the Program Directors at all other treatment centers in your state, your registered clinic staff and all patients that have consented to be notified.

When to use the Emergency Clinic Closure System?

This process should only be used if you intend to close your treatment facility due to an emergency or disaster such that you will not be providing medication or dosing services to your patients. If your patients have provided a written consent form and a cell phone number or email address, the Central Registry will send a Reverse 911 Emergency Closure notice the moment you initiate an emergency closure.

How to use the Emergency Closure Screen:

**STEP 1:** Click on the Emergency Communications option of the main menu, then click on Emergency Clinic Closure:

![Emergency Communications Menu]

**STEP 2:** This will bring up a list of clinics that you have access to. Locate the clinic you want to report as closing and click the Process Closure button to the right of the appropriate clinic.
**STEP 3:** The only required field on the screen is the Estimated Close Date. If you know your clinic will be closed ahead of time, if is best to give your patients advanced notice.

Information entered in the Reason for Closure box will be sent to your SOTA and SAMHSA. Patients instructions should include exact instructions for your patients about where you want them to get dosed, or any specific information you want to share.

Be very clear about the reason for closure. This information is sent to SAMHSA and your SOTA to help plan an emergency response.

If you know when your clinic will re-open, add the estimated date to re-open.

Give as much detailed information to your patients as possible. This information should aid your patients about when, where and how to get dosed while your clinic is closed.

**STEP 4:** Click the Submit button to send the message.

⚠️ Be very clear about the reason for closure. This information is sent to SAMHSA and your SOTA to help plan an emergency response.

If you know when your clinic will re-open, add the estimated date to re-open.

Give as much detailed information to your patients as possible. This information should aid your patients about when, where and how to get dosed while your clinic is closed.

**STEP 4:** Click the Submit button to send the message.

There is a web-based portal where your patients can go to get more information about the closure as well as any instructions you provide in this closure process. The web address for the patient portal is [www.centralreg.us](http://www.centralreg.us). This website can be accessed using any device that can connect to the internet, including smart phones or tablets. We suggest you inform your patients of the Emergency Closure Information website before you have a reason to close your clinic, and as a part of your basic emergency preparation procedures.
Using the Emergency Messages to Patients System

⚠️ **WARNING: Do not send any patient identifying information with this system.**

When to use the Emergency Message to Patients System?

This process can create and send text and/or email messages to all your active patients that have provided a written consent form and a cell phone number or email address. Messages will only be sent to active patients in your facility. Messages can be about:

1. Warn patients about possible closures due to weather or other disasters
2. Ask patients to return to clinic to pick up emergency dosing
3. Notify patients about a change in your operating or dosing hours
4. Notify patients when clinic re-opens

How to use the Emergency Messages Screen:

**STEP 1:** Click on the Emergency Communications option of the main menu, then click on Emergency Messages to Patients

**STEP 2:** This will bring up a dashboard of any previously created Emergency Messages from your clinic. Click the New button to create a new message.
**STEP 3:** You will see a screen similar to the one below. Select your site, message type and message. Keep in mind that a text message can only be 131 characters long. A file can be uploaded (such as a map) but be sure that this file does not contain any patient identifying information.

![Emergency Messages to Patients](image)

To be HIPAA Compliant, you must:
1. Maintain accurate email and phone information so as to not inadvertently disclose information.
2. Do NOT include any information in the message field that has patient identifying information in it. NO PATIENT NAMES!
3. Do NOT upload/attach any document that has patient identifying information in it.

Once you click Submit - do NOT close this screen. You will be returned to the dashboard once the messages are sent. It can take up to several minutes.

---

**DO NOT CLOSE THIS SCREEN – IT WILL AUTOMATICALLY RETURN TO THE DASHBOARD ONCE THE MESSAGE IS SENT. THIS CAN TAKE SEVERAL MINUTES.**

**STEP 4:** Click the Submit button to send the message.

Once a message has been sent, there is no option to edit or delete the message. If your staff abuses this tool, their access to it will be removed. All inappropriate messages are subject to review and sanctions by your State Opioid Treatment Authority.
Planning Steps

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

Narrative Question:
This step should identify the unmet service needs and critical gaps in the state’s current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state’s M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state’s priorities and goals. 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 sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD 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 M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

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

Footnotes:
PLANNING STEP 2: Identifying the unmet Service Needs and Gaps

Some Specific challenges faced by Utah include:

- Utah is home to 8 federally recognized American Indian Tribes including the Northern Ute, Navajo, Paiute, Goshute, Northwestern Band of Shoshone, San Juan Southern Paiute, Skull Valley Band of Goshute and White Mesa Band of the Ute Mountain.
- Our state is growing increasingly diverse in culture: minority populations have increased from 2% to 8.9% of the total population during the past decade, and Utah’s Hispanic population continues to be the fastest growing community in the state.
- Compared to national averages, our population is younger and lives longer, has a higher birth rate, and currently Utah averages the highest number of persons per household (3.62 for Utah versus 2.64 nationally).
- Utah has the 4th highest growth rate in the nation.
- Utah is currently the nation’s fastest growing state over the past year, growing by 1.64% in 2019. [http://worldpopulationreview.com/states/utah-population/](http://worldpopulationreview.com/states/utah-population/).
- The US Census estimates Utah’s population to be 3,161,105 million a 14.4% increase from 2010 (2,763,885).
- Salt Lake City is estimated to contain 80% of the State’s population making it densely populated and leaving other areas of the state rural or uninhabited.
- Utah has 29.5% of the population under the age of 18 compared to 22.8% nationally.
- Overall poverty rate in the State of Utah is 9.7%
- The native population accounts for 29.71% below the poverty level.
- By legislative intent, with the exception of the Utah State Hospital, no substance abuse or community mental health center is operated by the State; the state does not provide clinical care.
- Native American populations reside in various reservations across the state, with the bulk living in the Northeastern and Southeastern regions of the state; Federal, State, County and Native American jurisdictions are all involved in providing services.
  - Both of these areas are relatively remote with poor transportation and sparse populations, which further stretch the state’s resources.
  - The direct planning and provision of services is the responsibility of the Local Authorities in those areas, and the provision of services to Native American populations is a part of the annual contract review and audit.
  - Success in negotiating service agreements and coordinating services is often an issue of local politics and personalities.
  - Utah’s Department of Human Services has developed an inter-tribal council and signed a coordination/collaboration agreement with the various Native American tribal representatives supporting the need for planning and coordination at a state level.
  - DSAMH attends the council meetings and has presented at several, and continues to work with the council on common issues.
  - Participation in the frontier areas of the state. In some counties, the drive is approximately 1.5 hours to attend a parenting class or an indicated program. Three hours of driving for 1 hour of service is disheartening and discourages people from attending. LSAAs are looking at unique ways to serve the frontier.
areas, but other barriers are coming to light. One suggestion was to provide an online course. With some areas, the service must be available on a mobile device because few people have computers in the home (in frontier areas). These communities often have some of the highest rates of suicide and substance use disorder.

Access to MAT services has shown to be limited in some regions. Utah is an expansive state and some Rural locations do not have prescribers available to provide MAT. Some areas have began services through Telehealth but services still have limited availability.

DSAMH has collected a list of MAT (Buprenorphine) prescribers across the State and although the list indicates there are plentiful amounts of prescribers in the State we have licensed prescribers that choose not to prescribe or limit the number of individuals they will treat. DSAMH has identified this as an access issue and has been working with Local Authorities and other community partners to identify the reasons for these practices. Our goals is to educate prescribers and offer support in order for them to be open to providing services.

DSAMH has been working with Local Authorities and their community partners in providing educational opportunities and efforts towards use of MAT and FDA guidelines, and will continue to offer efforts to support the use of MAT by reaching out to identified prescribers and providing education and support. Local Authorities will be encouraged to reach out to their community partners in an effort to expand services as well as work outside their regular community network to find alternative ways of providing MAT to their clients.

There is a lack of information and surveillance in regards to the number of individuals who use substances intravenously. It can therefore be assumed that this is another gap in treatment throughout the state of Utah. While we have service numbers for individuals who are in treatment who have been using intravenously, but no identified ways to see how this compares to the general population and the needs of those who are not currently being served in the public systems. DSAMH will continue to work on ways to identify those who use substances intravenously in order to expand services. Some ways to do this are by partnering with the Health Department and their medically focused programs who serve individuals who also use substances intravenously to share data and referrals (some programs could include syringe exchange, HIV and Hep C treatment programs and infectious disease outreach teams). DSAMH will be working with the Department of Health in FY20 in expanding communicable disease testing within our Local Authority agencies to provide direct testing and provide education and resources as needed in order to address this gap.

DSAMH has worked for years to obtain funds for residential services for women with dependent children. With research supporting the practice to keep children with their mother DSAMH is working to provide support for these services. In the FY18 and FY19, DSAMH and Women’s Treatment Providers were able to secure 1 Million Dollars in ongoing State General Funds to help sustain the two of the larger Women and Children’s Residential Treatment Programs in Salt Lake County which were at risk for closure, but is in need of additional funding to support other Women and Children’s treatment programs. In addition, DSAMH and the Utah Division of Child and Family Services (DCFS) have worked together to provide ongoing IV-E entitlement funding through the Family First Prevention Services Act (FFPSA) to the six Women and
Children’s Residential Treatment Programs in Utah to pay for the children’s room and board, which Medicaid does not cover. DSAMH also provides ongoing State General Formula Funds to the thirteen Local Authority Substance Use Disorder Providers for pregnant and parenting women to provide gender responsive and trauma-informed services for pregnant and parenting women. Medicaid also helps cover services for women and their children who are eligible for this coverage. Through these efforts, women and their children receive a full continuum of individualized services in Utah.

With the lack of access to residential treatment services across the state, DSAMH will be working on a collaborative effort with some Local Authorities to identify areas with the most need and ability to create a cross county Residential program in an effort to meet everyone’s needs but also share in the cost of supporting the program. We will also be encouraging the contracting with private treatment agencies for better access to services and also the use of agreements with other Local Authorities with better access for the use of their treatment service network. DSAMH is currently working to implement a bed referral platform that will allow tracking and monitoring of Residential beds in an effort to provide better referrals into available Residential treatment services and reduce barriers.

The numbers of youth referred into mental health treatment, substance use disorder (SUD) treatment, and SUD early intervention programs have decreased steadily over the past 7 years. The decreases in youth served are inconsistent with the epidemiological data showing the need for treatment among Utah youth. SHARP data from 2017 identify 4%, or 12,314 youth, are in need of alcohol and drug treatment, with 1,517 receiving SUD and co-occurring treatment services through local authority providers.

One problem that has been identified is Utah lacks a uniform data set to evaluate youth treatment admissions. The data DSAMH gathers represents youth treatment provided through the county local authority system. No entity collects data from private treatment programs, nor physical healthcare providers who may be treating substance use disorders. Even within the Department of Human Services (DHS), comparing data is difficult. DSAMH can match client data with the Division of Child and Family Services (DCFS) and Juvenile Justice Services (JJS). However, standards and definitions and data collection among the three agencies varies considerably. Efforts to standardize data collection and documentation by all providers, at least regarding admittance and discharge data would help DHS understand what services youth are receiving.

Another access issues comes in the form of lack of referrals from physical health professionals. The State has identified that Physicians, seen as one of the first to identify or make contact with individuals with substance use disorders, are uneducated regarding SUD treatment services which leads to a lack of addressing the SUD issue while the patient is being seen. DSAMH has placed emphasis on providing SBIRT training to physical health providers and has also taken steps to contract with a platform provider that will allow Physical Health providers to search available treatment slots. DSAMH is currently working with Juvare and the State Health Department to pilot the project that will allow monitoring and tracking of State hospital beds for individuals with SMI. We hope to expand this project and are able to track all available treatment services across the public and those willing to participate in the private sector as well. This effort is to empower Physical Health and other community providers in knowing what
services are available when they come across someone that identifies as needing services. We would like to target prenatal care providers as an effort to reach pregnant women with SUD.

Recovery Support Services have been widely provided across our state for several years but with limited funding available. Starting in FY20 DSAMH has made an effort to open up other federal and state funding options to help support and fund recovery support services. Although this funding is available it may be difficult with our current medicaid expansion and state funding cuts to gage what funding will be used for recovery support services. One of the biggest needs in our State is appropriate housing. There is currently a housing crisis and Utah lacks the ability to provide appropriate housing across the State. We have opened up eligible funding to support clients with their need for Licensed Recovery Residences across the state and to focus efforts on the lack of housing options for this population. Licensed Recovery Residence, however, is a huge need in our State and an important factor to ones Recovery. Utah currently has 98 licensed Recovery Residence spanned across the state which is not enough to meet the need for individuals seeking a safe sober living environment. DSAMH has been working with the State Office of Licensing to identify appropriate Licensed Recovery Residence as well as identifying those that are not operating within our guidelines and work to get the facilities in compliance. Local Authorities will continue to be encouraged to contract with Licensed Recovery Residence in an effort to improve housing needs. DSAMH will also put efforts forth that will identify other housing providers and encourage them to become Licensed Recovery Residence that can then contact with Local Authorities.

In the 2019 Legislative session Senate bill 96 was passed that put Utah’s Medicaid Expansion bill into Law. This new law expands Medicaid to parents and adults without dependent children earning up to 100% federal poverty level (approximately $12,490 annual income for an individual). Approximately 70,000 – 90,000 Utah residents will become newly eligible for Medicaid. Approximately 40,000 individuals from 101-138% FPL will continue to receive services through the federal Marketplace. Enrollment eligibility started April 1, 2019. The State will also submit a new 1115 Waiver to CMS called the Per Capita Cap Plan. This plan will replace the plan implemented on April 1, 2019 and will be effective upon CMS approval. The Per Capita Plan covers adults up to 100% FPL and requests the following provisions: self-sufficiency requirement, enrollment cap, up to 12-month continuous eligibility, employer-sponsored insurance enrollment, lockout for program violation provision, and a per capita cap. This plan will also request 90% federal/10% state funding.

DSAMH overall budget was cut by 10 million dollars in the expectation that medicaid expansion would become the majority payor for behavioral health services. A percentage of these cuts were taken fourth quarter of FY19 and the remainder took effect for FY20. We currently have not seen the enrollment as expected and are not truly aware of what our behavioral health system will look like during these changes for client data or for funding.

For unmet primary prevention service needs, the system is struggling with identifying shared risk factors between both mental illness and substance use disorder. Research has told us that the two have shared risk factors. But at the community level, being able to identify those risk factors has been difficult. In part, there is a barrier in combining the two outcomes. We have directed that
our communities focus on substance use related outcomes, but when they are experiencing an outbreak of negative outcomes from mental illness, the communities struggle to focus on the risk factors.

The 2018 US Census estimates Utah’s population to be 6,161,105 at a growth rate of 1.64%

- The Utah Department of Health reports 22% of Utah’s adult population suffers from chronic health conditions, and has continuously found statistical information concurrent with national research indicating a high rate of co-occurring chronic physical illness and mental illness in Utah’s adult population (Source: Utah Department of Health, CDC Behavioral Risk Factor Surveillance System Report).
- Utah’s adults with mental illness are at greater risk of chronic health conditions, just as those with chronic health conditions are at increased risk of mental illness. (Source: Utah Department of Health, CDC Behavioral Risk Factor Surveillance System Report).
- Through growing partnership with the Utah Department of Health, DSAMH of Substance Abuse and Mental Health is working to analyze the need and capacity for programming and create integrated solutions to support this population.
- Of twenty rural hospitals in 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. In 2016 the Utah Community Health Needs Assessment reported a lack of mental health services largely due to lack of insurance coverage.
- Economic Factors
  - Compared to National data, Utah has a higher median household income, but a significantly lower per capita income, a function of the high birthrate and lower median age.
  - Individuals and families living in rural Utah are more likely to experience more dire risk factors due to economic limitations and the geographic challenges that cause limited access to resources, services and opportunities.
    - According to the USDA Economic Research Service, the average per-capita income for Utahns in 2017 was $43,459 with 9.7% of the population living in poverty. Source: https://data.ers.usda.gov/reports.aspx?StateFIPS=49&StateName=Utah&ID=17854
    - Rural Utah per-capita income in 2017, was $44,910
  - 2017 estimates indicate a poverty rate of 12.2% exists in rural Utah, compared to a 9.4% level in urban areas of the state.
  - USDA data from 2013-2017, reports that 9.6% of the rural population has not completed high school, compared to 8.1% of urban populations.
  - As of 2018, the unemployment rate in rural Utah is at 3.9%, while in urban Utah it is at 3.0% (https://data.ers.usda.gov).
- Tobacco Use
  - Although a relatively low number of adults use tobacco in Utah (9.0% compared to the national average of 16.9%),
  - 44.3 percent of all cigarettes in America are consumed by individuals who live with mental illness and/or substance abuse disorders. Source The Journal of the American Medical Association
70.6% of individuals admitted for SUD Services use tobacco (TEDS Data, 2018).

In Utah, smoking claims the lives of more than 1,150 adults each year. We know smoking exacerbates or causes nearly every chronic condition and contributes to Utah's primary causes of death including heart disease, respiratory disease, and cancer, especially in the disparate population of adults with serious mental illness.

Nationally, people with mental illness die 25 years earlier on average than the general population, largely due to conditions caused or worsened by smoking. (Source: National Association of State Mental Health Program Directors)

In Utah, adults with serious mental illness die 27 years earlier on average than the general population... at age 47.

**Suicide**

- The Utah suicide rate in 2017 was 22.7 per 100,000 population ages 10 and over. Utah has the 5th highest suicide rate in the United States. Suicide was the 7th-leading cause of death in Utah and is the leading cause of injury related death.
- Utahs suicide rate has been increasing annually for over a decade and preliminary data indicates a leveling off of the increase for 2017-2018.
- There were 660 suicide deaths in 2018 (Crude Rate: 25.0*)
  - Male: 77% (Crude Rate: 38.6; F:11.3)
  - Average Age of Men: 39
  - Average Age of Women: 41
  - 93% White
  - Rates are similar for Native Americans and White
- Use of a firearm was the most common method of suicide death for Utahns followed by suffocation and then poisoning.
- Suicide rates are higher among males in every age group.
- 1 in 15 adults report considering suicide in a given year according to the National Survey on Drug Use and Health.
- In 2013, suicide surpassed unintentional injuries to become the leading cause of death among youth ages 10–19 in Utah. Between 2011-2015 an average, 46 youth (10-19) in Utah died from suicide. The youth suicide rate in Utah is consistently higher than the U.S. rate, and has been increasing for nearly a decade. Preliminary data suggests the youth suicide rate is also leveling off for 2017-2018.
- According to the 2017 YRBS, 16% of youth grades 6-12 report considering suicide and 7.1% of Utah youth grades 6-12 students attempted suicide one or more times.

**Whole Health and Resiliency** (Source: The 2009 Utah Disease/Risk Factor Integration Matrix),

- Utahns who have serious mental illness also have rates of arthritis, asthma, and hypertension that are significantly higher than the general population.
Adults with serious mental illness in Utah have excessively high rates of poor nutrition, smoking, obesity, and over 66% of this population does not engage in regular physical activity.

In 2005, Utah published its Wellness Directive which requires public behavioral health care 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.

According to the Utah State Health Department, Utah’s base line, set in SFY 1991 and 1992, expenditures for tuberculosis services for individuals in substance use disorder treatment is $12,760 and in SFY 2014 the State expended $35,726 annually. Utah’s local substance abuse authorities are required to conduct tuberculosis testing within their agencies and refer positively screened clients to appropriate health care services for further testing and treatment.

Unmet Treatment Needs.

As mentioned previously, In the 2019 Legislative session Senate bill 96 was passed that put Utah’s Medicaid Expansion bill into Law. This new law expands Medicaid to parents and adults without dependent children earning up to 100% federal poverty level (approximately $12,490 annual income for an individual). Approximately 70,000 – 90,000 Utah residents will become newly eligible for Medicaid. Approximately 40,000 individuals from 101-138% FPL will continue to receive services through the federal Marketplace. It is based upon CMS approval.

DSAMH overall budget was cut by 10 million dollars in the expectation that medicaid expansion would become the majority payor for behavioral health services. A percentage of these cuts were taken in the fourth quarter of FY19 and the remainder took effect for FY20. We currently have not seen the medicaid enrollment as expected and are not truly aware of what our behavioral health system will look like during these changes for client data or for funding.

As a result, only 46.6% of individuals with past year illicit drug use received SUD treatment services, and 41.8% of individuals with Alcohol Dependence of Abuse received treatment. However, we expect these numbers to change with medicaid expansion. More individuals will have access to behavioral health benefits but there may be less that choose to receive those services in the public service network. (https://store.samhsa.gov/system/files/sma17-barous-16-ut.pdf)

Due to the availability of Medicaid for individuals with serious mental illness, 43.6 % of individuals with any mental illness received services. (https://store.samhsa.gov/system/files/sma17-barous-16-ut.pdf)

Location of Treatment Services. A significant issue for much of Utah’s Local Authorities is the difficulty in providing a complete continuum of ASAM level services due to the Frontier nature of much of the state. Over 75% of the state’s population is concentrated...
in five local authorities comprising six counties and only 5.1% of the state’s geographical area. This makes providing residential services extremely problematical and providing intensive services almost equally as challenging. This has led to focusing scant resources to provide a broader continuum of care on the priority populations of IV using Pregnant women, pregnant women with dependent children and women with dependent children.

Utah's State Epidemiological Outcomes Workgroup (SEOW) meets bimonthly to review and discuss the available data sets. The following agencies and organizations participate regularly on the SEOW: Utah State Board of Education, Utah Department of Health, Utah Poison Control Center, Division of Child and Family Services, Juvenile Justice Services, University of Utah Family Medicine, Utah Department of Public Safety, National Alliance for Mental Illness, Local Substance Abuse Authorities (Rural and Urban representatives), Bach Harrison, and DSAMH of Substance Abuse and Mental Health - representatives from mental illness prevention, Substance Use prevention and treatment, and data analysis team.

The SEOW has been integral in identifying statewide priorities for SUD and Mental Health related issues. The SEOW had access to vital statistics, injury and death data related to substance use and mental health, treatment needs, consumption data for youth and adults, risk factor data and archival data sets (ex. Juvenile Justice, Child and Family Services). The SEOW reviewed the following available datasets: Student Health and Risk Prevention survey, death related to substance use, suicide rates, injury data from hospital reports related to suicide, injury data from hospital reports related to substance use (DAWN), overdose and unintentional death data (Medical examiner’s office, IBIS), treatment needs and admission data collected through the public system, and measures related to substance use and mental health collected through the Behavioral Risk Factor Surveillance System, such as prescription drug use and mental health needs.

The SEOW then weighed the external factors (such as magnitude, time to issue, years of life loss), and ultimately identified Suicide, Prescription Drug abuse, and Underage Drinking as high priorities. Additionally, the use of Electronic Cigarettes and marijuana use have been identified as trending issues for the state. The SEOW continues to provide support to MH and SUD. The SEOW reviewed the mental health datasets, including death by suicide, major depressive episodes, Adverse childhood Experiences, and treatment data. SEOW works with the Mental Health Team and their contractor to identify needs and critical issues. Substance Use Disorder Treatment works with the SEOW to identify areas of high need throughout the state. The SEOW is used to assist the state in planning and allocating resources for both treatment and prevention. It is made widely available to all state and local governmental agencies as private organizations and individuals.

The strengths of the primary prevention service system in Utah is that the Local Substance Abuse Authority (LSAA) system reaches the entire state. There are coordinators and coalitions in each of the LSAAAs. The coordinators and DSAMH collaborate with state level initiatives. Then the LSAAAs execute the Strategic Prevention Framework locally to identify and implement appropriate strategies for their communities.
The prevention system in Utah is one of the most effective. With that said, there are still challenges and barriers. While the LSAAs have all completed an assessment, some areas struggle with producing a full comprehensive strategic plan (outlining the full Strategic Prevention Framework process used in their communities). We continue to provide ongoing technical assistance on strategic planning. In Rural areas there are barriers due to travel to services. There are some rural offices, but with a portion of Utah's landscape considered "frontier", some areas are more remote. This issue impacts some of the most at need communities. The DSAMH will assist in resolving these gaps and needs by utilizing Regional Directors that provide additional technical assistance to LSAAs. The RDs are responsible for specific LSAAs and have developed action plans to support the unique needs of that LSA.

Workforce development is another need and gap throughout our state. This is true for our whole network from urban, rural and frontier. Newly hired staff tend to stay for a shorter period of time before they move on. With medicaid expansion being an all willing provider we are aware that private providers may be looking to expand their agencies and be looking to higher more trained clinical staff which may lead to more demands for additional qualified behavioral health professionals. DSAMH is working with a Quality Care Workgroup that is looking at ways to collaborate with the local Universities to provide better EBP and additional exposure to Substance Use and Mental Health practices to encourage and grow the workforce.
Planning Steps

Quality and Data Collection Readiness

Narrative Question:
Health surveillance is critical to SAMHSA’s ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA’s NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable. SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

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

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data. The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

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

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA’s state, provider, and practitioner partners. SAMHSA anticipates this movement is consistent with the current state authorities’ movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

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

1. Briefly describe the state’s data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state’s current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures? Please indicate areas of technical assistance needed related to this section.
Utah Department of Human Services Division of Substance Abuse and Mental Health (DSAMH) Comprehensive Emergency Management Plan

August 16, 2017

Section I - Base Plan
August 16, 2017

The Division of Substance Abuse and Mental Health is committed to protect individuals being served by the Utah Public Mental Health and Substance Use Local Authorities, Utah State Hospital and our staff. To that end, I strongly support the Comprehensive Emergency Management Plan (CEMP). This Plan addresses the challenges and responsibilities of pre-event mitigation and post-event recovery in addition to preparedness and response. It is established under and is in accordance with state, federal and presidential laws, statutes and authorities for Emergency Management. The National Incident Management System (NIMS) and Incident Command System (ICS) are incorporated into this plan and will be implemented in the event of an emergency.

The purpose of this plan is to provide the framework for an effective system of comprehensive emergency management utilizing an all-hazards approach, it clarifies the following strategies:

1. Reduce the vulnerability of people and facilities;
2. Prepare for prompt and efficient response and recovery;
3. Respond to emergencies using all systems plans and resources available;
4. Recover from emergencies by providing for the rapid and orderly start of operations
5. Provide an emergency management system embodying all aspects of pre-emergency preparedness and mitigation, as well as post emergency response and recovery.

With the knowledge that the most timely and appropriate response can best occur when a well-documented plan has been implemented and integrated throughout the Division, it is my expectation that all staff of the Division will use this document as a guide and will develop their own site specific plans to effectively organize, coordinate, and direct available resources toward emergency response and recovery. Personnel and programs assigned specific emergency responsibilities must have a working knowledge of functions and actions to be prepared to act in accordance with a plan when emergencies occur.

The CEMP is designed to help Division employees respond appropriately when emergency conditions exist although these situations are unpredictable, this plan allows for an immediate response by Division employees, thereby minimizing danger to those we serve, our staff and our facilities. Every employee of the Division of Substance Abuse and Mental Health should understand his or her role in emergency situations. I urge you to review this plan and support your colleagues to protect our youths, staff, and visitors in the event of an emergency.

Sincerely,

Doug Thomas, Director
Utah Division of Substance Abuse and Mental Health
<table>
<thead>
<tr>
<th>Change Number</th>
<th>Section of EOP</th>
<th>Date of Change</th>
<th>Individual Making Change</th>
<th>Description of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Entire Plan</td>
<td>August 16, 2017</td>
<td>Robert H. Snarr &amp; Tyson Walker</td>
<td>Plan update</td>
</tr>
</tbody>
</table>
### 3. Record of Distribution

<table>
<thead>
<tr>
<th>Facility</th>
<th>Address</th>
<th>Phone Number</th>
<th>Contact Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary: MASOB</td>
<td>195 N. 1950 W., SWLC, UT</td>
<td>801-538-3939</td>
<td>Robert Snarr/Doug Thomas</td>
</tr>
<tr>
<td>Secondary: Utah State Hospital</td>
<td>1300 E Center St, Provo, UT</td>
<td>801-344-4400</td>
<td>Dallas Earnshaw</td>
</tr>
<tr>
<td>Tertiary: Local Authorities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bear River Mental Health</td>
<td>90 East 200 North Logan, Utah 84321</td>
<td>435-734-9449</td>
<td>Reed Ernstrom</td>
</tr>
<tr>
<td>Bear River Substance Abuse</td>
<td>655 East 1300 North, Logan, Utah 84321</td>
<td>435-881-0358</td>
<td>Brock Alder</td>
</tr>
<tr>
<td>Central Utah Counseling Services</td>
<td>152 North 400 West, Ephraim, Utah 84321</td>
<td>435-283-8400</td>
<td>Brian Whipple</td>
</tr>
<tr>
<td>Davis Behavioral Health</td>
<td>934 South Main, Layton, Utah</td>
<td>801-773-7060</td>
<td>Brandon Hatch</td>
</tr>
<tr>
<td>Four Corners Community Behavioral Health</td>
<td>575 E 100 S Price, UT</td>
<td>435-637-2358</td>
<td>Karen Dolan</td>
</tr>
<tr>
<td>Northeastern Counseling Center</td>
<td>285 West 800 South, Roosevelt, Utah</td>
<td>435-725-6300</td>
<td>Kyle Snow</td>
</tr>
<tr>
<td>Salt Lake County Behavioral Health Services</td>
<td>2001 South State, Suite S2300, Salt Lake City, Utah</td>
<td>801-468-2009</td>
<td>Tim Whalen</td>
</tr>
<tr>
<td>San Juan Counseling</td>
<td>356 South Main, Blanding, Utah</td>
<td>435-678-2992</td>
<td>Tammy Squires</td>
</tr>
<tr>
<td>Southwest Behavioral Health Center</td>
<td>474 West 200 North, St. George, Utah</td>
<td>435-634-5600</td>
<td>Mike Deal</td>
</tr>
<tr>
<td>Valley Behavioral</td>
<td>1753 Sidewinder</td>
<td>435-649-8347</td>
<td>Gary Larcenaire</td>
</tr>
</tbody>
</table>
B. **Purpose, Scope, Overview, and Assumptions**

1. **Purpose**
The purpose of this plan is to ensure that the Utah Division of Substance Abuse and Mental Health’s critical functions can continue to be carried out during an emergency, and to define the actions and roles necessary for an effective and coordinated emergency response. The basic plan provides guidance before, during, and after an emergency. The plan takes a systematic approach to addressing all hazards through emergency management and planning for mitigation/prevention, preparedness, response, and recovery efforts.

2. **Scope**
This plan applies to the Utah Division of Substance Abuse and Mental Health within the Geographical boundary of the State of Utah. Specific plans for each facility will be added to this plan as appendices.

3. **Situation Overview**

**Characteristics**
The Utah Division of Substance Abuse and Mental Health facility currently offices 41 employees. These facilities consists of one main building, with a few employees working out of local community provider offices. All facilities have parking areas.
Demographics
Following is a breakdown of the number of employees in the Utah Division of Substance Abuse and Mental Health:

Program Management/Leadership: 25
Support: 16

During normal operations, DSAMH operates as an administrative/oversight organization that does not provide direct services to clients. DSAMH contracts with 15 Local Substance Abuse and Mental Health Authorities who provide individualized emergency plans for their areas.

A complete list of Demographics by Facility is listed in Appendix A (See Appendices for Local Authority Emergency Plans)

Goals and Objectives
The purpose of this plan is to provide the framework for an effective system of comprehensive emergency management, utilizing an all-hazards approach. It clarifies the following strategies:

1. Reduce the vulnerability of people and facilities;
2. Prepare for prompt and efficient response and recovery;
3. Respond to emergencies using all systems, plans, and resources available;
4. Recover from emergencies by providing for the rapid and orderly start of rehabilitation; and
5. Provide an emergency management system embodying all aspects of pre-emergency preparedness and mitigation, as well as post-emergency response and recovery.

Hazard Profile
The Department of Human Services and the Division of Substance Abuse and Mental Health partner with the Utah Division of Emergency Management, coordinating and collaborating on emergency planning efforts utilizing a top-down approach. A Threat and Hazard Identification and Risk Assessment (THIRA) was completed by the Utah Division of Emergency Management and determines that Utah Division of Substance Abuse and Mental Health facilities are at risk of experiencing disruptions in day-to-day operations as a result of the following emergencies: earthquake, flood, wildfire, pandemic-human, solar flares, terrorist attacks, and cyber-attacks. In addition to the Utah Division of Emergency Management’s THIRA, we have also identified HAZMAT spills/releases, aircraft accidents, blizzards, and extreme heat/cold weather as potential incidents that the Division of Substance Abuse and Mental Health may face including when a person with a history or current diagnosis of serious mental illness is involved in a high-profile, tragic incident. Often, incomplete and/or inaccurate information quickly spreads not only about the incident, but also about the likelihood of violence among individuals with mental illnesses. This is often fueled by community members’ mistaken assumptions that mental health treatment is ineffective and that most people with mental illnesses are violent.
The Pandemic Plan is attached as Appendix B

Facing these hazards it is important to be able to understand that different emergencies require different actions. Earthquake, flooding, wildfires, and terrorist attacks would likely require an evacuation while blizzards, aircraft accidents, and many HAZMAT spills may require that the facility shelter in place. These situations will be listed in the functional annex plan for each facility.
Human Services and DSAMH have also forged relationships with many other agencies throughout the state to assist during times of crisis including the Utah Transit Authority and local law enforcement agencies in the facilities jurisdiction.

4. Planning Assumptions and Critical Functions/Roles

Planning Assumptions
- In a major emergency, there will be a surge in the need for medical and behavioral health services.
- Staff and residents will sustain injuries of varying degrees of severity.
- Security issues will arise with contractor and subcontractor agencies.
- Support will be limited for the first 72 hours.

Critical Functions
Understanding that the security level is not the same across all facilities, DSAMH has created the following list of critical functions that must be carried out across all facilities in an emergency event. A more comprehensive list will be included in each facility specific functional annex of the plan.

1. Life safety of all facility staff.
2. Facility security, staff will maintain the integrity of the facility and ensure the facility remains secure.
3. Ensure appropriate staffing is in place, and coverage is available for ongoing crisis situation.
   - Prioritize staff duties and what will be needed.
4. Prioritize all programming and activities for essential operations. Keep as normal a schedule as possible in regards to DSAMH functions.
5. Schedule times for briefing communications with the DSAMH Administrator in Department of Emergency Operations Center (DEOC).
6. Schedule times for briefing communications with facility staff.
7. Outline clear procedures for internal and external communication with special consideration given to staff and their families, state, counties, and the general public.
8. Ongoing planning and consideration for staff in facilities. Comprehensive preparedness is critical for a range of emergencies, staff should be aware that this is not an option, but a fundamental responsibility. DSAMH will communicate with contractors.

Critical Roles
The Crisis Management Team and the DSAMH Administrator are the only roles who will be activated in an emergency regardless of location of emergency. Most of the locations across the state are spaced far enough apart that the likelihood of having all facilities affected by an emergency is extremely low. Facility level plans will have more extensive list of critical roles, but they will be listed only in the Facility Emergency Plan.

Crisis Management Team: The Crisis Management Team is comprised of the executive management for the Utah Department of Human Services (DHS) and made up of Division Directors. At the request of the DSAMH Administrator, the Crisis Management Team will appropriate
resources needed for the response to the facility’s emergency. Requests for resources will come from the Scene Control Officer at the facility in need.

DSAMH Administrator: The DSAMH Administrator will be the Division Liaison for all emergency events. They will be in contact with the facility Assistant Director (AD) and or the Risk Manager.

Program Administrator for Crisis in a disaster, will report to the Risk Manager and/or at the Department Emergency Operations Center (DEOC), and DEOC will coordinate the response for different facilities based on the needs of the facilities. This role will be executed by the Director of DSAMH, or the Deputy Director.

Scene Control Officers: The Scene Control Officer (managers of the contracted facilities) will be in control of operations and will contact the DSAMH Program Administrator Assistant Admin and/or liaison for unmet needs.

Emergency Response Team: The Emergency Response Team will be a group of individuals appointed by the AD who will respond to and operate during any emergency event at the facility. The ERT will be responsible for ensuring that the critical functions are carried out at each facility.

Public Information Officer: The Public Information Officer (PIO) is the dedicated contact for media representatives to correspond with concerning all Department and Division matters. DSAMH utilizes a staff member that coordinates with the Department of Human Services PIO for all media inquiries and public information releases.

C. Concept of Operations (CONOPS)
Utilizing the All-Hazards approach to emergency response, this plan has been created to guide response to various hazardous events that the Utah Division of Substance Abuse and Mental Health may be faced with at any time. The Utah Division of Emergency Management supplied the Threat and Hazard Identification and Risk Assessment (THIRA) which is utilized in the creation of this plan. Incident Command System (ICS) training will be given to all DSAMH personnel and will be used by all personnel during emergencies and training operations. The DSAMH planning team understands that not all hazards can employ the same response and that evacuation or sheltering-in-place may be necessary in different emergencies.

The Assistant Director (AD) for the facility will be the Scene Control Officer and will direct all on-scene operations. The AD will conduct the initial and on-going situation assessments as well as coordinate all response moves with the representatives at the Department Emergency Operations Center (DEOC). The AD will provide information to the DEOC concerning the short and long-term needs of the staff and residents at their facility and ensure that essential operations and critical functions are continuing to be carried out. The Executive Staff housed in the DEOC will communicate with the Public Information Officer all information concerning the notification of families of the staff, as well as external stakeholders and the public.

The Department of Human Services and the Division of Substance Abuse and Mental Health utilize the National Incident Management System (NIMS) for all emergency
response events. NIMS identifies the Incident Command System as the formal system for management of the on-scene operations. The system is modular in nature and flexible to the user. It brings together agencies from different departments to manage the response to a situation. ALL MEMBERS of the planning group, the DSAMH Administrator, the Crisis Management Team, and the Emergency Response Team will be trained to at least FEMA IS 100, IS 700, and IS 775.
Incident Command Post: The Incident Command Post (ICP) is located at or very close to the scene of the emergency and is where the Scene Control Officer (SCO) and general staff coordinate on-scene operations.

Department Emergency Operations Center: The Emergency Operations Center is the physical location from which the Crisis Management Team provide support to the on-scene response, at the request of the Incident Commander.

D. Organization and Assignment of Responsibilities

Crisis Management Team: The Crisis Management Team is comprised of the executive management for the Utah Department of Human Services (DHS) and made up of Division Directors. At the request of the DSAMH Administrator, the Crisis Management Team will appropriate resources needed for the response to the facility’s emergency. Requests for resources will come from the Scene Control Officer at the facility in need.

DSAMH Administrator: The DSAMH Administrator will be in contact with the facility AD in a disaster and will report to the Crisis Management Team at the Emergency Operations Center (EOC) and will coordinate the response based on the needs of the facility. This role will be executed by the Director of DSAMH or the Deputy Director.

Scene Control Officers: The Scene Control Officer (SCO) will be in control of all operations at each contracted facility and will coordinate with the DSAMH Administrator, Assistant Administrator/liaison.

Emergency Response Team: The Emergency Response Team will be a group of individuals appointed at the facility by the AD who will respond to and operate during any emergency event at their facility. The ERT will be responsible for ensuring that the critical functions are carried out at the facility.

Public Information Officer: The Public Information Officer (PIO) is the dedicated contact for media representatives to correspond with concerning all Department and Division matters. DSAMH utilizes the Department of Human Services PIO for all media inquiries and public information releases.

Emergency Management Planning Group: The planning group is responsible for the initial creation and annual review/update of the Comprehensive Emergency Management Plan (CEMP) for the Utah Division of Substance Abuse and Mental Health (DSAMH). The planning team will be a vital part of yearly training, exercises, and updates.

E. Direction, Control, and Coordination

The Utah Division of Substance Abuse and Mental Health utilizes the Incident Command System for responding to all emergencies. The Assistant Director (AD) and/or the Program Administrator for Crisis will function as the Incident Commander (IC) for every emergency at THEIR facility and will be in control of all operations on-scene and all information going to the Emergency Operations Center (EOC). The IC will direct the emergency response team in their operations and will coordinate all activities with the DSAMH Administrator at the EOC. The AD will also coordinate with any outside
agencies needed for response to the event and initiate contact with any agencies needed that have entered an MOU for assistance.

The DSAMH Administrator in the EOC will direct the coordinated response across all affected DSAMH facilities and provide information to other facilities that may become involved during the recovery phase. They will also communicate all response operations and response needs with the Crisis Management Team to coordinate assistance where needed.

The DHS BAS Director and Emergency Planner/Risk Manager are the points of contact to coordinate needs with the Utah Division of Emergency Management. Any needs at the state level will be coordinated through these positions.

The DHS BAS Emergency Planner/Risk Manager is the Point of Contact (POC) for the Transportation Memorandum of Understanding (MOU) with the Utah Transit Authority (UTA). The POC will contact UTA and coordinate transportation needs for facilities needing evacuation to their alternate facility. This is the authorized POC for this MOU specified in the document.

**F. Communications - External/Internal**

**Communications with Media**
The Division of Substance Abuse and Mental Health Public Information Officer will coordinate all communications with Media/Reporters regarding the Division through the Department of Human Services Public Information Officer as outlined in the Department of Human Services Policy and Procedures Reference 01-06: Public Information Policy.

---

**POLICY:**
All information and records created by the Department and its Divisions/Institutions/Offices (D/I/O’s) are available to the public and news media representatives provided the release is not restricted by Government Records Access Management Act (GRAMA) or other statute.

**Media Contact Protocol**
The Department of Human Services and its D/I/O’s shall expedite contacts from members of the news media and provide a consistent on-message response. No initial call from a journalist should wait longer than 30 minutes without a callback to report the status of the journalist's request. Procedures for Handling Media Calls
1) Note the time of the call. Find out all the information the journalist needs. Explain that you may not have the answers, but you can find someone to answer the questions.
2) Ask if the journalist has a deadline.
3) Refer the request to an Authorized Media Contact or Public Information Contact who could best handle the journalist's needs and make a return call within 30 minutes or contact the Department Public Information Officer at 801-520-2777 (24-hour media line).

---

The Public Information Officer will be housed in the DHS Emergency Operations Center or the Joint Information Center (JIC) at the State Emergency Operations Center.
Emergency Communications
The Utah Division of Substance Abuse and Mental Health utilizes many different methods for communications, including:
Cellular phones including calls and texting
Landline Telephone
Email
Social Media options
2-way radios - 800 MHz Radios
Use of 211 or set-up 800 number

During an emergency event, communication between staff and control will be done through intercom, 2-way radios, and land line telephone if possible. This communication will be for coordinating emergency response operations by the emergency response team members. Direction for the response will be given by the facility AD, acting as Incident Command for the response.

- The AD will utilize cellular phones, when the cellular system is still functioning, 800 MHz radios, and email to communicate with the members of the Crisis Management Team at the EOC. The AD will also initiate communications with local fire/rescue/police if needed, as well as request action from any outside agency that the facility has entered a Memorandum of Understanding or Mutual Aid Agreement with. The Incident Commander will communicate all operations to the DSAMH Administrator in the EOC.

G. Administration, Finance, and Logistics

All emergency purchases and resources utilized during a Presidentially Declared Emergency will be tracked and all financing/purchasing will be logged in accordance with the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. §§ 5121-5206 (Stafford Act). All purchases will continue to go through FINET and State Contract.

H. Plan Development and Maintenance
This plan was created as an overarching plan for the entire division. The goal for the plan is to direct actions taken during an emergency event, towards the maximum achievable positive outcome. It was created utilizing National Incident Management System and Incident Command System practices to be utilized by the facilities affect by an emergency event.

The Planning Team consist of the following positions: DSAMH Director
DSAMH Assistant Directors (Administrative Director AD)
DSAMH Crisis Counseling Program Administrator
USH Superintendent
DSAMH Children Youth and Family Program Administrator
DSAMH Contracts Analyst
DSAMH Training Manager
Tests, Training Evaluations:
This Comprehensive Emergency Management Plan will receive at least a yearly review, to include all appendices and annexes, by the Emergency Planning Team. The EPT will assist in the exercise design and completion of the exercises. Exercises will be carried out at different facilities, and the EPT will invite outside evaluators to observe the exercise and critique the plan and response. Each exercise will end with an After Action Review (AAR) followed by the addition of any needed changes into the written plan.

DSAMH Administration and the EPT will implement a training path for all employees describing employee roles and responsibilities during an emergency event which will provide specific training for those employees tasked with caring for youth after a disaster. This will aid in ensuring employees have the resources necessary for carrying out the tasks. Completion of semi-annual testing in the form of: Drills, Tabletop Exercises, Functional Exercises, and Full-Scale Exercises.

Exercises will include formal evaluation of the exercise players and exercise injects. Planning team will assist in evaluation and arrange outside evaluators.

I. Authorities and References
The legal basis for all day to day and emergency operations are authorized by Utah Code and approved by the State Legislature. The current code can be found in its entirety at http://le.utah.gov/UtahCode/section.jsp?code=62A-7 and should be included in the plans yearly review to ensure the link is correct.

Section II - Functional Annexes
These annexes are variations of functional annexes tailored to the EOP format used by the jurisdiction. They focus on critical operational functions and who is responsible for carrying them out. These annexes clearly describe the policies, processes, roles, and responsibilities that agencies and departments carry out before, during, and after any emergency. While the basic plan provides broad, overarching information relevant to the EOP as a whole, these annexes focus on specific responsibilities, tasks, and operational actions that pertain to the performance of a particular emergency operations function. These annexes also establish preparedness targets (e.g., training, exercises, equipment checks and maintenance) that facilitate achieving function-related goals and objectives during emergencies and disasters.

A. Continuity of Government / Operations-Utah State Hospital (USH) and Local Mental Health and Substance Abuse Authorities
Continuity of government (COG) / continuity of operations (COOP) may have a separate plan from the EOP. If a separate COG / COOP plan is used, it should be identified in the EOP. Each Local Mental Health and Substance Abuse Authority and the Utah State Hospital will submit Emergency plans to DSAMH annually with the following identified:
(1) Describe essential functions, such as providing vital services, exercising civil authority, maintaining the safety and well-being of the populace, and sustaining the industrial/economic base in an emergency.
(2) Describe plans for establishing recovery time objectives, recovery point objectives, or recovery priorities for each essential function.
(3) Identify personnel and/or teams needed to perform essential functions.
(4) Describe orders of succession and delegations of authority.
(5) Describe continuity/alternate facilities and continuity communications methods.
(6) Describe plans for vital records and human capital management.
(7) Describe plans for devolution or direction and control.
(8) Describe plans for reconstitution of operations.

Transportation
(1) Describe/identify the process for monitoring and reporting the status of, and damage to, the transportation system and infrastructure as a result of an incident.
(2) Describe alternative transportation solutions that can be implemented when systems or infrastructure are damaged, unavailable, or overwhelmed.
(3) Describe the methods by which appropriate aviation, maritime, surface, railroad, and pipeline incident management measures will be implemented.
(4) Describe the method of coordinating the restoration and recovery of the transportation systems and infrastructure.

Warning
(1) Identify and describe the actions that will be taken to initiate/disseminate the initial notification that a disaster or threat is imminent or has occurred (e.g., Emergency Alert System [EAS] activation, door-to-door warnings, sirens, cable/TV messages).
(2) Describe the use of emergency condition levels in the public notification process (e.g., snow emergencies, HAZMAT incidents, nuclear power plant incidents).
(3) Identify and describe the actions that will be taken to alert individuals with sensory or cognitive disabilities and others with access and functional needs in the workplace, public venues, and in their homes.
(4) Include pre-scripted EAS messages for identified hazards.

Resource Management
A system for identifying available resources at all jurisdictional levels to enable timely, efficient, and unimpeded access to resources needed to prepare for, respond to, or recover from an incident. Resource management under the National Incident Management System includes mutual aid and assistance agreements; the use of special Federal, state, territorial, tribal, and local teams; and resource mobilization protocols.

Damage Assessment
The process used to appraise or determine the number of injuries and deaths, damage to public and private property, and status of key facilities and services (e.g., hospitals and other health care facilities, fire and police stations, communications networks, water and sanitation systems, utilities, transportation networks) resulting from a human-caused or natural disaster.

Logistics Management and Resource Support
(1) Identify and describe the actions that will be taken for resource management in accordance with the NIMS resource typing and include the pre-positioning of resources to efficiently and effectively respond to an incident.
(2) Describe the process used to identify, deploy, use, support, dismiss, and demobilize affiliated and spontaneous unaffiliated volunteers.
(3) Describe the process used to manage unsolicited donations.
(4) Describe plans for establishing logistical staging areas for internal and external response personnel, equipment, and supplies.
(5) Describe plans for establishing points of distribution across the jurisdiction.
(6) Describe plans for providing support for a larger, regional incident.
Financial Management
Identify and describe the actions that will be taken to ensure that funds are provided expeditiously and that financial operations are conducted in accordance with established law, policies, regulations, and standards.

Mutual Aid / Multi-Jurisdictional Coordination
Describe the processes to establish and execute mutual aid agreements and multijurisdictional coordination in support of incident response.

Private Sector Coordination
(1) Describe the processes to ensure effective coordination and integration with the private sector, both for-profit and not-for-profit, engaged in incident response and recovery activities.
(2) Describe the processes to ensure a shared situational awareness across sectors and between the jurisdiction and the private sector as a whole.

Volunteer and Donations Management
(1) Describe the method by which unaffiliated volunteers and unaffiliated organizations will be managed and their resources applied to incident response and recovery activities.
(2) Identify and describe the actions that will be taken to establish and staff donation management functions (e.g., set up toll-free hotlines, create databases, appoint a donations liaison/office, use support organizations).
(3) Identify and describe the actions that will be taken to verify and/or vet voluntary organizations and/or organizations operating relief funds.
(4) Identify and describe the actions that will be taken to collect, sort, manage, and distribute in-kind contributions, including methods for disposing of or refusing goods that are not acceptable. (5) Identify and describe the actions that will be taken to coordinate donation management issues with neighboring districts and the state’s donations management system.
(6) Describe the process used to tell the general public about the donations program (e.g., instructions on items to bring and not bring, scheduled drop-off sites and times, the way to send monies), including a process for issuing routine updates.
(7) Identify and describe the actions that will be taken to handle the spontaneous influx of volunteers.
(8) Identify and describe the actions that will be taken to receive, manage, and distribute cash contributions.
(9) Pre-identify sites that will likely be used to sort and manage in-kind contributions (e.g., private warehouses, government facilities).

Worker Safety and Health
Describe the processes to ensure response and recovery worker safety and health during incident response and recovery.

How are you going to prevent worker burnout?
How are you going to ensure worker safety?
## Section III: Hazard-, Threat-, or Incident Specific Annexes

### Incident Response Checklist

<table>
<thead>
<tr>
<th>Gather Information Quickly</th>
</tr>
</thead>
<tbody>
<tr>
<td>% What happened?</td>
</tr>
<tr>
<td>% Internal event? Where?</td>
</tr>
<tr>
<td>% External to organization?</td>
</tr>
<tr>
<td>% When? Where? Who?</td>
</tr>
<tr>
<td>% Is it over or still in progress?</td>
</tr>
<tr>
<td>% Who is the target victim group?</td>
</tr>
<tr>
<td>% What is the estimated number of people who are seriously injured and/or with high exposure to trauma?</td>
</tr>
<tr>
<td>% Are vulnerable populations involved (e.g., children, disabled)?</td>
</tr>
<tr>
<td>% How bad is it?</td>
</tr>
<tr>
<td>% Is there current or future danger? (Take action to protect.)</td>
</tr>
</tbody>
</table>

### Find Out: What Is Being Done

<table>
<thead>
<tr>
<th>Find Out: What Is Being Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>% What responders are already on scene?</td>
</tr>
<tr>
<td>% Are you in communication with them?</td>
</tr>
<tr>
<td>% Are evacuations needed?</td>
</tr>
<tr>
<td>% Are there injury or death notifications that need to be made?</td>
</tr>
<tr>
<td>% Is there a need to secure site?</td>
</tr>
<tr>
<td>% Has an Incident Command been established? Who is in charge?</td>
</tr>
</tbody>
</table>
Verify

‰ Is information accurate? __________________________________________
‰ Is additional information needed? _________________________________

* Adapted from The Red Pages,
My Agency Emergency Contacts List

Use, expand and/or adapt the following form to include those individuals within or closely connected with your agency who you want to have on hand in the event of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. Be certain to update this list regularly and file it with your other emergency preparedness materials.

**Deputy Commissioner**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Cell:</th>
</tr>
</thead>
</table>

**Work**

<table>
<thead>
<tr>
<th>E-mail:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

**Home**

<table>
<thead>
<tr>
<th>E-mail:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

**Attorney**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Cell:</th>
</tr>
</thead>
</table>

**Work**

<table>
<thead>
<tr>
<th>E-mail:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

**Home**

<table>
<thead>
<tr>
<th>E-mail:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

**Public Information Officer**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Cell:</th>
</tr>
</thead>
</table>

**Work**

<table>
<thead>
<tr>
<th>E-mail:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

**Home**

<table>
<thead>
<tr>
<th>E-mail:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

**Disaster Coordinator**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Cell:</th>
</tr>
</thead>
</table>

**Work**

<table>
<thead>
<tr>
<th>E-mail:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

**Home**

<table>
<thead>
<tr>
<th>E-mail:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

**Issue Expert (add as many as needed)**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Cell:</th>
</tr>
</thead>
</table>

**Work**

<table>
<thead>
<tr>
<th>E-mail:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

**Home**

<table>
<thead>
<tr>
<th>E-mail:</th>
<th>Phone:</th>
</tr>
</thead>
</table>

**Areas of Expertise: **
### Contact

**Issue Expert**

Name: __________________________  Cell: __________________

**Work**  E-mail: __________________  Phone: __________________

**Home**  E-mail: __________________  Phone: __________________

Areas of Expertise: ________________________________

---

**Issue Expert**

Name: __________________________  Cell: __________________

**Work**  E-mail: __________________  Phone: __________________

**Home**  E-mail: __________________  Phone: __________________

Areas of Expertise: ________________________________

---

**Issue Expert**

Name: __________________________  Cell: __________________

**Work**  E-mail: __________________  Phone: __________________

**Home**  E-mail: __________________  Phone: __________________

Areas of Expertise: ________________________________

---

**Legislator (add as many as needed)**

Name: __________________________  Cell: __________________

**Work**  E-mail: __________________  Phone: __________________

**Home**  E-mail: __________________  Phone: __________________

---

**Legislator**

Name: __________________________  Cell: __________________

**Work**  E-mail: __________________  Phone: __________________

**Home**  E-mail: __________________  Phone: __________________
Add other contacts as appropriate

Name: ___________________________ Cell: ___________________________

Work E-mail: ___________________________ Phone: ___________________________

Home E-mail: ___________________________ Phone: ___________________________

Name: ___________________________

Work E-mail: ___________________________ Phone: ___________________________

Home E-mail: ___________________________ Phone: ___________________________

Name: ___________________________

Work E-mail: ___________________________ Phone: ___________________________

Home E-mail: ___________________________ Phone: ___________________________
My State Emergency Contacts List

Use, expand and/or adapt the following form to include those individuals within or closely connected with your state who you want to have readily at hand in the event of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. Include agency heads and public information officers (PIOs) for key agencies. Be certain to update this list regularly and file it with your other emergency preparedness materials.

**Governor’s Office**

Key contact: ___________________________ Cell: ___________________________

**Work** E-mail: ________________________ Phone: __________________________

**Home** E-mail: ________________________ Phone: __________________________

**Governor’s Office**

PIO: ___________________________ Cell: ___________________________

**Work** E-mail: ________________________ Phone: __________________________

**Home** E-mail: ________________________ Phone: __________________________

**State Health Department**

Director: ___________________________ Cell: ___________________________

**Work** E-mail: ________________________ Phone: __________________________

**Home** E-mail: ________________________ Phone: __________________________

**State Health Department**

PIO: ___________________________ Cell: ___________________________

**Work** E-mail: ________________________ Phone: __________________________

**Home** E-mail: ________________________ Phone: __________________________

**Substance Abuse Agency**

Director: ___________________________ Cell: ___________________________

**Work** E-mail: ________________________ Phone: __________________________

**Home** E-mail: ________________________ Phone: __________________________
Substance.Abuse.Agency
PIO: ________________________________________
Cell: ________________________________________
Work E-mail: __________________________________
Home E-mail: __________________________________

Director: ________________________________________
Cell: ________________________________________
Work E-mail: __________________________________
Home E-mail: __________________________________

PIO: ________________________________________
Cell: ________________________________________
Work E-mail: __________________________________
Home E-mail: __________________________________

State.Police.
Director: ________________________________________
Cell: ________________________________________
Work E-mail: __________________________________
Home E-mail: __________________________________

State.Police
PIO: ________________________________________
Cell: ________________________________________
Work E-mail: __________________________________
Phone: ________________________________________
**Contact**

**Local.Police/County.Law.Enforcement.**

Chief Executive: ___________________________ Cell: ___________________________

**Home**
E-mail: ___________________________

**Work**
E-mail: ___________________________

**Home**
E-mail: ___________________________

**Local.Police/County.Law.Enforcement**

PIO: ___________________________

**Work**
E-mail: ___________________________ Phone: ___________________________

**Home**
E-mail: ___________________________ Phone: ___________________________
## District Attorney’s Office/Victims’ Assistance

<table>
<thead>
<tr>
<th>District Attorney:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Home E-mail:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

## Military Base

<table>
<thead>
<tr>
<th>Key contact:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Home E-mail:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

## National Guard

<table>
<thead>
<tr>
<th>Key contact:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Home E-mail:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

## Reserves

<table>
<thead>
<tr>
<th>Key contact:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Home E-mail:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

## American Red Cross Chapter

<table>
<thead>
<tr>
<th>Key contact:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Home E-mail:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

## National Mental Health Association Chapter

<table>
<thead>
<tr>
<th>Key contact:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Home E-mail:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

## National Alliance on Mental Illness Chapter

<table>
<thead>
<tr>
<th>Key contact:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Home E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>NASMHPD.</strong></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Key contact:</td>
<td>Cell:</td>
</tr>
<tr>
<td><strong>Work</strong> E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>Home</strong> E-mail:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SAMHSA</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Key contact:</td>
<td>Cell:</td>
</tr>
<tr>
<td><strong>Work</strong> Address:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>Home</strong> Address:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

**Add other contacts as appropriate**

<table>
<thead>
<tr>
<th>Name:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work</strong> E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>Home</strong> E-mail:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work</strong> E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>Home</strong> E-mail:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work</strong> E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>Home</strong> E-mail:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work</strong> E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>Home</strong> E-mail:</td>
<td>Phone:</td>
</tr>
</tbody>
</table>
Use, expand and/or adapt the following form to include external content experts who you want to have on hand in the event of a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. Be certain to update this list regularly and file it with your other emergency preparedness materials. Make sure that experts have given prior approval for their contact information, biographies or other background information to be shared with media before releasing it.

**Content.Expert.(add.as.many.as.appropriate)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Cell</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work</strong>  E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>Home</strong>  E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Areas of Expertise:</td>
<td></td>
</tr>
</tbody>
</table>

**Content.Expert**

<table>
<thead>
<tr>
<th>Name</th>
<th>Cell</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work</strong>  E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>Home</strong>  E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Areas of Expertise:</td>
<td></td>
</tr>
</tbody>
</table>

**Content.Expert**

<table>
<thead>
<tr>
<th>Name</th>
<th>Cell</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work</strong>  E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>Home</strong>  E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Areas of Expertise:</td>
<td></td>
</tr>
</tbody>
</table>

**Content.Expert**

<table>
<thead>
<tr>
<th>Name</th>
<th>Cell</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work</strong>  E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>Home</strong>  E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td>Areas of Expertise:</td>
<td></td>
</tr>
</tbody>
</table>
Contact
Name: ____________________________ Cell: ________________________
Work E-mail: _____________________ Phone: ______________________
Home E-mail: _____________________ Phone: ______________________
Areas of Expertise: ____________________________________________

Contact
Name: ____________________________ Cell: ________________________
Work E-mail: _____________________ Phone: ______________________
Home E-mail: _____________________ Phone: ______________________
Areas of Expertise: ____________________________________________

Contact
Name: ____________________________ Cell: ________________________
Work E-mail: _____________________ Phone: ______________________
Home E-mail: _____________________ Phone: ______________________
Areas of Expertise: ____________________________________________

Contact
Name: ____________________________ Cell: ________________________
Work E-mail: _____________________ Phone: ______________________
Home E-mail: _____________________ Phone: ______________________
Areas of Expertise: ____________________________________________
Use, expand and/or adapt the following form to include local, regional and national media that may report on a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. Be certain to update this list regularly and file it with your other emergency preparedness materials. Use this form to make calls to reporters to establish a working relationship in advance of an event. Make note of key deadlines.*

**Associated Press or Other Wire Service**

<table>
<thead>
<tr>
<th>Media outlet:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporter’s name:</td>
<td>Cell:</td>
</tr>
<tr>
<td><strong>Work</strong> E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>Personal</strong> E-mail:</td>
<td></td>
</tr>
<tr>
<td>News deadlines:</td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
</tr>
</tbody>
</table>

**Radio Station**

<table>
<thead>
<tr>
<th>Media outlet:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporter’s name:</td>
<td>Cell:</td>
</tr>
<tr>
<td><strong>Work</strong> E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>Personal</strong> E-mail:</td>
<td></td>
</tr>
<tr>
<td>News deadlines:</td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
</tr>
</tbody>
</table>

**Newspaper**

<table>
<thead>
<tr>
<th>Media outlet:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporter’s name:</td>
<td>Cell:</td>
</tr>
<tr>
<td><strong>Work</strong> E-mail:</td>
<td>Phone:</td>
</tr>
<tr>
<td><strong>Personal</strong> E-mail:</td>
<td></td>
</tr>
<tr>
<td>News deadlines:</td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
</tr>
</tbody>
</table>
Blogger
Media outlet: ____________________________
Reporter’s name: ___________________ Cell: __________________
Work E-mail: ___________________ Phone: __________________
Personal E-mail: __________________
News deadlines: __________________
Notes: __________________

Add other contacts as appropriate
Media outlet: ____________________________
Reporter’s name: ___________________ Cell: __________________
Work E-mail: ___________________ Phone: __________________
Personal E-mail: __________________
News deadlines: __________________
Notes: __________________

Media outlet: ____________________________
Reporter’s name: ___________________ Cell: __________________
Work E-mail: ___________________ Phone: __________________
Personal E-mail: __________________
News deadlines: __________________
Notes: __________________

Media outlet: ____________________________
Reporter’s name: ___________________ Cell: __________________
Work E-mail: ___________________ Phone: __________________
Personal E-mail: __________________
News deadlines: __________________
Notes: __________________
General Contacts Log

Use, expand and/or adapt the following form to keep track of all communications related to a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. Be certain all staff in your agency who are authorized to answer phones during an emergency have a copy of this form. File this list with paperwork related to the incident to be used in internal and external reviews and legislative hearings.

Contact
Staff who took call: __________________ Date and time: __________________
Name of caller: __________________ Phone: __________________
Agency/affiliation: __________________
Reason for call: __________________
Response: __________________
Follow-up needed: % Yes % No When: __________________ By whom: _______________
Preferred number/e-mail address for follow-up: __________________
Status: __________________
Notes: __________________

Contact
Staff who took call: __________________ Date and time: __________________
Name of caller: __________________ Phone: __________________
Agency/affiliation: __________________
Reason for call: __________________
Response: __________________
Follow-up needed: % Yes % No When: __________________ By whom: _______________
Preferred number/e-mail address for follow-up: __________________
Status: __________________
Notes: __________________
Contact
Staff who took call: __________________________ Date and time: __________________________
Name of caller: __________________________ Phone: __________________________
Agency/affiliation: __________________________
Reason for call: __________________________
Response: __________________________
Follow-up needed: % Yes % No When: __________________________ By whom: __________________________
Preferred number/e-mail address for follow-up: __________________________
Status: __________________________
Notes: __________________________

Contact
Staff who took call: __________________________ Date and time: __________________________
Name of caller: __________________________ Phone: __________________________
Agency/affiliation: __________________________
Reason for call: __________________________
Response: __________________________
Follow-up needed: % Yes % No When: __________________________ By whom: __________________________
Preferred number/e-mail address for follow-up: __________________________
Status: __________________________
Notes: __________________________
**Media Contacts Log**

Use, expand and/or adapt the following form to keep track of all press inquiries related to a high-profile, tragic incident involving a person with a history or current diagnosis of serious mental illness. Be certain all staff in your agency who are authorized to take media calls have a copy of this form. Make careful note of when reporters need a response. File the form with your agency public information officer or designee.*

### Contact

| Staff who took call: ____________________ | Date and time: ____________________ |
| Name of caller: _______________________ | Phone: ___________________________ |
| Media outlet: _________________________ |                                    |
| Reason for call: _____________________ |                                    |
| Response: ___________________________ |                                    |
| Follow-up needed: % Yes % No When: ____________________ | By whom: ____________________ |
| Preferred number/e-mail address for follow-up: ____________________ |                                    |
| Status: _______________________________ |                                    |
| Notes: ________________________________ |                                    |

### Contact

| Staff who took call: ____________________ | Date and time: ____________________ |
| Name of caller: _______________________ | Phone: ___________________________ |
| Media outlet: _________________________ |                                    |
| Reason for call: _____________________ |                                    |
| Response: ___________________________ |                                    |
| Follow-up needed: % Yes % No When: ____________________ | By whom: ____________________ |
| Preferred number/e-mail address for follow-up: ____________________ |                                    |
| Status: _______________________________ |                                    |
| Notes: ________________________________ |                                    |
### Contact Form

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff who took call:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Date and time:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Name of caller:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Phone:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Media outlet:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Reason for call:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Response:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Follow-up needed: % Yes % No</td>
<td>____________________________</td>
</tr>
<tr>
<td>When:</td>
<td>____________________________</td>
</tr>
<tr>
<td>By whom:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Preferred number/e-mail address for follow-up:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Status:</td>
<td>____________________________</td>
</tr>
<tr>
<td>Notes:</td>
<td>____________________________</td>
</tr>
</tbody>
</table>
### Contact

<table>
<thead>
<tr>
<th>Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff who took call</td>
<td></td>
</tr>
<tr>
<td>Date and time</td>
<td></td>
</tr>
<tr>
<td>Name of caller</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Media outlet</td>
<td></td>
</tr>
<tr>
<td>Reason for call</td>
<td></td>
</tr>
<tr>
<td>Response</td>
<td></td>
</tr>
<tr>
<td>Follow-up needed</td>
<td>% Yes % No When: By whom:</td>
</tr>
<tr>
<td>Preferred number/e-mail address for follow-up</td>
<td></td>
</tr>
<tr>
<td>Status</td>
<td></td>
</tr>
<tr>
<td>Notes</td>
<td></td>
</tr>
</tbody>
</table>

### Contact

<table>
<thead>
<tr>
<th>Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff who took call</td>
<td></td>
</tr>
<tr>
<td>Date and time</td>
<td></td>
</tr>
<tr>
<td>Name of caller</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Media outlet</td>
<td></td>
</tr>
<tr>
<td>Reason for call</td>
<td></td>
</tr>
<tr>
<td>Response</td>
<td></td>
</tr>
<tr>
<td>Follow-up needed</td>
<td>% Yes % No When: By whom:</td>
</tr>
<tr>
<td>Preferred number/e-mail address for follow-up</td>
<td></td>
</tr>
<tr>
<td>Status</td>
<td></td>
</tr>
<tr>
<td>Notes</td>
<td></td>
</tr>
</tbody>
</table>
Planning Step: Quality and Data Collection Readiness

1) The State system is unique to mental health and substance use disorder data. The system currently collects data at the client level for both mental health and substance use disorder data. Data is being uploaded to the CLD system for mental health, and to TEDS for substance use data. In mental health, the State receives event-level data from each of our local authorities. In substance use disorder data, the State receives admission and discharge records for each modality in which the client is treated. For Prevention, our data collection and reporting system is DUGS (Data Users Gateway System) for Universal and Selective services. We currently collect both client level (as appropriate) and community level data. This includes demographics, types of programming according to the CSP 6, and associated strategies. The data system collects the minimum requirements for the block grant report. In July 2017, Indicated Prevention services started submitting on a client-level basis into the same system that houses the current mental health and substance use disorder data. In 2017, the state started collecting client-level data on recovery support services.

2) The State is able to collect and report on the current NOMs/CLD/TEDS specifications at the client level utilizing a statewide client ID. The proposed CLD measures present significant challenges, financially, culturally, and procedurally to the State’s ability to collect the measures.

3) Many of the proposed CLD measures are a radical departure from the current required measures, and will take a significant investment in order for our procedural and data systems to be ready to collect these data. The State has built the data collection systems around the current requirements, and will need significant lead-time in order to make a change over to new measures.

a. Perception of Care – The State is currently using the MHSIP to determine perception of care. The switch to another instrument will take resources and time to move to the new instruments. Additionally, the State would lose any trending data that has been done for many years.

b. Reduced morbidity – Many of these measures are not collected in the State data system, so would need resources for programming to collect these data. If our Local Authorities are not collecting these data, then they will require resources in order to modify their systems.

c. Decrease in MH symptoms – The State has made a significant investment in using the OQ/YOQ as our outcome measure of choice.

d. Education – The State may have significant barriers in obtaining daily attendance data from the local schools.

e. Criminal Justice – New charges are a new way of collecting the data, and will require procedural changes at our provider level. If the measure is to be anything but clinician-verified self-report, there will need to be an interface with the courts systems, which has been a consistent challenge to the State.
## Planning Tables

### Table 1 Priority Areas and Annual Performance Indicators

<table>
<thead>
<tr>
<th>Priority #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Priority Area</td>
<td>Prevention</td>
</tr>
<tr>
<td>Priority Type</td>
<td>SAP</td>
</tr>
<tr>
<td>Population(s)</td>
<td>PP</td>
</tr>
</tbody>
</table>

**Goal of the priority area:**

- Goal A: Reduce underage drinking in adolescents
- Goal B: Reduce prescription drug abuse through collaboration with state and local agencies, as well as provide education and awareness to communities to reduce abuse.
- Goal C: Reduce e-cigarette use
- Goal D: Reduce 30 day marijuana use for 8th, 10th, and 12th grades through education, awareness and referrals prevention programs.
- Goal E: Build an infrastructure of prevention prepared communities through SAPST certification and CTC implementation to prioritize prevention risk factors.

**Objective:**

Decrease risk factors and increase protective factors within the State of Utah to see change in the substance use among youth and communities.

**Strategies to attain the objective:**

- **Goal A:**
  1. Through collaboration with partner agencies develop a comprehensive strategy to:
     a. reduce availability of alcohol to underage adolescents through compliance and environmental strategies; Compliance to state and local laws to decrease access to alcohol to youth; and
     b. Decrease 30 day use through universal, selective and indicated services.
- **Goal B:**
  1. Include information and education on Prescription Drug abuse in all Division sponsored and supported conferences and training.
  2. Participate and provide prevention expertise in the Department of Health and DEA Prescription Drug Committees.
  3. Assist communities in addressing Prescription Drug abuse prevention in their communities as appropriate.
- **Goal C:**
  1. Reduce E-cigarette use among youth grades, 6, 8, 10 and 12. 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 30 day use rates of e-cigarettes. Focus on counties or LSAA areas with high e-cig use rates. Collaborate with other state and local agencies through education and awareness campaigns regarding the reduction of e-cig use rates. Emphasize the need to address e-cigarette use rates as a statewide issue during SAPST, CTC trainings, town hall meetings and other community forums.
- **Goal D:**
  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 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 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

<table>
<thead>
<tr>
<th>Indicator #:</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Goal A: 30 Day alcohol use - all grades</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>2017: 6.7%</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>2020: 5.0%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>2021: 4.5%</td>
</tr>
</tbody>
</table>
Data Source:
Student Health and Risk Prevention (SHARP) Survey

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

Data issues/caveats that affect outcome measures:
Survey is collected biennially. Also note that confidence interval is +/-5%.

Indicator #: 2
Indicator: Goal B: Decrease Prescription Drug use among youth all grades
Baseline Measurement: 2017: 2.4%
First-year target/outcome measurement: 2020: 2.0%
Second-year target/outcome measurement: 2021: 1.5%

Data Source:
Student Health and Risk Prevention Survey

Description of Data:
The statewide survey administered to 6, 8, 10, 12th grade students. Collects substance abuse, mental health, risk, and protective factor data.
On how many occasions (if any) have you used narcotic prescription drugs (such as OxyContin, methadone, morphine, codeine, Demerol, Vicodin, Percocet) without a doctor telling you to take them, during the past 30 days?
On how many occasions (if any) have you used prescription tranquilizers (such as Librium, Valium, Xanax, Ativan, Soma, or Klonopin) without a doctor telling you to take them, during the past 30 days?
On how many occasions (if any) have you used prescription sedatives including barbiturates or sleeping pills (such as phenobarbital, Tuinal, Seconal, Ambien, Lunesta, or Sonata) without a doctor telling you to take them, during the past 30 days?
On how many occasions (if any) have you used prescription stimulants or amphetamines (such as Adderall, Ritalin, or Dexedrine) without a doctor telling you to take them, during the past 30 days?

Data issues/caveats that affect outcome measures:
Survey is collected biennially. Also note that confidence interval is +/-5%.

Indicator #: 3
Indicator: Goal B: Decrease Opioid Drug deaths by 10%
Baseline Measurement: 2018: 392
First-year target/outcome measurement: 2020: 373
Second-year target/outcome measurement: 2021: 353

Data Source:
Office of the Medical Examiner, Utah Coalition for Opioid Overdose Prevention

Description of Data:
All Opioid poisonings (illicit and prescription) per Mortality: ICD 10 - X40, X41, X42, X43, X44, X60, X61, X62, X63, X64, X85, Y10, Y11, Y12, Y13, Y14

Data issues/caveats that affect outcome measures:
There is significant lag time on the availability of the data.

Indicator #: 4
Indicator: Goal C: Decrease 30 Day E cigarette use among youth - all grades

Baseline Measurement: 2017: 8.6
First-year target/outcome measurement: 2020: 7.0%
Second-year target/outcome measurement: 2021: 6.0%

Data Source: Student Health and Risk Prevention Survey

Description of Data: The statewide survey administered to 6, 8, 10, 12 grade students collects substance abuse, mental health, risk, and protective factor data. Question: Have you used e-cigarettes in the past 30 days?

Data issues/caveats that affect outcome measures: The survey is collected biennially. Also note that confidence interval is +/-5%.

Indicator #: 5

Indicator: Goal D: Decrease 30 Day Marijuana use among youth - All Grades

Baseline Measurement: 2017: 6.1%
First-year target/outcome measurement: 2020: 5.5%
Second-year target/outcome measurement: 2021: 5.0%

Data Source: Student Health and Risk Prevention Survey

Description of Data: The statewide survey administered to 6, 8, 10, 12 grade students collects substance abuse, mental health, risk, and protective factor data. Question: Have you used marijuana (THC, pot, Hash hish) in the past 30 days?

Data issues/caveats that affect outcome measures: The survey is collected biennially. Also, note that the confidence interval is +/-5%.

Indicator #: 6

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

Baseline Measurement: 2017: 19.5%
First-year target/outcome measurement: 2020: 18.5%
Second-year target/outcome measurement: 2021: 18.0%

Data Source: Student Health and Risk Prevention Survey

Description of Data: The statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data. Questions: How wrong would most adults in your neighborhood think it was for kids your age: to use marijuana. How wrong would most adults in your neighborhood think it was for kids your age: to drink alcohol. How wrong would most adults in your neighborhood think it was for kids your age: to smoke cigarettes. If a kid smoked marijuana in your neighborhood would he or she be caught by the police? If a kid drank some beer, wine, or hard liquor (for example, vodka, whiskey, or tequila) in your neighborhood, would he or she be caught by the police? If a kid carried a handgun in your neighborhood would he or she be caught by the police?
Data issues/caveats that affect outcome measures:
Survey is collected biennially. Also note that confidence interval is +/-5%.

Indicator #: 7
Indicator: Goal E: Reduce Parental Attitudes favorable towards alcohol, tobacco, and other drug use
Baseline Measurement: 2017: 11.2
First-year target/outcome measurement: 2020: 11.0
Second-year target/outcome measurement: 2021: 10.8
Data Source: Student Health and Risk Prevention Survey

Description of Data:
Statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data.
Questions:
How wrong do your parents feel it would be for YOU to: drink beer, wine, or hard liquor (for example, vodka, whiskey, or tequila) regularly?
How wrong do your parents feel it would be for YOU to smoke cigarettes?
How wrong do your parents feel it would be for YOU to smoke marijuana?

Data issues/caveats that affect outcome measures:
Survey is collected biennially. Also note that confidence interval is +/-5%.

Priority #: 2
Priority Area: Zero Suicide Initiative
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED

Goal of the priority area:
Decrease or eliminate the number of suicides across the state.

Objective:
Goal A: Number of health systems/organizations formally adopting the Zero Suicide framework.
Goal B: Number of people trained in an evidence-based gatekeeper training.
Goal C: Number of formal partnerships established/engaging in research guided means reduction activities.

Strategies to attain the objective:
A: 1- Educate and promote the Zero Suicide Framework to health systems and other organizations.
A: 2- Increase the number of agencies using the Zero Suicide Framework.
B: 1- Provide training to individuals and providers regarding evidence based gatekeeper tools.
B: 2- Contract with a trainer to provide evidence based gatekeeper training across the state.
C: 1- Locate and engage community partners on establishing and engaging research opportunities.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Goal A: Number of health systems/organizations formally adopting the Zero Suicide framework.
Baseline Measurement: Zero organizations have adopted the Zero Suicide framework.
First-year target/outcome measurement: Five health systems/organizations in Utah have formally adopted the Zero Suicide Framework.
Second-year target/outcome measurement:
Ten health systems/organizations in Utah have formally adopted the Zero Suicide Framework.

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

Description of Data:
Data will include numbers of agencies attending Zero Suicide activities and providing Zero Suicide outcomes.

Data issues/caveats that affect outcome measures:
Suicide is a low baseline level event and long-term outcomes may be difficult to quantify. Community leaders can be resistant to addressing suicide.

Indicator #:
2
Indicator:
Goal B: Number of people trained in an evidence-based gatekeeper training.
Baseline Measurement:
25,000 individuals (state average, aggregate)
First-year target/outcome measurement:
A minimum of 100,000 Utahns are trained in an evidence-based gatekeeper training
Second-year target/outcome measurement:
A minimum of 299,592 Utahns are trained in an evidence-based gatekeeper training

Data Source:
DSAMH training records and reporting tools

Description of Data:
DSAMH and agencies/individuals that DSAMH has trained provide evidence-based gatekeeper training and retain sign-in sheets.

Data issues/caveats that affect outcome measures:
Some individuals who have participated in train-the-trainer training may not report back to DSAMH regularly.

Indicator #:
3
Indicator:
Goal C: Number of formal partnerships established/engaging in research guided means reduction activities.
Baseline Measurement:
Zero partnerships established
First-year target/outcome measurement:
Five firearm retailers, instructors, enthusiasts in Utah have incorporated suicide education, prevention, and awareness efforts into their businesses.
Second-year target/outcome measurement:
Ten firearm retailers, instructors, enthusiasts in Utah have incorporated suicide education, prevention, and awareness efforts into their businesses.

Data Source:
Federal grant reporting tools, membership on Means Reduction committees, MOUs/BAAs.

Description of Data:
SAMHSA grant reports, sign-in sheets, MOUs through DSAMH contracting.

Data issues/caveats that affect outcome measures:
Many partnerships may be informal and more difficult to track.

Priority #:
3
Priority Area:
Promote Recovery
Priority Type:
SAT, MHS
Population(s): SMI, SED, PWDC, PP, ESMI, PWID, EIS/HIV, 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:
The goal is to expand access to vital services and support systems that facilitate recovery for individuals.

Objective:

Goal A: Increase number of accredited Clubhouses in Utah
Goal B: Increase number of Peer Support Specialists trained for certification
Goal C: Number of teams offering evidence-based supported employment (Individual Placement and Support/IPS) services
Goal D: Increase the number of waivered providers throughout Utah - unduplicated
Goal: E Increase use of FDA approved Medication Assisted Treatment.
Goal F: Increase number of Local Authorities reporting the Recovery Support Services (RSS) data in SAMHIS
Goal G: Increase the number of pregnant women served (priority population goal)

Strategies to attain the objective:

A: Submit application for clubhouse accreditation to increase the number of accredited clubhouses in Utah.
B: Increase the number of Peer Support certifications offered per year.
C: Increase the number of trained teams that can provide evidence based supported employment training’s.
D: Provide Education and support to physicians that could possibly be waivered to provide MAT services.
E: Provide education, funding and service providers that can provide MAT services in order to increase the number of clients that have access to MAT through the public behavioral health system.
F: Provide support, training and education around approved Recover Support Services to the Local Authorities.
F: Provide documentation of the RSS manual and service list to each Local Authority so they can provide services.

Annual Performance Indicators to measure goal success

| Indicator # | 1 |
| Indicator: | Goal A: Increase number of accredited Clubhouses in Utah |
| Baseline Measurement: | 4 accredited Clubhouses in Utah |
| First-year target/outcome measurement: | Increase # of Clubhouses by 25% (5 accredited Clubhouses in Utah) |
| Second-year target/outcome measurement: | Increase # of Clubhouses by 75% (7 accredited Clubhouses in Utah) |
| Data Source: | Local Mental Health Authority Area Plans, Accreditation reports provided by Clubhouses. |
| Description of Data: | Accredited Clubhouses provide the accreditation report to DSAMH for reimbursement toward accreditation costs. |
| Data issues/caveats that affect outcome measures: | Accreditation can take multiple years which may delay number of Clubhouses that can be reported. |

| Indicator # | 2 |
| Indicator: | Goal B: Increase number of Peer Support Specialists trained for certification |
| Baseline Measurement: | 297 CPSS are currently trained and have been certified by DSAMH. |
| First-year target/outcome measurement: | Increase # of CPSS by 10% (327 CPSS) |
| Second-year target/outcome measurement: | Increase # of CPSS by 20% (357) |
| Data Source: | CPSS database, LMHA surveys, HRSA grant information |
| Description of Data: | CPSS database is used to track all CPSS certified by DSAMH, surveys are given to LMHA asking about CPSS they have employed, grant information is collected for HRSA paraprofessional training grant. |
### Data issues/caveats that affect outcome measures:

All data sources collect both unique and duplicative data, potentially leading to inaccuracies.

### Indicator #:

3

### Indicator:

Goal C: Number of teams offering evidence-based supported employment (Individual Placement and Support/IPS) services

### Baseline Measurement:

Four (4) IPS teams in Utah have reached fidelity of good or exemplary

### First-year target/outcome measurement:

Increase # of IPS teams at good or exemplary fidelity by 50% (Six IPS teams)

### Second-year target/outcome measurement:

Increase # of IPS teams at good or exemplary fidelity by 75% (Seven IPS teams)

### Data Source:

DSAMH fidelity reviews, LMHA Area Plans

### Description of Data:

DSAMH and VR provide fidelity reviews, LMHA report on evidence-based supported employment on Area Plans

### Data issues/caveats that affect outcome measures:

Due to the number of fidelity reviews being completed around the state, completed reports may be delayed which may impact data.

### Indicator #:

4

### Indicator:

Goal D: Increase the number of waivered providers throughout Utah - unduplicated

### Baseline Measurement:

June 2019 388 unduplicated on the SAMHSA waivered physicians locator public list.

### First-year target/outcome measurement:

Increase by 2% from established baseline in Fy2020

### Second-year target/outcome measurement:

Increase by 2% from previous year in Fy2021

### Data Source:

SAMHSA waivered physicians locator public list.

### Description of Data:

SAMHSA collected data in relation to the number of waivered physicians by State or by city. SAMHSA waivered physician locator list found at https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/treatment-practitioner-locator?field_bup_physician_us_state_value=UT

### Data issues/caveats that affect outcome measures:

Not all waiverd physicians that are on the list are actively prescribing or maximizing the amount of clients they will treat.

### Indicator #:

5

### Indicator:

Goal: E Increase use of FDA approved Medication Assisted Treatment.

### Baseline Measurement:

established baseline FY2018 2166 clients using MAT

### First-year target/outcome measurement:

increase number of clients using MAT by 5% from baseline in FY2020

### Second-year target/outcome measurement:

increase number of clients using MAT by 5% from previous year outcomes in Fy2021

### Data Source:

These numbers are pulled from our state fiscal year SAMHIS submissions of clients served with OUD identified as primary, secondary or tertiary that have the MAT or Methadone indicators

### Description of Data:

State date collection submitted, data is pulled using clients identified as primary, secondary or tertiary OUD that have a MAT or Methadone indicator.
Data issues/caveats that affect outcome measures:
Utah became a Medicaid expansion state in April 2019, clients have the option to go to outside MAT providers that are outside of out public behavioral health network and in doing so the data for these clients accessing MAT services elsewhere will not be accounted for.

Indicator #: 6
Indicator: Goal F: Increase number of Local Authorities reporting the Recovery Support Services (RSS) data in SAMHIS
Baseline Measurement: established 2018: 9/13 Local Authorities reporting RSS in SAMHIS
First-year target/outcome measurement: Increase baseline by 2. 11/13 local authorities reporting RSS in SAMHIS in FY2020
Second-year target/outcome measurement: Increase baseline by 2 from FY2020. 13/13 local authorities reporting RSS in SAMHIS in FY2021
Data Source: monthly SAMHIS data submissions from Local Authorities
Description of Data: Local Authorities upload monthly SAMHIS data in which data can be filtered to determine services being utilized and reported.

Data issues/caveats that affect outcome measures:
SAMHIS data is submitted 30 days past the end of a month so data has a short lag. data may indicate errors and need to be cleaned up and resubmitted. With Medicaid expansion some qualifying RSS services could be done outside of the public behavioral health system in which we would not be able to collect that data.

Indicator #: 7
Indicator: Goal G: Increase the number of pregnant women served (priority population goal)
Baseline Measurement: established in FY2019
First-year target/outcome measurement: Increase pregnant women served in treatment services by 2% from baseline.
Second-year target/outcome measurement: Increase pregnant women served in treatment services by 4% from baseline.
Data Source: State SAMHIS data, TEDs.
Description of Data: Based on State SAMHIS data that is submitted monthly by the Local Authorities, using TEDs we can determine pregnant women that have accessed and been served in public treatment services.

Data issues/caveats that affect outcome measures:
With Utah's recent passed medicaid expansion the majority of pregnant women seeking treatment services will qualify for medicaid behavioral health benefits and can access those services through all medicaid providers including private providers in which DSAMH does not collect that information and those clients accessing services will not be accounted for.

Priority #: 4
Priority Area: Improve care for children and youth
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, ESMI, Other (Adolescents w/SA and/or MH, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Children/Youth at Risk for BH Disorder, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:
Improve the quality of adolescent treatment services in Utah through the Treatment Research Institute (TRI) Consumer Guide to Adolescence Substance
Objective:

Goal A: Provide community-based services through increased access to school-based behavioral health services for children and youth.
Goal B: Provide community-based services through increased access to family and youth peer support services for children and youth via Family Resource Facilitation.
Goal C: Increase the number of youth served in SUD treatment services

Strategies to attain the objective:

A: Educate the community regarding services available through school based programs.
B: Provide education and TA around what peer services by Family Resource Facilitators can be provided to children and how they could assist with supporting individuals and families.
B: Ensure funding and school based service agreements are in place to ensure services are accessible.
C: Increase the number of youth treatment providers that are going through the quality improvement process which will ultimately increase service and outcomes.
C: Increase access for youth services through collaborate efforts with community referral sources.

Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Goal A: Provide community-based services through increased access to school-based behavioral health services for children and youth.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>established in FY18: 4,438 children and youth receiving services via school-based behavioral health.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Increase # of children and youth receiving school-based behavioral by 10%.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Increase # of children and youth receiving school-based behavioral by 15%.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>SAMHIS data, MOU Reporting requirements.</td>
</tr>
<tr>
<td>Description of Data:</td>
<td>SAMHIS and school-based reporting data.</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures::</td>
<td>FY19 State Legislation encouraging Local Education Agencies to provide more direct services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Goal B: Provide community-based services through increased access to family and youth peer support services for children and youth via Family Resource Facilitation.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>established in FY18: 651 children and youth receiving family and youth peer support services.</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Increase # of children and youth receiving family and youth peer support services by 15%.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Increase # of children and youth receiving family and youth peer support services by 15%.</td>
</tr>
<tr>
<td>Data Source:</td>
<td>SAMHIS data</td>
</tr>
<tr>
<td>Description of Data:</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures::</td>
<td>Data issues/caveats that affect outcomes measures: Medicaid rate increase of ~64% per quarter hour for peer support services.</td>
</tr>
</tbody>
</table>
Indicator #: 3
Indicator: Goal C: Increase the number of youth served in SUD treatment services
Baseline Measurement: established in 2018: 876
First-year target/outcome measurement: Increase 5% from established baseline in FY2020
Second-year target/outcome measurement: Increase 10% from established baseline in FY2021
Data Source: State SAMHIS data
Description of Data: Local Authorities upload data into the State SAMHIS system monthly. Youth served will be derived from the TEDs data and reported.
Data issues/caveats that affect outcome measures: Medicaid expansion in Utah may effect the number of youth served in the Public system as clients will have a choice to go to public medicaid providers. We don’t expect this to effect the numbers of youth much.

Priority #: 5
Priority Area: Health Systems Integration
Priority Type: SAT, MHS
Population(s): SMI, SED, PWWDC, EIS/HIV, 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: Improved coordination of care and integration of physical and behavioral health

Objective:
Goal A: Improve Behavioral Health/Primary Care Collaboration
Goal B: Increase CPSS working in an integrated setting
Goal C: Decrease time in discharge list for individuals ready to discharge from Utah State Hospital (USH)
Goal D: Increase the number of Local Authorities that are trained in communicable disease (HIV/TB) testing/or partner with the Health Department.
Goal E: Decrease tobacco use from Intake to discharge

Strategies to attain the objective:
A: Establish relationships with Primary Care Facilities and FQHC’s and work towards collaborative efforts to serve SUD/MH clients.
B: In combination with A above, educate and train CPSS to work in physical health settings.
C: Work with the Utah State Hospital to decrease discharge times, work to establish alternative treatment agencies that individuals can be transferred/referred to.
D: Work with the Utah Health Department to start a pilot project to train LA staff on administering quick tests for communicable disease testing and work with the LA to establish collaborative efforts to have the Health Department come in and conduct the testing directly.
E: Work with the LA to educate staff and clients regarding the health benefits of quit tobacco use. Identify Smoking Cessation trainers and hold annual Cessation training’s. Encourage LA to build Smoking Cessation efforts into client treatment plans.

Annual Performance Indicators to measure goal success
Indicator #: 1
Indicator: Goal A: Improve Behavioral Health/Primary Care Collaboration
Baseline Measurement: Pilot integrated care teams have been hired at three Local Authorities
First-year target/outcome measurement: All three teams will be trained to use at least 4 evidence-based screening tools for behavioral health.
Second-year target/outcome measurement: All three teams will be trained to use at least 3 brief intervention techniques based on screening results.
Data Source: Annual Performance Indicators to measure goal success
Utah Promoting Integration of Primary and Behavioral Healthcare program (SAMHSA grant)

Description of Data:
Trainings will be collected by the Program Administrator and recorded within the SPARS system.

Data issues/caveats that affect outcome measures:
Staff turnover will likely result in a need for multiple trainings for each tool and intervention.

Indicator #:
2
Indicator: Goal B: Increase CPSS working in an integrated setting
Baseline Measurement: No CPSS are completing integrated practicums in Primary Care/Behavioral Health (PC/BH) settings
First-year target/outcome measurement: 10 CPSS engaged in integrated practicums in PC/BH settings.
Second-year target/outcome measurement: 20 CPSS engaged in interated practicums in PC/BH settings.

Data Source:
CPSS training agencies (Utah State University, Allies with Families)

Description of Data:
Practicum placements are provided to DSAMH as part of the HRSA BHWET paraprofessional training grant.

Data issues/caveats that affect outcome measures:
Individuals who receive the core CPSS training do not always complete assigned practicums.

Indicator #:
3
Indicator: Goal C: Decrease time in discharge list for individuals ready to discharge from Utah State Hospital (USH)
Baseline Measurement: For those on the discharge list more than 30 days, there is an average wait time of 150 days
First-year target/outcome measurement: Identification of profile for individuals who are typically difficult to place in appropriate housing after discharge and integration of the list into the REDI system
Second-year target/outcome measurement: Decrease wait time for those on the REDI list more than 30 days by 10% (135 days average)

Data Source:
SAMHIS, REDI data

Description of Data:
Individuals who are ready to discharge from the civil side of the Utah State Hospital, includes the number of days that the individual has been on the list. USH, DSAMH staff and LMHA liaisons are creating a list of most significant barriers and will work with programmers to integrate the list into the REDI system.

Data issues/caveats that affect outcome measures:
A few individuals who are extremely difficult to place (ie. due to dangerous behaviors) can skew the average on the list.

Indicator #:
4
Indicator: Goal D: Increase the number of Local Authorities that are trained in communicable disease (HIV/TB) testing/or partner with the Health Department.
Baseline Measurement: established in FY19. none established officially
First-year target/outcome measurement: 4 Local Authorities trained in communicable disease testing/or partner with the Health Department in FY2020
Second-year target/outcome measurement: 8 Local Authorities trained in communicable disease testing/or partner with the Health Department in FY2021

Data Source:
Utah Department of Health will submit information regarding how many Local Authorities/providers they have trained or how many they will be providing the testing to directly.

Description of Data:
Utah Department of Health will submit information regarding how many Local Authorities/providers they have trained or how many they will be providing the testing to directly. Specifically HIV/TB testing

Data issues/caveats that affect outcome measures:
None

Indicator #:
5

Indicator:
Goal E: Decrease tobacco use from Intake to discharge

Baseline Measurement:
Established in 2018: 3.8% decrease on tobacco use from intake to discharge (state average)

First-year target/outcome measurement:
decrease tobacco use by 1% in year 1 from baseline in FY2020

Second-year target/outcome measurement:
decrease tobacco use by 2% in year 2 from baseline in FY2021

Data Source:
DSAMH annual scorecard

Description of Data:
The DSAMH scorecard data is derived from SAMHIS data uploaded monthly to DSAMH by the Local Authorities

Data issues/caveats that affect outcome measures:
Tobacco use data is valid only if the data for admission and discharge is collected by the local authorities.

Footnotes:
Student Health and Risk Prevention (SHARP) Data is collected on the odd years; baseline is 2015, first year is 2019 data, second year is 2021 data. NSDUH data is only available for 2016 as the baseline at this time. Prevention outcome measures will continue to use the SHARP data as it is the most reliable and most current data available for substance use related outcomes. Utah’s State Epidemiological Outcomes Workgroup (SEOW) will continue to seek out additional measures for the even year reporting.
### Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG.

**Planning Period Start Date:** 7/1/2019  
**Planning Period End Date:** 6/30/2021

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention* and Treatment</td>
<td>$9,870,206</td>
<td>$18,653,918</td>
<td>$3,793,589</td>
<td>$7,463,444</td>
<td>$7,460,237</td>
<td>$6,672,315</td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children**</td>
<td>$3,257,168</td>
<td>$8,922,292</td>
<td>$1,251,884</td>
<td>$2,462,936</td>
<td>$1,223,884</td>
<td>$1,153,925</td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td>$6,613,038</td>
<td>$9,731,626</td>
<td>$2,541,705</td>
<td>$5,000,508</td>
<td>$6,236,353</td>
<td>$5,518,390</td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td>$4,230,028</td>
<td>$0</td>
<td>$1,176,490</td>
<td>$235,452</td>
<td>$355,827</td>
<td>$599,400</td>
<td>$0</td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)</td>
<td>$829,556</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. Total</td>
<td>$14,929,790</td>
<td>$0</td>
<td>$18,653,918</td>
<td>$4,970,079</td>
<td>$7,698,896</td>
<td>$7,816,064</td>
<td>$7,271,715</td>
</tr>
</tbody>
</table>

* Prevention other than primary prevention  
** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.
Footnotes:
Numbers are for FY2020, which is the same as other tables.
## Planning Tables

### Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

**Planning Period Start Date:** 7/1/2019  
**Planning Period End Date:** 6/30/2021

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td>$5,176,944</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)</td>
<td></td>
<td></td>
<td></td>
<td>$609,052</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)**</td>
<td></td>
<td></td>
<td></td>
<td>$304,526</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. Total</td>
<td>$0</td>
<td>$6,090,522</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.
### Planning Tables

#### Table 3 SABG Persons in need/receipt of SUD treatment

<table>
<thead>
<tr>
<th></th>
<th>Aggregate Number Estimated In Need</th>
<th>Aggregate Number In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnant Women</td>
<td>1000</td>
<td>413</td>
</tr>
<tr>
<td>2. Women with Dependent Children</td>
<td>20000</td>
<td>4041</td>
</tr>
<tr>
<td>3. Individuals with a co-occurring M/SUD</td>
<td>30000</td>
<td>8528</td>
</tr>
<tr>
<td>4. Persons who inject drugs</td>
<td>6000</td>
<td>4920</td>
</tr>
<tr>
<td>5. Persons experiencing homelessness</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Please provide an explanation for any data cells for which the state does not have a data source.

We have been unable to find the number for those that are in need and are homeless.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**
### Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019    Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment*</td>
<td>$10,784,233</td>
</tr>
<tr>
<td>2. Primary Substance Abuse Prevention</td>
<td>$4,977,338</td>
</tr>
<tr>
<td>3. Early Intervention Services for HIV**</td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$829,556</td>
</tr>
<tr>
<td>6. Total</td>
<td>$16,591,127</td>
</tr>
</tbody>
</table>

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case
rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

Footnotes:
### Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th></th>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
<td>IOM Target</td>
<td>FFY 2020 SA Block Grant Award</td>
</tr>
<tr>
<td>1. Information Dissemination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>2. Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>3. Alternatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>4. Problem Identification and Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>5. Community-Based Process</td>
<td>Selective</td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$0</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. Environmental</th>
<th>Universal</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Selective</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$0</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Section 1926 Tobacco</th>
<th>Universal</th>
<th>$730,000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Selective</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$730,000</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Other</th>
<th>Universal</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Selective</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$0</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Total Prevention Expenditures</strong></th>
<th><strong>$730,000</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total SABG Award</strong>*</td>
<td><strong>$16,591,127</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>4.40 %</strong></td>
</tr>
</tbody>
</table>

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

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

Footnotes:
### Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019  
Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$1,185,933</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$989,343</td>
</tr>
<tr>
<td>Selective</td>
<td>$1,639,119</td>
</tr>
<tr>
<td>Indicated</td>
<td>$718,498</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$4,532,893</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong>*</td>
<td><strong>$16,591,127</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>27.32 %</strong></td>
</tr>
</tbody>
</table>

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

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

**Footnotes:**
### Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019       Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Targeted Substances</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>✓</td>
</tr>
<tr>
<td>Tobacco</td>
<td>✓</td>
</tr>
<tr>
<td>Marijuana</td>
<td>✓</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>✓</td>
</tr>
<tr>
<td>Cocaine</td>
<td>✓</td>
</tr>
<tr>
<td>Heroin</td>
<td>✓</td>
</tr>
<tr>
<td>Inhalants</td>
<td>✓</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td></td>
</tr>
<tr>
<td>Synthetic Drugs (i.e. Bath salts, Spice, K2)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Populations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
<td>✓</td>
</tr>
<tr>
<td>Military Families</td>
<td>✓</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>✓</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
<td>✓</td>
</tr>
<tr>
<td>African American</td>
<td>✓</td>
</tr>
<tr>
<td>Hispanic</td>
<td>✓</td>
</tr>
<tr>
<td>Homeless</td>
<td>✓</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
<td>✓</td>
</tr>
<tr>
<td>Asian</td>
<td>✓</td>
</tr>
<tr>
<td>Rural</td>
<td>✓</td>
</tr>
<tr>
<td>Underserved Racial and Ethnic Minorities</td>
<td>✓</td>
</tr>
</tbody>
</table>
## Planning Tables

### Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019  Planning Period End Date: 9/30/2021

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. SABG Treatment</th>
<th>B. SABG Prevention</th>
<th>C. SABG Combined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td></td>
<td>$7,000</td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$60,000</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$40,000</td>
<td>$100,000</td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td></td>
<td>$3,200</td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$35,100</td>
<td>$10,000</td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
<td>$575,000</td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$321,095</td>
<td>$160,000</td>
<td></td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$456,195</strong></td>
<td><strong>$855,200</strong></td>
<td><strong>$0</strong></td>
</tr>
</tbody>
</table>

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020
Footnotes:

? Amount of SABG Primary Prevention funds (from Table 4, Row 2) to be used for Non-Direct-Services/System Development Activities for SABG Prevention, Column B, and/or SABG Combined, Column C = $855,200.

? Amount of SABG Administration funds (from Table 4, Row 5) to be used for Non-Direct-Services/System Development Activities for SABG Prevention, Column B, and/or SABG Combined, Column C = $0.00.
## Planning Tables

### Table 6 Non-Direct-Services/System Development [MH]

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2020 Block Grant</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$16,000</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$218,200</td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$420,000</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$50,000</td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$100,000</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$77,564</td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$322,850</td>
</tr>
<tr>
<td>8. Total</td>
<td>$1,204,614</td>
</tr>
</tbody>
</table>

MHBG Planning Period Start Date: 07/01/2019  MHBG Planning Period End Date: 06/30/2020

Footnotes:
Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions. Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease. It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders. SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity. For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care. Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes and ACOs may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

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

Printed: 8/1/2019 4:02 PM - Utah - OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022 Page 161 of 295
partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers; consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states’ Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

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

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.


26 http://www.samhsa.gov/health-disparities/strategic-initiatives


Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings.

   The State provides oversight for the Local Authority Substance Use Disorder (LSAA) and Mental Health Providers (LMHA) who integrate substance use disorder (SUD) and mental health (MH) services through direct service delivery or contracted services. They provide a continuum of services including prevention, treatment outpatient treatment and residential services. The LSAA and LMHA's coordinate closely with physical health care providers, including Federally Qualified Health Care Centers (FQHC's) to provide integrated behavioral health and physical health care services. Several of the LSAA/LMHA's have integrated behavioral and physical health care clinics. Some examples are: (1) Fourth Street Clinic (physical health, mental health, substance use disorder treatment in Salt Lake City); (2) Odyssey House of Utah - Martindale Clinic; (3) Weber Human Services with an integrated health home and Midtown Community Health Center (Ogden); (4) Bear River Health Department - SUD Treatment; (5) Summit Valley Behavioral Health co-located with the Summit Health Department; (6) Wasatch Mental Health with physical health nursing on site; (7) Utah County Department of Drug and Alcohol Prevention and Treatment (ADAPT) co-located with Utah County Health Department in Provo (8) ADDAPT, Wasatch Mental Health, Workforce Services and Health Department co-located in Payson; (9) San Juan Counseling Center co-located with the San Juan Health Department; and (10) Family Health Center provides a physical health and mental health provider at each clinic session. The LSAA/LMHAs also coordinate closely with Accountable Care Organizations, such as Intermountain Health Care (IHC) and the Utah Association for Community Health (AUCH). Summit County has collaborated with a pediatric clinic to provide primary prevention parenting programs. The pediatricians see this as a way to decrease Adverse Childhood Experiences and increase overall physical health along with mental health and prevention substance use disorders.

   The State received the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) grant from SAMHSA. As a result, integrated care is being provided in the Bear River, Utah County, and Southwest areas of the state.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

   The State requires that the LSAA/LMHA's provides services on a sliding scale fee basis for individuals with SUD, MH and co-occurring SUD and MH disorders. They also offer services through insurance, Medicaid, SAPT Block Grant funds, private grants and other funding sources. In addition, the State works closely with the Utah Medicaid Office, Accountable Care Organizations and the Utah Association for Community Health to ensure that various funding options are available for the public. The Utah Department of Human Services (DHS) also operates on a Systems of Care Approach, where individuals and their families are able to access services through various options and funding sources. It is expected the Medicaid Expansion will increase opportunities for individuals to receive integrated care within the state.
3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?  
Yes ☒  No ☐

b) Is there a plan for monitoring access to M/SUD services by the QHP?  
Yes ☒  No ☐

4. Who is responsible for monitoring access to M/SUD services by the QHP?  
The Division of Substance Abuse and Mental Health (DSAMH) is responsible for monitoring Local Authorities and coordination of access to MH and SUD services through the QHP’s. DSAMH provides an Annual Site Visit where they monitor the LSAA/LMHA’s compliance with SAPT/MHDBG Block Grant Requirements, service delivery and access to services. Part of this Site Visit includes access to integrated behavioral and physical health care services through the FQHC’s and integrated clinics. At the Site Visit, DSAMH meets with the LSAA/LMHA Teams to review policies and procedures related to health and wellness and recovery goals. At times, the Site Visit includes an on-site visit to clinics such as the Odyssey House Martindale Clinic, Utah County Department of Drug and Alcohol Prevention and Treatment, Bear River integrated care unit located in Tremonton and Weber Human Services to review how SUD and MH services are delivered in the Integrated Clinics.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?  
Yes ☒  No ☐

6. Do the M/SUD providers screen and refer for:
   a) Prevention and wellness education  
Yes ☒  No ☐

   b) Health risks such as  
      ii) heart disease  
Yes ☒  No ☐

      iii) hypertension  
Yes ☒  No ☐

      iv) high cholesterol  
Yes ☒  No ☐

      v) diabetes  
Yes ☒  No ☐

   c) Recovery supports  
Yes ☒  No ☐

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?  
Yes ☒  No ☐

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?  
Yes ☒  No ☐

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?  
Utah has made progress toward parity for mental health and substance abuse. While the Mental Health and Parity Final Rule does not require Medicaid or CHIP to provide certain mental health or substance abuse benefits, it does require parity if those benefits are provided. In 2016, Utah requested a five-year extension of the Primary Care Network Demonstration waiver (1115). An amendment added to the waiver includes the implementation of Mental Health parity for the Non-Traditional Medicaid group. However, there is an exemption in the regulation for small employer plans for CHIP and additional changes need to be made regarding the current residential treatment benefit under the CHIP program. In addition, Utah just passed a Medication Expansion bill and enrollment started April 1, 2019.

10. Does the state have any activities related to this section that you would like to highlight?

   1. Opioid Treatment Providers: There are 14 Opioid Treatment Providers (OTP’s) in Utah that provide medication-assisted treatment (MAT) for individuals diagnosed with opioid-use disorders. They serve approximately 3495 individuals each year. At least two clinics, Project Reality and Metamorphosis Ogden are contracted with pubic system.

   2. Opioid Community Collaborative: IHC, Davis and Weber County have an Interdisciplinary approach to providing MAT for pregnant women, women between 20-35 and individuals who are homeless.

   3. Salt Lake County Extended Release Naltrexone Pilot: Salt Lake County, Midtown health Clinic, Utah Department of Corrections One of the largest jail MAT programs in Country (248 Participants). The first shot administered within County jail.

   4. Certified Peer Support Specialists are offered an Integrated Care Enhancement, a 12 hour training focused on supported clients as they manage the combination of behavioral health and physical health challenges.

   5. DSAMH received a Primary Care and Behavioral Health Integration grant from SAMHSA. The grant provides funding to three Local Authorities (urban and rural) and has multiple goals related to system change to improve integrated services.

   6. One of the LSAA, Summit County, has partnered with a local pediatrics office to provide the primary prevention parenting program, Systematic Training for Effective Parenting (STEP). They have reached over 2,000 people in a smaller county. The initiative has also decreased the stigma that those who attend parenting programs are “failing.” The outcomes are expected to show change on our biennial survey out Fall 2019.

Please indicate areas of technical assistance needed related to this section

None at this time.
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the HHS Action Plan to Reduce Racial and Ethnic Health Disparities\(^\text{42}\), Healthy People, 2020\(^\text{43}\), National Stakeholder Strategy for Achieving Health Equity\(^\text{44}\), and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)\(^\text{45}\).

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

The HHS Secretary’s top priority in the Action Plan is to “assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits.”\(^\text{46}\)

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status\(^\text{47}\). This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations\(^\text{48}\). In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA’s and HHS’s attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.


\(^{43}\) http://www.healthypeople.gov/2020/default.aspx

\(^{44}\) http://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf

\(^{45}\) http://www.ThinkCulturalHealth.hhs.gov

Printed: 8/1/2019 4:02 PM - Utah - OMB No. 0930-0168  Approved: 04/19/2019  Expires: 04/30/2022
Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
   - a) Race [ ] Yes [ ] No
   - b) Ethnicity [ ] Yes [ ] No
   - c) Gender [ ] Yes [ ] No
   - d) Sexual orientation [ ] Yes [ ] No
   - e) Gender identity [ ] Yes [ ] No
   - f) Age [ ] Yes [ ] No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? [ ] Yes [ ] No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? [ ] Yes [ ] No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? [ ] Yes [ ] No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? [ ] Yes [ ] No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? [ ] Yes [ ] No

7. Does the state have any activities related to this section that you would like to highlight?
   DSAMH participates on a Community of Practice for Cultural Competence through Georgetown University.

   Although there is no formal workforce training plan, Peer Support Specialists providing recovery services do have the opportunity to receive enhancement training in cultural competence. Mental Health Block Grant funds have been used for projects to improve services for minority and marginalized populations.

   Please indicate areas of technical assistance needed related to this section
   None at this time.

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, \( V = Q ÷ C \)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA’s Evidence Based Practices Resource Center assesses the research evaluating an intervention’s impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA’s Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

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

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA’s Treatment Improvement Protocol Series (TIPS) are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA’s Evidence-Based Practice Knowledge Informing Transformation (KIT) was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.
SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers’ decisions regarding M/SUD services.


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


53 http://psychiatryonline.org/

54 http://store.samhsa.gov

55 http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  
   - Yes  - No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   
   a) [ ] Leadership support, including investment of human and financial resources.
   b) [ ] Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c) [ ] Use of financial and non-financial incentives for providers or consumers.
   d) [ ] Provider involvement in planning value-based purchasing.
   e) [ ] Use of accurate and reliable measures of quality in payment arrangements.
   f) [ ] Quality measures focus on consumer outcomes rather than care processes.
   g) [ ] Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   h) [ ] The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

   DSAMH has recently implemented the Utah Behavioral Health Outcome Improvement Initiative Pilot and Technical Assistance Collaborative (OII). The goal of OII is to assist behavioral health organizations in utilizing implementation frameworks and other strategies to increase the effective use of treatments that improve client outcomes.

   DSAMH requires the use of Evidence Based Practices and requires EBP be listed on an approved list kept and updated by DSAMH or requires that all other practices go though a Evidence Review Committee for review before they can be used or implemented by the the public behavioral health system.

   The Quality Care Workgroup is comprised of staff from DSAMH, Department of Human Services, Bach Harrison LLC, employees from local Universities, employees from the Utah Center for Evidence Based Treatment, Local Authorities, Utah’s National Association of Social Workers, ESI management. This work group is working towards implementing more EBP within the behavioral health undergrad and graduate programs and to encourage more field study and training within the behavioral health system. The goal is to have graduates have broader experience in different behavioral health programs through the system and to be better equipped with EBP training prior to graduating. This will lead to more effective and efficiency in EBP for the workforce and lead to better outcomes for clients.

   DSAMH also conducts annual monitoring visits with each of the Local Authorities which include Governance and oversight, financial operations, Prevention, SUD and MH services, documentation, screening and assessments, chart reviews, priority population reviews, data reviews, etc. The finds from these visits are reviewed by leadership and any areas of concern are addressed and reported.

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

   None at this time.
Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA’s working definition of an Early Serious Mental Illness is “An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset.”

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?
   - Yes
   - No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?
   - Yes
   - No

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   The Utah State Division of Substance Abuse and Mental Health (DSAMH) uses the 10% set aside funds to contract with four Local Mental Health Authorities in the State of Utah to provide Coordinated Specialty Care (CSC) programs for individuals experiencing early serious mental illness. Weber Human Services was the pilot site for the 5% set aside, with expansion to Davis Behavioral Health and Wasatch Mental Health with the 10% set aside. Within the last year, Four Corners Community Behavioral Health has also introduced a CSC program. Each of the LMHAs providing CSC services include the following components: Medication Management, Individual and Group Psychotherapy, Dialectical Behavioral Therapy, Supported Employment/Individual Placement and Support, Supported Education, Case Management, Peer Support, Multi or Single-Family Psychoeducation, and Recovery Oriented Cognitive Behavioral Therapy.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?
DSAMH does not provide direct services. Instead, the DSAMH contracts with 13 Local Mental Health Authorities (LMHAs) statewide to provide services to individuals with SMI and SED. DSAMH promotes the use of evidence-based practices by providing training on the CSC model and contracting for Technical Assistance from the Early Assessment and Support Alliance (EASA) Center for Excellence at the Oregon Health and Science University. Three of the LMHAs receiving set-aside funds have had the following: Onsite training from OnTrack NY and EASA, training and continued technical assistance to provide a Structured Interview for Prodromal Syndromes (SIPS) from Barbara Walsh, and training on Multi and Single--Family Groups from both EASA and the PIER program. In addition, all of the LMHAs provide an area plan annually, with details of how they are going to provide services including the 10 mandated services from Medicaid, following the Division Directives. The LMHAs outline how they are going to provide integrated mental health and physical health services, including how they will coordinate with community partners such as their locally Federally Qualified Health Centers. The DSAMH provides training in evidence based practices (EBPs), and support conferences to train clinicians in evidence based practices. The DSAMH also track EBPs through the Substance Abuse Mental Health Information System (SAMHIS) and work with clinical directors from each LMHA to promote evidence based practices. The DSAMH monitors annually to the LMHA area plans.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? ○ Yes ○ No

5. Does the state collect data specifically related to ESMI? ○ Yes ○ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ○ Yes ○ No

7. Please provide an updated description of the state’s chosen EBPs for the 10 percent set-aside for ESMI.
   Several EBPs are used as part of the Prevention and Recovery in Early Psychosis (PREP) program in Utah. All the centers are using the Coordinated Specialty Care model and have had training from Ontrack NY, EASA program from Oregon and the PIER model. EBPs within the CSC include Dialectical Behavioral Therapy, Supported Employment/Individual Placement and Support, Supported Education, Multi and Single-Family Psychoeducation, and Recovery Oriented Cognitive Behavioral Therapy.

8. Please describe the planned activities for FY 2020 and FY 2021 for your state’s ESMI programs including psychosis?
   Programs at the primary pilot site (Weber Human Services) and the expansion sites (Davis Behavioral Health, Wasatch Mental Health,) will continue to be developed. Ongoing training will be provided to ensure that EBPs are provided to fidelity and that an array of treatment services and recovery supports are being offered.
   **Strategic Plan for FY17-19**
   **Goal I: Early psychosis is well understood and accepted by the community.**
   **Objective 1:** School personnel understand early psychosis and are able to identify and refer young people of transition age for services.
   **Objective 2:** Faith-based communities understand early psychosis and are able to identify and refer young people of transition for services.
   **Objective 3:** First responders (mobile crisis, law enforcement) and medical personnel understand early psychosis and are able to identify and refer young people of transition for services.
   **Objective 4:** Criminal/juvenile justice system personnel understand early psychosis and are able to identify and refer young people of transition for services.
   **Objective 5:** Child welfare system personnel understand early psychosis and are able to identify and refer young people of transition for services.
   **Objective 6:** Intellectual and Physical disability system personnel understand early psychosis and are able to identify and refer young people of transition for services.
   **Objective 7:** Families, young people, and natural supports understand early psychosis and are able to identify and refer young people of transition for services.
   **Objective 8:** General public understands early psychosis and the stigma associated with it is reduced and/or eliminated.
   **Goal II: Behavioral health providers have the capacity and capability to provide effective screening, assessment, interventions, and support through training and implementation consultation**
   **Objective 1:** Behavioral health providers are trained in early psychosis screening, assessment, interventions, and supports.
   **Objective 2:** Behavioral health providers have the capacity to provide assertive outreach and engagement.
   **Objective 3:** Behavioral health providers provide early psychosis screening, assessment, interventions, and supports to fidelity through implementation support.
   **Goal III: Early psychosis service will be available statewide**
   **Objective 1:** Integrate early psychosis services into the Mental Health Centers Area Plan by 2019 (regional training)
   **Objective 2:** Expand fully structured early psychosis program to four Mental Health Centers by 2019
   **Objective 3:** Expand fully structured early psychosis program to six Mental Health Centers by 2020

Specific planned activities for FY 2020 and 2021 are:
- Incorporate Occupational Therapy into CSC.
- Incorporate cognitive remediation/health into CSC.
- Collaborate with the Office of Medicaid and Health Financing, Utah Department of Health to enhance service arrays for ESMI.
- Develop the PREP Practice Model.
- Develop fidelity tools and begin fidelity reviews in 2020.
- Exploring the feasibility of integrating adolescent health and behavioral health.
9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

A spreadsheet on the data being collected through SAMHIS as well as through biannual reports from the programs has been created and will be used to monitor the impact of the 10% set aside. The matrix, the baseline data form and the outcome review form have been attached. Data will be collected biannually and the programs will be monitored annually on regular site visits, which will include chart reviews and sitting in on team meetings.

Fidelity tools are being developed to assess the fidelity implementation of CSC by LMHAs. Fidelity reviews will start in early 2020.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Primary Focus Diagnosis: Nonaffective Psychotic Disorder  
Secondary Focus: Affective Psychotic Disorder

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

Receiving technical assistance from EASA and CLASP.

Footnotes:
Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question
States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person’s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person’s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person’s needs and desires.

1. Does your state have policies related to person centered planning?
   - Yes  [ ]  No  [ ]

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.
   The Recovery Oriented System of Care (ROSC) Committee and Utah Behavioral Health Committee (UBHC) have created the Utah Preferred Practice Guidelines that include the development of person-centered planning. This committee includes individuals from Local Authorities and the Division of Substance Abuse and Mental Health, with ongoing monthly meetings to continue to develop strengths-based person-centered planning that is recovery based.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.
   DSAMH does not provide direct services to consumers. Division Directives created by DSAMH, and the Utah Preferred Practice Guidelines, emphasize that an important aspect of effective treatment is the ability for providers to engage clients so that the client has hope for their recovery and desires to participate in treatment. One barrier to effective engagement is the belief that all elements of assessment and planning must be gathered at the very beginning of services. Therefore, these guidelines emphasize that assessment and planning are a process rather than an event, and should be balanced with the process of engagement. A more concerted focus on engagement will result in improvements in client retention and improved treatment outcomes. DSAMH monitors assessments and treatment plans to look for client and caregiver input in treatment decisions. Consumer satisfaction surveys (Mental Health Statistics Improvement Program) are collected system wide and reviewed annually.

4. Describe the person-centered planning process in your state.
   Utah Preferred Practice Guidelines requires that services be provided in a person-centered, strengths-based and trauma-informed manner. Person-centered and strengths-based questions will lead both client and therapist in a solution-oriented direction. This establishes a bridge between assessment and development of a person centered treatment/recovery plan. Information for creating a person centered treatment/recovery plan is documented. The electronic health records used by Local Authorities have been improved so that assessments and recovery plans can be continually updated as the individual in treatment reaches goals. Annual monitoring by DSAMH includes chart reviews, which focus on person-centered planning and evidence of client voice in the treatment choices. When client voice is not evident in goals and objectives, DSAMH offers technical assistance to treatment providers, requiring that treatment and recovery efforts are person-centered.

   Please indicate areas of technical assistance needed related to this section.
   No technical assistance needed at this time.

Footnotes:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Printed: 8/1/2019 4:02 PM - Utah - OMB No. 0930-0168  Approved: 04/19/2019  Expires: 04/30/2022
Page 174 of 295
Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ☐ Yes ☐ No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? ☐ Yes ☐ No

3. Does the state have any activities related to this section that you would like to highlight?

The Division uses its contracts, its Division Directives, its onsite auditing process, a review of all billing statements and review of annual Area Plans and end of year Area Plan reports to ensure information is disseminated and followed appropriately. The Division leadership meets with the 15 Local Authority Directors each month, and there are also monthly meetings of the Division with the Local Authority Prevention Managers, Finance Managers, Data Managers and Clinical Directors. Through yearly audit visits of each Local Authority that along with compliance checks, provide technical assistance on improving procedures and practices. Through yearly educational conferences funded by the Division (Generations Conference, Fall Substance Abuse Conference, Utah Valley Addictions Conference). Through monthly and Semi annual meetings of the Utah Behavioral Health Care Committee that includes meetings with Agency Directors, Clinical Directors, Finance Directors and Data/Information Systems Directors. Through Annual Division Directive Trainings. Through Reviews of Area Plans submitted annually.

Budget reviews are accomplished as part of the Area Plan Approval Process. http://dsamh.utah.gov/provider-information/localauthoritycounty-area-plans/
Claims/payment adjudication; Cost Reimbursement billings are reviewed by program administrators and finance managers prior to disbursement.

Expenditure report analysis; These are done periodically during the year with a wrap up at year end.

Compliance reviews; The Division conducts onsite audit visits to all Local Authorities annually. Client level encounter/use/performance analysis data. The Division uses Outcome Score Cards as well as information submitted to SAMHIS for ongoing analysis. Please see the Division’s annual report at: https://dsamh.utah.gov/pdf/Annual%20Reports/2018%20Executive%20Summary.pdf. As stated above the Division conducts annual audits of each Local Authority.

https://dsamh.utah.gov/providers/contracts-and-monitoring

Please indicate areas of technical assistance needed related to this section

None at this time.

Footnotes:

DSAMH would like to use SABG funds for SUD co-pays and deductibles as outlines and defined in http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf.
Environmental Factors and Plan

7. Tribes - Requested

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

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

Utah is home to 8 federally recognized American Indian Tribes including the Northern Ute, Navajo, Paiute, Goshute, Northwestern Band of Shoshone, San Juan Southern Paiute, Skull Valley Band of Goshute and White Mesa Band of the Ute Mountain. Native American populations reside in various “reservations” in the Northeastern and Southeastern regions of the state; Federal, State, County and Native American jurisdictions are involved in providing services. Both of these areas are relatively remote with poor transportation and sparse populations, which further stretch the state’s resources. The direct planning and provision of services is a responsibility of the Local Authorities in those areas, and the provision of services to Native American populations is a part of the annual contract review and audit. Success in negotiating service agreements and coordinating services is often an issue of local politics and personalities. Utah’s Department of Human Services has developed a Tribal Indian Issues Committee and signed a coordination/collaboration agreement with the various Native American tribal representatives supporting the need for planning and coordination at a state level. DSAMH has taken an active role in working with the Native American tribal organizations. This has included attendance at the quarterly Tribal Indian Issues Committee and active discussions with the tribal authorities during the annual site visits to the local authorities. A representative from DSAMH attends the Annual Native American Governor’s Summit. There are ongoing efforts to include representatives from the tribal organizations on the Behavioral Health Consumer Advisory Council.

2. What specific concerns were raised during the consultation session(s) noted above?

Issues include getting mental health services and substance abuse services in the frontier areas of Utah, including the Navajo and the Goshute Tribes. Transportation in these areas is a significant barrier, with two Local Authorities flying into remote regions weekly in order to provide services. Telehealth services can also be impacted as cell service can be unpredictable.

3. Does the state have any activities related to this section that you would like to highlight?
The DSAMH attends the quarterly Tribal Indian Issues Committee, hosted by the tribal nations. These meetings have been coordinated to happen in the same week as the Tribal Leadership meetings to facilitate tribal leadership representation. Having the meetings on the reservations have greatly improved the quality of these meetings.

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

None at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. 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 use disorder 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 requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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 Process** 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.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?
   – Yes
   – No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)
   - [ ] Data on consequences of substance-using behaviors
   - [ ] Substance-using behaviors
   - [ ] Intervening variables (including risk and protective factors)
   - [ ] Other (please list)

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
   - [ ] Children (under age 12)
   - [ ] Youth (ages 12-17)
   - [ ] Young adults/college age (ages 18-26)
   - [ ] Adults (ages 27-54)
   - [ ] Older adults (age 55 and above)
   - [ ] Cultural/ethnic minorities
   - [ ] Sexual/gender minorities
   - [ ] Rural communities
   - [ ] Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)
Archival indicators (Please list)
Juvenile arrest data, children in protective custody, adult arrest data

- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

Treatment needs data (substance upon admission), death data.

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds?  
   - Yes  
   - No

If yes, (please explain)
A formula using incidence and prevalence of substance use disorder and population is used to allocate funding to communities.
If no, (please explain) how SABG funds are allocated:
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. 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 use disorder 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 requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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 Process** 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.

### Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?  
   - [ ] Yes  - [ ] No
   
   If yes, please describe
   
   Utah has a certification program of Substance Use Prevention Specialist Training (SAPST). It was originally developed with assistance from the Western Regional Expert Team, CAPTs. Currently, Utah is working with our Prevention Technology and Transfer Center (PTTC) to revise and update the curriculum. All contracted prevention professionals are required to have SAPST certification.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?  
   - [ ] Yes  - [ ] No
   
   If yes, please describe mechanism used
   
   The Division of Substance Abuse and Mental Health provides Technical Assistance through our Regional Directors. Each RD meets with the local providers and does a review with them to identify needs. Then the RD coordinates with the Division to provide necessary TA.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?  
   - [ ] Yes  - [ ] No
   
   If yes, please describe mechanism used
   
   The State supports and local providers use the Tri Ethnic Center model to assess community readiness to implement prevention strategies.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. 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 use disorder 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 requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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 Process** 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.

### Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No

   If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)
   - Yes  
   - No  
   - N/A

3. Does your state’s prevention strategic plan include the following components? (check all that apply):
   - a) Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
   - b) Timelines
   - c) Roles and responsibilities
   - d) Process indicators
   - e) Outcome indicators
   - f) Cultural competence component
   - g) Sustainability component
   - h) Other (please list):
     - i) Not applicable/no prevention strategic plan
   - j) Other (please list):

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?
   - Yes  
   - No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?
   - Yes  
   - No

   If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

   The Utah Evidence Based Workgroup uses the SAMHSA guidance document (2007) as the basis for the determinations of which programs, policies, and strategies are evidence based. The intervention may be considered evidence-based if:

   Definition 1: It is included on Division of Substance Abuse and Mental Health approved Federal Lists or Registries of evidence based interventions
   - Definition 2: It is reported (with positive effects) in peer-reviewed journals
   - Definition 3: Documented effectiveness supported by other sources of information and the consensus judgment of informed
experts, as described in the following set of guidelines, all of which must be met: (Please note that all four criteria must be met):

a. The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and

b. The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and

c. The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern or credible and positive effects; and

d. The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

The Evidence-Based Workgroup will serve as the informed experts for Utah. The EBW developed a tier tool for providers and developers to identify which tier of effectiveness the program, policy or strategy might fit. In addition, there is a checklist for submission and a guidance document on how to submit for approval. https://dsamh.utah.gov/services/prevention/implement-an-evidence-based-program
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. 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 use disorder 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 requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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 Process** 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.

### Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a) SSA staff directly implements primary prevention programs and strategies.
   
   b) The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
   
   c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
   
   d) The SSA funds regional entities that provide training and technical assistance.
   
   e) The SSA funds regional entities to provide prevention services.
   
   f) The SSA funds county, city, or tribal governments to provide prevention services.
   
   g) The SSA funds community coalitions to provide prevention services.
   
   h) The SSA funds individual programs that are not part of a larger community effort.
   
   i) The SSA directly funds other state agency prevention programs.
   
   j) Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a) Information Dissemination:
      
      Use Only As Directed • Parents Empowered - media • Community Awareness Events • Women’s Prevention Resource Facilitation - clearing house • Conferences, Local
   
   b) Education:
      
      • All Stars • Prevention Dimensions – classroom, universal • Prevention Dimension Training • Prevention Dimension – Elementary Lessons • Prevention Dimension – Secondary Lessons • Parenting Wisely • Parenting with Love and Logic • Incredible Years • Guiding Good Choices • Mindfulness Based Stress Reduction • Botvins LifeSkills • Families Plus: Making Choices • Families Plus: Strong Families • Too Good for Drugs • SMART Moves • Active Aging • Parent and Teen Alternative Program • Prevention Relationship Enhancement Program • Cool Minds • Hope for Tomorrow • Why Try • Nueva Dia - parenting program • Parents as Teachers • Collaborative Multi-Family Prevention Program - parenting program • Systematic Training for Effective Parenting • Growing Up Strong - classroom, selective • GrandFamilies • Keepin’ it REAL - community, school, initiative with law enforcement • Community Empowering Parents • Strengthening Families • Smoking Prevention Classes • Drug Offenders Classroom - first offenders, in school education • Daily ATOD Class Prime for Life – Adult • Prime for Life – Under 21 • Personal Empowerment Program - selective, school based education group. High school • Kid Power - selective, school based education group, elementary • Personal Power - universal, school based education group, elementary • Truancy Program • First Offender
c) Alternatives:
- Tutoring
- Social Media Prevention
- Voices - tutoring and mentoring
- SPORT Prevention + Wellness
- Vocational Mentoring
- APP – Activities that Promote Prevention
- Mentoring
- Tradition of Caring
- Leadership and Resiliency
- Trio Talent Search - mentoring
- Big Brothers Big Sisters - mentoring

d) Problem Identification and Referral:
- Prime for Life – Adult
- Prime for Life – Under 21
- Personal Empowerment Program
- Kid Power
- Personal Power
- Truancy Program
- First Offender
- Getting it Right
- Peer Court
- Academic Assistance
- Drop Out Prevention

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

f) Environmental:
- Minor in Possession
- Shoulder Tap
- Retailer Education
- Server Management Alcohol Responsibility Training – On Premise
- Server Management Alcohol Responsibility Training – Off Premise
- Counter Advertising (media)

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? 
   - Yes ☒
   - No ☐

   If yes, please describe
   There are statutorily mandated site visits throughout the fiscal year. In addition, Utah is a reimbursement process state. This means that the provider must submit an invoice with supporting documentation for approval to be paid. Prior to the monitoring, each site submits a prevention plan that highlights services to be offered. The State reviews these plans to ensure services are primary prevention.
Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. 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 use disorder 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 requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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 Process** 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.

**Evaluation**

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No  
   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan.

2. Does your state’s prevention evaluation plan include the following components? (check all that apply):  
   a) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks  
   b) Includes evaluation information from sub-recipients  
   c) Includes SAMHSA National Outcome Measurement (NOMs) requirements  
   d) Establishes a process for providing timely evaluation information to stakeholders  
   e) Formalizes processes for incorporating evaluation findings into resource allocation and decision-making  
   f) Other (please list):  
   g) Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:  
   a) Numbers served  
   b) Implementation fidelity  
   c) Participant satisfaction  
   d) Number of evidence based programs/practices/policies implemented  
   e) Attendance  
   f) Demographic information  
   g) Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:  
   a) 30-day use of alcohol, tobacco, prescription drugs, etc  
   b) Heavy use  
   c) Binge use  
   d) Perception of harm  
   e) Disapproval of use
d) Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) Other (please describe):

30 day youth marijuana use, 30 day youth prescription drug use, past year prescription drug use adult
Division of Substance Abuse and Mental Health Strategic Plan (DSAMH)

Revised November 2018

*This is a working document, meant to be updated regularly. Other objectives not listed are being worked on by DSAMH.

DSAMH Vision -- Healthy Individuals, Families, and Communities
DSAMH Mission -- Promote Health, Hope, and Healing from Mental Illness and Substance Use Disorders
DSAMH Functions-- Partnerships, Quality, Education, Accountability and Leadership
DSAMH Principles-- Trauma-Informed, Evidence Based Practices, Sustainable, Culturally and Linguistically Competent

STRATEGIC INITIATIVES

Strategic Initiative #1 - Prevention and Early Intervention (Craig)
Strategic Initiative #2 – Zero Suicides (Kim)
Strategic Initiative #3 – Promote Recovery (Pam - Shanel)
Strategic Initiative #4 – Improve Care for Children and Youth (Eric - Shanel)
Strategic Initiative #5 – Health System Integration (Shanel - Pam)

GOALS - OBJECTIVES - METRICS

<table>
<thead>
<tr>
<th>Strategic Initiative #1 - Prevention and Early Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOALS</strong></td>
</tr>
</tbody>
</table>
| Goal 1.1 Prevent and reduce underage drinking | Objective 1.1.1 Reduce community norms favorable to underage drinking | **Indicator:** Decrease the percentage of underage drinking
| | Objective 1.1.2 Reduce parental attitudes favorable towards underage drinking | 30 Day Alcohol Use, youth |
| | | **Baseline:** 7%, all grades, 2013 |
| | | **Target:** 5%, all grades, 2023 |
| | | **Timeframe:** 2013-2023 |
| | | **Responsible:** Prevention Program Administrator (Craig) |
| Goal 1.2 Prevent and reduce prescription drug misuse and abuse | Objective 1.2.1 Reduce community norms favorable to misuse and abuse  
Objective 1.2.2 Reduce illicit access to prescription drugs  
Objective 1.2.3 Increase Communities That Care efforts  
Objective 1.2.4 Increase access to person-centered prevention services  
Objective 1.2.5 Decrease risk factors and increase protective factors |
|---|---|
| Indicator: Decrease percentage of prescription drug misuse and abuse  
Prescription Drug Misuse in past 30 days among youth; adults  
**Baseline:** Youth: 2.3, all grades, 2013  
**Target:** Youth: 1.0, all grades, 2023  
**Timeframe:** 2013-2023  
**Responsible:** Prevention Program Administrator (Craig PoVey) |
| OUTCOMES - UPDATES:  
2017: Youth 2.4%, All grades (stable) | PoVey) |
| OUTCOMES - UPDATES:  
2017: 6.7% all grades (stable) |
## Goal 1.3 Prevent and reduce marijuana use

| Objective 1.3.1 Reduce community norms favorable to misuse and abuse |
| Objective 1.3.2 Reduce access to marijuana |
| Objective 1.3.3 Increase Communities That Care efforts |
| Objective 1.3.4 Increase access to person-centered prevention services |
| Objective 1.3.5 Decrease risk factors and increase protective factors |

**Indicator:** Decrease the percentage of marijuana use Past 30 day use, youth

- **Baseline:** 5.2, all grades, 2013
- **Target:** 4.0, all grades, 2019
- **Timeframe:** 2013-2019
- **Responsible:** Prevention Program Administrator (Craig PoVey)

**Outcomes - Updates:**
- 2017: 6.1%, All Grades (slight increase)

---

## Goal 1.4 Prevent and reduce depression and other mental illness

| Objective 1.4.1 Identify opportunities to integrate Substance Use Disorder (SUD) and mental illness prevention systems, models, policies, and practices |
| Objective 1.4.2 Increase access to evidence based programs proven to reduce mental illness |
| Objective 1.4.3 Promote, educate, and provide leadership to increase the number of Communities That Care Coalitions addressing mental illness issues |
| Objective 1.4.4 Decrease risk factors and increase protective factors |

**Indicator:** Reduce the percentage of mental illness needs for Mental Health Treatment(MH) - High mental health needs

- **Baseline:** 13.0 of all grades, 2013
- **Target:** 12.0 of all grades, 2019
- **Timeframe:** 2013-2019
- **Responsible:** Prevention Program Administrator (Craig PoVey)

**Outcomes - Updates:**
- 2017: 18%, all grades (Increase)

---

## Goal 1.5 Prevent tobacco and nicotine use

| Objective 1.5.1 Cooperate with the State Department of Health in the planning and administration of Synar Checks |
| Objective 1.5.2 Reduce community norms favorable to use of tobacco and other nicotine products |

**Indicator:** Reduction of percentage of tobacco use

- Reduction of percentage of nicotine use, including e-cigs
- **Past 30 day use, e-cigs youth**
- **Baseline:** 4.7, all grades, 2013
- **Target:** 4.0, all grades, 2019
| Objective 1.5.3 Increase Communities That Care efforts | Timeframe: 2013-2019  
**Responsible:** Prevention Program Administrator (Craig PoVey)  
**OUTCOMES - UPDATES:**  
2017: 8.6%, all grades (stable) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1.5.4 Decrease Risk factors and Increase protective factors</td>
<td></td>
</tr>
</tbody>
</table>

### Goal 1.6 Prevent and Reduce Opioid Misuse

| Objective 1.6.1 Reduce community norms favorable to opioid misuse | **Indicator:** Decrease the percentage of adults 18+ who report using opioids non-medically (NSDUH)  
**Baseline:** 4.33% (12 and older)  
**Target:** 2.10% (12 and older)  
**Timeframe:** 2013-2023  
**Responsible:** Prevention Program Administrator (Craig PoVey)  
**Outcomes:** 4.66 (12 and older) 2017 (Stable from baseline, but trending down) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1.6.2 Reduce illicit access to opioids</td>
<td></td>
</tr>
<tr>
<td>Objective 1.6.3 Increase number of coalitions implementing Communities that Care model</td>
<td></td>
</tr>
<tr>
<td>Objective 1.6.4 Increase access to person-centered prevention services</td>
<td></td>
</tr>
<tr>
<td>Objective 1.6.5 Decrease risk factors and increase protective factors</td>
<td></td>
</tr>
</tbody>
</table>
| Indicator: Decrease the percentage of any opioid misuse lifetime, youth  
**Baseline:** 6.4%, all grades, 2013  
**Target:** 3.2%, all grades, 2023  
**Timeframe:** 2013-2023  
**Outcomes:**  
2017- All grades, 6.4% (stable)  
**Responsible:** Prevention Program Administrator (Craig PoVey)  
**Visits to Use Only As Directed (UOAD) 20,035**  
**Pounds drugs 2018: 38,673 (April & October 2018)**  
**Take back events:** Two (2) events, 50 locations each event  
**# Communities that Care (CTC) Coalitions in Utah:** 24  
**# Selective, indicated Prevention: Number of programs** |
<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
<th>METRICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 1.7 Reduce overdose deaths</td>
<td>Objective 1.7.1 Educate the general public on ways to reduce overdose deaths</td>
<td>Indicator: Opiate Overdose Deaths Baseline: 274, 2013 Target: 250, 2019 Timeframe: 2013-2023 Responsible: Prevention Program Administrator (Craig PoVey)</td>
</tr>
<tr>
<td></td>
<td>Objective 1.7.2 Educate the general public on Naloxone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Objective 1.7.3 Incorporate education,, and distribution of Naloxone kits among strategic plans of Local Substance Abuse Authorities (LSAAs), Local Mental Health Authorities (LMHAs), Communities That Care and other prevention coalitions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Objective 1.7.4 Raise public awareness of opioid overdose using STO campaign and other resources</td>
<td>OUTCOMES - UPDATES: 2016: 262 (decrease) Visits to Opidemic.org 15,400 # of people trained as Naloxone end users: 76 # of Naloxone kits distributed: 428 # of documented reversals: 15 # of pounds from take back events/disposal: 38, 673 # of Take Back events scheduled: - 2019, 2 (two) events scheduled with 50 locations each event # of permanent disposal locations added: as of Oct 2018, 183 permanent drop off locations.</td>
</tr>
<tr>
<td></td>
<td>Objective 1.7.5 Educate the general public on ways to reduce overdose deaths</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Objective 1.7.6 Increase availability and usage of Naloxone</td>
<td></td>
</tr>
</tbody>
</table>

### Strategic Initiative #2 – Zero Suicides

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
<th>METRICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 2.1 Support UDOH and other stakeholders in implementation of the Utah Health Improvement Plan</td>
<td>2.1.1 Increase availability and access to quality physical and behavioral health care- Goal: Promote the adoption of the ‘Zero Suicide’ framework by health and behavioral health care providers statewide. 2.1.2 Increase social norms supportive of help-seeking and recovery- Goal: Train 10% of the Utah population in an evidence based gatekeeper training</td>
<td>Indicator: Number of health systems/organizations formally adopting the Zero Suicide framework. Baseline: Zero organizations have adopted the Zero Suicide framework. Target: Ten health systems/organizations in Utah have formally adopted the Zero Suicide Framework. Time frame: 2017-2021</td>
</tr>
</tbody>
</table>
Goal 2.1.3 Reduce access to lethal means
Goal: Partner with firearm retailers and gun owners to incorporate suicide awareness and prevention as a basic tenet of firearm safety and responsible firearm ownership.

**Responsible:** UHIP/Suicide Prevention Coordinator

**Outcomes:**
- July 2018 - 13 health systems/orgs adopting Zero Suicide.
- July 2019 - 28 health systems/org adopting ZS.

**Indicator:** Number of people trained in an evidence-based gatekeeper training.

**Baseline:** 25,000 (estimated)

**Target:** A minimum of 299,592 Utahns are trained in an evidence-based gatekeeper training.

**Time frame:** 2017-2021

**Responsible:** UHIP/Suicide Prevention Coordinator

**Outcomes:**
- July 2018 - trained an additional 9000 individuals for total 34,000.
- July 2019 - Trained an additional 35,953 individuals for a total 69,953

**Indicator:** Number of formal partnerships established/engaging in research guided means reduction activities.

**Baseline:** Zero partnerships established

**Target:** Ten firearm retailers, instructors, enthusiasts in Utah have incorporated suicide education, prevention, and awareness efforts into their businesses.

**Time frame:** 2017-2021

**Responsible:** UHIP/Suicide Prevention Coordinator

**Outcomes:** 2018 - 7 mini grants awarded to communities to carry out activities.
- July 2019 - 14 organizations with formal partnerships.

Goal 2.2 Engage community stakeholders and

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

**Indicator:** Number of engaged community prevention coalitions

**Baseline:** # of prevention coalitions engaging in evidence
| Prevention coalitions in suicide prevention and mental health promotion efforts statewide | 2.2.2 Engage workplaces in suicide prevention by using the Action Alliance Blueprint for Workplace Suicide Prevention and by training using Working Minds model | Based suicide prevention efforts  
**Target:** Increase # of prevention coalitions engaged by 10%  
**Time frame:** 2015-2021  
**Responsible:** Suicide Prevention Coordinator  
**Outcomes:**  
Baseline: 2015: 12 active coalitions  
July 2019 update: 25 active coalitions |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.3 Engage Institutes of Higher Education in suicide prevention using the Jed Foundation Campus Model</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Goal 2.3**  
Develop broad based support through public/private partnerships dedicated to implementing and sustaining suicide prevention efforts |
| 2.3.1 Sustain and strengthen collaborations across agencies and public/private partners to advance suicide prevention | **Indicator:** Participation in Suicide Prevention Coalition meetings  
**Baseline:** 15 stakeholders represented at meetings  
**Target:** Maintain or increase the number of stakeholders engaged  
**Time frame:** 2015-2017  
**Responsible:** Suicide Prevention Coordinator (Kim Myers)  
**OUTCOMES - UPDATES (July 2018):**  
DSAMH continues to provide leadership to the coalition. Coalition meets every other month with approximately 40 participants at each meeting. Objective will continue. Utah Suicide Prevention Plan 2017-2021 revised and released May 2017  
July 2019: Coalition still meeting bi-monthly with approximately 40 to 50 participants per meeting. Eight sub-committees continue to meet regularly to implement strategies. Gov Herbert formed Suicide Prevention Taskforce to continue to advance public/private partnerships to advance efforts. |
| 2.3.2 Provide ongoing leadership to collaborate and coordinate the Utah Suicide Prevention Coalition, including the Executive Committee and relevant workgroups |  
**2.3.3 Update current state suicide prevention plan for 2017** |
| 2.3.3 Update current state suicide prevention plan for 2017 | **2.4.1 Promote suicide prevention as a core component of health care services. Promote the adoption of “zero suicides” as an aspirational goal by health care and community support systems that provide** | **Indicator:** Universal Screening Rates in public mental health system  
**Baseline:** Dependent on Local Authority |
|  | **Goal 2.4**  
Improve the ability of health providers | **Indicator:** Universal Screening Rates in public mental health system  
**Baseline:** Dependent on Local Authority |
<table>
<thead>
<tr>
<th>Goal 2.5 Promote</th>
<th>2.5.1 Promote responsible media reporting of suicide, accurate</th>
</tr>
</thead>
<tbody>
<tr>
<td>(including Behavioral Health) to better support individuals who are at risk of suicide through adoption of Zero Suicide framework</td>
<td>services and support to defined patient populations</td>
</tr>
</tbody>
</table>
| 2.4.2 Promote the adoption of universal screening for suicide risk within the public behavioral health care system | Target: Increase screening rates by 25%  
Time frame: 2015-2018  
Responsible: Suicide Prevention Coordinator (Kim Myers) |
| 2.4.3 Promote same day safety planning for individuals who screen positive for suicide risk | OUTCOMES - UPDATES: 2016 first implementation year for LA PIP, 2015 was baseline year.  
Indicator: Same-day safety planning for individuals screened as at risk for suicide  
Baseline: Dependent on Local Authority  
Target: Increase same day safety plans by 25%  
Time frame: 2015-2018  
Responsible: Suicide Prevention Coordinator (Kim Myers) |
| 2.4.4 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means | OUTCOMES - UPDATES: 2017 Dec. update- BASELINE Screening: 11%  
Same Day Safety Plan: 45%  
2016 Screening: 55% Same Day Safety plan: 62%  
Zero Suicide Academy- 19 health/behavioral health care organizations represented  
July 2019:  
2015 Baseline Screening Rates: 6%  
2015 Baseline Safety Plan Rates: 40%  
2016 Year 1 Screening Remeasurement: 24%  
2016 Year 1 Safety Plan Remeasurement: 47%  
2017 Year 2 Screening Remeasurement: 50%  
2017 Year 2 Safety Plan Remeasurement: 54%  
2018 Year 3 Screening Remeasurement: 55%  
2018 Year 3 Safety Plan Remeasurement: 62%  
Indicator: Number of Media/Safe Messaging Trainings |
| 2.4.5 Provide training to community and clinical service providers on the prevention of suicide and related behaviors |  
| 2.4.6 Develop collaborations between emergency departments and other healthcare providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow up after discharge |  
| 2.4.7 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide |  

| Indicator: Number of Media/Safe Messaging Trainings | |
**Strategic Initiative #3 – Promote Recovery**

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
<th>METRICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 3.1 Promote and establish Peer Support Services</td>
<td>3.1.1 Provide Training for Mental Health (MH) and Substance Use Disorders (SUD) Peer Specialists including evidence-based practices, Certified Peer Support Specialist (CPSS) training and support for the annual Peer Support conference. - Revision of CPSS basic training, including the approval of curricula with standardized components.</td>
<td>Indicator: Increase # CPSSs and FRFs who have received training in specialized topics. Baseline: FY18 - 22 CPSSs/FRFs received Cultural Competence training. 54 CPSSs/FRFs received Suicide Prevention training. Target: FY20 - 75 CPSSs/FRFs trained per year (aggregate)</td>
</tr>
</tbody>
</table>
3.1.1 Facilitate annual Peer Support conference
- Facilitate training of EBPs and Best Practices, including health and wellness strategies, to CPSS
- Provide information to CPSS on educating legislators on the value of Peer services

3.1.2 Educate and Promote the availability of trained PSS to Local Authorities and other potential employers (public and private MH, SUD and health care providers) of the benefits of using Peer Support Specialists. This will include an increase in the visibility of CPSS in the State and development of the CPSS website.
- Establish an increased understanding of Peer roles, and the importance of Peers, among all agency staff.
- Education to LAs during annual Area Plan review and site monitoring
- Develop and implement a model for effective supportive supervision of Peers.
- Development of a DSAMH CPSS website

3.1.3 Increase sustainability of CPSS services within the state
- Explore funding opportunities for CPSS positions
- Notification of CPSS job opportunities to trained CPSS.
- Assist with identifying need for CPSS in the system

3.1.4 Develop Additional Training for Peer Support in the State.
- Develop a Peer Supervision Curriculum and Implement Training.
- Develop an Integrated Health Training for CPSSs and FRFs, including online training modules.
- Develop a Suicide Prevention Training for FRFs and CPSSs and a T4T Training on Peer Suicide Prevention.

3.1.5 Increase Support for CPSS who are employed

with enhancement curricula (Youth-in-Transition, Cultural Competence, Suicide Prevention, Integrated Care)

**Timeframe:** 2018-2020

**Responsible:** Heather Rydalch

**OUTCOMES - UPDATES:**

**July 2018**

3.1.1
- The Annual Peer Support Conference was held on June 8, 2018. Over 200 attended including CPSS’s FRF’s and other paraprofessionals.
- A total of 83 new CPSSs were trained between October 2017 and July 2018.
- USU has scheduled a Training for August 2018 and October 2018.
- An Integrated Health Curriculum for Peer Support is being finalized by DSAMH and will be available by August 2018 for an endorsement training for CPSSs and FRFs.
- A Cultural Competency Training for CPSSs and FRFs was held in March 2018.

3.1.2
- LAs have been educated throughout the year on annual monitoring visits regarding the Peer Role and Value of Peers, as well as the current wages across the state.
- 98 CPSSs and 44 FRFs are employed by the Local Authorities.
- A flyer promoting recovery and the Value of Peer work has been developed and will be handed out in 2018.
- A Supervision Curriculum for the State is being finalized and Supervision will be presented at the
- Hold monthly calls and quarterly webinars for Peer Support Specialists. These will provide them with CEUs for their recertification, as well as educate and support them.

Fall Substance Abuse Conference in 2018.
- A presentation was held by CPSSs and FRFs at the Generations Conference in March 2018. This was to promote the use and role of Peers. A panel of 6 CPSSs and FRFs presented.
- The new website has been developed and the Information and Applications have been updated.

3.1.3
- Notifications of Job openings have been distributed to the Peer email contact list as they become available.

<table>
<thead>
<tr>
<th>Goal 3.2 Promote and establish employment and education services statewide</th>
<th>Objective 3.2.1 Identify current programs and barriers in both urban and rural counties. Develop a continuum across available services to describe funding gaps and create a strategic plan to address barriers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 3.2.2 Increase engagement of employment services for individuals in recovery</td>
<td></td>
</tr>
<tr>
<td>Objective 3.2.3 Work with Medicaid and other sources to expand services through various funding mechanisms</td>
<td></td>
</tr>
<tr>
<td>Objective 3.2.4 Increase the number of SUD participants employed/attending school</td>
<td></td>
</tr>
<tr>
<td>Objective 3.2.5 Encourage IPS employment specialists to attend trauma-informed training and motivational interviewing.</td>
<td></td>
</tr>
</tbody>
</table>

**Indicator:** Increase integrated and competitive employment opportunities through Supported Employment (SE)/Individual Placement and Support (IPS)

**Baseline:** Two LMHAs engaged in SE/IPS providing services to approximately 100 individuals per year

**Target:** Engage two rural LMHAs and encourage hiring an employment specialist to provide SE/IPS services. Engage all accredited Clubhouses to provide SE/IPS services to approximately 25 additional individuals

**Timeframe:** 2014-2019

**Responsible:** Supported Employment Program Manager (Sharon Cook)

**Education Baseline:** Increase measured from admit to discharge

**OUTCOMES - UPDATES:**

**May 2018**
- An IPS Trainer was hired at Alliance House to provide IPS training and services for accredited Clubhouses and Clubhouse-like programs. Rural LMHAs engaged in SE/IPS training and provided SE services. **January 2018**
3.2.1 - The Supported Employment Coordinating Committee (SECC) continues to address SE/IPS barriers and provides strategies for sustainability and scalability.  
3.2.2 - Total of eight sites are providing SE/IPS services.  
  ○ SE/IPS trainer provided statewide quarterly training for all employment specialists for FY18.  
  ○ The employment specialists have completed the Association of Community Rehabilitation Educators (ACRE) training. Expansion sites are implementing the IPS model to fidelity. All of the employment specialists received quarterly on-site IPS training with the IPS statewide trainer in FY18.  
  ○ 3.2.3 - Psychoeducational services and Targeted Case Management billing is being used as a funding method to sustain SE/IPS. Two IPS sites are receiving Vocational Rehabilitation Milestone Payments for providing SE services. An additional expansion site plans to collect Milestones in August 2018.

**Update June 2018**

3.2.1 - The Supported Employment Coordinating Committee (SECC) will continue to address SE/IPS sustainability and scalability. The data evaluator with U of U Criminal Justice Center will provide data outcomes to identify gaps and improve SE/IPS services.

3.2.2 - Total of eight sites are continuing to provide SE/IPS services and three accredited Clubhouses are in providing SE/IPS services.  
  ○ Alliance House hired an FTE IPS Trainer and continues to provide IPS training for accredited Clubhouses and Clubhouse-like...
<table>
<thead>
<tr>
<th>Goal 3.3</th>
<th>Objective 3.3.1 Review Division Directives and contracts to include the provision of services in a trauma informed environment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Objective 3.3.2 Create a Trauma Informed Workgroup that reports to the UBHC Clinical Directors to make recommendations about changes in policy, procedures, and funding strategy to move to a TIC system</td>
</tr>
<tr>
<td></td>
<td><strong>OBJECTIVE COMPLETE:</strong> Objective 3.3.2 Provide increased training and technical assistance for Local Authorities. Through the CABHI Grant, providing evidence based training on Trauma Informed Care (TIC)</td>
</tr>
</tbody>
</table>

### Indicator: Increase trauma informed services for clients

**Baseline:** Four LAs are currently undergoing training

**Target:** All LAs would be trained in trauma informed approach

**Timeframe:** FY18

**Responsible:** SUD and MH Program Administrators (Becky King, Robert Snarr)

**OUTCOMES - UPDATES - February and April 2018:**

The following statewide trauma-informed and gender responsive training events were provided for Local Authority and Private SUD and MH Providers:

**Beyond Trauma: A Healing Journey for Women**

**Healing Trauma: Brief Intervention for Women**

February 20 - 21, 2018

---

- All employment specialists have received online IPS practitioner training and receive quarterly training from the statewide IPS trainer.
- All employment specialists have received ACRE certification to become vendors for job coaching services.
- 3.2.3 - Psychoeducational services and Targeted Case Management billing and VR Milestone payments are being used as a funding method to sustain SE/IPS.
- 3.2.4 - Employment specialists are participating in integrated SUD meetings and Drug Court First Step House plans to implement IPS to fidelity.
- 3.2.5 - Employment specialists will be encouraged to attend upcoming trauma-informed training and motivational interviewing.
### Goal 3.4
Develop array of non-clinical services designed to provide necessary supports for individuals seeking recovery or in early recovery

| Objective 3.4.1 | Expand contract language to encourage and incentivize expansion of services providing early intervention and post-acute treatment services to support recovery |
| Objective 3.4.2 | Work with appropriate committees and groups to ensure that essential health benefits in Utah include early intervention and recovery support services in insurance plans |
| Objective 3.4.3 | Work with state and local community stakeholders to continue developing recovery oriented standards of care and work towards implementation planning and delivery |
| Objective 3.4.4 | Recovery Support data specifications reported from |

#### Indicator: Increase recovery oriented support services to clients

- **Baseline:** Scorecard history of recovery oriented services including: employment, housing, and peer support related services
- **Target:** Increase recovery oriented support services provided by 5%
- **Timeframe:** SFY20
- **Responsible:** (Pam Bennett, Shanel Long)

#### OUTCOMES - UPDATES: June 2018

- **3.4.1**- FY19 Division Directives modified RSS services (RSS manual and approved service list)
### Goal 3.5
**Improve housing services across the state**

| Objective 3.5.1 Identify current housing programs and barriers in both urban and rural counties |
| Objective 3.5.2 Develop a continuum across available services to describe funding gaps and create a strategic plan to address barriers |
| Objective 3.5.3 Explore Medicaid services to maximize funding mechanisms and ensure that those eligible for Medicaid are enrolled |

### OUTCOMES - UPDATES:
- Indicator: Explore the development of additional affordable supported housing and Medicaid resources
- **Baseline:** Scorecard history for housing indicators
- **Target:** Development of increase of 5% of additional affordable supported housing for individuals who are homeless/mental illness and/or substance use disorders.
- **Timeframe:** SFY18
- **Responsible:** Robert Snarr

---

Each LA into TEDS

**Objective 3.4.5 Expand funding sources and opportunities to support and expand Recovery Support Services to the Local Authorities and other community partners**

- **3.4.3** - ROSC and UBHC committee continue to address RSS and best practices. ROSC committee looking at Recovery Capital Scales: Possible selection: DLA-SUD. USARA developed Recovery Support Guidelines.
- **3.4.4** - 9 out of the 13 Local Authorities are now reporting in TEDS RSS services. RSS services to be expanded in FY20 to expand RSS services to additional clients and to use additional funding sources.
- **3.4.5** - TANF Contracts to increase and support RSS services through CPSS: USARA Completed & SouthWest completed contracted ends June 30, 2019. CPSS services will be expanded under the RSS program to all LAs. RSS Funding for FY20: JRI, Drug Court, Corrections, SOR, ORG-Recovery Residence (WFS), SABG MHBG.

---

**continually updated;** Contract developed for provide funding for LBHS to work with LGBTQ Latinx youth.
| **Goal 3.6** Promote JRI certification and implementation throughout public and private MH and SA systems. | **Objective 3.6.1** Identify JRI providers and have them complete application for certification
Objective 3.6.2 Promote JRI throughout the State also identify and address barriers
Objective 3.6.3 Require each local authority to develop an annual plan that identifies their JRI committee and implementation plans
Objective 3.6.4 Develop treatment standards for all public and private facilities and promote compliance of those standards to all providers
Objective 3.6.5 Increase number of providers and individuals trained in EBP | **Indicator:** Increase the number of certified JRI providers that are trained in the use of evidence based practices
**Baseline:** 99 sites, 24 private providers and all 13 Local Authority Providers certified
**Target:** Maintain the certification process and continual certification of new and current providers
**Timeframe:** SFY 2019
**Responsible:** Thom Dunford

**OUTCOMES - UPDATES:**
**July 2018**

3.6.1 DSAMH continues to reach out to public and private stakeholders to educate and inform them on the JRI certification process. New agencies continue to submit applications for Justice Certification on a monthly basis. The following update reflects the current certified provider count:
- Received applications for 251 sites (up 32 over SFY 18) representing 110 (up 17 over SFY 18) private agencies and all 13 Local Authorities
- Provisionally certified 208 sites (up 17 over SFY 18) with 168 (up 8 over SFY 18) private agency sites and 40 Local Authority sites
- Provisionally certified 6 prison programs
- Provisionally certified 15 jail programs
- Provisionally certified 22 Adult Probation and Parole Programs
- Revoked certification on 2 agencies 6 sites
- Reinstated certification on 2 agencies 5 site

3.6.2 The Justice Program Administrator is a member on the following committees:
- CCJ JRI Implementation Committee
3.6.3 The FY 2019 annual review of Local Authority programs was completed and all Local Authorities are holding regular implementation committee meetings. Some are very strong and collaborative in their function.

3.6.4 DSAMH continues to review program standards that are established in R523-4. A quarterly outreach meeting is held with a group of private providers and standards are regularly discussed. The Division is in a current rule revision process that makes sweeping changes to the certification process and simplifies screening and assessment expectations.

3.6.5 The following training has been offered to increase the use of EBPs:

- 3rd annual Utah Criminal Justice Conference at the University of Utah
- The Fall Substance Use Conference - September 2018
- ASAM
  - ASAM Skill-Building 2-day training opened to 40 participants Completed:
    - March 20-21, 2018
    - August 10-11, 2018
    - October 23-24, 2018
  - MI Enhanced ASAM/Tx Planning 2-day training opened to 42 participants Completed:
    - May 21-22, 2018
    - January 16-17, 2019
    - February 12-13, 2019
    - April 2-3, 2019
| Goal 3.7 Improve outcomes related to mental health treatment | Objective 3.7.1 - Demonstrate client’s self-report improved functioning after mental health services | Indicator: Positive outcomes (stable, improved and in recovery) during treatment (or discharged) as measured by OQ.  
Baseline FY2015: Reporting positive OQ outcomes - 84.1% Adults  
Target (DHS target): 69% of clients report positive outcomes  
Timeframe: 2016-2018  
Responsible: MH Administrator- Pam Bennett  
OUTCOMES - UPDATES:  
July 2019  
3.7.1 - FY18 Scorecard indicates that 84.96% in treatment and 84.83% are discharged with positive outcomes.  
3.7.1 - FY19 site monitoring demonstrated that several Local Authorities are not using the OQ as a clinical intervention as required. |
|---|---|---|
| Goal 3.8 Expand access and participation in evidence-based treatment services for opioid use disorders | Objective 3.8.1 Increase the number of qualified prescribers who can prescribe medications approved to treat opioid use disorder  
Objective 3.8.2 Increase participation in Opioid Treatment Programs (OTP)  
Objective 3.8.3 Increase access and use of Naltrexone, Vivitrol, and Buprenorphine | Responsible: Shanel Long and VaRonica Little  
Indicator: 3.8.1 # of Providers waivered to prescribe MAT through SAMHSA  
Baseline FY2017: 288  
Target: Increase providers by 1% each year, focusing on Rural Areas  
TimeFrame: May 2017 - May 2018 |
<table>
<thead>
<tr>
<th>Objective 3.8.4</th>
<th>Increase use and training of SBIRT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 3.8.5</td>
<td>Improve treatment retention for individuals with opioid use disorders</td>
</tr>
<tr>
<td>Objective 3.8.6</td>
<td>Increase number and percent of clients with opioid use disorder who complete treatment successfully</td>
</tr>
<tr>
<td>Objective 3.8.7</td>
<td>Increase number of clients with public/private insurance</td>
</tr>
<tr>
<td>Objective 3.8.8</td>
<td>Increase the number of individuals voluntarily participating in Community Support Activities</td>
</tr>
</tbody>
</table>

**Update:**
- **July 2018:** 342 unduplicated waivered physicians
- **June 2019:** 388 unduplicated on the SAMHSA waivered physicians locator public list.

**Indicator:**
- 3.8.2 # of Participants in OTP’s based on Quarterly and Annual Reports.
- **Baseline:** Calendar Year 2013, 1449 participants
- **Target:** increase participants by 5% within 2 years
- **TimeFrame:** Update Annually, per calendar year
- **Update:** CY2017 Average census 2724 CY 2018 Average census 2847

**Indicator:**
- 3.8.3 Increase the use of all forms of FDA approved Medication Assisted Treatment including but not limited to Methadone, Naltrexone, Vivitrol and Buprenorphine within the public providers.
- **Baseline:** FY17 1624
- **Target:** increase baseline by 5%
- **TimeFrame:** State Fiscal Year monitoring.
- **Update:** FY2018 2166
These numbers are pulled from our state fiscal year TEDs submissions of clients served with OUD that have the MAT or Methadone indicators.

**Indicator:**
- 3.8.4 Providing SBIRT Trainings to partners
- **Baseline:** None
- **Target:** Complete at least 2 trainings in behavioral and...
physical health settings.

**TimeFrame:** May 1, 2017 - May 1, 2019

**Update:** July 2018 8 in person trainings with 239 participants. Update: June 2019 10 in person trainings and 720 participants in the online SBIRT training throughout the year.

**Indicator:** 3.8.5 Treatment Retention

**Baseline:** FY2016 62.7% (retained in treatment for minimum of 60 days)

**Target:** Increase by 5% of baseline

**TimeFrame:** Annual Monitoring

**Update:**
* FY2017 57.8%
* FY2018 55.4%

*The annual reporting data for this has changed and the retention rate went from retained in treatment for 60 days or more to retained in treatment for 90 or more. This continues to only indicate those with OUD as primary diagnoses which makes year to year accurate comparison but not the baseline.

**Indicator:** 3.8.6 OUD clients who successfully complete treatment

**Baseline:** FY2016 36.1%

**Target:** Increase 5% of baseline

**TimeFrame:** Annual Monitoring

**Update:** FY2017 34.2%
FY2018 40.2%
*limitation of data is that only those with primary OUD can be identified with outcome data.

**Indicator:** 3.8.7 Percent of clients with insurance
**Baseline:** Service was not provided previously
**Target:** Enroll 200 Clients per year
**TimeFrame:** May 1, 2017 - May 1, 2019
**Update:** July 2018 438 new enrollments into insurance programs between May 1, 2017 - April 30, 2018
**Update:** June 2019 between April 2018 - May 1, 2019 there were 1,424 new enrollments into insurance programs

**Indicator:** 3.8.8 OUD clients engagement in Recovery Support Services within the public system.
**Baseline:** FY 16 18.1%
**Target:** Increase by 10% from baseline
**TimeFrame:** May 1, 2017 - May 1, 2019
**Update:** FY17 33.3%
**Update:** FY18 30.5%

---

**Strategic Initiative #4 – Improve Care for Children and Youth**

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
<th>METRICS</th>
</tr>
</thead>
</table>
| Goal 4.1 Promote Community Based Services (Systems of Care) | Objective 4.1.1 Increase in state system knowledge of, and compliance with, the Interstate Compact on the Placement of Children (ICPC) process through a collaboration with Office of Licensing (OL), Division | **Indicator:** Compliance with ICPC process  
**Baseline:** Numbers of out of state clients accessing State or County services without reimbursement from the |
| Care Values) through increasing accountability of states placing youth in Residential Treatment Centers (RTCs) in Utah | Objective 4.1.2 Establish and utilize collaboratively developed procedures to ensure ICPC compliance.  
Objective 4.1.3 Identify all states sending children and youth to RTCs in Utah and increase collaboration regarding compliance and oversight by sending state. |
|---|---|
| Objective 4.1.1 Office of Licensing (OL) has incorporate ICPC compliance in monitoring.  
Objective 4.1.1 All LMHAs have been trained by DCFS regarding the ICPC system.  
Objective 4.1.2 -  
1. All LMHAs have been trained by DSAMH regarding procedures to follow when ICPC issues arise  
2. All DJJS staff supervising Detention, Receiving Centers and Multi-use Facilities have been trained to notify DJJS administration when a youth placed in Utah from out of state is ending up in one of their facilities.  
3. DSAMH, DJJS and DCFS are working to resolve ICPC situations when the arise and involve OL when violations occur. |
| Goal 4.2 Increasing system knowledge for adolescent co- | Objective 4.2.1 Develop and publish dashboard with data regarding the provision of services and outcomes for adolescents with co-occurring substance use and mental health disorders. |
| Indicator: Adolescent Dashboard for Co-Occurring MH and Substance Use Disorders developed and used  
Baseline: None, this would be a newly developed Scorecard |
| Occurring substance use and mental health disorders treatment | Objective 4.2.2 Increase utilization of LMHA/LSAA supplied data regarding the provision of services and outcomes for adolescents with co-occurring substance use and mental health disorders | June 2018: Dashboard developed and published  
**Data Source:** SAMHIS, Local Authority Reports,  
**Responsible:** Children, Youth and Family Program Administrator and Business Analysts (Leah Colburn, Ryan Carrier)  
**OUTCOMES - UPDATES: July 2018:** The dashboard is completed and is being updated as needed. |
|---|---|---|
| **Goal 4.3**  
Improve the quality of adolescent SUD treatment services through evaluation | Objective 4.3.1 Evaluate and measure treatment quality and effectiveness. Create a continuous quality improvement system through the Utah Quality Youth Treatment Project.  
Objective 4.3.2 SRI will create The Utah Directory of Quality Youth Treatment dashboard and website.  
Objective 4.3. Evaluation strives to meet improvement benchmarks. Bi-Annual and Annual Reports generated for agencies and DSAMH Program Administrators. | **Indicator:** Annually review 24+ private and public adolescent SUD treatment providers during the project period (January 1, 2016 - June 30, 2021).  
**Baseline:** 24 Providers/Agencies reviewed and assessed for quality adolescent SUD treatment  
**Target:** Increase the number of new participating agencies by 5 by FY20  
**Timeframe:** January 1, 2016 - June 30, 2021 Bi-annual and annual reports will be provided regarding the progress and effectiveness of this project.  
**Responsible:** (Shanel Long, Shanin Rapp)  
**OUTCOMES - UPDATES:**  
4.3.1 -  
- 24 public, private, and one tribal treatment provider commit to participate in the Quality Youth Treatment Project.  
- Project name changed to **Utah Quality Youth Treatment Project**, updated **May 2018** |
### Goal 4.4

Improve SUD and co-occurring early intervention, treatment and recovery support services for adolescents and transitional aged youth ages 12-25 with SUD and/or co-occurring mental health disorders.

<table>
<thead>
<tr>
<th>Objective 4.4.1</th>
<th>Assure youth and their families/caregivers have access to improved screening, evidence-based assessments, early and brief intervention services, treatment models, and recovery support services by strengthening the existing infrastructure system.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 4.4.2</td>
<td>Provide training, consultation, and technical assistance to five treatment agencies in Screening, Assessment, and Brief Intervention using Gain Q3 MI, evidence-based treatment modality A-CRA, and training in the implementation of the Trauma-Informed Approach, Seeking Safety training, and Adolescent Development training.</td>
</tr>
</tbody>
</table>

**Indicator:**

**Baseline:** Establish a quality baseline of treatment among participating adolescent SUD treatment providers.

**Target:** Improve the integration and efficiency of the treatment and recovery support systems through the study and application of specific evidence-based treatment practices (EBPs).

**Timeframe:** Utah SYT Implementation project period (September 30, 2017 - June 30, 2021).

**Responsible:** Shanel Long and Shanin Rapp

### UPDATE: May 2019

5 locations visited and many prepared after early pre-emptive visits from SRI. Many sites have no youth currently being treated or any outside referrals coming in. Recruiting private programs to come aboard has some challenges.

#### 4.3.2

**UPDATE: MAY 2019** Project tools include the evaluation form, pre and post surveys for each agency, and youth input surveys. Website is under construction. Dashboard Directory is under construction.

#### 4.3.3

**UPDATE: May 2019** Evaluation reports for agencies are being redesigned to include a creative recruitment piece per each agency. Tools reconsidered to address recruitment and retention plans for agencies, where many sites aren’t receiving youth.
Objective 4.4.3 - Increase access to services along the continuum for youth and families by further support and collaboration of prevention, intervention, treatment and recovery support efforts. Expansion of existing resources, and creation of new resources., RECOVERY SUPPORT SERVICES

Objective 4.4.4 - Continual participation in the Utah Quality Youth Treatment Project to insure the advancement of EBPs in treatment programming, improving treatment quality, providing transparency in service delivery, and reinforcing goals and providing support to providers.


4.4.1 -

UPDATE 2019: Continued efforts to strengthen the system through grant goals. Many partnerships are being forged.

4.4.2

UPDATE 2019: Certification for agencies has continued in A-CRA, with 4 of the 5 agencies having a Supervisor Clinician certified to train other clinicians in A-CRA. A-CRA and Gain Q3 MI have regular fidelity call opportunities. Seeking Safety training and fidelity calls, Trauma-Informed Care training and fidelity calls, and Adolescent Development Training all within FY19. GPRA data being collected.

4.4.3

Mar 2018

A special SUD Workgroup met July 2018 to consider tactics to address improved youth SUD treatment access and referral. Met with KOPPIR Founder August 2018 to discuss replicating, organizing, and disseminating the community family support model for use across the state.

UPDATE 2019: Several smaller work groups have combined to address the all-time low numbers of referrals for youth to the continuum of treatment services. The group is called the Youth Treatment and Early Intervention Referral Development Work Group.

UPDATE 2019: Discussions to create a handbook on how to hold a KOPPIR meeting in any community has commenced. The model was created by kids for kids and requires adults that are supportive of the meetings and
<table>
<thead>
<tr>
<th>Goal 4.5</th>
<th>Improve outcomes related to mental health early intervention services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 4.5.1</td>
<td>- Improve School-Based Behavioral Health (SBBH) partnerships and increase the number of Schools and Local Education Agency (LEA) partnerships.</td>
</tr>
<tr>
<td>Objective 4.5.2</td>
<td>- Demonstrate client's improved functioning after mental health early intervention services (School-based behavioral Health (SBBH), Family Resource Facilitator (FRF) and Mobile Crisis)</td>
</tr>
<tr>
<td>Objective 4.5.3</td>
<td>- Build and grow the mental health early intervention programs (School-based behavioral Health (SBBH), Family Resource Facilitator (FRF) and Mobile Crisis)</td>
</tr>
</tbody>
</table>

**Indicator:** Positive outcomes (stable, improved and in recovery) during treatment or post discharge as measured by Y/OQ. Other Proxy outcomes:
- **SBBH:** Improve GPA or DIBELS literacy score and reduce office disciplinary referrals
- **FRF:** Data outcomes collected by the Utah Family Coalition FRF database to include staying at home with proper supports, being enrolled at school, and staying out of legal trouble
- **Mobile Crisis:** Avoiding police involvement and out-of-home placement;

**Baseline FY2015:**
- Reporting positive OQ outcomes - 86.7% Children/Youth
- Avoiding police involvement: 74%
- Avoiding out-of-home placement: 67.4%
- Improved GPA: 14% or DIBELS: 42%

---

active participators in the model. A board is being organized, with 50% youth members, to discuss the plans to move forward.

**4.4.4 Oct 2018**

SOW and continued participation throughout the grant period, with a sustainability plan for long-term quality programming and evaluation

**Update 2019:** The concept of sustainability has changed a bit with Medicaid expansion and the lack of services being provided for youth. Continued gathering of data, and ongoing discussions to address long-term planning are crucial for sustainability.
<table>
<thead>
<tr>
<th>Reduced office of disciplinary referrals: 45.6%</th>
</tr>
</thead>
<tbody>
<tr>
<td>At home with proper supports: 68.7%</td>
</tr>
<tr>
<td>Enrolled at school: 25%</td>
</tr>
<tr>
<td>Staying out of legal trouble: 59%</td>
</tr>
</tbody>
</table>

**Target (DHS Targets):**

- Reporting positive OQ outcomes 69% (DHS target) of clients report positive outcomes
- Avoiding police involvement: 73%
- Avoiding out-of-home placement: 68%
- Improved GPA: 14% or DIBELS: 42%
- Reduced office of disciplinary referrals: 46%

<table>
<thead>
<tr>
<th>Reduced office of disciplinary referrals: 46%</th>
</tr>
</thead>
<tbody>
<tr>
<td>At home with proper supports: 70%</td>
</tr>
<tr>
<td>Enrolled at school: 30%</td>
</tr>
<tr>
<td>Staying out of legal trouble: 70%</td>
</tr>
</tbody>
</table>

**Timeframe:** 2016-2018

**Responsible:** Children, Youth, and Families Program Administrator (Eric Tadehara)

### 4.5.2 Baseline FY2017

**FRFs:** July, 2017: There are 2 FRFs working directly with Mobile Crisis Teams, 10 working solely as school-based FRFs, 2 working directly with DCFS, 2 working directly in the juvenile mental health courts, 2 working with The Children’s Center, 1 with USARA, 1 with the Early Psychosis team, and 1 working at USH.

2,410 children were served by FRFs.
<table>
<thead>
<tr>
<th><strong>SBBH: July 2017</strong></th>
<th>313 total schools served; 89 specific to areas with high rates of Intergenerational Poverty; 3,335 youth served via SBBH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mobile Crisis Teams: July 2017</strong></td>
<td>Provided in 5 counties (Washington, Iron, Utah, Davis, and Salt Lake); 4,193 served by mobile crisis teams</td>
</tr>
<tr>
<td><strong>Target (DHS Targets):</strong></td>
<td></td>
</tr>
<tr>
<td><strong>FRF</strong></td>
<td>Continue to maintain and grow the number of certified FRFs, Family Peer Support, and Wraparound Specialists.</td>
</tr>
<tr>
<td><strong>FRF</strong></td>
<td>Currently 59 total certified and available in all catchment areas; <strong>Target:</strong> Maintain 55-65 total FRFs through LMHAs</td>
</tr>
<tr>
<td><strong>Family Peer Support</strong></td>
<td>New certification, <strong>Target:</strong> 10 throughout DHS in collaboration with each Division</td>
</tr>
<tr>
<td><strong>Wraparound Specialists</strong></td>
<td>New certification, <strong>Target:</strong> 10 through LMHAs and SOC</td>
</tr>
<tr>
<td><strong>SBBH</strong></td>
<td>Grow number of schools and youth served by 5% each year</td>
</tr>
<tr>
<td><strong>Mobile Crisis Teams</strong></td>
<td>5% increase in the number served</td>
</tr>
<tr>
<td><strong>OUTCOMES - UPDATES:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>4.5.1</strong></td>
<td></td>
</tr>
<tr>
<td><strong>FY2018:</strong></td>
<td>Reporting positive OQ outcomes - N/A</td>
</tr>
<tr>
<td><strong>Children/Youth</strong></td>
<td>Avoiding police involvement: 54.58%</td>
</tr>
<tr>
<td></td>
<td>Avoiding out-of-home placement: 67.74%</td>
</tr>
<tr>
<td></td>
<td>Improved GPA: 1.13% or DIBELS: 37.74%</td>
</tr>
</tbody>
</table>
| Goal 4.6 Increase system knowledge and ability to provide services to children and youth with co-occurring mental health and intellectual/developmental disabilities | Reduced office of disciplinary referrals: 44.86%  
At home with proper supports: 52.94%  
Enrolled at school: 7%  
Staying out of legal trouble: 71%  
4.5.2  
FY2018  
FRF: 59 FRFs statewide in each catchment area  
SBBH: 342 Schools served; 89 IGP Schools; 3,504 total youth served with MHEI  
Mobile Crisis Teams: Provide in 4 counties (Salt Lake, Utah, Iron, and Washington; Davis County shifted funding to School Based Behavioral Health); 3,639 children and youth served |
| Objective 4.6.1 DSAMH will collaborate with the Division of Services for People with Disabilities, Family Advocacy Agencies, System of Care, UNI Home, and Department of Health to identify gaps and barriers in service delivery | Indicator: Gaps and barriers are identified and shared with partners  
Baseline: Zero gaps and barriers formally identified  
Target: One coordinated plan identifying gaps and barriers. Plan will include ways to improve workforce development across systems  
Timeframe: SFY18  
Responsible: Children, Youth, and Families Program Administrator (Eric Tadehara)  
Update July 2018: Gap in services identified for individuals with co-occurring mental health and intellectual/developmental disorders. Individuals with co-occurring disorders have difficulty accessing treatment to address their complete needs. Often, the services they receive only address the Mental Health or the Intellectual/Developmental Disabilities and |
| Objective 4.6.2 DSAMH will partner with allied agencies to increase workforce development to improve competencies and skills in providing services to children and youth with complex issues | |
professionals do not feel adequately prepared to provide co-occurring treatment.

Funding has been secured to provide a professional development training in the State of Utah. Preliminary plan involves 2 single day trainings to go over the best practices for working with this population occurring in October/November 2018. January/February 2019 will then introduce a train the trainer model for professional development for those working with these populations.

Goal 4.7 Improve collaboration among child serving entities and provide consultation for early childhood mental health

Objective 4.7.1 DSAMH will participate in statewide and inter-agency councils focused on early childhood health

Objective 4.7.2 DSAMH will lead efforts to engage with community partners and include national technical assistance to develop a formal structure and model for early childhood consultation

Indicator: Formalized structure for collaboration and consultation for early childhood mental health is established, as well as ongoing workforce development opportunities

Baseline: Limited collaboration among child serving entities for early childhood mental health as well as limited access for early childhood mental health training

Timeframe: SFY18-SFY20

Responsible: Children, Youth, and Families Program Administrator (Eric Tadehara and Codie Thurgood)

Update July 2018: A previous needs assessment for infant and early childhood mental health services was reviewed and updates made. A vision statement and goals have been developed to begin efforts to create a clear structure for collaboration and consultation, as well as workforce development. Community partnerships have also been developed to bring national infant and early childhood competencies and endorsements to Utah. No direct funding is supporting infant and early
childhood mental health at this time; but efforts are being made to secure needed funding.

**Update July 2019:** Input on infant and early childhood mental health has been provided for a qualitative and quantitative statewide needs assessment being completed by the Office of Child Care through a Preschool Development Grant. Efforts are being made towards workforce development around infant and early childhood mental health. No direct funding is supporting infant and early childhood mental health at this time; but efforts are being made to secure needed funding.

### Strategic Initiative #5 – Health System Integration

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
<th>METRICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal 5.1 Increase partnerships with Department of Health, accountable/ care organizations (ACOs), federally qualified health centers (FQHCs), and the Local Authorities</td>
<td>Objective 5.1.1 DSAMH will collaborate with Department of Health/Medicaid to facilitate at least three meetings to discuss integration with Local authorities, ACOs and FQHC representatives annually</td>
<td>Indicator: Number of local authorities that submit integration area plan. Baseline: in SFY 2016, 100% of local authorities submitted integration plan. Target: 100% in SFY 2018 Timeframe: 2015-2018 Responsible: Shanel Long, Jeremy Christensen</td>
</tr>
<tr>
<td></td>
<td>Objective 5.1.2 Require each local authority to develop an annual plan that describes their efforts to integrate services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Objective 5.1.3 Local authorities will contract for services with FQHCs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Objective 5.1.4 Local authorities will contract for services with ACOs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Objective 5.1.5 Educate FQHCs regarding trauma-informed care - Find out what is already being done</td>
<td></td>
</tr>
</tbody>
</table>

**OUTCOMES - UPDATES:**

**July 2018**

5.1.1 DSAMH Leadership meeting with Medicaid regularly to discuss integration.

5.1.2 All FY19 Local Authority Area Plans have been printed.
reviewed and approved. LAs were required to provide more detail regarding integrated care.
5.1.3 and 5.1.4 FY19 Area Plans describe contracts with 18 FQHCs and relationships with several ACOs.
5.1.5 New objective to be implemented in FY19 July 2019 Update
5.1.1 DSAMH Leadership meeting with Medicaid expansion and regularly to discuss integration. DSAMH hosted 6 Webinar trainings provided by Medicaid to educate on TAM (Justice Involved, SUD providers, OTP’s)
5.1.2 All FY20 Local Authority Area Plans have been reviewed. LAs were required to provide more detail regarding integrated care.
5.1.3 and 5.1.4 FY20 Area Plans describe contracts with 18 FQHCs and relationships with several ACOs.
5.1.5 Trauma informed care trainings were provided, FQHC’s were a targeted audience member for these trainings.

<table>
<thead>
<tr>
<th>Goal 5.2</th>
<th>Objective 5.2.1 Provide or arrange for a diabetes/HIV/TB screening, as indicated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Objective 5.2.2 Identify tobacco use in the assessment and offer resources as indicated.</td>
</tr>
<tr>
<td></td>
<td>Objective 5.2.3 Provide services in a tobacco free environment</td>
</tr>
<tr>
<td></td>
<td>Objective 5.2.5 Provide information to individuals on physical health concerns and ways to improve their physical health including referrals where needed</td>
</tr>
</tbody>
</table>

Indicator: Percent of clients using tobacco at discharge will decrease from admission.
Baseline: FY16 based off outcome data for each LA.
Target: Decrease by 1% by each LA in FY20 outcome data.
Timeframe: SFY17-SFY21

5.2.1 New Indicator: Number of Local Authorities trained by the Health Department to conduct communicable disease testing or that has the health department coming to provide testing directly.
Baseline: 2019 None officially
Target: 2020 4 Local Authorities will be trained or have
Objective 5.2.6 Incorporate wellness and physical care into individual person centered Recovery Plans as needed

Objective 5.2.7 Increase coordination of care between physical health providers and behavioral health providers

agreement with Health department to provide communicable disease testing.
**Timeframe:** SFY19-SFY21

**Responsible:** SUD Administrator - Shanel Long

**OUTCOMES - UPDATES:**

**July 2018**

- FY18 Site monitoring included review of assessment of tobacco use, review of agency as a tobacco free zone, priority populations engagement and services provided including education and referrals, emphasis of physical health and wellness within the treatment plan, and have included screenings for need of MAT.
- DSAMH STR grant year one end and year 2 starting. SOR application for FY19 being submitted (Opioid prevention and treatment funding)
- MH/SUD/Prevention meet monthly with DOH Tobacco Prevention and Control Program Outreach Coordinator
- All FY19 Local Authority Area Plans have been approved. LAs were required to provide more detail regarding integrated care and tobacco cessation referrals/services
- DOH provides needle exchange services and programs.
- State MASOB installing Non-Tobacco signage at entrances as indicated by law.
- Increase Coordination of Care and provide education between behavioral health and physical health: June 2018- Addictions Update Conference.
- 5.2.8 Working with Health Department based on CDC
FY2019 Updates:

- 5.2.8 Working with Health Department based on CDC determination of Need on HIV/Hep C for outreach, screenings, referrals and treatment of infections diseases (New 2018/2019 Block Grant requirements)
- 2/2019 Meeting with Health Department to discuss testing for Communicable Disease testing and identification of gaps. 6/2019 Discussion with Health Department to address gaps in the system for Communicable Disease testing and available funding to LA’s.
- DSAMH STR grant year 2 ended April 2019 and SOR grant began October 2018. MH/SUD/Prevention meet monthly with DOH Tobacco Prevention and Control Program Outreach Coordinator
- All FY20 Local Authority Area Plans have submitted and reviewed. LAs were required to provide more detail regarding integrated care and tobacco cessation referrals/services
- DOH provides needle exchange services and programs.
- State MASOB has installed Non-Tobacco signage at entrances as indicated by law as identified in FY18.
- Increase Coordination of Care and provide education
between behavioral health and physical health: June 2019- Addictions Update Conference.
- The Promoting Integration of Primary and Behavioral Health Care (PIPBHC) grant has begun and has a target to serve 350 individuals in SFY19.
Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems
Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

DSAMH operates under four guiding principles:
Systems, services, programs, activities, strategies, and policies should be trauma-informed, evidence-based, sustainable and culturally and linguistically competent.

Trauma-Informed: Most individuals with mental health and substance use disorders are also dealing with trauma issues. DSAMH recognizes the prevalence of trauma and takes a universal precautions position. Trauma affects all individuals involved, including staff and the local workforce. DSAMH is working to ensure that all aspects of its system recognize the impact of trauma and make every effort to avoid re-traumatization. DSAMH will continue in its efforts to promote the use of trauma-informed care and trauma specific services through training and technical assistance for the local authorities and community partners.

Evidence-based Practices: Utah’s publicly funded behavioral health system is committed to provide the best possible services to individuals, families and communities. DSAMH provides training and consultation designed to promote evidence based practices. “Evidence-based” stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

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

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

DSAMH has set the following priorities to emphasize specific goals and strategies in the coming years:

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

Sub State Organization: Utah State Statute specifically mandates the Local Substance Abuse Authorities (LSAA) provide a “continuum of services for Adolescents and Adults” aimed at substance abuse prevention and substance use disorder treatment. Utah’s Local Mental Health Authorities are given the responsibility to provide mental health services to their citizens, including the 10 mandated services. Utah utilizes MHBG and SAPT Block Grant funds, along with State General Funds, other State and Federal appropriations, and the Counties’ 20% funding match to fulfill the requirements to provide for services required by federal and state statutes.

State and federal funds are allocated to Local Authorities through a formula which takes into account the percent of the state’s population residing within the county’s boundaries and a rural differential. Each county is required to provide at least a 20% match on all state general funds. The majority of general and county funds allocated for mental health services are used to meet Medicaid match requirements. In the 2019 Legislative session Senate bill 96 was passed that put Utah’s Medicaid Expansion bill into Law. This new law expands Medicaid to parents and adults without dependent children earning up to 100% federal poverty level (approximately $12,490 annual income for an individual). Approximately 70,000 – 90,000 Utah residents will become newly eligible for Medicaid. Approximately 40,000 individuals from 101-138% FPL will continue to receive services through the federal Marketplace. It is based upon CMS approval. DSAMH overall budget was cut by 10 million dollars in the expectation that medicaid expansion would become the majority payor for behavioral health services. A percentage of these cuts were taken in the fourth quarter of FY19 and the remainder took effect for FY20. We currently have not seen the medicaid enrollment as expected and are not truly aware of what our behavioral health system will look like during these changes for client data or for funding.
As authorized in statute, the 29 counties in Utah have organized themselves into 13 Local Substance Abuse Authorities and 13 Local Mental Health Authorities. (See attached diagram). A Local Mental Health or Substance Abuse Authority is generally the governing body of a county i.e. a commissioner or council member. Many counties have joined together under inter-local agreements to create a single Local Authority where one commissioner representing each county holds a seat on the governing board. Services are delivered through contracts with Mental Health and Substance Abuse Providers, and in compliance with statute, administrative rule, and under the administrative direction of the Division of Substance Abuse and Mental Health. Short-term acute hospitalization is provided through contracts with local private hospitals in most areas. Local Authorities set the priorities to meet local needs, but at a minimum must provide ten statutorily mandated mental health services and a continuum of substance use disorder services either directly or through contracts and agreements.

Each local authority submits an Area Plan annually that must be approved by the DSAMH. The Area Plans are submitted in May of each year, and describe the Local Authority’s plan to provide services for the coming Fiscal Year. Each Area Plan describes what services will be provided and how Federal and State requirements will be met. This plan is based on statutory requirements and Division Directives that are provided each year to the Local Authorities shortly after the Legislative Session ends in March. The current Division Directives are located The current Division Directives are located at https://dsamh.utah.gov/pdf/contracts_and_monitoring/FY19%20Division%20Directives%20v.3.pdf. These Plans become the foundation of contracts between the Division and each of the Local Authorities. Contracts and with the Local Authorities and their funding allocations are approved only after the Area Plans have been approved by the Division Director.

Utah’s public Behavioral Health system for child, youth/adolescent and family services has the same organizational structure as the adult system. Local Authorities are required to outline in their area plan how they are planning to provide mental health and substance abuse treatment and prevention services to this population as well as the adult population.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

   a) Physical Health  
   b) Mental Health  
   c) Rehabilitation services  
   d) Employment services  
   e) Housing services  
   f) Educational Services  
   g) Substance misuse prevention and SUD treatment services  
   h) Medical and dental services  
   i) Support services  
   j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)  
   k) Services for persons with co-occurring M/SUDs

   Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.) DSAMH’s Division Directives require Local Mental Health Authorities (LMHAs) assess for physical health, mental health, and substance use disorders for individuals receiving treatment. This evaluation includes questions on primary care providers, all medication, current and desired state of employment and education (including accommodations), housing situation and need for support services. A case management needs assessment is completed to ensure coordination of care across multiple providers and to provide access to support services (Peer Support, Employment Services, Housing Providers).

3. Describe your state’s case management services

   Case managers (CM) are certified by DSAMH and provide a Medicaid billable service to adults with SMI and children with SED. Case management provides coordination, advocacy, linking and management for individuals in treatment. Case Management is a service that assists consumers to gain access to needed medical (including Mental Health), social, educational, and other services. The overall goal of the services is not only to help consumers to access needed services, but to ensure that services are coordinated among all agencies and providers. The need for Case Management will be determined by a formal needs assessment (typically the DLA-20) and may also consider the following factors: Consumer requests, Preferences or right of refusal, Consumer self direction, Social resources and natural supports, Safety, Culture, Co-occurring conditions and/or Legal issues. Case management is a mandated Medicaid service and is provided by all the Local Mental Health Authorities throughout the State of Utah.

4. Describe activities intended to reduce hospitalizations and hospital stays.

   The Utah public mental health system provides an array of services that ensure an effective continuum of care to target the mental
health needs of individuals with serious mental illness to prevent hospitalizations and reduce hospital stays. This includes the 10 mandated services, such as inpatient care, residential care, outpatient care, 24 hour crisis care, psychotropic medication management, case management, community supports, services to unfunded individuals, consultation and education services, and services to people incarcerated in county jails or other county correctional facilities. These all provide the support necessary to help individuals with SMI remain stable in the community and to return to the community after a psychiatric crisis. In addition, many of the Local Mental Health Authorities (LMHA) provide Clubhouses which is a model of psychosocial rehabilitation where attendees are considered members and are empowered to function in a work-ordered day. They provide a pre-educational, pre-vocational environment where individuals with a history of mental illness can rebuild their confidence and purpose. Other LMHAs provide Day Programs with psychosocial rehabilitation programs for individuals with SMI.

Utah’s largest county provides a robust crisis response system including crisis lines, warm lines, mobile crisis outreach teams, and a receiving center to provide immediate support and stabilization with the goal of keeping people stable in the community. This system works closely with law enforcement (CIT officers), fire, and EMS to provide crisis response and to connect with outpatient services. All the crisis services utilize Peer Support Specialists (with Peers in recovery) to promote connectedness, social interaction, and encourage individuals to take responsibility for their treatment and recovery. If hospitalized, the Peer Bridger program helps individuals in an inpatient setting to step out of inpatient and follows them for two weeks post hospitalization to provide the support necessary to connect with outpatient services an appointments to prevent rehospitalization.

Assertive Community Treatment, Assertive Community Outreach Treatment and Assisted Outpatient Treatment teams are available in urban counties, providing a “hospital without walls” for individuals on civil commitment, AOT court orders, and those who struggle to remain stable in the community. Rural counties provide a similar level of care through Intensive Case Management.
In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>113,106</td>
<td>19,050</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>107,439</td>
<td>13,532</td>
</tr>
</tbody>
</table>

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

We use the SAMSHA numbers for the prevalence, and create the incident numbers by looking at the past years and making a prediction based on those years.
**Criterion 3**

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Social Services</td>
<td>Yes ☐  No ☐</td>
</tr>
<tr>
<td>b)</td>
<td>Educational services, including services provided under IDE</td>
<td>Yes ☐  No ☐</td>
</tr>
<tr>
<td>c)</td>
<td>Juvenile justice services</td>
<td>Yes ☐  No ☐</td>
</tr>
<tr>
<td>d)</td>
<td>Substance misuse prevention and SUD treatment services</td>
<td>Yes ☐  No ☐</td>
</tr>
<tr>
<td>e)</td>
<td>Health and mental health services</td>
<td>Yes ☐  No ☐</td>
</tr>
<tr>
<td>f)</td>
<td>Establishes defined geographic area for the provision of services of such system</td>
<td>Yes ☐  No ☐</td>
</tr>
</tbody>
</table>
a. Describe your state’s targeted services to rural population.

In Utah, 9 of 13 Local Authorities are classified as rural or frontier. In SFY18, 31% of the individuals served by the public health system were in one of these rural or frontier regions. This includes 1,532 court-compelled and 222 individuals on civil commitment. All rural Local Authorities provide the 10 mandated services to their consumers, including psychiatric inpatient care, residential care, outpatient programs, medication management, 24 hour crisis care, psychosocial/psychoeducational rehabilitation programs, case management, community supports, services for incarcerated individuals and services for unfunded individuals. In some cases, particularly inpatient and residential care, rural Local Authorities will subcontract services from urban centers where more resources are available. Two of the rural/frontier Local Authorities will fly staff into more remote regions in order to provide in-person care.

In response to a workforce shortage and the inherent difficulties in providing services in a rural area (ie. transportation), DSAMH has encouraged rural and frontier Local Authorities to explore opportunities for telehealth. In addition to telehealth across counties within the agency catchment area, programs such as the University of Utah ECHO program provide an opportunity for collaboration and consultation on more complex physical and mental health clients without requiring the consumer to travel outside their county.

b. Describe your state’s targeted services to the homeless population.

The Continuum of Care (CoC) is the primary decision-making entity that is defined as the official body representing a community plan in each of the LMHAs catchment areas to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. Utah has three CoCs: Salt Lake, Mountainland, and Balance of State. The Salt Lake continuum consists of Salt Lake County. The Mountainland continuum consists of Utah, Summit, and Wasatch counties. The Balance of State continuum consists of all other counties not contained in the other two continua. The CoCs have a variety of responsibilities such as “oversight of the Homeless Management Information Systems (HMIS), developing and implementing strategic plans, identification of housing and service capacity and gaps, ensuring broad and inclusive participation. The LMHAs provide an array of services from outreach to engagement, case management, EBPs in mental health and substance use treatment, peer support services and other supports and recovery services based on individual needs.

c. Describe your state’s targeted services to the older adult population.

The Local Mental Health Authorities provide Specialized Rehabilitative Services for individuals 55 and older in the community and Nursing Facilities, dependent on capacity, with the array of services based on individual needs.

DSAMH works with the Division of Aging and Adult Services, who administers a wide variety of home and community-based services for Utah residents who are 60 and older. Programs and services are primarily delivered by a network of 12 Area Agencies on Aging which reach all geographic areas of the state.

The Department of Human Services has a goal to provide services that allow people to remain independent. These services include:
- Meals on Wheels – to homebound seniors
- Senior Centers – community-based center where seniors gather for services and activities
- Caregiver Support – short-term program that supports and assists caregivers
- Healthcare benefits and fraud prevention information and assistance
- Investigations of vulnerable adult abuse, neglect and exploitation

DSAMH partners with the Department of Health who administers the Aging Waiver: This waiver is designed to provide services statewide to help older adults remain in their homes or other community based settings. Individuals are able to live as independently as possible with supportive services provided through this waiver program. Waiver services may include:

- Adult Companion Services
- Adult Day Health Services
- Case Management
- Chore Services
- Community Transition Services
- Emergency Response Systems
- Environmental Accessibility Adaptations
- Fiscal Management Services
- Home Delivered Supplemental Meals
- Homemaker Services
- Medication Reminder Systems
- Non-medical Transportation
- Personal Attendant Program Training
Personal Attendant Services
Personal Budget Assistance
Respite Care Services (May Be Provided in Long Term Care Settings)
Specialized Medical Equipment
Supportive Maintenance Home Health Aide
Describe your state's management systems.

DSAMH has developed a Disaster Counseling Certification Program that supports short term interventions with individuals and groups experiencing psychological reactions to small and large scale disasters. These interventions involve using Psychological First Aid goals to assist disaster survivors in understanding their current situation and reactions, mitigating additional stress, promoting the use of coping strategies, providing emotional support, and encourages linkages with other individuals and agencies that may help survivors recover to their pre-disaster level of functioning.

Mental Health Block Grant (MHBG) dollars are targeted to providing the development of a Crisis Intervention Team program statewide for individuals with SMI and SED as well as suicide prevention and intervention. Block Grant dollars are funneled through the Local Mental Health Authorities to provide crisis response services to those who are unfunded. DSAMH contracts to provide support to the Salt Lake County's Mobile Crisis Outreach Team (MCOT) and Salt Lake County Lifeline Crisis Line. Legislative funds have been appropriated to add five more MCOT across the state and to expand to a statewide Lifeline Crisis Line.
Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question
Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

   a) A full continuum of services

      i) Screening

      ii) Education

      iii) Brief Intervention

      iv) Assessment

      v) Detox (inpatient/social)

      vi) Outpatient

      vii) Intensive Outpatient

      viii) Inpatient/Residential

      ix) Aftercare; Recovery support

   b) Services for special populations:

      Targeted services for veterans?

      Adolescents?

      Other Adults?

      Medication-Assisted Treatment (MAT)?
Narrative Question

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 8. Primary Prevention - Required SABG.

Criterion 2
Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  
   - Yes  
   - No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?  
   - Yes  
   - No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  
   - Yes  
   - No

4. Does your state have an arrangement for ensuring the provision of required supportive services?  
   - Yes  
   - No

5. Has your state identified a need for any of the following:  
   a) Open assessment and intake scheduling  
      - Yes  
      - No  
   b) Establishment of an electronic system to identify available treatment slots  
      - Yes  
      - No  
   c) Expanded community network for supportive services and healthcare  
      - Yes  
      - No  
   d) Inclusion of recovery support services  
      - Yes  
      - No  
   e) Health navigators to assist clients with community linkages  
      - Yes  
      - No  
   f) Expanded capability for family services, relationship restoration, and custody issues?  
      - Yes  
      - No  
   g) Providing employment assistance  
      - Yes  
      - No  
   h) Providing transportation to and from services  
      - Yes  
      - No  
   i) Educational assistance  
      - Yes  
      - No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   The Utah State Division of Substance Abuse and Mental Health (DSAMH) conducts annual site visits for the Local Authority Substance Use and Mental Health Disorder Treatment Providers, which either provide direct or contracted services for Women, Pregnant Women and Women with Dependent Children’s Programs. SAPT Block Grant Requirements for PWWDC are reviewed during the Annual Site Visit and throughout the year to ensure that programs are meeting these requirements. Utah also passed legislation that requires the following: (1) A local substance abuse authority to ensure that all substance abuse treatment programs that receive public funds provide priority for admission to a pregnant woman or a pregnant minor; (2) Requires a local substance abuse authority to provide a comprehensive referral for interim services to a pregnant woman or pregnant minor that cannot be admitted for substance abuse treatment within 24 hours of the request for admission; (3) Provides that, if a substance abuse treatment program is not able to accept and admit a pregnant woman or pregnant minor within 48 hours of the time that request for admission is made, the local substance abuse authority shall contact, and the Division of Substance Abuse and Mental Health shall provide, assistance in providing services to the pregnant woman or pregnant minors; (4) Requires a local substance abuse authority to provide counseling on the effects of alcohol and drug use during pregnancy. DSAMH’s Monitoring Protocol has different level of findings for the Local Authorities that require a correction action plan which needs to be submitted to DSAMH for approval. DSAMH also hosts a quarterly Women’s Treatment Provider Meeting, where providers learn best practice for the PWWDC and network with other providers. Finally, DSAMH provides ongoing training and technical assistance for the Local Authority Providers regarding the PWWDC and ensure that their needs are being met. Each year, DSAMH hosts annual training regarding gender specific and trauma-informed approaches, including the following (1) Trauma and Recovery Empowerment Model; (2) Seeking Safety; (3) Beyond Trauma: A Healing Journey for Women; (4) Helping Women Recover: A Program for Treating Addiction.
### Narrative Question

**Criterion 4, 5 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program**

#### Criterion 4,5&6

**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
   - a) 90 percent capacity reporting requirement
   - b) 14-120 day performance requirement with provision of interim services
   - c) Outreach activities
   - d) Syringe services programs
   - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation

2. Has your state identified a need for any of the following:
   - a) Electronic system with alert when 90 percent capacity is reached
   - b) Automatic reminder system associated with 14-120 day performance requirement
   - c) Use of peer recovery supports to maintain contact and support
   - d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   The State conducts annual monitoring visits with each Local Authorities in which all Block Grant requirements including PWID are monitored and reviewed. The Local Authorities also conduct interagency monitoring and are encouraged to conduct NIAItx reviews of their own agency and procedures. The state also reviewed data submissions, conducts monthly meetings with Directors and Clinical Directors and provides TA if requested or required. Based on the findings from the annual monitoring visits a report is written and provided that outlines any areas of concern to be addressed and a written response is required on how the issue will be resolved. Areas identified as problems can result in a finding, the findings range from recommendations, Minor/Significant/Major Non-compliance issues that require action plans.

**Tuberculosis (TB)**

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

2. Has your state identified a need for any of the following:
   - a) Business agreement/MOU with primary healthcare providers
   - b) Cooperative agreement/MOU with public health entity for testing and treatment
   - c) Established co-located SUD professionals within FQHCs

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   The State conducts annual monitoring visits with each Local Authorities in which all Block Grant requirements including TB screenings and referrals are monitored and reviewed. The Local Authorities also conduct interagency monitoring and chart audits. Each Local Authority is required to have Policy and Procedures for the screening and referrals for TB. Currently anyone that indicates they could be at risk for TB is referred to the Local State Health Departments for testing. Based on the findings from the annual monitoring visits a report is written and provided that outlines any areas of concern to be addressed and a written response is required on how the issue will be resolved. Areas identified as problems can result in a finding, the findings range from recommendations, Minor/Significant/Major Non-compliance issues that require action plans.

**Early Intervention Services for HIV (for “Designated States” Only)**

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery?

2. Has your state identified a need for any of the following:
a) Establishment of EIS-HIV service hubs in rural areas
   ☐ Yes ☑ No

b) Establishment or expansion of tele-health and social media support services
   ☑ Yes ☐ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS
   ☑ Yes ☐ No

**Syringe Service Programs**

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C § 300x-31(a)(1)(F))?  
   ☐ Yes ☑ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  
   ☐ Yes ☑ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?  
   ☑ Yes ☐ No

   If yes, please provide a brief description of the elements and the arrangement.
Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state’s approach for improvement

   - Yes ☐ No ☐

2. Has your state identified a need for any of the following:

   a) Workforce development efforts to expand service access
      - Yes ☐ No ☐
   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services
      - Yes ☐ No ☐
   c) Establish a peer recovery support network to assist in filling the gaps
      - Yes ☐ No ☐
   d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)
      - Yes ☐ No ☐
   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations
      - Yes ☐ No ☐
   f) Explore expansion of services for:
      i) MAT
      - Yes ☐ No ☐
      ii) Tele-Health
      - Yes ☐ No ☐
      iii) Social Media Outreach
      - Yes ☐ No ☐

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?

   - Yes ☐ No ☐

2. Has your state identified a need for any of the following:

   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
      - Yes ☐ No ☐
   b) Establish a program to provide trauma-informed care
      - Yes ☐ No ☐
   c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education
      - Yes ☐ No ☐

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 ($54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?

   - Yes ☐ No ☐

2. Does your state provide any of the following:

   a) Notice to Program Beneficiaries
      - Yes ☐ No ☐
   b) An organized referral system to identify alternative providers?
      - Yes ☐ No ☐
   c) A system to maintain a list of referrals made by religious organizations?
      - Yes ☐ No ☐

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?

   - Yes ☐ No ☐

2. Has your state identified a need for any of the following:

   a) Review and update of screening and assessment instruments
      - Yes ☐ No ☐
   b) Review of current levels of care to determine changes or additions
      - Yes ☐ No ☐
   c) Identify workforce needs to expand service capabilities
      - Yes ☐ No ☐
d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background

Patient Records

1. Does your state have an agreement to ensure the protection of client records?  Yes  No

2. Has your state identified a need for any of the following:
   a) Training staff and community partners on confidentiality requirements  Yes  No
   b) Training on responding to requests asking for acknowledgement of the presence of clients  Yes  No
   c) Updating written procedures which regulate and control access to records  Yes  No
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure  Yes  No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?  Yes  No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

   Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

   13 Local Substance Abuse Authorities (15 Local Authorities all together include MH authorities). They each conduct Peer to Peer Reviews on one another annually, giving feedback verbally and written. These Peer reviews are used to make changes to improve quality, service delivery, efficiency and overall system improvement. We also include the Department of Corrections in our Peer Review.

3. Has your state identified a need for any of the following:
   a) Development of a quality improvement plan  Yes  No
   b) Establishment of policies and procedures related to independent peer review  Yes  No
   c) Development of long-term planning for service revision and expansion to meet the needs of specific populations  Yes  No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?  Yes  No

   If Yes, please identify the accreditation organization(s)
   i) ✔ Commission on the Accreditation of Rehabilitation Facilities
   ii) ✔ The Joint Commission
   iii) □ Other (please specify)
Criterion 7\&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  
   - Yes  
   - No

2. Has your state identified a need for any of the following:
   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  
      - Yes  
      - No
   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  
      - Yes  
      - No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state’s substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
   a) Recent trends in substance use disorders in the state  
      - Yes  
      - No
   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  
      - Yes  
      - No
   c) Preformance-based accountability  
      - Yes  
      - No
   d) Data collection and reporting requirements  
      - Yes  
      - No

2. Has your state identified a need for any of the following:
   a) A comprehensive review of the current training schedule and identification of additional training needs  
      - Yes  
      - No
   b) Addition of training sessions designed to increase employee understanding of recovery support services  
      - Yes  
      - No
   c) Collaborative training sessions for employees and community agencies’ staff to coordinate and increase integrated services  
      - Yes  
      - No
   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  
      - Yes  
      - No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
   a) Prevention TTC?  
      - Yes  
      - No
   b) Mental Health TTC?  
      - Yes  
      - No
   c) Addiction TTC?  
      - Yes  
      - No
   d) State Targeted Response TTC?  
      - Yes  
      - No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
   a) Allocations regarding women  
      - Yes  
      - No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
   a) Tuberculosis  
      - Yes  
      - No
   b) Early Intervention Services Regarding HIV  
      - Yes  
      - No

3. Additional Agreements
   a) Improvement of Process for Appropriate Referrals for Treatment  
      - Yes  
      - No
   b) Professional Development  
      - Yes  
      - No
c) Coordination of Various Activities and Services

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Footnotes:
Utah became a medicaid expansion state as of April 1, 2019. DSAMH took substantial funding cuts starting in the last quarter of FY19. Medicaid enrollment opened up April 1, 2019 cut has been slow and has not met the expected enrollment rate as predicted. This has concerns as the financial benefit to medicaid expansion has not been seen within our Behavioral Health system and financial cuts have already been taken. Utah is a non-designated state. Medicaid expansion also opened up an all willing provider model which means that the public system will most likely see a decline in numbers served as we do not track nor monitor the clients in the private sector.

When reported it is a wavered state the intent is to clarify the non-designation for funding obligations required by the SABG.
Environmental Factors and Plan

11. Quality Improvement Plan- Requested

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019?  
   - Yes  
   - No

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

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

   Providers and contract compliance.

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

   Additionally, Consumer Surveys are distributed each year and a consumer report card is also published, comparing the Local Authorities on their results. The reports are broken down by substance abuse and mental health, as well as by adult, youth and family satisfaction. These are also color coded for easy reference. Copies of the Mental Health, Substance Abuse and Consumer Surveys are attached.

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

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

Footnotes:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

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

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma paper.

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

58 Ibid

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

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?  
   - Yes  
   - No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?  
   - Yes  
   - No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?  
   - Yes  
   - No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?  
   - Yes  
   - No

5. Does the state have any activities related to this section that you would like to highlight.

The Utah State Division of Substance Abuse and Mental Health (DSAMH) has been providing ongoing training and consultation for public and private providers across the state of Utah since 2009 regarding the Trauma-Informed Approach and evidence-based trauma specific interventions, including the following: (1) Trauma Recovery and Empowerment Model for Women and Girls (2) Trauma Recovery and Empowerment Profile (3) Trauma-Recov...
Conference; (13) Critical Issues Facing Children and Adolescents (14) Generations Conference (15) Troubled Youth Conference (16)

TIC Training by DSAMH staff to various organizations.

DSAMH has worked with Dr. Stephanie Covington, Gabriella Grant, MA, Director of the Center of Excellence for Trauma-Informed Care and Treatment Innovations to receive ongoing training and consultation on trauma, Trauma-Informed Approach and Seeking Safety. DSAMH is also working with the Utah Department of Human Services (DHS) and community partners to further efforts on the Trauma-Informed Approach through the implementation on policies, procedures and statewide training and consultation on Trauma-Informed Supervision and program evaluation.

Utah is currently working on becoming a Trauma-Informed State through Resilient Utah, a sub-committee of the Lieutenant Governor's Inter-generational Poverty Committee. Resilient Utah will be submitting a proposal to the Inter-generational Poverty Committee that includes the development of a “Resilient Utah Coordinating Center” that provides training, technical assistance and resources to providers on trauma and the trauma-informed approach. Meanwhile, Resilient Utah has been consulting with Trauma-Informed Oregon, to receive guidance and information on becoming a trauma-informed state in Utah.

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

None at this time.

Footnotes:
Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.59

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.60

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid 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.

The MHBG and SABG 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.


60 http://csjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?  Yes  No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?  Yes  No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?  Yes  No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?  Yes  No

5. Does the state have any activities related to this section that you would like to highlight?

In FY15 Utah legislatures passed the Justice Reinvestment Initiative (JRI) for adults and in FY17 HB 239 Juvenile Justice Reform was passed. The State has been working with community partners to enhance diversion, re-entry and integration of care. The legislature also passed requirements for the Division to oversee program certification for all agencies treating individuals that have been compelled to seek behavioral health services this also encourages the use of Evidence Based screening and assessments tools and the use of EBP to fidelity. Utah had its first CIT class in 2001 and was the start of a statewide CIT program. In FY16 the State conducted an RFP process for a continued statewide CIT program, and our state contractor collaborates with community partners to strengthen and expand this model. To assist with training’s and provide education and training to assist with provider certification requires for Utah Rule R523-4 @ https://rules.utah.gov/publicat/code/r523/r523-004.htm the division’s JRI certification rule. These training opportunities that are being contracted to run through 2023, will assist in providing better adherence to the use of the ASAM Criteria, which is the Utah required national standard for assessing substance use treatment placement, continued stay and discharge planning. Based on the positive effects of training on this subject, and the amount of turnover of staff in the substance use treatment filed, the division will continue to contract for the two major trainings, ASAM Skill -Building and Motivational Interviewing Enhanced ASAM/Treatment Planning, in the current contract, twice per year, and the
following additional trainings that will increase provider competency: ASAM Advance Training four time per yearly, Introduction to Motivational Interviewing twice per year and Advanced Motivational Interviewing twice per year. We also continue to provide Seeking Safety, Trauma-Informed approaches, Trauma Recovery and Empowered Model for Women and Men.

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

None at this time

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question
There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient’s needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA’s activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  
   - Yes  
   - No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?  
   - Yes  
   - No

3. Does the state purchase any of the following medication with block grant funds?  
   - Yes  
   - No
   a) Methadone
   b) Buprenorphine, Buprenorphine/naloxone
   c) Disulfiram
   d) Acamprosate
   e) Naltrexone (oral, IM)
   f) Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately?  
   - Yes  
   - No

5. Does the state have any activities related to this section that you would like to highlight?

DSAMH coordinates with the following organizations to ensure that education and Quality Assurance (QA) is provided on MAT and FDA-Approved medications for Utah State Opioid Treatment Providers and Office Based Opioid Treatment Providers:

Education on Evidenced-Based MAT:
1) Utah Department of Health
2) Commission on Accreditation of Rehabilitation Facilities (CARF)
3) Joint Commission on the Accreditation of Healthcare Organizations (JACHO)
4) Department of Professional Licensing, DOPL, through Academic Detailing for prescribers

FDA Approved Medications:
1) Drug Enforcement Agency (DEA)
2) Utah Division of Occupational Licensing - Pharmacy Board
3) Department of Professional Licensing, DOPL, through the Controlled Substance Database (Utah’s PDMP) and Academic Detailing

The State hosts a quarterly Opioid Treatment Provider Meeting (OTP) to address MAT and OTP functions, collect quarterly and annual data and outcome reports to ensure ongoing quality of care. The State has also contract with a provider to conduct
Naloxone Trainings and Train the Trainer (TOT) education. Through the Federal Opioid Grants, the State has hired a Project Director and Medical Consultant to collaborate closely with the Opioid Treatment Providers, Accountable Care Organizations, Federally Quality Health Care Centers, Local Substance Use Authority and Mental Health Providers and the private sector to address the opioid epidemic through coordination of care, training, technical assistance.

The State is working with the Department of Corrections and the Utah State Prison to provide MAT prior to release to Parolees at the Utah State Prison. This is a project that the State has been working on for many years and is set to start in FY20.

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Footnotes:
Environmental Factors and Plan

15. Crisis Services - Requested

Narrative Question
In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.61 SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises62.

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention
   a) ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) ☑ Psychiatric Advance Directives
   c) ☑ Family Engagement
   d) ☑ Safety Planning
   e) ☑ Peer-Operated Warm Lines
   f) ☑ Peer-Run Crisis Respite Programs
   g) ☑ Suicide Prevention

2. Crisis Intervention/Stabilization
   a) ☑ Assessment/Triage (Living Room Model)
   b) ☑ Open Dialogue
   c) ☑ Crisis Residential/Respite
   d) ☑ Crisis Intervention Team/Law Enforcement
   e) ☑ Mobile Crisis Outreach
   f) ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support
   a) ☑ Peer Support/Peer Bridgers
   b) ☑ Follow-up Outreach and Support
   c) ☑ Family-to-Family Engagement
   d) ☑ Connection to care coordination and follow-up clinical care for individuals in crisis
   e) ☑ Follow-up crisis engagement with families and involved community members

---

f) Recovery community coaches/peer recovery coaches

g) Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

The Utah Department of Human Services, Division of Substance Abuse and Mental Health in partnership with law enforcement, dispatch, fire, mental health, emergency medical system, emergency departments and advocates, hosted its third annual Mental Health Crisis Response Summit on June 12th, 2019. The purpose of this Summit is to bring together first responders in each discipline, who are involved in intervening in a mental health crisis. This Summit provided the opportunity statewide to network, identify strengths and challenges in crisis response, and discuss ways to improve the relationship and collaboration between law enforcement, fire and mental health professionals in urban, rural, and frontier areas. The summit also provides a mental health track for first responders by focusing on stress management and resilience. This summit has proven to be a valuable opportunity to bring together the different disciplines, and identify more effective and efficient ways to assist those experiencing a mental health crisis.

In 2018 legislation passed to create a statewide crisis line, a 40 hour crisis worker certification process for all crisis workers in the state, and 5 new mobile crisis outreach teams (MCOT) in 5 counties, including Salt Lake, Davis, Weber, Utah, and Washington counties.

Juvenile Mobile Crisis teams are available in 4 of the 5 counties in Utah that have populations over 125,000. These include Salt Lake County, Davis, Utah and Washington counties also provide mobile crisis response for children, youth and families. Since FY2016, Iron County has also developed a Juvenile Mobile Crisis team. Each of the teams have a partnership with parent support centers and receiving centers and provide crisis respite and follow-up services.

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

None at this time

Footnotes:
Environmental Factors and Plan

16. Recovery - Required

Narrative Question
The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](https://www.samhsa.gov). States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

**Please respond to the following:**

1. Does the state support recovery through any of the following:
5. Does the state have any activities that it would like to highlight?

The Utah Substance Abuse Advisory Council (USAAV) and Utah Behavioral Health Planning Advisory Council (UBHPAC) consist of members of the community including family/peers and individuals in recovery. The UBHPAC reviews the State’s Division Directives, Strategic Plan and Block Grant application. They also give insightful feedback and advice on priority initiatives they would like to see addressed. DSAMH hosts Peer Support Specialist (PSS) meetings in which Peers give input on system implementation and changes. DSAMH has also emphasized the use of Peer Support Specialists at each Local Authority. All Local Authorities have Peer Support Specialists and/or Family Resource Facilitators (FRFs) on staff, and some use peer volunteers that assist with local MH/SUD system evaluations and input. DSAMH conducts Clubhouse and Day Program visits annually, including focus groups consisting of Peers who are encouraged to provide feedback regarding the MH/SUD system. DSAMH works closely with the Peer organizations in Utah including National Alliance on Mental Illness (NAMI), Utah Substance Abuse Recovery Advocates (USARA), Latino Behavioral Health (LBHS - Hispanic PSS), Utah American Foundation for Suicide Prevention (AFSP) and Peers working with the National Guard and Veteran Affairs Medical Center. Local Authorities also host alumni groups for individuals that have completed treatment in Drug Court programs for feedback and input. SAMHSA grants to develop employment (Supported Employment/Individual Placement and Support) Pete’s grant, Ming’s grant YESS, AOT, Utah saw the importance of Recovery Support services and continues to strive to provide these services. 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.

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

None at this time.

Footnotes:

None at this time.
Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court’s decision in *Olmstead v. L.C., 527 U.S. 581 (1999)*, provide legal requirements that are consistent with SAMHSA’s mission to reduce the impact of M/SUD on America’s communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court’s Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

**Please respond to the following items**

1. Does the state’s Olmstead plan include:
   - Housing services provided.
   - Home and community based services.
   - Peer support services.
   - Employment services.

   - Yes
   - No

2. Does the state have a plan to transition individuals from hospital to community settings?

   - Yes
   - No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

   Utah incorporates the ADA community integration mandate into all of its practices. DSAMH PASRR Program (Preadmission Screening and Resident Review) helps to ensure that individuals are not inappropriately placed in nursing facilities, that individualized services are offered depending on their needs and to help determine the most appropriate setting. The PASRR program also works with the Utah Department of Health Waiver Program to help individuals transition into community based settings.

   The Division of Substance Abuse and Mental Health incorporates the ADA’s mandate (as recognized in Olmstead) to serve clients in the least restrictive, most integrated setting into every aspect of our organization.

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

   None at this time.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in ten suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children’s needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children’s Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.

According to data from the 2015 Report to Congress on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD 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 (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED?  
   b) The recovery and resilience of children and youth with SUD?

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
   a) Child welfare?
   b) Juvenile justice?
   c) Education?

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization?
   b) Costs?
   c) Outcomes for children and youth services?

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?
   b) Mental health treatment and recovery services for children/adolescents and their families?

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult M/SUD system?
   b) for youth in foster care?

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Utah Department of Human Services (DHS) provides integrated services through a Systems of Care Approach through close collaboration with the Division of Substance Abuse and Mental Health, Division of Child and Family Services, Juvenile Justice Services, Utah State Board of Education, Law Enforcement, and other community partners. The Utah State Division of Substance Abuse and Mental Health (DSAMH) provides integrated services for mental health (MH) and substance use disorder (SUD) needs for children and youth through the Local Authority Substance Use and Mental Health System and contracted providers. Integrated approaches are being evaluated to better serve individuals with physical health and intellectual/developmental disabilities and needs.

There are fifteen Local Authorities in Utah, which provide integrated services. Two geographic areas are divided into separate MH and SUD Local Authorities: (1) Bear River - Bear River Health Department - SUD Treatment / Bear River Mental Health and (2) Utah County - Utah County Department of Alcohol and Drug Prevention and Treatment / Wasatch Mental Health. The Local Authority Providers provide a continuum of services ranging from prevention, outpatient treatment, intensive outpatient treatment, residential treatment and recovery support services.

Utah continues to be in good position to expand and evolve 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

---

65 The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America’s #1 Public Health Problem.
68
6. Support for schools with high rates of intergenerational poverty still exists. DSAMH has supported LMHA school-based work in 71
   including DWS, the USBE, and local schools. As of June 2019, the funding allocated for this project is no longer available, but the
   Intergenerational Poverty Mitigation Act has helped to strengthen partnerships with agencies outside of DHS, An area of focus has been schools with high rates of Intergenerational Poverty as identified by the Utah Department of Workforce
   development, technical assistance, monitoring and oversight. In FY20, CYF plans to enhance the support of recovery and resilience
   of children and youth with mental health, substance use disorders, and intellectual, developmental, and autism disorders within a
   System of Care approach. Through continued work with DHS divisions, Local Mental Health and Substance Abuse Authorities, the
   Utah Family Coalition (UFC), the Utah State Board of Education (USBE), and other providers throughout the state, DSAMH will
   continue to work collaboratively to ensure children, youth, and their families have their needs supported.

7. Does the state have any activities related to this section that you would like to highlight?
   DSAMH contributes and provides integrated services through following action steps and activities:
   a. Collaborate with the DHS child serving agencies to develop an integrated family and youth development plan across the
      department. The plan will address issues of staff development, training, and family and youth leadership training.
   b. Support the Utah Family Coalition’s (UFC) effort to expand family and youth involvement activities, including family and youth
      peer support, to the other systems within Utah. The 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, which also merged with New Frontiers for Families during FY17) and the National Alliance on Mental Illness (NAMI)
      – Utah Chapter. In FY20, 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 and to provide greater
      access for families and youth in need. UFC also plans to continue to develop workforce through trainings supported by DSAMH
      that will reach each child serving division in DHS. UFC also plans on working collaboratively with DSAMH and the DHS divisions to
      further develop and evolve the training methods used to develop roles such as Family Resource Facilitators (FRF), family peer
      support, youth peer support, and Wraparound facilitators. DSAMH will support UFC’s effort by taking part in discussions with
      UFC, DCFS, DJJS, DSPD, and SOC that focus on family and youth development and peer support.
   c. Increase the number of Certified Family Resource Facilitators (FRF). FRF are family members who are trained to provide resource
      facilitation and family to family peer support services to children, youth, and families regardless of insurance coverage. DSAMH
      oversees the certification process and works with UFC to ensure the trainings continue to improve and provide the best possible
      workforce throughout the State of Utah. The certification process includes an initial 40-hour training, certification exam, on-going
      training, and 152 hours supervised practicum. In FY 2012, there were 15 FRF throughout the state who completed the supervised
      practicum. As of June 2019, there are 58 FRF statewide. The number of FRF will continue to grow through the collaborative efforts
      with Utah’s System of Care and involvement with other child serving agencies throughout the state. With continued DHS
      collaboration, the number of peer support should also increase as each child serving agency is able to hire and support their own
      focused peer support staff.
   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. Each FRF is in the process of being fully certified as a
      Wraparound Facilitator through the new training performed by UFC.
   e. Support a Youth-in-Transition focused 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).
   f. Support School Based Behavioral Health through partnerships with the LMHAs, the USBE, and the local schools throughout
      Utah. The USBE continues to be a key partner and helps provide technical assistance on collaborating with Local Education
      Authorities and on gathering outcome data. This technical assistance helped the mental health system understand schools’
      governing requirements and policies. It also helped the LMHAs strengthen referral practices and options to gather outcomes.
      Parent consent and involvement is integral for all school-based services. Services vary by school and may include individual, family,
      and group therapy; Parent Education; Social Skills and other Skills Development Groups; Family Resource Facilitation and
      Wraparound; Case Management; and Consultation Services.
   After receiving school-based services, parents identified several barriers that prevented them from seeking mental health services
   previously. Barriers included transportation and lack of access, lack of awareness of treatment options, parents feeling
   overwhelmed, time away from school for the child and work for the parent, and cost of treatment. Behavioral health services in
   schools overcome these barriers and promote healthy children and youth, and in turn increases academic success. As of June 2019,
   School-Based Programs were accessible in 323 schools. This includes access to services via a telehealth based pilot project being
   facilitated by Bear River Mental Health and Wasatch Mental Health. These new partnerships and pilot programs are meant to
   creatively serve more students while reducing barriers for the clinical teams and youth and families.
   An area of focus has been schools with high rates of Intergenerational Poverty as identified by the Utah Department of Workforce
   Services (DWS). The Intergenerational Poverty Mitigation Act has helped to strengthen partnerships with agencies outside of DHS,
   including DWS, the USBE, and local schools. As of June 2019, the funding allocated for this project is no longer available, but the
   support for schools with high rates of intergenerational poverty still exists. DSAMH has supported LMHA school-based work in 71
current schools with identified high rates of Intergenerational Poverty (schools where 10% or more of the student body are experiencing intergenerational poverty). DSAMH plans to continue to increase the number of schools supported by School Based Behavioral Health.

g. Collaborate with DHS child serving agencies to create a state driven plan to increase the services for children, youth, and their families who are experiencing co-occurring mental health and intellectual/developmental/autism related disabilities. Beginning in FY17, DSAMH received a Transformation Transfer Initiative (TTI) grant and began efforts with DSPD, UFC, and the Utah Parent Center to find innovative approaches to provide services to children, youth, and their families who are presently awaiting services from DSPD. The current programming includes providing two FRFs (one representing rural areas and one in urban areas) to families who are pursuing DSPD services. In addition, DSAMH meets with the group regularly and plans to develop training and technical assistant opportunities for provider agencies who serve individuals with each of the above listed concerns. DSAMH plans to continue to support the program as funding is still available and will be working with other partners to increase the access to both the parent training and the FRF services.

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

Through the collaborative efforts to provide a system of care in Utah, there are multiple technical assistance opportunities that DSAMH and the state are utilizing. DSAMH has partnered with The Children’s Center, DWS, and The Utah Department of Health (DH) to gain technical assistance for mental health consultation and service delivery for early childhood populations. The focus is helping Utah strengthen the system of early childhood providers who can focus on providing the best possible array of services to youth ages 0-5.

For continued improvement in service delivery, policy development, monitoring and oversight, DSAMH would benefit from technical assistance regarding the following:

a. Family and youth peer support, with a focus on youth peer support and the national trends for this type of work.

b. School based services. SAMHSA has identified schools as being a primary access point for providing mental and behavioral health services and has worked with the Mental Health Technology Transfer Centers to create trainings for schools and mental health systems. In addition to these resources, Local Authorities ask for more assistance to better prepare and train their workforce when they are working within school settings and with school based populations and to improve the continuum of care provided in conjunction with school systems.

c. Continued assistance for intellectual/developmental/autism disabilities and treating comorbid issues. Although the providers throughout Utah are able to sufficiently address the mental health problems or the intellectual/developmental/autism related problems, often there are questions about serving the co-occurring problems most effectively. Better training and workforce development are primary concerns for this type of technical assistance.
Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question
Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state’s suicide prevention plan in the last 2 years?  
   - Yes  
   - No

2. Describe activities intended to reduce incidents of suicide in your state.
   There are many activities in place aimed at suicide prevention. For youth, all secondary schools are required to have a suicide prevention program/strategy and all licensed school staff are required to have ongoing training; these efforts are led by the Utah State Board of Education.
   DSAMH has youth/school based initiatives (described in detail in the youth section) that contribute to prevention efforts including school based mental health and youth mobile crisis outreach teams. DSAMH partners with our local crisis centers to provide 24/7 support including with the local National Suicide Prevention Lifeline (NSPL) affiliate who also provides application-based chat/text crisis support to youth needing support. DSAMH has been working on building out a continuum of crisis services and recently awarded a contract for a statewide crisis line and expansion of mobile crisis outreach teams into five new counties/regions of the state. DSAMH has also developed and implemented a crisis worker certification training.
   DSAMH contracts with National Alliance for Mental Illness (NAMI) Utah and local coalitions statewide to help them review data and choose local suicide prevention strategies for implementation through an RFP process. DSAMH currently provides funding and technical assistance to 18 local coalitions who have embedded suicide prevention activities ranging from awareness and gatekeeper training to school based programming to reducing access to lethal means.
   DSAMH leads a robust firearm safety for suicide prevention effort including providing leadership to a committee of firearm related partners. Through this, DSAMH has developed education and training materials specific to firearm suicide prevention, distributed over 40,000 cable style gun locks, embedded a suicide prevention module into the Utah concealed carry permit training course, initiated a comprehensive study of firearm suicide, partnered with the local Children’s Hospital on an Emergency Department (ED) means restriction initiative, and is beginning a training program for firearm retailers.
   DSAMH works extensively on implementing the Zero Suicide (ZS) model in the public behavioral health care system with a focus on individuals with SMI/SED. We also work to implement in partner health and behavioral health systems statewide. After working for many years on suicide prevention with the largest health care system in Utah, they announced the formal adoption of the aspirational goal of zero through the Zero Suicide model in July 2017. DSAMH has several ZS-focused training initiatives including providing training and case consultation in Brief Cognitive Behavioral Therapy for Suicide Risk, the Collaborative Assessment and Management of Suicidality, Counseling of Access to Lethal Means, and Crisis Response Planning.
   Through the National Strategy for Suicide Prevention cooperative agreement with SAMHSA, DSAMH has contracted with a rural and urban provider to provide structured follow up/caring contact outreached to individuals discharging from emergency department and inpatient units after being seen in these setting for suicide risk or behaviors.
   DSAMH provides leadership to the Utah Suicide Prevention Coalition and Executive Committee as well as a number of subcommittees. This diverse group of stakeholders has been involved with the Utah Suicide Prevention Plan, ongoing strategic planning, and implementation of strategies. DSAMH has updated the Utah Suicide Prevention Plan (see attached).

3. Have you incorporated any strategies supportive of Zero Suicide?  
   - Yes  
   - No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  
   - Yes  
   - No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted?  
   - Yes  
   - No

If so, please describe the population targeted.
Utah completed a multi-year statewide Medicaid Improvement Project to improve suicide screening and same day interventions.

Data outcomes for the Utah Performance Improvement Project:

| Screening rate from Baseline to 2018 | 816% increase |

Printed: 8/1/2019 4:02 PM - Utah - OMB No. 0930-0168  Approved: 04/19/2019  Expires: 04/30/2022  Page 259 of 295
Safety Plan Rate from Baseline to 2018 increased 55%

2015 Baseline Screening Rates: 6%
2015 Baseline Safety Plan Rates: 40%
2016 Year 1 Screening Remeasurement: 24%
2016 Year 1 Safety Plan Remeasurement: 47%
2017 Year 2 Screening Remeasurement: 50%
2017 Year 2 Safety Plan Remeasurement: 54%
2018 Year 3 Screening Remeasurement: 55%
2018 Year 3 Safety Plan Remeasurement: 62%

Through the National Strategy for Suicide Prevention cooperative agreement with SAMHSA, DSAMH has contracted with a rural and urban provider to provide structured follow up/caring contact outreach to individuals discharging from emergency department and inpatient units after being seen in these setting for suicide risk or behaviors for adults 25 and older.

DSAMH was recently awarded SAMHSA Garrett Lee Smith (GLS) Youth Suicide Prevention grant and will be expanding the structured follow up/caring contact outreach program into three new rural counties and expanding to youth 10-24 in the urban county. We will also be partnering with several school districts on several suicide prevention activities.

Please indicate areas of technical assistance needed related to this section.
None at this time.

Footnotes:
Goal

The Utah Suicide Prevention Coalition is dedicated to long-term suicide prevention efforts. Our goal is to reduce suicide rates in Utah by 10% by 2021 with the ultimate goal of zero suicides in Utah.

Dedication

We dedicate this plan to those whose life has been impacted by suicidal thoughts or feelings and who bravely face each day and choose to hope and continue to live. We also dedicate this plan to survivors who have lost a loved one to suicide and to those professionals, clinicians, first responders, individuals and families who continue to engage in this work of Suicide Prevention.
Preface

I am pleased to share with you Utah’s Suicide Prevention Plan, the collaborative work of suicide prevention professionals, researchers, healthcare workers, advocates, survivors, family members and others affected by suicide. Unfortunately, suicide is a leading cause of death in Utah. Each year we lose too many family members, friends and neighbors to suicide; more than breast cancer, motor vehicle accidents, homicide, and many chronic physical health problems.

The purpose of any plan is to lay out long-term and short-term goals detailing the strategies and metrics that will be used to achieve lofty goals. We should measure our efforts, and adjust our plans and strategies accordingly. That’s the essence of the continuous quality improvement built into this plan, meant to be a living, changing, working document that adds another important element: hope. Hope will empower individuals, families and communities to do the work laid out in this plan. We must act together now to prevent suicide in Utah.

Prevention works, treatment is effective, and people can and do recover from suicidal thoughts, feelings and behaviors. In fact, 90% of people who attempt suicide do not go on to die by suicide. Together we can make a difference to prevent suicide, provide caring, evidenced based interventions, and foster environments that promote acceptance, healing and recovery. With a problem as complex as suicide, no one solution will be enough. Our health, behavioral health systems, schools and communities need to collectively work together implementing the best practices and data available to achieve our goals.

I invite you to review our plan and find a way to become involved in local or statewide efforts.

Some key elements of our plan include:

• Safe and Effective Messaging for Suicide Prevention with Safe Reporting of Suicide
• Increasing Availability and Access to Quality Behavioral and Physical Health Care Including Screening, Evidenced Based Interventions and Safety Planning
• Coping and Problem Solving Skills
• Connectedness to Individuals, Family, Community and Social Institutions
• Reducing Access to Lethal Means
• Support to Survivors of Suicide Loss

I want to thank those who have been instrumental in moving suicide prevention work forward in Utah; those working in the field who help facilitate this process; the many caring and dedicated family members, friends and professionals, whose support is life-altering for so many. I also want to personally thank the brave individuals struggling with suicidal thoughts and encourage them to continue reaching out for hope. As we work together collaboratively to address this problem, we will save lives and reduce the impact suicide has on individuals, families and communities in Utah.

Please join us in this movement to prevent suicide in Utah.

Sincerely,
Doug Thomas, LCSW
Director
Utah Division of Substance Abuse and Mental Health
# Table of Contents

INTRODUCTION.........................................................................................................................4

UTAH SUICIDE DATA.................................................................................................................5
  Data Quality Improvement................................................................................................5
    Intermountain West........................................................................................................6
    Utah and the US.............................................................................................................6
  Age and Sex......................................................................................................................7
  Methods............................................................................................................................7
  Youth and LGBT..............................................................................................................8

RISK AND PROTECTIVE FACTORS........................................................................................9
  Social Ecological Model....................................................................................................9
  Risk and Protective Factors............................................................................................10
  Comprehensive Suicide Prevention Approach.............................................................11
    Protective Factors.........................................................................................................12
      Increase availability and access to behavioral and physical health care.................13
      Increased social norms supportive of help-seeking and recovery..........................14
      Reduce access to lethal means..................................................................................14
      Increase connectedness to individuals, family, community and social institutions by creating safe and supportive school and community-environments.................................................................15
      Increase safe media portrayals of suicide and adoption of safe messaging principles......................................................................................................................16
      Increase coping and problem solving skills..............................................................16
      Increase support to survivors of suicide loss...........................................................17
      Increase prevention and early intervention for mental health problems, suicide ideation behaviors and substance misuse.................................................................18
      Increase comprehensive data collection and analysis regarding risk and protective factors for suicide to guide prevention effort.................................................................19

CONCLUSION..............................................................................................................................20

RESOURCES..................................................................................................................................21

APPENDIX....................................................................................................................................24
Introduction

Living in Utah has many advantages including the best snow on Earth and many beautiful national and state parks in which the opportunity for outdoor adventure is almost unlimited. Utah also ranks high in a number of health and happiness related outcomes. In spite of all that Utah has to offer, Utah continually ranks in the top ten states for high suicide rates in the U.S. People in Utah also experience higher rates of associated mood disorders. The Utah Suicide Prevention Coalition is dedicated to better understanding this paradox and implementing prevention, intervention and postvention strategies to decrease suicide and the associated suffering it brings.

Suicide is a major preventable public health problem in Utah and the 8th leading cause of death (2010-2015 inclusive). Every suicide death causes a ripple effect of immeasurable pain to individuals, families, and communities throughout the state. From 2009 to 2015, Utah's age-adjusted suicide rate was 19.9 per 100,000 persons. This is an average of 525 suicide deaths per year. Suicide was the second-leading cause of death for Utahns ages 10 to 39 years old in 2013 and the number one cause of death for youth ages 10-17. Many more people attempt suicide than die by suicide. The most recent data show that 6,039 Utahns were seen in emergency departments (2014) and 2,314 Utahns were hospitalized for self-inflicted injuries including suicide attempts (UDOH Indicator-based Information System for Public Health, 2014). One in fifteen Utah adults report having had serious thoughts of suicide in the past year (SAMHSA National Survey on Drug Use and Health, 2008-2009). According to the Student Health and Risk Prevention Survey, 14.4 % of youth grades 6-12 report seriously considering suicide, 6.7% of Utah youth grades 6-12 students attempted suicide one or more times and 13.9% of students report harming themselves without the intention of dying in the prior year.

While suicide is a leading cause of death and many people report thoughts of suicide, the topic is still largely met with silence and shame. It is critical for all of us to challenge this silence using both research and personal stories of recovery. Everyone plays a role in suicide prevention and it is up to each one of us to help create communities in which people are able to feel safe and supported in disclosing suicide risk, including mental illness and substance use problems. We need to break down the barriers that keep people from accessing care and support for prevention, early intervention and crisis services. As you review this plan, we encourage you to identify how you can implement any of the strategies and help create suicide safer communities.
Data Quality Improvement

The Utah Suicide Prevention Coalition seeks to continuously improve its prevention strategies and measure proximal and distal outcomes by monitoring Utah data relating to risk and protective factors, suicide deaths, suicide attempts, emergency department visits, hospitalizations, and any other available outcomes. Local community coalitions are strongly encouraged to conduct similar data driven quality improvement, while including the voices of suicide survivors and community stakeholders in their evaluation and improvement efforts.

There are models that help support and guide communities through this data driven process. The Strategic Prevention Framework (SPF) developed by the Substance Abuse Mental Health Services Administration (SAMSHA) and the Communities That Care (CTC) are complimentary models communities can use. The SPF is a planning process that guides states, jurisdictions, tribes, and communities in the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. Overall, SPF uses findings from public health research along with evidence-based prevention programs to build capacity and sustainable prevention. CTC is a coalition-based prevention system that activates community stakeholders to collaborate on the development and implementation of a science-based community prevention system. Activating a coalition of stakeholders holds promise for coordinated, widespread change in preventive services across organizations and agencies in a community.
The Intermountain West has seven out of ten of the highest rates of suicide in the nation. Utah had the 7th highest suicide rate in the U.S. in 2014, ages 10 years and older. An average of 557 Utahns die from suicide and 4,410 Utahns attempt suicide each year.

Utah’s suicide rate has been consistently higher than the national rate for more than a decade (Figure 2). On average, two Utahns die as a result of suicide every day and twelve Utahns are treated for suicide attempts every day. All suicide attempts should be taken seriously. Those who survive suicide attempts are often seriously injured and many have depression and other mental health problems.
Overall, Utah males (36.0 per 100,000 population) had a significantly higher suicide rate compared to Utah females (10.6 per 100,000 population). However, Utah females had significantly higher ED visit and hospitalization rates for suicide attempts compared to Utah males. Utah males had significantly higher rates of suicide compared to Utah females in every age group (Figure 3).

**Methods**

Use of a firearm was the most common method of suicide deaths for Utahns followed by suffocation, then poisoning.
Utah Schools

According to estimates from the 2015 Utah Prevention Needs Assessment self-report data, an average classroom of 30 Utah students may have:

- Five students who seriously considered attempting suicide in the last year
- Four who made a suicide plan in the last year
- 2 students who attempted suicide in the last year

Thoughts of suicide?

Utah’s youth suicide rate

Has been consistently higher than the national rate for more than a decade

Rate of Suicides by Year, Youth Ages 10-17, Utah and U.S., 1999-2014

Lifetime Suicide Attempts by Highly Rejected LGBT Young People

Low Rejection  Moderate rejection  High Rejection

Level of Family Rejection

Gay and transgender teens who were highly rejected by their parents and caregivers were more than eight times as likely to attempt suicide compared with gay and transgender teens who were not at all or only rejected a little by their parents and caregivers because of their identity.

Source: Caitlin Ryan, Family Acceptance Project
The Utah Suicide Prevention Coalition is a partnership of community members, suicide survivors, service providers, researchers, and others dedicated to saving lives and advancing suicide prevention efforts in Utah. The Utah Suicide Prevention Coalition has worked to create and implement the 2013 state plan and this 2017 plan in order to outline effective, evidence based strategies for promoting wellness and preventing suicide and the suffering that accompanies it. The Utah Suicide Prevention Plan addresses suicide from a risk and protective factor model.

Suicide is a complex outcome influenced by individual, family, relational, community, and societal factors. Comprehensive prevention strategies must address the factors that increase risk for suicide and the factors that protect from suicide risk across all of these levels. The social ecological model provides a framework for this understanding. The figure below represents the National Suicide Prevention Strategy. The Utah Plan models the national plan but is not an exact replica.

### Protective Factors
- Restrictions on lethal means of suicide
- Sources of continued care after psychiatric hospitalizations
- Supportive relationship with health care providers
- Coping and problem solving skills

### Risk Factors
- Unsafe media portrayals
- Few available sources of supportive relationships
- Family history of suicide
- Substance abuse
Risk and Protective Factors

The Suicide Prevention Resource Center has highlighted the following as major risk and protective factors for suicide. These factors are addressed throughout the Utah Suicide Prevention Plan:

<table>
<thead>
<tr>
<th>Protective Factors</th>
<th>Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connectedness</td>
<td>Prior Suicide Attempt(s)</td>
</tr>
<tr>
<td>Effective Behavioral Health Care</td>
<td>Mood Disorder</td>
</tr>
<tr>
<td>Contact with Caregivers</td>
<td>Substance Abuse</td>
</tr>
<tr>
<td>Problem Solving Skills</td>
<td>Access to Lethal Means</td>
</tr>
</tbody>
</table>

As discussed above, risk and protective factors interact in many contexts to influence an individual’s level of risk for suicide. Unfortunately, there is limited data available concerning suicide deaths and individuals who experience suicidal behaviors and thoughts, which can make it difficult to identify subgroups in the population with an increased risk for suicide. This plan will address efforts to improve data collection in order to better understand the problem of suicide broadly and in subgroups. The National Action Alliance has provided guidance on groups who have been identified as higher risk for suicide behaviors than the general population. In each of the goals and strategies outlined in the Plan, communities are encouraged to examine their data, get input from local stakeholders and focus implementation on applicable high risk populations. High-risk populations identified include:

- American Indians/Alaskan Natives
- Individuals bereaved by suicide, also known as survivors of suicide loss
- Individuals in justice and welfare settings
- Individuals engaged in non-suicidal self-injury
- Individuals who have attempted suicide
- Individuals with medical conditions
- Individuals with mental and or substance use disorders
- Lesbian, gay, bisexual and transgender (LGBT+) population
- Members of the Armed Forces and Veterans
- Men in midlife and older men
- Individuals with a history of multiple Adverse Childhood Experiences (ACES)
Reducing risk factors and enhancing protective factors are critical components of any prevention plan. It is not enough to focus on one risk factor, one protective factor, or one of the levels in which risk and protection exist. Efforts must work to address as many factors in as many settings as possible and create a comprehensive approach to suicide prevention. The goal of the Utah Suicide Prevention plan is to create a comprehensive approach and roadmap for suicide prevention in which we reach both a universal population and those with increased risk. The plan aims to follow the comprehensive approach outlined by the Suicide Prevention Resource Center and the 2012 National Strategy for Suicide Prevention.

To further increase the impact of the outlined suicide prevention strategies, the Utah Suicide Prevention Coalition strives to implement evidence-based programs and strategies. An evidence-based program is one that has high evidence of effectiveness that has been proven over time and across multiple replications by independent researchers, preferably in randomized controlled trials. Suicide prevention is a complex and nuanced field, and some interventions or efforts, while well intentioned, may cause more harm than good; particularly if they raise awareness of the problem of suicide without giving adequate resources and skills to build protective factors, or if they lead to suicide contagion by normalizing or glorifying suicide unintentionally. To facilitate the use of evidence-based programs in local Utah communities, the Utah Suicide Prevention Coalition strives to provide opportunities, resources, and training. Fortunately, there are many evidence-based programs and strategies available, some of which can be found here: http://www.sprc.org/resources-programs.
Protective Factors

As mentioned previously, this suicide prevention plan addresses suicide from a risk and protective model. Reducing risk factors and enhancing protective factors are critical components of any prevention plan. Nine protective factors were identified and are presented in the following pages as a guide for prevention. Each protective factor includes goals and corresponding strategies to achieve the goals. The level of the social ecological model (SEM) is also included.

<table>
<thead>
<tr>
<th>Level of SEM:</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Societal</td>
<td>Increase availability and access to quality physical and behavioral health care</td>
</tr>
<tr>
<td>Community</td>
<td>Increase social norms supportive of help-seeking and recovery</td>
</tr>
<tr>
<td>Interpersonal</td>
<td>Reduce access to lethal means</td>
</tr>
<tr>
<td></td>
<td>Increase connectedness to individuals, family, community and social institutions by creating safe and supportive school and community environments</td>
</tr>
<tr>
<td></td>
<td>Increase safe media portrayals of suicide and adoption of safe messaging principles</td>
</tr>
<tr>
<td></td>
<td>Increase coping and problem solving skills</td>
</tr>
<tr>
<td></td>
<td>Increase support to survivors of suicide loss</td>
</tr>
<tr>
<td></td>
<td>Increase prevention and early intervention for mental health problems, suicide ideation and behaviors and substance misuse</td>
</tr>
<tr>
<td></td>
<td>Increase comprehensive data collection and analysis regarding risk and protective factors for suicide to guide prevention efforts</td>
</tr>
</tbody>
</table>
### Protective Factors

**Increase Availability and Access to Quality Physical and Behavioral Health Care**

<table>
<thead>
<tr>
<th>GOAL 1: Promote the adoption of the ‘Zero Suicide’ framework by health and behavioral health care providers statewide. Strategies: 1. Engage leadership in a commitment to reduce suicide deaths 2. Develop a confident, competent, and caring workforce (quality training CMEs and CEUs for healthcare professionals) 3. Identify every person at risk for suicide using quality assessments (increase use of the Columbia-Suicide Severity Rating Scale) 4. Suicide Care Management Plan (policies and procedures) 5. Use evidence based treatment to treat suicidal thoughts and behaviors directly (use of the Stanley Brown Safety Plan, Counseling on Access to Lethal Means, Collaborative Assessment and Management of Suicidality, Dialectical Behavioral Therapy, and Cognitive Behavioral Therapy for Suicide Prevention) 6. Support patients through every transitions in care (sources of continued care after psychiatric hospitalization, warm handoffs and caring contacts and follow up procedures during care transitions) 7. Apply data driven quality improvement</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>GOAL 2: Expand and strengthen Utah’s existing crisis services and follow-up after a crisis Strategies: 1. Promote existing services to increase awareness andutilization 2: Increase use of areas offering Mobile Crisis Outreach Teams (MCOT), receiving centers and other stepped interventions and services</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>GOAL 3: Increase access to physical and behavioral healthcare services Strategies: 1: Increase % of Utahns with health and behavioral health insurance 2: Increase access to services of Utahns who remain uninsured 3: Increase telehealth availability, particularly in rural communities 4: Increase access to psychotropic medication Prescribers / Psychiatrists</th>
</tr>
</thead>
</table>
Protective Factors

Increase Social Norms Supportive of Help-seeking and Recovery

GOAL 1: Increase awareness of suicide as a preventable public health problem utilizing research-informed communication that is designed to prevent suicide by changing knowledge, attitudes and behaviors.

Strategies:
1. Annually distribute data and resource flyers to professionals and individuals in Utah which includes suicide data, prevention resources and crisis line numbers
2. Continue to increase Utah capacity for evidence based gatekeeper trainings (such as ASIST, Mental Health First Aid, Question, Persuade, Refer (QPR), etc.)
3. Develop, implement and evaluate communication initiatives that reach the whole or segments of the population to increase help seeking and promote recovery (e.g., Man Therapy, Health Minds Utah, YOUTH Campaign, social media, www.utahsuicideprevention.org)

Reduce Access to Lethal Means

GOAL 1: Provide training to providers (pharmacists, counselors, and physicians) who interact with individuals who may be at risk for suicide on counseling on access to lethal means.

GOAL 2: Partner with firearm retailers and gun owners to incorporate suicide awareness and prevention as a basic tenet of firearm safety and responsible firearm ownership.

GOAL 3: Promote and distribute tools/strategies to reduce access to lethal means such as gun locks, safes, and medication lock boxes/bags, etc. Promote existing resources such as drug take back event, rx drop off, and Use Only As Directed campaign.
### Protective Factors

**Increase Connectedness to Individuals, Family, Community and Social Institutions by Creating Safe and Supportive School and Community Environments**

| GOAL 1: Support primary prevention and early identification of Adverse Childhood Experiences using partnerships with government, healthcare and behavioral health providers, schools and non-profits |
| GOAL 2: Promotion of child abuse prevention services such as in home intervention and parenting programs (Love and Logic, Strengthening Families, Nurse Family Partnership) |
| GOAL 3: Create safe environments for Lesbian, Gay Bisexual, Transgender, and Queer/Questioning (LGBTQ+) youth and young adults including the promotion of research-supported initiatives such as Gay Straight Alliances, the Family Acceptance Project, and the Trevor Project |
| GOAL 4: Utilize community coalitions to increase opportunities for prosocial involvement by all community members |
| GOAL 5: Promote evidence based training, policies and protocols for first responders to support them in responding to mental health, substance use and suicide related incidences in the community |
| GOAL 6: Partner with businesses to implement workplace wellness and suicide prevention/postvention strategies |
| GOAL 7: Support USBE and Local Education Authorities in the adoption of evidence based suicide prevention, intervention, and postvention strategies and policies |
| GOAL 8: Utilize the existing peer support infrastructure to embed suicide prevention strategies in supporting individuals in recovery |
### Protective Factors

#### Increase Safe Media Portrayals of Suicide and Adoption of Safe Messaging

<table>
<thead>
<tr>
<th>Goal 1: Increase positive hopeful communications efforts and support safe communication strategies in all media channels.</th>
<th>Level of SEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL 2: Educate stakeholders and media representatives about safe messaging principles through resources like the National Action Alliance for Suicide Prevention.</td>
<td></td>
</tr>
<tr>
<td>GOAL 3: Use multiple media channels to increase sharing of lived experience stories of recovery from suicide and mental health conditions.</td>
<td></td>
</tr>
</tbody>
</table>

#### Increase Coping and Problem Solving Skills

<table>
<thead>
<tr>
<th>GOAL 1: Implement universal and indicated evidence-based health education and social/emotional health programs (such as: DBT STEPS-A, Positive Behavioral interventions and Supports in schools, The Good Behavior Game, Botvin’s Life Skills, etc.).</th>
<th>Level of SEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL 2: Implement and promote evidence-based parenting programs like Guiding Good Choices or Strengthening Families.</td>
<td></td>
</tr>
</tbody>
</table>
### Increase support to Survivors of Suicide Loss

<table>
<thead>
<tr>
<th>GOAL 1: Increase outreach to survivors of suicide loss through key partnerships to promote awareness of and access to suicide specific grief supports.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL 2: Improve the quality and quantity of resources available to survivors of suicide loss by providing research-supported training opportunities.</td>
</tr>
<tr>
<td>GOAL 3: Promote and disseminate postvention protocols including but not limited to Connect Suicide Postvention Training, in a variety of settings: workplace, schools, clinical settings, community, and media to promote healing and reduce risk of contagion.</td>
</tr>
<tr>
<td>GOAL 4: Provide support and resources to health and behavioral healthcare providers for when a client under their care dies by suicide.</td>
</tr>
</tbody>
</table>
Increase Prevention and Early Intervention for Mental Health Problems, Suicide Ideation and Behavior and Substance Misuse

**GOAL 1:** Increase awareness of suicide as a preventable public health problem using research-informed communication that is designed to prevent suicide by changing knowledge, attitudes and behaviors.

**GOAL 2:** Develop and sustain public-private partnerships to advance suicide prevention.

Strategies:
1. Utah Suicide Prevention Coalition including workgroups as currently constituted: Youth, LGBTQ, First Responders, Community Awareness, Firearm Safety, Workplace, Zero Suicide, Executive Committee
2. The Utah Suicide Prevention Coalition will provide support and technical assistance to community coalitions statewide to improve infrastructure and ability to address suicide prevention in their local communities

**GOAL 3:** Continue to increase Utah capacity for evidence based gatekeeper trainings (such as ASIST, Mental Health First Aid and/or Question, Persuade, Refer (QPR)).

**GOAL 4:** Promote and support the expansion of school based mental health services, Mobile Crisis Outreach Team, and Family Resource Facilitator Programs in all communities throughout Utah.

**GOAL 5:** Promote the implementation of mental health screening and referral in work sites, schools, senior centers, and community settings.
## Increase Comprehensive Data Collection and Analysis Regarding Risk and Protective Factors for Suicide to Guide Prevention Efforts

<table>
<thead>
<tr>
<th>GOAL 1:</th>
<th>Partner with the Office of the Medical Examiner to increase access to data regarding suicide fatalities.</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL 2:</td>
<td>Implement the state level suicide fatality review committee to reduce gaps in services, improve inter-agency collaboration, and reduce barriers to accessing care.</td>
</tr>
<tr>
<td>GOAL 3:</td>
<td>Strategize and prioritize methods to collect more comprehensive data regarding LGBTQ persons’ risk of suicide ideation and suicide fatality.</td>
</tr>
<tr>
<td>GOAL 4:</td>
<td>Increase timely availability of suicide data to key stakeholders involved in prevention efforts.</td>
</tr>
</tbody>
</table>
Conclusion

We are using these resources

- Evidence-based strategies
- Health data
- State and federal funding
- Existing program resources
- Experience and knowledgeable staff
- Strong state and local partnerships
- Suicide Prevention Coalition

to implement these strategies

- Strengthen policies, systems and environments
- Influence health care systems
- Engage communities
- Enhance surveillance and evaluation systems
- Communicate positive norms through various modalities
- Build capacity for suicide prevention at the local level

Have access to physical and behavioral healthcare
Experience positive social norms
Restrict access to lethal means when suicide is present
Are connected to supportive networks
Hear safe messages from the media
Have strong coping and problem solving skills
Receive support after a suicide loss
Receive care for mental health problems and substance misuse
Have access to comprehensive and timely data to guide prevention efforts

and ultimately reduce...

suicide rates in Utah by 10% by 2021 with the ultimate goal of zero suicides in Utah.
• **Utah Suicide Prevention Coalition:**  
The Utah Suicide Prevention Coalition provides suicide prevention basics; listings of local, state and national resources for those in need; resources for suicide survivors (after a suicide loss) and for after a suicide attempt; information regarding trainings and education the coalition offers; and ManTherapy.  
http://utahsuicideprevention.org/  
https://www.facebook.com/utahsuicideprevention  
www.vimeo.com/utahsuicideprevention  
• **Youth Resources:**  
https://mentalhealthscreening.org/programs  
http://hopesquads.com/  
http://www.sprc.org/resources-programs?type=All&populations=All&settings=All&problem=All&planning=All&strategies=All&state=All  
http://nrepp.samhsa.gov/01_landing.aspx  
http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669  
https://afsp.org/our-work/education/after-a-suicide-a-toolkit-for-schools/  
• **Native American Resources:**  
http://www.sprc.org/settings/aian  
https://www.samhsa.gov/tribal-ttac  
• **Older Adults:**  
http://www.sprc.org/populations/older-adults  
• **Data Resources:**  
• **Mental Health Resources:**  
www.namiut.org  
http://hs.utah.gov/overview/treatment/  
www.dsamh.utah.gov  
healthymindsutah.org  
https://findtreatment.samhsa.gov/  
workingminds.org  
• **Veteran Resources:**  
https://www.va.gov/directory/GUIDE/state.asp?STATE=UT&dnum=ALL  
http://www.mentalhealth.va.gov/suicide_prevention/  
http://veterans.utah.edu/
• **LGBTQ+ Suicide Prevention Resources**

  American Association of Suicidology: LGBT Resource Sheet (http://www.suicidology.org/resources/lgbt) and Suicidal Behavior Among LGBTQ Youth LGBT Fact Sheet


  Celebrating LGBTQ Youth: The Role of Educators and Families (http://scholarworks.gvsu.edu/cgi/viewcontent.cgi?article=1215&context=colleagues)

  Family Acceptance Project General Booklet and Family Acceptance Project Latter-day Saint Booklet (http://familyproject.sfsu.edu/publications) These family education booklets have been designated as a “Best Practice” resource for suicide prevention for LGBT people.


  Suicide Prevention among LGBT Youth: A Workshop for Professionals Who Serve Youth (http://www.sprc.org/training-institute/lgbt-youth-workshop)


  Talking About Suicide and LGBT Populations (AFSP, Trevor, GLSEN, GLAAD) (http://glsen.org/article/talking-about-suicide-lgbt-populations)

  Transgender Suicide: Myths, Reality and Help (http://www.masstpc.org/pubs/Community_Suicide_Brochure.pdf)

  Trevor LifeGuard Materials (http://www.thetrevorproject.org/pages/lifeguard)

  LGBTQyouth.org (http://www.lgbtqyouth.org/resources/lgbtq-youth-suicide/pilot-prevention-project/suicide-prevention-resources)
• **Safe Messaging Resources:**
  http://reportingonsuicide.org/
  http://suicidepreventionmessaging.actionallianceforsuicideprevention.org/

• **After an Attempt:**
  http://www.utahsuicideprevention.org/after-a-suicide-attempt
  https://afsp.org/find-support/ive-made-attempt/
  https://afsp.org/find-support/my-loved-one-made-attempt/

• **Postvention Resources:**
  https://afsp.org/our-work/education/after-a-suicide-a-toolkit-for-schools/
  http://www.utahsuicideprevention.org/after-a-suicide-loss
  https://afsp.org/find-support/ive-lost-someone/
  http://www.theconnectprogram.org/
  http://www.sprc.org/keys-success/safe-messaging-reporting
  https://afsp.org/unsafe-reporting-suicide-can-cost-lives/

**After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances**

SPRC provides a guide to help community and faith leaders who plan memorial observances and provide support for individuals after the loss of a loved one to suicide.

**After a Suicide: A Toolkit for Schools**

After a Suicide: A Toolkit for Schools was developed by AFSP and the Suicide Prevention Resource Center to assist schools in the aftermath of a suicide (or other death) in a school community.

**Supporting Survivors of Suicide Loss: A Guide for Funeral Directors**

This guide can help funeral directors and the funeral services industry serve as they are a vital line of first response to those impacted by the profound and crippling effects of suicide loss.

• **Faith-based Resources:**
  https://www.lds.org/preventingsuicide/?lang=eng
  http://actionallianceforsuicideprevention.org/faith-communities
Appendix

Acronyms

- ACE - Adverse Childhood Experiences
- ASIST - Applied Suicide Intervention Skills Training
- CEU - Continuing Education Unit
- CME - Continuing Medical Education
- CTC - Communities That Care
- DBT STEPS-A - Dialectical Behavioral Therapy Skills Training for Emotional Problem Solving for Adolescents
- EBT - Evidence Based Treatment
- IBIS - Indicator-Based Information System for Public Health
- LGBT - Lesbian, Gay, Bisexual, and Transgender Population
- LMHA - Local Mental Health Authorities
- MCOT - Mobile Crisis Outreach Team
- QPR - Question Persuade Refer
- Rx - Prescription
- SAMHSA - Substance Abuse and Mental Health Services Administration
- SEM - Social Ecological Model
- SPF - Strategic Prevention Framework
- SPRC - Suicide Prevention Resource Center
- UDOH - Utah Department of Health
- USBE - Utah State Board of Education

Icons made by: http://www.flaticon.com/ Authors: Zlatko Najdenovski, Madebyoliver, Vectors Market, Freepik and Gregor Cresnar
License: http://creativecommons.org/licenses/by/3.0/
Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question
The success of a state’s MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;

- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD 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 factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;

- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;

- The state public housing agencies which can be critical for the implementation of Olmstead;

- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and

- The state’s office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state’s ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  
   - Yes  
   - No

2. Has your state identified the need to develop new partnerships that you did not have in place?  
   - Yes  
   - No

If yes, with whom?
There is not a need for new relationships, as DSAMH has had varying levels of relationships with partners over the years. As integrated health is emphasized and Medicaid Expansion is implemented (began on April 1, 2019), DSAMH has recognized the need to strengthen relationships with primary care providers, Federally Qualified Health Centers, Accountable Care Organizations, and other possible network providers. DSAMH has added additional contractual obligations to the University of Utah to expand Screening, Brief Intervention, and Referral to Treatment (SBIRT) trainings across the State, and are working on adding additional training from other providers such as the Change Companies, Optum, Utah State University, Utah Support Advocates for Recovery Awareness etc.

In addition, Legislative changes emphasizing improved suicide prevention and crisis care have renewed the focus on emergency and crisis care at all levels. The focus on Mental Health Commissioners, Designated Examiners, Prosecutor/Defense Attorneys, State and County Corrections and Public Safety Agencies, Probation and Parole, Mobile Crisis Outreach, and justice reinvestment and forensic competency issues continues to increase. Many efforts have been made to forge stronger relationships with each agency, relationships with new staff in these agencies and partnerships around mutually important issues related to behavioral health across sequential intercepts in continuum of care access by Utah citizens.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

General: The Division is involved in numerous partnerships, committees, work groups, coalitions and day-to-day collaboration with program managers and administrators of both internal and external organizations. Listed below are just a few of the ongoing partnerships that the Division is currently involved in:
a. Utah Behavioral Health Planning and Advisory Council (UBHPAC) is a council composed primarily of Peers who review Mental Health Block Grant activities and provide feedback to DSAMH. UBHPAC is a subcommittee of the Utah Substance Abuse Advisory Council (USAAV). USAAV is a committee established by statute to advise the Governor on Substance Use Disorder issues. The Division sits on the council and provides membership to all four of the Council’s Committees.

b. Office of Licensing: The Division has worked closely with the Office of Licensing to update rules and requirements for Opioid Treatment programs as well as a work group that created a Recovery Residence Licensing process to assist in providing safe sober housing for individuals in recovery. DSAMH staff sit on the Comprehensive Review Committee to review appeals submitted to the Office of Licensing.

c. Criminal Justice: The Division has a long history of collaboration and cooperation with the Criminal Justice workers, to include the Administrative Office of the Courts, the Programming Division in the Department of Corrections which provides substance use disorder (SUD) services inside the prison system, with Adult Probation and Parole, and with the judges and other Drug Court Team Members. The collaboration with the Department of Corrections and the Commission on Criminal and Juvenile Justice (CCJJ) is discussed in section 13.

d. Board of Education (BOE) staff sit on DSAMH committees related to employment. One staff member works directly as a liaison between the two government agencies focused on early intervention programs.

e. University of Utah. The Division conducts quarterly meetings with three key departments of the University of Utah to continue the partnership established over many years.

f. Recovery Support: The Division contracts with and meets with the following Recovery support organizations on numerous issues on a monthly basis: National Alliance for Mental Illness (NAMI), Utah Support Advocates for Recovery Awareness (USARA), Latino Behavioral Health Services (LBHS).

g. Utah Department of Veterans Affairs and the Utah National Guard: The Assistant Division Director sits on a statutory mandated Veteran’s Affairs Committee, and monthly meetings are held with the VA and UDOVA to coordinate on issues such as Suicide Prevention, Mental Health Conferences, and improving service to Veterans and National Guard members.

h. Department of Health (DOH). A few of the committees and work groups that the Division either attends with the DOH, co-chairs with the DOH or has DOH membership on its committees are:
   1) Recovery Plus (Tobacco Cessation)
   2) Prescription Drug Abuse Task Force
   3) Narcan Distribution Work Group
   4) Care Management Work Group
   5) Prevention Coalitions statewide
   6) Community Health Workers Workforce Development Work Group
   7) Utah Community Health Worker Coalition

i. DSAMH and other DHS Divisions meet regularly with Department leadership. These include the Division for Child and Family Services, Division for the Aging, Division of People with Disabilities, Division of Juvenile Justice Services

j. Department of Workforce Services, Vocational Rehabilitation

k. Insurance Commissioner

l. Opioid Treatment Programs

m. Private Health Care and Managed Care Organizations

n. Department of Professional Licensing (DOPL)

o. Utah Behavioral Health Care Council (UBHC)

Children’s mental health and support of state partners:

DSAMH partners with child serving agencies throughout the state of Utah to ensure that children and youth are allowed to receive care in the least restrictive setting. According to the Foster Care Mental Health Treatment Restructuring Initiative Guiding Principles developed by the Division of Child and Family Services (DCFS) and the Division of Juvenile Justice Services (DJJS), Principle 1.3 reads: Each child is cared for in the least restrictive setting and for the shortest, appropriate duration to help the child achieve outcomes defined for that child, such as safety, connection to a permanent family or other caring adults, progress towards treatment plan goals, prevention of recidivism, or increasing skills and ability to function in society successfully as an adult. Children should grow up in family settings not institutions. Although it is the goal to serve all children and youth within their own communities, there are situations when residential care, inpatient hospitalizations, and even the Utah State Hospital are necessary resources to provide the best care possible.

When children and youth are in these settings, DSAMH, in partnership with LMHAs, DCFS, DJJS, System of Care (SOC), the Division for Services with People with Disabilities (DSPD), the State Board of Education, Local Education Authorities, and other necessary providers and community partners collaborate to find effective transition services. Collaboration occurs throughout all levels of the state with individualized staffing’s at a local level to high level staffing’s at the state level. DSAMH and the LMHAs will ensure that services are in place for a child and youth’s mental health. The collaboration that occurs also allows for a focus on family and peer needs (with the help of Family Resource Facilitators and Family Peer Support), education needs including Individualized Education Plans (IEPs) and Section 504 Plans for behavioral needs, and any other needs that will allow for the child and their family to succeed within their community.

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

DSAMH was awarded the Assisted Outpatient Treatment (AOT) Grant for the SAMHSA four-year (2016-2020) pilot Program for Individuals with Serious Mental Illness (SMI). AOT is for adults 18- years of age and older, which consequently includes individuals with early serious mental illness (ESMI). AOT is an Evidence Based Program that aims to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarceration and interactions with the criminal justice system while providing intensive...
treatment that improves the health and social welfare of individuals with SMI. DSAMH established and oversees the AOT Program at two sites: Davis Behavioral Health (DBH) and Weber Human Services (WHS). As part of its grant responsibilities, DSAMH must provide a quarterly data report (from the SAMHSA Performance and Accountability Reporting System database) on the AOT project. DSAMH has contracted with the University of Utah's Utah Criminal Justice Center to analyze the data and compile this report. In a recent effort to determine the cost-benefit analysis of the AOT Program, DSAMH has turned to the Utah Department of Health Office of Health Care Statistics for access to the Emergency Discharge data needed. The Utah Criminal Justice Center will also help with data analysis for this effort.
Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.

Planning Councils: The Road to Planning Council Integration

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.


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

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

      The Division of Substance Abuse and Mental Health (DSAMH) presents on and provides the State Plan to the Utah Behavioral Health Planning and Advisory Council (UBHPAC). On August 1st, when the plan is submitted for public comment, a printed version of the plan is distributed to members for continued discussion and feedback. Subcommittees have been formed, including a prevention, treatment, and recovery committees, to look over the State Plan and provide feedback. The DSAMH will post a copy of the State Plan on the front page of their website for public comment on August 1st, and UBHPAC will be made aware via email as well as in meeting (August 1, 2019), a hard copy of the State Plan will be provided at the front desk of the DSAMH, and a copy posted on the DSAMH Bulletin Board. The public will be encouraged to provide feedback via email or calling DSAMH.

      Minutes for UBHPAC and the UBHPAC executive meetings are posted on the DSAMH website, along with an audio recording of each meeting:

      https://dsamh.utah.gov/providers/behavioral-health-planning-council

      DSAMH provides guidance to all of the Local Substance Abuse Authorities and Local Mental Health Authorities during a combined Area Plan training in the spring of each year. The Local Authorities use that guidance to develop their Area Plans, in conjunction with their local partners. Each Local Authority also has consumers involved in the development of their plans and priorities. The Local Authorities are responsible for planning for and providing MH and SUD services to the residents of their counties.

      Clinical directors for each of the Local Authorities, in conjunction with DSAMH, have a monthly Recovery-Oriented System of Care (ROSC) meeting to facilitate movement of the public behavioral health system to a recovery-oriented model. This includes review and discussion of cost, quality, access, outcomes, integration, engagement and retention for mental health, substance use disorders and prevention.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?  Yes  □  No  □

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?  Yes  □  No  □

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   The Public Health Service Act (42 U.S.C.300x) mandates each state establish a State Mental Health Planning Council. The council is required to review and provide feedback on the states Mental Health Block Grant (MHBG) application and submit any...
recommendations. The Council monitors, reviews and evaluates the allocation and adequacy of mental health services in the state; and serves as an advocate for adults with serious mental illness (SMI), children with serious emotional disturbances (SED), and other individuals with mental illness or emotional disturbances. UBHPAC is comprised of mental health and substance use disorder providers, peers in recovery, family members of individuals in recovery, advocates, state agencies, and other agencies that interact with the mental health system. From each member’s perspective, issues and concerns are brought up during the meeting and the council works together to better serve individuals with SMI and SED. An Executive subcommittee has been formed and UBHPAC is currently reformatting the final hour of the monthly meeting to target topics of interest for more in-depth review.

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

No technical assistance needed

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.70

Footnotes:

70There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
### Environmental Factors and Plan

#### Advisory Council Members
For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency  
State Vocational Rehabilitation Agency  
State Criminal Justice Agency  
State Housing Agency  
State Social Services Agency  
State Health (MH) Agency.

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership*</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email (if available)</th>
</tr>
</thead>
</table>
| Emily Bennett       | State Employees     | State Health Agency - AUCH          | 860 E 4500 S, Ste 206 Salt Lake City UT, 84107  
PH: 801-716-4617 | emily@auch.org                                    |
| Dan Braun           | Providers           |                                     | 7138 S Highland Dr, Ste 103 Salt Lake City UT, 84121  
PH: 801-453-9625 | danb@wasatchpeds.net                             |
| Ron Bruno           | Providers           | State Criminal Justice Agency - CIT | 299 S Main St, Ste 1300 Salt Lake City UT, 84111  
PH: 801-535-4653 | citutah@cit-utah.com                             |
| Nettie Byrne        | Parents of children with SED/SUD |                                  | 230W 200 S, Ste 138 Salt Lake City UT, 84101  
PH: 801-389-6943 | nettieb@allieswithfamilies.org                    |
| Lori Cerar          | Family Members of Individuals in Recovery (to include family members of adults with SMI) |                             | 261 E 300 S, Ste 210 Salt Lake City UT, 84111  
PH: 801-433-2595 | lori@allieswithfamilies.org                        |
| Julia Chandler      | Providers           |                                     | 3471 S West Temple Salt Lake City UT, 84115  
PH: 801-935-4447 | julia.lbhs@gmail.com                              |
| Donald Cleveland    | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) |                          | 50 W 200 N LaVerkin UT, 84745  
PH: 435-215-5085 | Theillustrator62@gmail.com                         |
| Cathy Davis         | State Employees     | State Education Agency - Utah Board of Education | 250 E 500 S Salt Lake City UT, 84111  
PH: 801-538-7861 | cathy.davis@schools.utah.gov                      |
| Finnegan Grenn      | Youth/adolescent representative (or member from an organization serving young people) |                             | 11358 S 1700 E Sandy UT, 84092  
PH: 385-210-7636 | finnigangreen@gmail.com                            |
| Lisa Hancock        | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) |                                     | 2526 Lake Park Blvd West Valley City UT, 84120  
PH: 385-529-8014 | lisa.hancock@optum.com                             |
<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Address</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peggy Hostetter</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>135 S 500 W, Apt 603 Salt Lake City UT, 801-355-3570</td>
<td><a href="mailto:phostetter@gmail.com">phostetter@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Ryan Hunsaker</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>PO Box 581287 Salt Lake City UT, 84158 801-634-9463</td>
<td><a href="mailto:mhrunsaker@icloud.com">mhrunsaker@icloud.com</a></td>
<td></td>
</tr>
<tr>
<td>Jason Jacobs</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>8483 S 1275 E Sandy UT, 84094 801-577-6893</td>
<td><a href="mailto:jasonjacobs77@gmail.com">jasonjacobs77@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Jane Lepisto</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>277 E 350 N Alpine UT, 84004 801-368-0271</td>
<td><a href="mailto:janelep1@gmail.com">janelep1@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Shanel Long</td>
<td>State Employees</td>
<td>195 N. 1950 W. Salt Lake City UT, 84116 801-538-4406</td>
<td><a href="mailto:shlong@utah.gov">shlong@utah.gov</a></td>
<td></td>
</tr>
<tr>
<td>Jennifer Marchant</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>1408 W Harris Ave Salt Lake City UT, 84104 901-971-6410</td>
<td><a href="mailto:jmarchant@q.com">jmarchant@q.com</a></td>
<td></td>
</tr>
<tr>
<td>Mary Jo McMillen</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>180 E 2100 S Salt Lake City UT, 84115 801-839-9950</td>
<td><a href="mailto:maryjo@myusara.com">maryjo@myusara.com</a></td>
<td></td>
</tr>
<tr>
<td>Rafael Montero</td>
<td>State Employees</td>
<td>926 W Baxter Dr South Jordan UT, 84095 801-446-2560</td>
<td><a href="mailto:rmontero@utah.gov">rmontero@utah.gov</a></td>
<td></td>
</tr>
<tr>
<td>Cyndie Moore</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>650 N 300 W, Apt 127 Salt Lake City UT, 84103 801-688-7556</td>
<td><a href="mailto:cyndiemoore12@gmail.com">cyndiemoore12@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Aubrey Myers</td>
<td>State Employees</td>
<td>1350 E. 1450 S Clearfield UT, 84015 801-776-7300</td>
<td><a href="mailto:amyers@utah.gov">amyers@utah.gov</a></td>
<td></td>
</tr>
<tr>
<td>Sigrid Nolte</td>
<td>Parents of children with SED/SUD</td>
<td>10238 Snow Iris Way Sandy UT, 84092 385-775-1012</td>
<td><a href="mailto:siggy.nolte@gmail.com">siggy.nolte@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>James Park</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>1122 Southwest Dr Tooele UT, 84074 801-841-1653</td>
<td><a href="mailto:jjpark9958@gmail.com">jjpark9958@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Jeanine Park</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>1122 Southwest Dr. Tooele UT, 84074 435-841-4989</td>
<td><a href="mailto:parkjeanie60@gmail.com">parkjeanie60@gmail.com</a></td>
<td></td>
</tr>
<tr>
<td>Kylee Porter</td>
<td>Providers</td>
<td>6771 S 900 W Midvale UT, 84047 801-386-9799</td>
<td><a href="mailto:kyleep@nextlevelrecovery.com">kyleep@nextlevelrecovery.com</a></td>
<td></td>
</tr>
<tr>
<td>Shanin Rapp</td>
<td>State Employees</td>
<td>195 N. 1950 W. Salt Lake City UT, 84116 801-538-4287</td>
<td><a href="mailto:slrapp@utah.gov">slrapp@utah.gov</a></td>
<td></td>
</tr>
<tr>
<td>Andrew Riggle</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>205 N 400 W Salt Lake City UT, 84103 801-521-8324</td>
<td><a href="mailto:ariggle@disabilitylawcenter.org">ariggle@disabilitylawcenter.org</a></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Type of Membership/Agency/Organization</td>
<td>Address</td>
<td>Phone</td>
<td>Email</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>----------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Kyli Rodriguez-Cayro</td>
<td>Youth/adolescent representative (or member from an organization serving young people)</td>
<td>230 W 200 S, Ste 142 Salt Lake City UT, 84101</td>
<td>801-433-2595</td>
<td><a href="mailto:kylirc@allieswithfamilies.org">kylirc@allieswithfamilies.org</a></td>
</tr>
<tr>
<td>Ken Rosenbaum</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>882 Foxboro Dr, Apt J304 North Salt Lake UT, 84054</td>
<td>801-759-0019</td>
<td><a href="mailto:unclekenny99@yahoo.com">unclekenny99@yahoo.com</a></td>
</tr>
<tr>
<td>Jacob Russell</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>1020 W 1020 S Provo UT, 84061</td>
<td>775-412-7435</td>
<td><a href="mailto:jacob_rssll@yahoo.com">jacob_rssll@yahoo.com</a></td>
</tr>
<tr>
<td>Adam Scherzinger</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>717 N Oakmount Ln Fruit Heights UT, 84037</td>
<td>801-865-2314</td>
<td><a href="mailto:scherzburg@comcast.net">scherzburg@comcast.net</a></td>
</tr>
<tr>
<td>Olivia Shakespeare</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>230 W 200 S Salt Lake City UT, 84101</td>
<td>801-433-2595</td>
<td><a href="mailto:olivias@allieswithfamilies.org">olivias@allieswithfamilies.org</a></td>
</tr>
<tr>
<td>Robert Snarr</td>
<td>State Employees Housing and Homelessness/DSAMH</td>
<td>195 N. 1950 W. Salt Lake City UT, 84116</td>
<td>801-538-4080</td>
<td><a href="mailto:rsnarr@utah.gov">rsnarr@utah.gov</a></td>
</tr>
<tr>
<td>Rob Wesemann</td>
<td>Providers</td>
<td>1600 W 2200 S, Ste 202 West Valley City UT, 84115</td>
<td>801-323-9900</td>
<td><a href="mailto:rob@namiut.org">rob@namiut.org</a></td>
</tr>
<tr>
<td>David Wilde</td>
<td>State Employees Utah State Medicaid Office</td>
<td>288 N 1460 W Salt Lake City UT, 84116</td>
<td>801-783-3853</td>
<td><a href="mailto:djwilde@utah.gov">djwilde@utah.gov</a></td>
</tr>
</tbody>
</table>

*Council members should be listed only once by type of membership and Agency/organization represented.
OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020   End Year: 2021

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
<td>32</td>
</tr>
<tr>
<td>Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>11</td>
</tr>
<tr>
<td>Family Members of Individuals in Recovery* (to include family members of adults with SMI)</td>
<td>2</td>
</tr>
<tr>
<td>Parents of children with SED/SUD*</td>
<td>2</td>
</tr>
<tr>
<td>Vacancies (Individuals and Family Members)</td>
<td>0</td>
</tr>
<tr>
<td>Others (Advocates who are not State employees or providers)</td>
<td>3</td>
</tr>
<tr>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>1</td>
</tr>
<tr>
<td>Representatives from Federally Recognized Tribes</td>
<td>0</td>
</tr>
<tr>
<td>Total Individuals in Recovery, Family Members &amp; Others</td>
<td>19</td>
</tr>
<tr>
<td>State Employees</td>
<td>8</td>
</tr>
<tr>
<td>Providers</td>
<td>5</td>
</tr>
<tr>
<td>Vacancies</td>
<td>0</td>
</tr>
<tr>
<td>Total State Employees &amp; Providers</td>
<td>13</td>
</tr>
<tr>
<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>1</td>
</tr>
<tr>
<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>1</td>
</tr>
<tr>
<td>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>2</td>
</tr>
<tr>
<td>Youth/adolescent representative (or member from an organization serving young people)</td>
<td>2</td>
</tr>
</tbody>
</table>

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:
Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
   
   a) Public meetings or hearings? ☺ Yes ☐ No
   
   b) Posting of the plan on the web for public comment? ☺ Yes ☐ No
      
      If yes, provide URL:

   c) Other (e.g. public service announcements, print media) ☺ Yes ☐ No

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes: