Utah

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

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

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 08/01/2017 3.59.30 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
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

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

IV. Date Submitted
   Submission Date
   Revision Date

V. Contact Person Responsible for Application Submission
   First Name  Shanel
   Last Name  Long
   Telephone  801-538-4406
   Fax  801-538-9892
   Email Address  shlong@utah.gov

Footnotes:
State Information

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

Fiscal Year 2018

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>

**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</td>
<td>Description</td>
<td>USC Code</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>1946</td>
<td>Prohibition Regarding Receipt of Funds</td>
<td>42 USC § 300x-56</td>
</tr>
<tr>
<td>1947</td>
<td>Nondiscrimination</td>
<td>42 USC § 300x-57</td>
</tr>
<tr>
<td>1953</td>
<td>Continuation of Certain Programs</td>
<td>42 USC § 300x-63</td>
</tr>
<tr>
<td>1955</td>
<td>Services Provided by Nongovernmental Organizations</td>
<td>42 USC § 300x-65</td>
</tr>
<tr>
<td>1956</td>
<td>Services for Individuals with Co-Occurring Disorders</td>
<td>42 USC § 300x-66</td>
</tr>
</tbody>
</table>
ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination 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.); (a)


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Lana Stohl

Signature of CEO or Designee: ________________________________

Title: Deputy Director ________________________________ Date Signed: ________________________________

mm/dd/yyyy

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

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

## Fiscal Year 2018

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

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

<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

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM’s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination 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)


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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

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

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

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

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Lana Stohl

Signature of CEO or Designee1: _____________________________

Title: Deputy Director ___________________________ Date Signed: ___________________________

mm/dd/yyyy

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

Title
Executive Director

Organization
Utah Department of Human Services

Signature:  

Date:  

Footnotes:
Planning Steps

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

Narrative Question:

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

Footnotes:
I. Overview of State Behavioral Health System

![Diagram of the State Behavioral Health System]

Organization of the Utah Public Behavioral Health System

a. State level organization—Utah Department of Human Services

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

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

Coordination is a major emphasis in the Department, and 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 comprise 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 is the 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. The DSAMH provides oversight, technical assistance and support to the 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 trainings on evidence based strategies, coalition efforts and data collection are offered by the DSAMH. Direct services are provided by the LSAA staff and contractors.
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 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 (DSAMH) is authorized under Utah State Code Annotated §62A-15-103 as the single state authority for mental health and substance abuse in Utah. Utah Statutes require that the State Division of Substance Abuse and Mental Health to: “… set policy for its operation and for programs funded with state and federal money… establish, by rule, minimum standards for local substance abuse authorities and local mental health authorities… develop program policies, standards, rules, and fee schedules for the division… ” (Utah Code Title 62A, Chapter 15, Section 105 “Authority and Responsibilities”) and that the Division “…contract with local substance abuse authorities and local mental health authorities to provide a comprehensive continuum of services in accordance with division policy, contract provisions, and the local plan…” (Utah Code 62A-15-103. “Division -- Creation – Responsibilities”).

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 go 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 DSAMH serves as the SSA and SMHA, and as such oversees the provision of Behavioral Health Services in the State. The Director of the DSAMH is supported by an Assistant Director of Mental Health and an Assistant Director of Substance Abuse. Utah’s 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 the DSAMH to expand its contracting responsibilities to include providing “(D) a statewide comprehensive continuum of community-based services designed to reduce criminal risk factors for individuals who are determined to have substance abuse or mental illness conditions or both, and who are involved in the criminal justice system.”
The DSAMH has implemented all of the mandates of this new 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, the DSAMH has increased workforce competency through statewide training opportunities in Moral Reconation Therapy (MRT), LSI/RNR assessments and 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 172 site and represents 135 community based treatment agencies.

**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.

**Sub State Organization**: Utah State Statute specifically mandates the Local Substance Abuse Authorities (LSAA) provide a “continuum of services for Adolescents and Adults” aimed at substance abuse prevention and treatment; and requires Local Mental Health Authorities
(LMHA) to provide ten mandatory services. Thus, Utah’s Local Mental Health Authorities are given the responsibility to provide mental health services to their citizens. Utah utilizes CMHS and SAPT Block Grant funds, along with State General Funds, other State and Federal appropriations and the Counties’ 20% funding match to fulfill these requirements to provide for services required by federal and state statute. State and federal funds are allocated to Local Authorities through a formula which takes into account the percent of the state's population residing within the county's boundaries and a rural differential. Each county is required to provide at least a 20% match on all state general funds. The majority of general and county funds allocated for mental health services are used to meet Medicaid match requirements. With only 27% of SUD clients qualifying for Medicaid, and as of June 2017, no authorization by the Utah State Legislature to expand healthcare coverage passed to include individuals not qualifying for a commercial insurance subsidy on the Federal exchange, most SUD clients receive services that are funded by state and federal appropriations specifically for SUD services, and the accompanying 20% county match.

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

A Local Mental Health or Substance Abuse Authority is generally the governing body of a county i.e. a commissioner or council member. Many counties have joined together under inter-local agreements to create a single Local Authority where one commissioner representing each county holds a seat on the governing board. Services are delivered through contracts with Mental Health and Substance Abuse Providers, and in compliance with statute, administrative rule, and under the administrative direction of the 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 the DSAMH. These plans become the foundation of contracts
between the 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>2015 Estimated Census Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Authority</td>
</tr>
<tr>
<td>Bear River</td>
</tr>
<tr>
<td>Weber</td>
</tr>
<tr>
<td>Salt Lake</td>
</tr>
<tr>
<td>Davis</td>
</tr>
<tr>
<td>Tooele</td>
</tr>
<tr>
<td>Wasatch</td>
</tr>
<tr>
<td>Utah</td>
</tr>
<tr>
<td>Summit</td>
</tr>
<tr>
<td>Central</td>
</tr>
<tr>
<td>Southwest</td>
</tr>
<tr>
<td>Northeastern</td>
</tr>
<tr>
<td>Four Corners</td>
</tr>
<tr>
<td>San Juan</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 estimates to exceed 3,652,547 by 2020. The 2016 US Census estimates Utah’s population to be 3,051,217 an increase of 11.03% 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:

<table>
<thead>
<tr>
<th>Authority</th>
<th>County(s)</th>
<th>Population %</th>
<th>Area %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salt Lake County</td>
<td>1 county</td>
<td>36.96%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Weber Human Services</td>
<td>2 counties</td>
<td>8.5%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Central Utah Counseling</td>
<td>6 counties</td>
<td>2.58%</td>
<td>20.3%</td>
</tr>
</tbody>
</table>

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 local authority is tasked with the requirement to include Native Americans as well as other minority and underserved groups in their planning process.

Given the diverse nature of the various Local Authorities, geographically, culturally, economically and organizationally, the specifics of planning for services is left to the Counties and their Local Authorities, and monitored closely by the 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.
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 behavioral health 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 behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data 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, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance 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.

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

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

Through the Healthy People Initiative, 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:

Identifying the unmet Service Needs and Gaps:

Some Specific challenges faced by Utah include:

- Utah is home to 5 federally recognized American Indian Tribes including the Ute, Navajo, Paiute, Shoshone and Goshute people.
- 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 (3.15 for Utah versus 2.64 nationally).
- Utah is currently the nation’s fastest growing state over the past year, growing by 2% from July 2015 to July 2016 versus a 0.7% growth nationally. ([https://www.census.gov/newsroom/press-releases/2016/cb16-214.html](https://www.census.gov/newsroom/press-releases/2016/cb16-214.html))
- Utah has 30.2% of the population under the age of 18 compared to 22.8% nationally.
- Compared to national averages, Utah is better educated at both the High school and bachelor’s degree level, and has a higher homeownership rate.
- By legislative intent, with the exception of the Utah State Hospital, no substance abuse or community mental health center is operated by the State; the state does not provide clinical care.
- Native American populations reside in various “reservations” across the state, with the bulk living in the Northeastern and Southeastern regions of the state; Federal, State, County and Native American jurisdictions are all involved in providing services.
  - Both of these areas are relatively remote with poor transportation and sparse populations, which further stretch the state’s resources.
  - The direct planning and provision of services is a responsibility of the Local Authorities in those areas, and the provision of services to Native American populations is a part of the annual contract review and audit.
  - Success in negotiating service agreements and coordinating services is often an issue of local politics and personalities.
  - Utah’s Department of Human Services has developed an inter-tribal council and signed a coordination/collaboration agreement with the various Native American tribal representatives supporting the need for planning and coordination at a state level.
  - DSAMH attends the council meetings and has presented at several, and continues to work with the council on common issues.
  - 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.
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 2016 US Census estimates Utah’s population to be 3,051,217 an increase of 11.03% since 2010.
- The Utah Department of Health reports 22% of Utah’s adult population suffers from chronic health conditions, and has continuously found statistical information concurrent with national research indicating a high rate of co-occurring chronic physical illness and mental illness in Utah’s adult population (Source: Utah Department of Health, CDC Behavioral Risk Factor Surveillance System Report).
- Utah’s adults with mental illness are at greater risk of chronic health conditions, just as those with chronic health conditions are at increased risk of mental illness. (Source: Utah Department of Health, CDC Behavioral Risk Factor Surveillance System Report).
- Through growing partnership with the Utah Department of Health, the Division of Substance Abuse and Mental Health is working to analyze the need and capacity for programming and create integrated solutions to support this population.
- Of twenty rural hospitals in the Utah, as of 2012, fourteen identified a “lack of access to mental health services” as the number one concern of their physicians and hospital administration. 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 2015 was $24,686, with 11.3% in poverty.
    - Rural Utah per capita, in 2015, was $37,877
  - 2015 estimates indicate a poverty rate of 13.9% exists in rural Utah, compared to a 17.2% level in urban areas of the state.
  - ACS data from 2015, reports that 15.3% of the rural population has not completed high school, compared to 13% of urban populations.
  - The unemployment rate in rural Utah is at 5.4%, while in urban Utah it is at 4.8% (https://data.ers.usda.gov).
- Tobacco Use
  - Although a relatively low number of adults use tobacco in Utah (11.3% compared to the national average of 16.8%),
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

69.2% of individuals admitted for SUD Services use tobacco (TEDS Data, 2017).

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 between 2011-2015 was 23.2 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.
  - An average of 554 Utahns died by suicide yearly between 2011-2015
  - An average of 3,968 Utahns attempt suicide each year.
  - Use of a firearm was the most common method of suicide death for Utahns followed by suffocation and then poisoning.
  - The rate of suicide for those 25 and older is higher than the overall suicide rate at 28 per 100,000 in 2015. On average 10 Utahns ages 25+ are treated for self-inflicted injuries including suicide attempts every day. Suicide is the 2nd leading cause of death among Utahns ages 25-44, and the 4th leading cause of death for those ages 45-54 (2015). In 2015, 492 Utah adults age 25 and older died by suicide.
  - Suicide rates are higher among males in every age group.
  - Adults ages 25+ comprise 53.5% of the population in Utah, 83% of all suicides in Utah, 57% of all Emergency department encounters for suicide, and 66% of all inpatient hospitalizations for suicide attempts/ideation. Men ages 25+ comprise 26% of the Utah population and 63% of all suicides. The 2015 Utah suicide rate ages 25+ was 41.71 for men and 14.93 for women per 100,000 population.
  - 1 in 15 adults report considering suicide in a given year according to the National Survey on Drug Use and Health.
  - Utah's suicide rate has been consistently higher than the U.S. rate for the last decade. A recent CDC study found that Utah had the highest prevalence of suicidal thoughts among adults in the U.S. In addition, Utah has the
    - 7th highest adult male (ages 25-64) suicide rate in the U.S
    - 9th highest adult female (ages 25-64) suicide rate in the U.S.
  - In 2013, suicide surpassed unintentional injuries to become the leading cause of death among youth ages 10–19 in Utah. 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.
According to the 2015 Student Health & Risk Prevention Surveys, 16.6% of students in grades 6-12 reported that during the past year they had seriously considered suicide and 7.6% reported having an actual attempt.

- 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.
  - Utah has submitted a waiver request to HHS to provide for a very small expansion of Medicaid services to a very specific population based on need and disability which can only be implemented based on funding approved. As of July 2017 Utah has not heard back from HHS regarding approval of this waiver request. This means that while other states have been able to expand their services using Medicaid and private insurance, Utah continues to rely on state and federal funding.
  - As a result, only 20.4% of individuals with past year illicit drug use received SUD treatment services, and 12.5% of individuals with Alcohol Dependence of Abuse received treatment. (Behavioral Health Barometer, 2013)
  - Due to the availability of Medicaid for individuals with serious mental illness, 42.5% of individuals with any mental illness received services. (Behavioral Health Barometer, 2013)

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

Utah's State Epidemiological Outcomes Workgroup (SEOW) meets bimonthly to review and discuss the available data sets. 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 all available datasets, 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, 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 LSAAs. The coordinators and DSAMH collaborate with state level initiatives. Then the LSAAs 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 LSAA.

One data gap is the access to the Prescription Drug Monitoring Program. Because of the highly sensitive nature of this database, the restrictions surrounding the use of the data are very limited. The DSAMH and the Utah Department of Health are working to gain useful access to the database.
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 local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

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

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

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

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

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

4. If not, what changes will the state need to make to be able to collect and report on these measures?

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

Footnotes:
Planning Step: Data Collection Readiness

1) The State 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 FEi’s WITS. 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. Starting in July 2017, indicated prevention services will start to be submitted on a client-level basis into the same system that houses the current mental health and substance use disorder data. Also beginning July 2017, the state will be collecting client-level data on recovery support services.

2) The State system is unique to mental health and substance use disorder data.

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

4) 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. A change to the PHQ-9 will require a change for both the State system and Local Authority systems and procedures.
   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 and Early Intervention</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, and increase early intervention
- **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 and focus resources on reducing substance abuse and mental health problems or disorders.

### 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
  b. Decrease 30 day use.
  2. Participate and provide prevention and treatment expertise in the Department of Health and DEA Prescription Drug Committees.
  3. Assist prevention prepared communities in addressing Prescription Drug abuse in their communities as appropriate.
- **Goal B:** 1. Include information and education on Prescription Drug abuse in all Division sponsored and supported conferences and trainings.  
  2. Participate and provide prevention and treatment expertise in the Department of Health and DEA Prescription Drug Committees.
  3. Assist prevention prepared communities in addressing Prescription Drug abuse in their communities as appropriate.
- **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>2015: 6.5%</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>2018: 5.0%</td>
</tr>
</tbody>
</table>
Second-year target/outcome measurement: 2019: 4.5%

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:
2015: 2.4%

First-year target/outcome measurement:
2018: 2.0%

Second-year target/outcome measurement:
2019: 1.5%

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. 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:
2015: 630

First-year target/outcome measurement:
2018: 599

Second-year target/outcome measurement:
2019: 567

Data Source:
Office of the Medical Examiner

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. 2015 is the most recent year available.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Goal C: Decrease 30 day E-Cigarette use among youth - all grades</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Measurement</td>
<td>2015: 8.1%</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>2018: 7.0%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>2019: 6.0%</td>
</tr>
</tbody>
</table>

**Data Source:**
Student Health and Risk Prevention Survey

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

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Goal D: Decrease 30 day marijuana use among youth - all grades</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Measurement</td>
<td>2015: 5.2%</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>2017: 4.4%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>2019: 3.5%</td>
</tr>
</tbody>
</table>

**Data Source:**
Student Health and Risk Prevention Survey

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

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Goal E: Reduce Community norms favorable to alcohol, tobacco and other drug use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Measurement</td>
<td>2015: 17.2%</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>2018: 15.2%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>2019: 13.0%</td>
</tr>
</tbody>
</table>

**Data Source:**
Student Health and Risk Prevention Survey

**Description of Data:**
Statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data.

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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Goal E: Reduce Parental attitudes favorable towards alcohol, tobacco, and other drug use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline Measurement</td>
<td>2015: 9.9%</td>
</tr>
</tbody>
</table>

**Data Source:**
Student Health and Risk Prevention Survey

**Description of Data:**
Statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data.

**Data issues/caveats that affect outcome measures:**
Survey is collected biennially. Also note that confidence interval is +/- 5%.
**First-year target/outcome measurement:** 2018: 8.0%

**Second-year target/outcome measurement:** 2019: 6.5%

**Data Source:**
Student Health and Risk Prevention Survey

**Description of Data:**
Statewide survey administered to 6, 8, 10, 12 grade students. Collects substance abuse, mental health, risk and protective factor data.

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

**Priority #:** 2

**Priority Area:** Zero Suicides Initiative

**Priority Type:** SAP, SAT, MHS

**Population(s):** SMI, SED, PWWDG, PP, PWID, 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:**
Goal A: Engage community stakeholders and prevention coalitions in suicide prevention and mental health promotion efforts statewide. Goal to see suicides decrease state wide as a result.
Goal B: Improve the ability of health providers (including Behavioral Health) to better support individuals who are at risk of suicide through adoption of Zero Suicide framework.

**Objective:**

**Goal A:**
1) Subcontract with a minimum of 13 local coalitions through Prevention by Design.
2) Train community members in Gatekeeper awareness and evidence-based training.

**Goal B:**
1) Promote the adoption of universal screening for suicide risk within the public behavioral healthcare system.
2) Promote same day safety planning for individuals who screen positive for suicide risk

**Strategies to attain the objective:**

**Goal A:**
1) An RFP process is used to request applications for Prevention by Design projects.
2) Coalitions have trainers that provide QPR, SafeTalk, ASIST and other evidence-based trainings.

**Goal B:**
1) Zero Suicide Initiative, Performance Improvement Plan, Division Directives, and Training focused on suicide prevention for LGBTQ, military and criminal justice populations.

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>Indicator</th>
<th>Baseline Measurement</th>
<th>First-year target/outcome measurement</th>
<th>Second-year target/outcome measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Goal A: Increase number of engaged community prevention coalitions by 20%</td>
<td># of prevention coalitions engaging in suicide prevention efforts</td>
<td>Increase # of prevention coalitions engaged by 10%</td>
<td>Increase # of prevention coalitions engaged by 20%</td>
</tr>
</tbody>
</table>

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

**Description of Data:**

---

Printed: 8/1/2017 3:59 PM - Utah - OMB No. 0930-0168  Approved: 06/12/2015  Expires: 09/30/2020
Data will include numbers of individuals trained in evidence-based trainings, pre- and post-test results.

Data issues/caveats that affect outcome measures:

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

---

Indicator #: 2
Indicator: Goal B: Universal Screening Rates in public mental health system by 50%
Baseline Measurement: Dependent on Local Authority
First-year target/outcome measurement: Increase screening rates by 25%
Second-year target/outcome measurement: Increasing screening rates by 50%
Data Source: DSAMH reporting tool, Electronic Health Records

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

Data issues/caveats that affect outcome measures:
Some Local Authorities do not have the required data built into their EHR, there are multiple EHR systems state-wide.

---

Indicator #: 3
Indicator: Goal B: Same-Day Safety Planning for individuals screened as at risk for suicide will increase by 50%
Baseline Measurement: Dependent on Local Authority
First-year target/outcome measurement: Increase same-day safety plans by 25%
Second-year target/outcome measurement: Increase same-day safety plans by 50%
Data Source: DSAMH reporting tool, Electronic Health Records (EHR)

Description of Data:
Use of same-day safety plan per individual endorsing 2 or higher on the Columbia Suicide Severity Rating Scale.

Data issues/caveats that affect outcome measures:
Some local authorities do not have the data built into the EHRs, there are different EHRs in use around the state.

---

Priority #: 3
Priority Area: Promote Recovery
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, PWDC, ESMI, PWID, EIS/HIV, TB, Other (Adolescents w/SA and/or M H, Students in College, 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:
Expand Access and Participation in Evidence-Based Treatment Services for Opioid Use Disorders
Goal A: Promote and establish Peer Support Services State wide.
Goal B: Promote individuals engaged in employment activities and finding employment.
Goal C: Increase the number of Local Authorities providing Trauma Informed environment for MH/SUD
Goal D: Increase the number of Local authorities providing Medication Assisted Services to over 5% of their SUD clients.
Goal E: Through Supported Housing decrease homelessness in urban counties.

Objective:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 1: Increase the number of qualified prescribers who can prescribe medications approved to treat opioid use disorder</td>
<td></td>
</tr>
<tr>
<td>Objective 2: Increase participation in Opioid Treatment Programs (OTP)</td>
<td></td>
</tr>
<tr>
<td>Objective 3: Increase access and use of Naltrexone, Vivitrol, and Buprenorphine</td>
<td></td>
</tr>
<tr>
<td>Objective 4: Increase use and training of Screening, Brief Intervention and Referral to Treatment (SBIRT)</td>
<td></td>
</tr>
<tr>
<td>Objective 5: Increase participation in evidence-based behavioral health treatments for opioid use disorders</td>
<td></td>
</tr>
<tr>
<td>Objective 6: Improve treatment retention for individuals with opioid use disorders</td>
<td></td>
</tr>
<tr>
<td>Objective 7: Increase number and percent of clients with opioid use disorder who complete treatment successfully</td>
<td></td>
</tr>
<tr>
<td>Objective 8: Increase number of clients with public/private insurance</td>
<td></td>
</tr>
<tr>
<td>Objective 9: Increase the number of individuals voluntarily participating in activities of benefit to their community</td>
<td></td>
</tr>
<tr>
<td>A: Provide Training for MH and SUD Peer Specialists to work in SAD and MH facilities and assist individuals in priority populations.</td>
<td></td>
</tr>
<tr>
<td>B: Increase engagement of employment services for individuals in recovery and in priority populations.</td>
<td></td>
</tr>
<tr>
<td>C: Review Division Directives and Contracts to include the provision of Trauma Informed environment.</td>
<td></td>
</tr>
<tr>
<td>D: To increase the number of LA’s providing MAT services.</td>
<td></td>
</tr>
<tr>
<td>E: Improve housing services across the state, and decrease chronic homelessness</td>
<td></td>
</tr>
</tbody>
</table>

Strategies to attain the objective:

| Objective 1 - Number of Qualified Prescribers in Utah |
| Indicator: Increased number of qualified prescribers who can prescribe medications to treat opioid use disorders |
| Baseline: 393 Suboxone Private Providers |
| Target: Increase the number of Suboxone providers in Rural Areas by 1% |
| Timeframe: May 1, 2017 - May 1, 2018 |

| Objective 2 - Number of Participants in OTP |
| Indicator: Increased number of participation in Opioid Treatment Programs |
| Baseline: 3429 |
| Target: Increase participation by 1% |
| Timeframe: May 1, 2017 - May 1, 2018 |

| Objective 3 - Number of Participants Using Naltrexone, Vivitrol and Buprenorphine |
| Indicator: Increase in the number of participants using Naltrexone, Vivitrol and Buprenorphine (MAT) |
| Baseline: (5722 Opioid clients/181 receiving MAT) |
| Target: Increase the number of participants using MAT by 5% |
| Timeframe: May 1, 2017 - May 1, 2018 |

| Objective 4 - Number of Screening and Brief Intervention (SBI) Codes Billed |
| Indicator: Increase number of SBI Codes billed to Medicaid and Commercial Insurance by physical and behavioral health care provider clinics |
| Baseline: Establish Baseline |
| Target: Receive no less than two SBI billings towards Medicaid and Commercial Insurance |
| Timeframe: May 1, 2017 - May 1, 2018 |

| Objective 4 - Number of SBIRT Training |
| Indicator: Provide 2 SBIRT Trainings each year for physical and behavioral health care providers |
| Baseline: Establish Baseline |
| Target: Provide no less than 2 SBIRT trainings each year |
| Timeframe: May 1, 2017 - May 1, 2018 |

| Objective 5 EBP Treatment in LSAAs |
| Indicator: Increase the use of fidelity measures for evidenced based practices in the LSAA’s for individuals with opioid use disorders. |
| Baseline: Establish Baseline |
| Target: Implement at least 1 fidelity measure for one EBP Timeframe: May 1, 2017 - May 1, 2018 |

| Objective 6 - Treatment Retention - LSAA Scorecard |
| Indicator: Improve treatment retention for individuals with opioid use disorders |
| Baseline: Percent of clients retained in treatment 60 or more days. State Average (2016) - 67.3% |
| Target: State Average of 70% |
| Timeframe: May 1, 2017 - May 1, 2018 |

| Objective 7 - Percent of Clients That Complete Treatment Successfully |
| Indicator: Improve treatment completion for individuals with opioid use disorders |
| Baseline: Successful Treatment Episode Completion is defined as a successful completion of an episode of treatment without readmission within 30 days. |
Objective 8 - Percent of Clients With Public/Private Insurance
Indicator: Increase the number of clients with public/private insurance
Baseline: (Establish a Baseline) UHPP contract.
Target: Expand eligibility and enrollment services through Navigators and Behavioral Health Care Providers
Timeframe: May 1, 2017 - May 1, 2018

Objective 9 - Recovery Support Community Activities
Indicator: Increase the number of individuals voluntarily participating in recovery support activities in their community. Recovery Support Activities can include 12-step groups, social, spiritual, recreational or any activity that promotes health, wellness and recovery. Baseline: Establish baseline
Target: Increase recovery community activities through contracted providers by 2%
Timeframe: May 1, 2017 - May 1, 2018

A: Promote Peer Support Services with LA’s statewide. Continue to contract for Training Providers
B: IPS training to all LA’s and collaborate with multiple agencies including USOR, DOE, DSPD, UDOWD, DWS, Medicaid, VA.
C: Provide training and technical assistance for LA’s to use TIC for SUD, MH, and priority populations.
D: Continued education to the LA’s and Medical providers on benefits of MAT services.
E: Identify current barriers to providing housing, work with Medicaid to expand services and provide outreach and education to individuals at risk of homelessness.

Annual Performance Indicators to measure goal success

| Indicator # | 1 |
| Indicator: | Goal A: Increase the Number of Qualified Prescribers who can Prescribe Medications Approved to Treat Opioid Use Disorders |
| Baseline Measurement: | 393 Suboxone Private Providers |
| First-year target/outcome measurement: | Increase the number of Suboxone providers in Rural Areas by 1% |
| Second-year target/outcome measurement: | Increase the number of Suboxone providers in Rural Areas by 2% |

Data Source:
National Survey of Substance and Alcohol Treatment Services (N-SSATS)
Treatment Episode Data Set (TEDS)
Division of Substance Abuse and Mental Health (DSAMH) Data Collection

Description of Data:
N-SSATA is an annual census of all substance abuse treatment facilities in the United States, both public and private.
Division of Substance Abuse and Mental Health (DSAMH) Data Collection.
TEDS is an administrative data set reported by states on the demographic characteristics and substance use problems of people admitted to substance use treatment facilities. It primarily focuses on treatment sites that receive public funds. TEDS has an admissions and a discharge data set that can be linked to provide information on treatment episodes.

Data issues/caveats that affect outcome measures:
None.

| Indicator # | 2 |
| Indicator: | Goal B: Increase Use and Training of Screening, Brief Intervention and Referral to Treatment (SBIRT) |
| Baseline Measurement: | Establish Baseline |
| First-year target/outcome measurement: | Receive no less than two SBI billings towards Medicaid and Commercial Insurance and at least 2 SBIRT Trainings per Year |
| Second-year target/outcome measurement: | Receive no less than three SBI billings towards Medicaid and Commercial Insurance and at least 3 SBIRT Trainings per Year |
**Data Source:**
Division of Substance Abuse and Mental Health Qualtrics and Google Forms Surveys

**Description of Data:**
- Qualtrics - Survey Platform
- Google Forms - Survey Platform

**Data issues/caveats that affect outcome measures:**
None

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>Indicator</th>
<th>Baseline Measurement</th>
<th>First-year target/outcome measurement</th>
<th>Second-year target/outcome measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Goal C: Increase Certified Peer Support Specialists who desire work are able to find CPSS-related employment</td>
<td>Determine % of CPSS currently employed in a CPSS position</td>
<td>Increase CPSS employed by 5%</td>
<td>Increase CPSS employed by 10%</td>
</tr>
</tbody>
</table>

**Data Source:**
Certified Peer Support Specialist data sheets, LMHAs

**Description of Data:**
CPSS contact DSAMH annually to recertify, employment information can be gathered at that time, CPSS trained through the USU program report on employment at the end of the practicum.

**Data issues/caveats that affect outcome measures:**
CPSS can be difficult to contact due to moving and/or changing contact information, many CPSS have found employment in other fields

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>Indicator</th>
<th>Baseline Measurement</th>
<th>First-year target/outcome measurement</th>
<th>Second-year target/outcome measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Goal D: Individuals engaged in employment activities and finding employment</td>
<td>Individual Placement and Support (IPS) services offered in accredited and non-accredited Clubhouse programs.</td>
<td>Development of Individual Placement and Support (IPS) in 3 accredited Clubhouse programs</td>
<td>Development of IPS in 2 more Clubhouse and Clubhouse-like programs</td>
</tr>
</tbody>
</table>

**Data Source:**
SPARS, SAMHIS, Electronic health records for each Local Authority - Full development will be measured by scoring on the IPS Fidelity Scale.

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

**Data issues/caveats that affect outcome measures:**
Not all Clubhouse-like programs have the funding to develop a "Good" or "Exemplary" IPS program. An "IPS" data element has been added to SAMHIS but Local Authorities are reluctant to use the element until they have a rating of good fidelity. Therefore, programs that have not had time to go through at least one fidelity review will

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>Indicator</th>
<th>Baseline Measurement</th>
<th>First-year target/outcome measurement</th>
<th>Second-year target/outcome measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Goal E: Number of Local Authorities providing Trauma Informed environment for MH/SUD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Printed: 8/1/2017 3:59 PM - Utah - OMB No. 0930-0168  Approved: 06/12/2015  Expires: 09/30/2020
Baseline Measurement: 4 LAs are being trained in Trauma Informed services/curriculum

First-year target/outcome measurement: Increase number of provider trained in trauma informed specific interventions by 2

Second-year target/outcome measurement: Increase number of providers trained in trauma informed specific interventions by additional 2

Data Source:
Audit Reports, LMHA scorecard, Area Plans

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

Data issues/caveats that affect outcome measures:
Resources for training and turnover of staff

Indicator #:
6

Indicator:
Goal F: Number of Participants using MAT (Maltrexone, Vivitrol and Bupenorphine)

Baseline Measurement:
5722 Opioid client admissions/ 181 receiving MAT services

First-year target/outcome measurement:
Increase client participation in MAT services by 1%

Second-year target/outcome measurement:
Increase client participation in MAT services by 2%

Data Source:
SAMHIs and Audit reports

Description of Data:
Number of clients reporting Opioid use at intake and the number receiving MAT services according the Local Authority reporting in SAMHIS. Will review MAT service options during Audit/Monitoring visits to the local authorities annually and will review SAMHIS data reported on MAT usage.

Data issues/caveats that affect outcome measures:
Not all LSAA's have adequate options to provide MAT services or physicians to prescribe MAT.

Indicator #:
7

Indicator:
Goal F: Decrease homelessness in urban counties

Baseline Measurement:
3277 homeless in Utah, approximately 819 have SUD and/or SMI

First-year target/outcome measurement:
decrease homeless veterans, chronically homeless veterans, and chronically homeless individuals with SMI served by 70.

Second-year target/outcome measurement:
decrease an additional 70 homeless veterans, chronically homeless veterans, and chronically homeless individuals with SMI served

Data Source:
HMIS, TRAC, Electronic medical records, disparity impact statement materials

Description of Data:
Demographics, service location, type of service and number of contacts, use of evidence-based practices - ACOT (Assertive Community Outreach Teams), MI, Trauma-Informed Care

Data issues/caveats that affect outcome measures:
Current CABHI grant has been collecting data without using national system as CDP was not functional. All previous data will need to be converted to the TRAC system.
Indicator #: 8
Indicator: Goal G: Promote Justice Reinvestment Initiative- Certification
Baseline Measurement: 2016-0 Providers Certified
First-year target/outcome measurement: 2018- Certify 160 Private and Public Providers
Second-year target/outcome measurement: 2019- Increase number of Certified Providers by 5%
Data Source: DOPL, State Department of Licensing, DSAMH Certification registration list.
Description of Data: The Number of Certified Providers will tracked, updated and maintained by DSAMH.
Data issues/caveats that affect outcome measures:
Providers that do not maintain certification will not receive certification. Those providers not treatment individuals “compelled” to treatment services by the criminal justice system are not required to be certified by DSAMH. There may be issues with collecting certification information if providers have closed during the certification year and DSAMH is not aware for reporting.

Indicator #: 9
Indicator: Goal H: Improve outcomes related to MH treatment- Positive outcomes (stable, improved and in recovery) during treatment (or discharged) as measured by OQ.
Baseline Measurement: 2015: 84.1% Adults Reporting positive OQ outcomes DSAMH requires a 50% utilization rate for the LMHA for clients served in publicly funded programs.
First-year target/outcome measurement: 2018: 69% of clients report positive outcomes
Second-year target/outcome measurement: 2019: increase of 2% (71%) reporting positive OQ outcomes
Data Source: OQ- Outcome Questionnaire
Description of Data:
Outcomes system data includes:
1. Adults:
   (a) OQ ® 45.2 - Adult Outcome measure (ages 18+);
   (b) OQ ® 30.0 – Adult Outcome measure (ages 18+);
   (c) SOQ ® 2.0 - SPMI Outcome instruments (Self or clinician); and
   (d) Mental Health Statistical Improvement Program (MHSIP) Consumer Survey.
OQ Measure instruments are to be completed in the OQ Analyst Hosted System (OQA HS).
e. Optional OQ Measure instruments not included in state reporting or monitoring.
f. Consumer Satisfaction Survey instruments are to be completed annually through the OQ Analyst System or through a website provided by DSAMH.
Data issues/caveats that affect outcome measures:
The instruments will require repeated administrations, required that the OQ/YOQ be given to patients and consumers at intake, every thirty days or every visit (whichever is less frequent), and at discharge/discontinuation (inpatient stays for community mental health are exempt).

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)
Improve the quality of adolescent treatment services in Utah through the Treatment Research Institute (TRI) Consumer Guide to Adolescence Substance Abuse Treatment for UTAH

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

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

Objective:

Objective 1: Train and recruit 24 private and public adolescent substance use disorder (SUD) treatment providers to become certified in the TRI Consumer Guide to Adolescent Substance Abuse Treatment for UTAH project

Objective 2: Train and certify 5 Tier 1 and 4 Tier II Consumer Guide Assessors (CGAs) through three phases of proficiency exams, which require a passing score of 90 or above. The Consumer Guide Assessors will be responsible for evaluating the programs participating in the TRI Consumer Guide Project on the following 10 Key Elements of Effective Treatment:

- Screening/Assessment
- Attention to Mental Health
- Comprehensive Treatment
- Developmentally Informed Programming
- Family Involvement
- Engage and Retain Clients
- Staff Qualifications/Training
- Continuing Care/Recovery Support
- Person-First Treatment
- Program Evaluation

Goal A: Increase in state system knowledge and compliance with the ICPC process through a collaboration with OL, DCFS, DSAMH and the LMHAs.

Goal B: Disseminate knowledge, and develop preferred practice guidelines for adolescent co-occurring substance use and mental health disorders treatment.

Strategies to attain the objective:

Indicator: Certify private and public providers during the project period (January 1, 2016 - January 1, 2021).
Baseline: 0 providers certified
Target: Development of certification process with DSAMH and TRI, including continual certification of the providers in the project.
Timeframe: January, 1, 2016 - January 1, 2021 (Initial Project Period). Quarterly and annual reports will be provided by TRI regarding the progress and effectiveness of this project.

OUTCOMES - UPDATES:

1. The TRI Kick-Off Meeting was held March 1, 2016, where all 46 public and private providers attended this event. (April 2016)
2. The TRI Consumer Guide Assessor Training was held March 2-3, 2016 for 5 Tier I and 4 Tier II CGAs.
3. A follow up webinar regarding the test scores and recommendations was held April 28, 2016 for the CGAs.
4. In March of 2016, TRI begins to conduct TCO-D Director Interviews with participating Agency Directors.
5. In June of 2016, the 5 CGAs performed a site visit and co-audit with a TRI representative as the last step of certification.

Goal A: All LA’s will be trained by DSAMH regarding procedures to follow when ICPC issues arise, and DSAMH will be notified by LA’s when ICPS issues arise.
Goal B: All available measurements of provision of services and outcomes for adolescents will be evaluated, and an ad hoc committee will be established and preferred practice guidelines specific to adolescent co-occurring substance use and mental health disorders drafted.

Annual Performance Indicators to measure goal success

| Indicator #: | 1 |
| Indicator: | Goal A: Certify 24 Private and Public Adolescent SUD Treatment Providers |
| Baseline Measurement: | Baseline: 0 providers certified |
| First-year target/outcome measurement: | Development of the Certification Process with the Division of Substance Abuse and Mental Health (DSAMH) and the Treatment Research Institute (TRI) |
| Second-year target/outcome measurement: | Certification of 24 Substance Use Adolescent SUD Treatment Providers |
| Data Source: | DSAMH and TRI Outcome Measures: Comparison of the Consumer Guide Assessment Findings and Management Reports developed by |
TRI to develop a rating score for the results of the Assessment Findings based on the 10 Key quality features of adolescent programs listed below.

**Description of Data:**

The Data is based on the 10 Key Quality Features of Adolescent SUD Programs:

- Treatment:
- Screening/Assessment
- Attention to Mental Health
- Comprehensive Treatment
- Developmentally Informed Programming
- Family Involvement
- Engage and Retain Clients
- Staff Qualifications/Training
- Continuing Care/Recovery Support
- Person-First Treatment
- Program Evaluation

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

The results of the Consumer Guide Assessor findings and TRI Management Reports have not always matched. The Adolescent SUD Providers have also found that the results of the TRI Management Reports were not accurate, which has lead to inaccurate findings, which affected the rating score. There has been a need to make corrections to the findings for the TRI Management Reports to provide an accurate rating score.

**Indicator #:** 2

**Indicator:** Goal B: Compliance with ICPC Process

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

**First-year target/outcome measurement:** Identify numbers of violations and states not in compliance with IPC process

**Second-year target/outcome measurement:** 20% reduction in violations (documented compliance efforts).

**Data Source:**

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

**Description of Data:**

Research results, SAMHIS and Outcome Data

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

Not all out of state clients nor providers report individuals from being out of state and may find caveats to use State funding to pay for services.

**Indicator #:** 3

**Indicator:** Goal C: Increased data on services for youth with co-occurring MH/SA disorders- Scorecard

**Baseline Measurement:** No current baseline or scorecard has been collected

**First-year target/outcome measurement:** Outcome measures agreed upon and collection methods established.

**Second-year target/outcome measurement:** Score card published.

**Data Source:**

SAMHIS, Local Authority Reports, TEDs, SHARP, NSSATS

**Description of Data:**

NSSATS- National survey for substance abuse services. Local Authorities data collection.

**Data issues/caveats that affect outcome measures:**
Data has been collected more collectively on the MH side for youth however SA has not collected information regarding youth with co-occurring disorders up to this point and new methods and measures have to be developed.

Priority #: 5
Priority Area: Provide Services for the following priority populations: a. Persons who are intravenous drug users (IDU). b. Women who are pregnant and have a substance use and/or mental disorder. c. Parents with substance use and/or mental disorders who have dependent children. d. Individuals with tuberculosis. e. Children with serious emotional disturbances (SED) and their families. f. Adults with Serious Mental Illness (SMI).
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED, PW/WDC, PP, TB. Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Homeless, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

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

Objective:

Increase services to priority populations.

Strategies to attain the objective:

Goal A: 1. Contract with Local Authorities for services as per statute 2. Include Block Grant requirements in Local Authority contracts.
Goal B: 1. Contract with Local Authorities for services as per statute 2. Include Block Grant requirements in Local Authority contracts.
Goal C: 1. Contract with Local Authorities for services as per statute 2. Include Block Grant requirements in Local Authority contracts.
Goal D: 1. Contract with Local Authorities for services as per statute 2. Include Block Grant requirements in Local Authority contracts.
Goal E: 1. Contract with Local Authorities for services as per statute 2. Include Block Grant requirements in Local Authority contracts.
Goal F: 1. Contract with Local Authorities for services as per statute 2. Include Block Grant requirements in Local Authority contracts.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Goal A: Compliance with Contract Requirements
Baseline Measurement: a. Baseline (FY 2015)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population
First-year target/outcome measurement: b. 1st Year (FY 2018)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations
Second-year target/outcome measurement: c. 2nd Year (FY 2019)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Data Source:

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

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

Data issues/caveats that affect outcome measures:

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

Indicator #:

2

Indicator:

Goal B: Compliance with Contract Requirements

Baseline Measurement:

a. Baseline (FY 2015)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population.

First-year target/outcome measurement:

b. 1st Year (FY 2018)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.

c. 2nd Year (FY 2019)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Data Source:

Division Audit Visit Reports

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Indicator #:

3

Indicator:

Goal C: Compliance with Contract Requirements

Baseline Measurement:

a. Baseline (FY 2015)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population.

First-year target/outcome measurement:

b. 1st year (FY 2018)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.

c. 2nd year (FY 2019)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Data Source:

Division Audit Visit Reports

Description of Data:

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

Data issues/caveats that affect outcome measures:

Statewide mandates for specific populations are not feasible due to the varied nature of the county/Local Authorities and their population’s needs. Some data on some populations is not available, and or not reliable, and while efforts are being made to improve the availability and accuracy of data, it is not anticipated to be reliable statewide for the foreseeable future.
Indicator #: 4
Indicator: Goal D: Compliance with Contract Requirements
Baseline Measurement: a. Baseline (FY 2015)—Two local authorities had findings, discrepancies or comments regarding services to Priority Populations
First-year target/outcome measurement: b. 1st Year (FY 2018)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.
Second-year target/outcome measurement: c. 2nd Year (FY 2019)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Data Source:
Division Audit Visit Reports, Department of Health Reports and DATA

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

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

Indicator #: 5
Indicator: Goal E: Compliance with Contract Requirements
Baseline Measurement: a. Baseline (FY 2015)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population
First-year target/outcome measurement: b. 1st Year (FY 2018)—No more than one local authority has a finding, discrepancy or comment on their annual site visit audit regarding services to priority populations.
Second-year target/outcome measurement: c. 2nd Year (FY 2019)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Data Source:
Division Audit Visit Reports

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

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

Indicator #: 6
Indicator: Goal F: 1. Compliance with Contract Requirements
Baseline Measurement: a. Baseline (FY 2015)—Two local authorities had findings, discrepancies or comments regarding services to Priority Population
First-year target/outcome measurement: b. 1st Year (FY 2018)—No more than one local authority has a finding, discrepancy or...
Second-year target/outcome measurement: c. 2nd Year (FY 2019)—No more than one local authority has a discrepancy or comment on their annual site visit report regarding services to priority populations.

Data Source:
Division Audit Visit Reports

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

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

Footnotes:
Student Health and Risk Prevention (SHARP) Data is collected on the odd years; baseline is 2013, first year is 2015 data, second year is 2017 data. NSDUH data is only available for 2014 as the baseline at this time.
### Table 2 State Agency Planned Expenditures [SA]

**Planning Period Start Date:** 7/1/2017  
**Planning Period End Date:** 6/30/2019

<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>$16,591,847</td>
<td>$20,690,201</td>
<td>$1,218,426</td>
<td>$33,907,528</td>
<td>$12,915,752</td>
<td>$8,351,732</td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children**</td>
<td>$2,266,268</td>
<td>$8,593,119</td>
<td>$323,148</td>
<td>$6,292,150</td>
<td>$2,979,705</td>
<td>$2,499,274</td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td>$14,325,579</td>
<td>$12,097,082</td>
<td>$895,278</td>
<td>$27,615,378</td>
<td>$9,936,047</td>
<td>$5,852,458</td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$8,460,182</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td>$8,460,182</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary</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 (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></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></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>$829,439</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>10. SubTotal (1,2,3,4,9)</td>
<td>$17,421,286</td>
<td>$0</td>
<td>$20,690,201</td>
<td>$1,218,426</td>
<td>$33,907,528</td>
<td>$12,915,752</td>
<td>$8,351,732</td>
</tr>
<tr>
<td>11. SubTotal (5,6,7,8)</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>12. Total</td>
<td>$25,881,468</td>
<td>$0</td>
<td>$20,690,201</td>
<td>$1,218,426</td>
<td>$33,907,528</td>
<td>$12,915,752</td>
<td>$8,351,732</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.
### Table 2 State Agency Planned Expenditures [MH]

**Planning Period Start Date:** 7/1/2017  
**Planning Period End Date:** 6/30/2019

<table>
<thead>
<tr>
<th>Activity</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>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</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>$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></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary*</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>3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**</td>
<td>$419,638</td>
<td>$0</td>
<td>$0</td>
<td>$0</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>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>7. Other 24 Hour Care</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>8. Ambulatory/Community Non-24 Hour Care</td>
<td>$3,566,923</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)</td>
<td>$209,819</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. SubTotal (1,2,3,4,9)</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>11. SubTotal (5,6,7,8)</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>12. Total</td>
<td>$0</td>
<td>$4,196,380</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 SMH or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside
### 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>Pregnant Women</td>
<td>0</td>
<td>353</td>
</tr>
<tr>
<td>Women with Dependent Children</td>
<td>0</td>
<td>3739</td>
</tr>
<tr>
<td>Individuals with a co-occurring M/SUD</td>
<td>30000</td>
<td>7734</td>
</tr>
<tr>
<td>Persons who inject drugs</td>
<td>0</td>
<td>4048</td>
</tr>
<tr>
<td>Persons experiencing homelessness</td>
<td>0</td>
<td>2002</td>
</tr>
</tbody>
</table>

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

Our need data comes from the NSDUH, the BRFSS and our state Student Health and Risk Prevention Survey. None of these sources have data for the categories requested in this table.

**Footnotes:**
# Planning Tables

## Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017       Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY 2018 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td>$12,441,581</td>
</tr>
<tr>
<td>2. Primary Substance Abuse Prevention</td>
<td>$3,317,755</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>$829,439</td>
</tr>
<tr>
<td>6. Total</td>
<td>$16,588,775</td>
</tr>
</tbody>
</table>

* 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.

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

Planning Period Start Date: 10/1/2017  Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Activity</th>
<th>FY 2018 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$2,550,031</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$1,038,132</td>
</tr>
<tr>
<td>Selective</td>
<td>$3,446,868</td>
</tr>
<tr>
<td>Indicated</td>
<td>$1,425,150</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$8,460,181</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong>*</td>
<td><strong>$16,588,775</strong></td>
</tr>
</tbody>
</table>

**Planned Primary Prevention Percentage**  51.00%

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

### Footnotes:

Printed: 8/1/2017 3:59 PM - Utah - OMB No. 0930-0168  Approved: 06/12/2015  Expires: 09/30/2020
### Planning Tables

#### Table 5c SABG Planned Primary Prevention Targeted Priorities

**Planning Period Start Date:** 10/1/2017  
**Planning Period End Date:** 9/30/2019

**Targeted Substances**

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

**Targeted Populations**

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

## Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017    Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. MHBG</th>
<th>B. SABG Treatment</th>
<th>C. SABG Prevention</th>
<th>D. SABG Combined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$153,000</td>
<td></td>
<td>$200,000</td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$290,000</td>
<td>$120,000</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$320,900</td>
<td>$80,000</td>
<td>$100,000</td>
<td></td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$10,000</td>
<td></td>
<td>$3,200</td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td></td>
<td>$70,200</td>
<td>$10,000</td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$134,000</td>
<td></td>
<td>$575,000</td>
<td></td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$1,237,470</td>
<td>$642,290</td>
<td>$160,000</td>
<td></td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$2,145,370</strong></td>
<td><strong>$912,490</strong></td>
<td><strong>$1,048,200</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.

**Footnotes:**
This is the proposed plan for spending on system development/non direct service activities. This will all come from the administrative portion of SABG and MHBG. These figures are estimated for 2 year period.
Environmental Factors and Plan

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

Narrative Question

1. The Health Care System, Parity and Integration

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 behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care. 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 behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between 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 behavioral health 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 behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. 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 behavioral health 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 behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should 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 HPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. 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 MHB 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.


29 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. Four of the LSAA/LMHA's and one contracted provider with Salt Lake County Behavioral Health have integrated behavioral and physical health care clinics: (1) Salt Lake County Behavioral Health (2) Weber Human Services - Midtown Community Health Center (3) Bear River Health Department - SUD Treatment (4) Odyssey House of Utah - Martinlade Clinic. The LSAA/LMHA also coordinates closely with Accountable Care Organizations, such as Intermountain Health Care (IHC) and the Utah Association for Community Health (AUCH).

2. Describe how the state provide 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 a Systems of Care Approach, where individuals and their families are able to access services through various available funding sources.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?
   - 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 access to M/H and SUD services through the QHP’s. DSAMH provides an Annual Site Visit where they monitor the LSAA/LMHA’s compliance with SAPT/MHBG 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 LSSA/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 and Weber Human Services to review how SUD and M/H services are delivered in the Integrated Clinics.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? 

6. Do the behavioral health providers screen and refer for:
   a) Prevention and wellness education
   b) Health risks such as
      i) heart disease
      ii) hypertension
      viii) high cholesterol
      ix) diabetes
   c) Recovery supports

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?

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 is not a Medicaid-expansion state and opportunities for coverage of substance use disorders is very limited.

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 County (248 Participants). The first shot administered within County jail.

None indicate areas of technical assistance needed related to this section

Footnotes:

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, Healthy People, 2020, National Stakeholder Strategy for Achieving Health Equity, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, 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).

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."

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. 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. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA’s and HHS’s attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states 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 SM; 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.

48 http://www.thinkculturalhealth.hhs.gov
51 http://www.whitehouse.gov/omb/fedreg_race-ethnicity
**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, LGBT, and age?
   - a) Race
   - b) Ethnicity
   - c) Gender
   - d) Sexual orientation
   - e) Gender identity
   - f) Age

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?

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?

4. Does the state have a workforce-training plan to build the capacity of behavioral health 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?
   - If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) standard?

5. Does the state have a budget item allocated to identifying and remedying disparities in behavioral health care?

6. Does the state have any activities related to this section that you would like to highlight?
   - None

Please indicate areas of technical assistance needed related to this section

**Footnotes:**
3. Innovation in Purchasing Decisions - Requested

Narrative Question
While there are different ways to define value-based purchasing, the 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 behavioral health 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 behavioral health 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. NREPP 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. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program’s impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program’s conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General, The New Freedom Commission on Mental Health, the IOM, and the NQF. 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 behavioral health 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. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private 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 behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA’s priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and
training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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

---

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

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

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

We would appreciate any technical assistance that could be provided in the area of reliable measures of quality in payment arrangements when constructing a value based contract. Specifically, how to create measures that avoid unintended consequences.

---

Footnotes:
This section is not required.
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 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 outcome 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.

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). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP (the RAISE model). 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 CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the 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 three Local Mental Health Authorities in the State of Utah to provide Coordinated Specialty Care (CSC) programs for individuals experiencing early serious mental illness. The plan is to implement CSC statewide. Weber Human Services was the pilot site for the 5% set aside, with expansion to two more LHMAS with the 10% set aside. Each of the LHMAS providing CSC services include the following components, Medication, psychotherapy, family education and support, supported employment, case management, outreach and multi-family group therapy.

3. How does the state promote the use of evidence-based practices for individuals with a 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 OnTrack NY. The three LMHAs receiving set-aside funds have had the following: Onsite training from OnTrack NY, training and continued technical assistance to provide a Structured Interview for Prodromal Syndromes (SIPS) from Barbara Walsh, and training on Multi-Family Groups from both the EASA program in Oregon and the Pier program. In addition, each LHMA provides 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 provide training in evidence based practices, and support conferences to train clinicians in evidence based practices. The DSAMH also track EBP through SAMHIS and work with clinical directors from each LMHA to promote evidence based practices.
4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a 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.  
   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 includes multi-family groups and supported employment/individual placement and support.
8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?  
   Programs at the primary pilot site (Weber Human Services) and the expansion sites (Davis Behavioral Health and 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. In FFY2018 and FFY2019, Utah will be increasing the set aside for expansion of FEP services to other Local Authorities across the state.
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 collecting through SAM HIS 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.
10. Please list the diagnostic categories identified for your state's ESMI programs.  
    Primary Focus Diagnosis: Nonaffective Psychotic Disorder  
    Secondary Focus: Affective Psychotic Disorder  
    Does the state have any activities related to this section that you would like to highlight?  
    The original pilot site, Weber Human Services is one of 38 centers involved in a nationwide study for First Episode Psychosis (FEP) Coordinated Specialty Care with the goal of testing a new training tool with practitioners in the field. Participant feedback will help to refine the tool. Lessons learned will be shared to improve services for people experiencing First Episode Psychosis.
    Please indicate areas of technical assistance needed related to this section.  
    We are currently consulting with EASA in Oregon for continued TA for our centers providing ESMI services. TA for IPS is being received from the IPS Employment Center at Westat/Rockville.

Footnotes:
<table>
<thead>
<tr>
<th>Data element</th>
<th>Data Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical health</td>
<td>biannual client interview/survey</td>
</tr>
<tr>
<td>Social Connectedness</td>
<td>biannual client interview/survey</td>
</tr>
<tr>
<td>Symptoms impact school</td>
<td>biannual client interview/survey</td>
</tr>
<tr>
<td>Symptoms impacts employment</td>
<td>biannual client interview/survey</td>
</tr>
<tr>
<td>Symptoms impact interactions with criminal justice</td>
<td>biannual client interview/survey</td>
</tr>
<tr>
<td>Symptoms resulted in hospitalization</td>
<td>biannual client interview/survey</td>
</tr>
<tr>
<td>Size or teams and roles of team members</td>
<td>Local data base (e.g. Credible)</td>
</tr>
<tr>
<td>Reduction of service intensity</td>
<td>Local data base (e.g. Credible)</td>
</tr>
<tr>
<td>OQ and/or YOQ scores (all since first FEP treatment)</td>
<td>Local data base (e.g. Credible)</td>
</tr>
<tr>
<td>Hospitilizations (client has medicaid)</td>
<td>Local data base (e.g. Credible)</td>
</tr>
<tr>
<td>Hospitilizations (client does not have medicaid)</td>
<td>Recorded by clinician</td>
</tr>
<tr>
<td>Measure of suicidality (score from C-SSRS)</td>
<td>Recorded by clinician</td>
</tr>
<tr>
<td>Client ID</td>
<td>Recorded by clinician</td>
</tr>
<tr>
<td>Approximate date of first symptoms</td>
<td>Recorded by clinician</td>
</tr>
<tr>
<td>Date of first FEP treatment</td>
<td>Recorded by clinician</td>
</tr>
<tr>
<td>Supported eduction services</td>
<td>Recorded by clinician</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>Recorded by clinician</td>
</tr>
<tr>
<td>Provider id</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Gender</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Dates of services (all since first FEP treatment)</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Service codes (all since first FEP treatment)</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Expected payment source and funding source</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Education completed years</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Enrolled in Education</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Employment status (UPMHS Categories)</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Number of arrests in past 30 days</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>DSM Diagnosis codes</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Location codes</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>previous USH (ever)</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Living arrangement</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Legal Status</td>
<td>SAMHIS</td>
</tr>
<tr>
<td>Possible/do-able</td>
<td>Notes</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Possible or not possible
Possible and do-able
Possible and not do-able
Not possible not do-able
# PREP Program – Outcome Review Form

Client Name: ____________________________  Client ID #: ________  DOB: ________

Date Review Completed: ____________  Review Year: ____________  
- 1st Qtr  - 2nd Qtr  - 3rd Qtr  - 4th Qtr

Insurance Status (check all that apply):
- None
- Private insurance (Company: ____________________________)
- Medicaid
- Unknown
- Medicare

Current Diagnoses:
- Psychosis Risk Syndrome

Primary Care Physician (PCP):
- Unknown if client has PCP
- Client has a PCP but PREP team is not in contact with them
- Client does not have PCP
- PREP team is in contact with client’s PCP

How many months since client’s last contact with their PCP? ________________  -  Unknown

Is client currently prescribed psychiatric medications?
- Yes
- No (if no, skip to Employment questions)
- Unknown

How consistently are they taking their prescribed medications?
- Takes as prescribed
- Not taking at all
- Takes sporadically as prescribed
- Unknown
**Current Employment**

How many weeks did the client work this quarter? ___________  □ Unknown

Employment status this quarter:  □ Full-time  □ Part-time  □ Not employed  □ Unknown

Employment type:  □ Competitive  □ Supported  □ Volunteer  □ Not employed  □ Unknown

Did symptoms impact employment situation this quarter? (check all that apply)

- □ Yes, work was discontinued
- □ Yes, increased absences
- □ Yes, negatively impacted employment procurement activities
- □ Yes, other difficulty (specify: ____________________________ )
- □ No
- □ Unknown

Client’s current Vocational Rehabilitation (VR) status:

- □ Not currently planning to apply  □ Applied but denied
- □ Planning to apply  □ Discharged from VR
- □ Application submitted  □ Unknown
- □ Accepted by VR

Client’s current disability benefits status:

- □ Not currently planning to apply for disability  □ On Social Security Disability Insurance (SSDI)
- □ Planning to apply – application not started  □ On Supplemental Security Income (SSI)
- □ Application in process or waiting for notification  □ On both SSDI and SSI
- □ Applied and denied, not appealing  □ Unknown
- □ Denied but appealing

**Educational History**

Last grade completed (count each year of post-high school as a grade): ___________  □ Unknown

Educational milestones client has completed (check all that apply):

- □ Junior high
- □ High school
- □ GED
- □ AA or AS degree
- □ BA or BS degree
- □ Voc/Tech certification/degree (specify: ____________________________ )
- □ Other (specify: ____________________________ )
- □ Unknown
- □ None
Current Education

School status this quarter:
- ☐ Full-time
- ☐ Part-time
- ☐ Not in school (if not in school, skip to Symptoms Impact on School Situation questions)
- ☐ Unknown

Type of school attending:
- ☐ Junior high
- ☐ Four-year college/university
- ☐ High school
- ☐ Vocational/technical school
- ☐ GED classes/Adult education
- ☐ Other (specify: ____________________________)
- ☐ Community College
- ☐ Unknown

Receiving school accommodations? (check all that apply)
- ☐ IEP
- ☐ Other (specify: ____________________________)
- ☐ 504 plan
- ☐ None
- ☐ College disability office
- ☐ Unknown

Did symptoms impact school situation this quarter? (check all that apply)
- ☐ Yes, school was discontinued
- ☐ Yes, increased absences
- ☐ Yes, course load reduced/classes dropped
- ☐ Yes, grades lower than in the past
- ☐ Yes, negatively impacted school search activities
- ☐ Yes, other difficulty (specify: ____________________________)
- ☐ No
- ☐ Unknown

If NOT in school, does the client express a desire to go to school (now or in the future)?
- ☐ Yes
- ☐ No
- ☐ Unknown

Legal involvement this quarter (check all that apply):
- ☐ None (if None, skip to Services questions)
- ☐ Probation/parole
- ☐ Incarcerated
- ☐ Arrested
- ☐ Unknown

If arrested or incarcerated, was this due to (check all that apply):
- ☐ Symptoms
- ☐ Substance use
- ☐ Other (specify: ____________________________)
- ☐ Unknown
Did the client experience a change in primary therapist this quarter?
- Yes
- No
- Unknown

What type of services did the PREP team provide this quarter? (check all that apply):
- Individual therapy
- Family therapy
- Group therapy (excluding MFG)
- Medication management
- Case management
- Occupational therapy services
- Individualized Placement and Support Services
- Resource acquisition
- Job search
- Career exploration
- Joining sessions
- Multi-family group
- Single family
- Psychoeducational workshop
- Peer support services
- School search
- School retention
- Skills training
- No services from PREP team this quarter
- Unknown

Living situation:
- Transient/homeless (no permanent address)
- Foster home
- Residential facility
- Jail
- Prison
- Supported housing
- Alcohol and drug free housing
- Private residence (lives alone)
- Private residence (lives with relative)
- Private residence (lives with non-relative)
- Other (specify: ________________________________)
- Unknown

Living situation funded by:
- Client (+ partner) responsible for all housing costs (their portion if roommates)
- Client contributes to housing costs and family provides the rest
- Family provides housing: lives apart from family (family pays client’s housing costs)
- Family provides housing: lives with family
- State/other institution funded housing
- Other (specify: ________________________________)
- Unknown
Psychiatric hospitalization during the quarter (any overnight treatment related to symptoms)?

- Yes
- No (if No, skip to Discharge questions)
- Unknown

**Hospitalization #1:**

Hospital name: __________________________________________

Type of admit:  □ Voluntary  □ Involuntary  □ Unknown

Type of Hospital:

- □ State Hospital
- □ Acute hospitalization
- □ Emergency room extended stay (over 1 day)
- □ Substance abuse residential treatment

Admit date: ____________________________  □ In this hospital stay in previous quarter

Discharge date: ____________________________  □ Still in the hospital

If dates unknown, number of days in hospital: ________

**Hospitalization #2:**

Hospital name: __________________________________________

Type of admit:  □ Voluntary  □ Involuntary  □ Unknown

Type of Hospital:

- □ State Hospital
- □ Acute hospitalization
- □ Emergency room extended stay (over 1 day)
- □ Substance abuse residential treatment

Admit date: ____________________________  □ In this hospital stay in previous quarter

Discharge date: ____________________________  □ Still in the hospital

If dates unknown, number of days in hospital: ________

**Hospitalization #3:**

Hospital name: __________________________________________

Type of admit:  □ Voluntary  □ Involuntary  □ Unknown

Type of Hospital:

- □ State Hospital
- □ Acute hospitalization
- □ Emergency room extended stay (over 1 day)
- □ Substance abuse residential treatment

Admit date: ____________________________  □ In this hospital stay in previous quarter

Discharge date: ____________________________  □ Still in the hospital

If dates unknown, number of days in hospital: ________

Place information about any other hospitalizations in the prior 3 months/this quarter on the back of this form.
Was the client discharged or transferred out of the program this quarter?

- ☐ Yes
- ☐ No (if No, form is complete)

Discharge date: _________________________ Late date client received services: _________________________

Did client have a transition plan when they were discharged?  ☐ Yes  ☐ No  ☐ Unknown

Reason for discharge from PREP:

- ☐ Completed program – achieved all or most of program goals
- ☐ Completed program – achieved some program goals
- ☐ Completed program – achieved few or none of program goals
- ☐ Moved (where to: _________________________)
- ☐ Referred to program in a different county?  ☐ Yes  ☐ No
- ☐ Disengaged/lost contact
- ☐ Chose other services (specify services: _________________________)
- ☐ Not appropriate for the program (specify reason: _________________________)
- ☐ Never engaged
- ☐ Incarceration
- ☐ Suicide
- ☐ Other death
- ☐ Other (specify: _________________________)
- ☐ Unknown
## PREP PROGRAM
### CLIENT BASELINE DATA FORM
*(Please complete based on 6-months prior to admission)*

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Client ID #:</th>
<th>DOB:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date Completed:</th>
<th>Date Accepted into PREP:</th>
<th>Referral Source:</th>
</tr>
</thead>
</table>

**Insurance Status (check all that apply):**
- [ ] None
- [ ] Private insurance (Company: ____________________________)
- [ ] Medicaid
- [ ] Unknown
- [ ] Medicare

**Current Diagnoses:**
- [ ] Psychosis Risk Syndrome

**Primary Care Physician (PCP):**
- [ ] Unknown if client has PCP
- [ ] Client does not have PCP

**How many months since client’s last contact with their PCP?**

<table>
<thead>
<tr>
<th>[ ] Takes as prescribed</th>
<th>[ ] Not taking at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Takes sporadically as prescribed</td>
<td>[ ] Unknown</td>
</tr>
</tbody>
</table>
Current Employment

How many weeks did the client work in the past 6 months? _________  □ Unknown

Employment status at admission:  □ Full-time  □ Part-time  □ Not employed  □ Unknown

Employment type:  □ Competitive  □Supported  □ Volunteer  □ Not employed  □ Unknown

Did symptoms impact employment situation during 6-month period before admission? (check all that apply)

□ Yes, work was discontinued
□ Yes, increased absences
□ Yes, negatively impacted employment procurement activities
□ Yes, other difficulty (specify: ______________________________)
□ No
□ Unknown

Client’s current Vocational Rehabilitation (VR) status:

□ Not currently planning to apply  □ Applied but denied
□ Planning to apply  □ Discharged from VR
□ Application submitted  □ Unknown
□ Accepted by VR

Client’s current disability benefits status:

□ Not currently planning to apply for disability  □ On Social Security Disability Insurance (SSDI)
□ Planning to apply – application not started  □ On Supplemental Security Income (SSI)
□ Application in process or waiting for notification  □ On both SSDI and SSI
□ Applied and denied, not appealing  □ Unknown
□ Denied but appealing

Educational History

Last grade completed (count each year of post-high school as a grade): _________  □ Unknown

Educational milestones client has completed (check all that apply):

□ Junior high
□ High school
□ GED
□ AA or AS degree
□ BA or BS degree
□ Voc/Tech certification/degree (specify: ______________________________)
□ Other (specify: ______________________________)
□ Unknown
□ None
**Current Education**

School status at admission:
- ☐ Full-time
- ☐ Part-time
- ☐ Not in school (if not in school, skip to Symptoms Impact on School Situation questions)
- ☐ Unknown

Type of school attending:
- ☐ Junior high
- ☐ High school
- ☐ GED classes/Adult education
- ☐ Community College
- ☐ Four-year college/university
- ☐ Vocational/technical school
- ☐ Other (specify: ____________________________)
- ☐ Unknown

Receiving school accommodations? (check all that apply)
- ☐ IEP
- ☐ 504 plan
- ☐ College disability office
- ☐ Other (specify: ____________________________)
- ☐ None
- ☐ Unknown

Did symptoms impact school situation during the 6-month period before admission? (check all that apply)
- ☐ Yes, school was discontinued
- ☐ Yes, increased absences
- ☐ Yes, course load reduced/classes dropped
- ☐ Yes, grades lower than in the past
- ☐ Yes, negatively impacted school search activities
- ☐ Yes, other difficulty (specify: ____________________________)
- ☐ No
- ☐ Unknown

If NOT in school, does the client express a desire to go to school (now or in the future)?
- ☐ Yes
- ☐ No
- ☐ Unknown

Legal involvement during 6-month period before admission (check all that apply):
- ☐ None (if None, skip to Services questions)
- ☐ Probation/parole
- ☐ Incarcerated
- ☐ Arrested
- ☐ Unknown

If arrested or incarcerated, was this due to (check all that apply):
- ☐ Symptoms
- ☐ Substance use
- ☐ Other (specify: ____________________________)
- ☐ Unknown
What type of services did client receive during the 6-month period before admission? (check all that apply):

- [ ] Individual therapy
- [ ] Family therapy
- [ ] Group therapy
- [ ] Medication management
- [ ] Case management
- [ ] Peer support services
- [ ] Occupational therapy services
- [ ] Skills training
- [ ] None
- [ ] Unknown

Living situation at time of admission:

- [ ] Transient/homeless (no permanent address)
- [ ] Alcohol and drug free housing
- [ ] Foster home
- [ ] Private residence (lives alone)
- [ ] Residential facility
- [ ] Private residence (lives with relative)
- [ ] Jail
- [ ] Private residence (lives with non-relative)
- [ ] Prison
- [ ] Other (specify: ____________________________)
- [ ] Supported housing
- [ ] Unknown

Living situation funded by:

- [ ] Client (+ partner) responsible for all housing costs (their portion if roommates)
- [ ] Client contributes to housing costs and family provides the rest
- [ ] Family provides housing: lives apart from family (family pays client’s housing costs)
- [ ] Family provides housing: lives with family
- [ ] State/other institution funded housing
- [ ] Other (specify: ____________________________)
- [ ] Unknown
Psychiatric hospitalization during 6-month period prior to admission (any overnight treatment related to symptoms)?

- [ ] Yes
- [x] No
- [ ] Unknown

**Hospitalization #1:**

Hospital name: 

Type of admit:  
- [ ] Voluntary
- [ ] Involuntary
- [ ] Unknown

Type of Hospital:

- [ ] State Hospital
- [ ] Acute hospitalization
- [ ] Emergency room extended stay (over 1 day)
- [ ] Substance abuse residential treatment

☐ Sub-acute care
- [ ] Other (specify: ______________________)

Admit date: ________________________________

Discharge date: ________________________________  ☐ Still in the hospital

If dates unknown, number of days in hospital: ______

**Hospitalization #2:**

Hospital name: 

Type of admit:  
- [ ] Voluntary
- [ ] Involuntary
- [ ] Unknown

Type of Hospital:

- [ ] State Hospital
- [ ] Acute hospitalization
- [ ] Emergency room extended stay (over 1 day)
- [ ] Substance abuse residential treatment

☐ Sub-acute care
- [ ] Other (specify: ______________________)

Admit date: ________________________________

Discharge date: ________________________________  ☐ Still in the hospital

If dates unknown, number of days in hospital: ______

**Hospitalization #3:**

Hospital name: 

Type of admit:  
- [ ] Voluntary
- [ ] Involuntary
- [ ] Unknown

Type of Hospital:

- [ ] State Hospital
- [ ] Acute hospitalization
- [ ] Emergency room extended stay (over 1 day)
- [ ] Substance abuse residential treatment

☐ Sub-acute care
- [ ] Other (specify: ______________________)

Admit date: ________________________________

Discharge date: ________________________________  ☐ Still in the hospital

If dates unknown, number of days in hospital: ______
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 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, 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 has 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.
The client remains at the center of all clinical efforts, whether they are Engagement, Assessment, Planning or Treatment. Relevance to the client and their needs should guide each provider in deciding how to engage the client, what information to gather and document, what strategies to plan and how treatment is delivered. While accurate and complete documentation of services and the gathering of information for organizational purposes and other systemic demands are important, they remain secondary to the needs of the client. It must be understood that Engagement, Assessment, Planning and Treatment occur continuously and simultaneously. Division Directives and 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.

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.

Does the state have any activities related to this section that you would like to highlight?
Emphasis on person-centered goals has been a focus in Utah for several years. Encouraging individuals in treatment to identify their needs and preferred methods of reaching their goals is a more recent emphasis within the system. SAMH now includes documentation of Recovery Support Services, and allows DSAMH and Local Authorities to focus on whether recovery needs that clients identify are being provided.

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

Footnotes:


Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question
In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction?
   - Yes
   - No

2. Are there any concretely planned initiatives in our state specific to self-direction?
   - Yes
   - No

   If yes, describe the currently planned initiatives. In particular, please answer the following questions:
   a) How is this initiative financed?
   b) What are the eligibility criteria?
   c) How are budgets set, and what is the scope of the budget?
   d) What role, if any, do peers with lived experience of the mental health system play in the initiative?
   e) What, if any, research and evaluation activities are connected to the initiative?
   f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

Does the state have any activities related to this section that you would like to highlight?
Utah received the Access to Recovery grant in 2010 which ended in 2015. In 2012, Utah used those same guiding principles from the ATR grant program to offer the choice of services and a choice of providers, with a client cap amount to engage individuals enrolled in the State Drug Court programs. In 2013 that State contract with the Department of Corrections to offer the same self-directed care to adults on parole that are reentering society which allows these individuals to receive the needed recovery support services to be successful and re-engaging into society. These 2 programs have been successful and continue to grow within our State. Utah is not a Medicaid Expansion State so we rely on other funding sources to support these efforts.

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

Footnotes:
Environmental Factors and Plan

7. 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 behavioral health 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](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 behavioral health 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 behavioral health 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 revisited 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 programs requirements, including quality and safety standard?  
   - Yes  
   - No

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.

Since Utah continues to struggle with what form, if any, of expansion of health care to individuals currently not eligible for insurance assistance and who do not qualify for Medicaid, the Block Grant continues to be the primary source of funding for SUD services, and the MHBG helps cover only a small part of the non Medicaid population. Both grants serve as a safety net for those...
who cannot afford other services. Combined with the State’s County Based organization, the Division’s role as a pass through agency for cost reimbursement contracts and the fact that only 15-17% of SUD clients qualify for Medicaid assistance, there have not been major changes in our efforts for the past several years. In the 2016 plans for a special session to address health care expansion were discontinued and no efforts to address healthcare expansion were addressed in the 2017 Legislative session.

Budget reviews are accomplished as part of the Area Plan Approval Process. http://dsamh.utah.gov/provider-information/local-authoritycounty-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: http://dsamh.utah.gov/data/annual-reports/

Audits. As stated above the Division conducts annual audits of each Local Authority. http://dsamh.utah.gov/provider-information/local-authoritycounty-monitoring-reports/

Please indicate areas of technical assistance needed to this section

None at this time.

Footnotes:
Environmental Factors and Plan

8. 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.

Please respond to the following items:

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

   Utah is home to 5 federally recognized American Indian Tribes including the Ute, Navajo, Piute, Shoshone and Goshute people. Native American populations reside in various “reservations” in the Northeastern and Southeastern regions of the state; Federal, State, County and Native American jurisdictions are involved in providing services. Both of these areas are relatively remote with poor transportation and sparse populations, which further stretch the state’s resources. The direct planning and provision of services is a responsibility of the Local Authorities in those areas, and the provision of services to Native American populations is a part of the annual contract review and audit. Success in negotiating service agreements and coordinating services is often an issue of local politics and personalities. Utah’s Department of Human Services has developed an intertribal council and signed a coordination/collaboration agreement with the various Native American tribal representatives supporting the need for planning and coordination at a state level.

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

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

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

   Issues are 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 also a barrier because the areas are remote.

   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 to this section

None at this time.

Footnotes:
Environmental Factors and Plan

9. 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:

- **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;

- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

- **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;

- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

- **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)
   - Others (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)
   a. Archival indicators (Please list)
   b. Juvenile arrest data, children in protective custody, adult arrest data
   c. National survey on Drug Use and Health (NSDUH)
   d. Behavioral Risk Factor Surveillance System (BRFSS)
   e. Youth Risk Behavioral Surveillance System (YRBS)
   f. Monitoring the Future
   g. Communities that Care
   h. State - developed survey instrument
   i. Others (please list)
   j. Treatment needs data (substance upon admission), death data.

5. Does your state use needs assessment data to make decisions about the allocation of 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:

Does the state have any activities related to this section that you would like to highlight?
None

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

- **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;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drugs used;
- **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;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **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 developed with assistance from the Western Regional Expert Team, CAPTs.

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 for community readiness to implement prevention strategies.

   Does the state have any activities related to this section that you would like to highlight?
   
   With the Regional Directors, Utah has been able to increase capacity throughout the state. This includes SAPST, identifying gaps and needs for assessment activities, building coalitions and technical support (on grants).

   Please indicate areas of technical assistance needed related to this section
   
   Increase the capacity of local coalitions - understanding and going through the SPF.
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:

- **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;

- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

- **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;

- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

- **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.

   Utah’s Division of Substance Abuse and Mental Health has a full strategic plan that includes substance use disorder prevention. It was developed in 2016, updated 2017.

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

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/provider-information/evidence-based-workgroup/

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

Utah recently connected the Evidence Based Workgroup with the Utah Society for Prevention Research. This enables the providers/those submitting to receive excellent support from prevention researchers in the field.

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

- **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;

- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

- **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;

- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

- **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:
      - Parents Empowered
      - Community Awareness Events
      - Women’s Prevention Resource Facilitation
      - Conferences, Local
   b) Education:
      - All Stars
      - Prevention Dimensions
      - 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
• Anger Management
• Families Plus: Making Choices
• Families Plus: Strong Families
• Too Good for Drugs
• SMART Moves
• Active Aging
• Parent and Teen Alternative Program
• Prevention Relationship Enhancement Program
• Cool Minds
• Hope for Tomorrow
• Why Try
• Nueva Dia
• Parents as Teachers
• Collaborative Multi-Family Prevention Program
• Systematic Training for Effective Parenting
• Growing Up Strong
• Dare to Be You
• GrandFamilies
• Keepin’ it REAL
• Community Empowering Parents
• Sixth Sense
• Strengthening Families
• Project Davis
• Smoking Cessation Classes
• Children’s Program Kit
• Drug Offenders Classroom
• Daily ATOD Class
• Discovering Possibilities

c) Alternatives:
• Tutoring
• Social Media Prevention
• Voices
• Friend 2 Friend Support Group
• SPORT Prevention + Wellness
• Vocational Mentoring
• APP – Activities that Promote Prevention
• Mentoring
• Tradition of Caring
• Leadership and Resiliency
• Trio Talent Search
• Big Brothers Big Sisters

d) Problem Identification and Referral:
• Prime for Life – Adult
• Prime for Life – Under 21
• Psycho-Educational Group
• Alcohol and Drug Intervention
• Courage to Change
• Personal Empowerment Program
• Kid Power
• Personal Power
• Truancy Program
• First Offender
• Getting it Right
• Mental Health First Aid
• QPR – Question Persuade Refer
• Peer Court
• Youth Mental Health First Aid
• Academic Assistance
• Drop Out Prevention

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.

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

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

The 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:

- **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;
- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- **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;
- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- **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?

   If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

   Yes  No

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
b) Binge use
b) Perception of harm
c) Disapproval of use
d) Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
e) Other (please describe):
**Division of Substance Abuse and Mental Health Strategic Plan (DSAMH)**
Revised July 25, 2017

*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 (Craig - Pam)
- Strategic Initiative #3 -- Promote Recovery (Pam - Shanel)
- Strategic Initiative #4 -- Improve Care for Children and Youth (Eric - Becky)
- Strategic Initiative #5 -- Health System Integration (Shanel - Pam)

**GOALS - OBJECTIVES - METRICS**

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
<th>METRICS</th>
</tr>
</thead>
</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 30 Day Alcohol Use, youth  
Baseline: 7%, all grades, 2013  
Target: 5%, all grades, 2023  
Timeframe: 2013-2023  
Responsible: Prevention Program Administrator (Craig PoVey) |
| | Objective 1.1.2 Reduce parental attitudes favorable towards underage drinking | |
| | Objective 1.1.3 Reduce youth access to alcohol | |
| | Objective 1.1.4 Increase Communities That Care coalitions | |
| | Objective 1.1.5 Increase access to person-centered prevention | |
| | | OUTCOMES - UPDATES:  
2015: 6.5% all grades (stable) |
| 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 | 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:  
2015: Youth 2.4%, 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 | Indicator: Decrease 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:  
2015: 5.2%, All Grades (stable) |
| Goal 1.4 Prevent and reduce depression and other mental illness | Objective 1.4.1 Identify opportunities to integrate substance abuse and mental illness prevention systems, models, policies, and practices  
Objective 1.4.2 Increase access to evidence based programs proven | Indicator: Reduce the percentage of mental illness Needs for Mental Health Treatment - High mental health needs  
Baseline: 13.0 of all grades, 2013 |
| Goal 1.4 Promote mental health | Objective 1.4.3 Promote, educate, and provide leadership to increase the number of Communities That Care Coalitions addressing mental illness issues | Target: 12.0 of all grades, 2019  
Timeframe: 2013-2019  
Responsible: Prevention Program Administrator (Craig PoVey)  
OUTCOMES - UPDATES:  
2015: 15%, 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**  
**Objective 1.5.3 Increase Communities That Care efforts** | **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  
**Timeframe:** 2013-2019  
**Responsible:** Prevention Program Administrator (Craig PoVey)  
OUTCOMES - UPDATES:  
2015: 8.1%, all grades (Increase) |
| **Goal 1.6 Prevent and Reduce Opioid Misuse** | **Objective 1.6.1 Reduce community norms favorable to opioid misuse**  
**Objective 1.6.2 Reduce illicit access to opioids**  
**Objective 1.6.3 Increase number of coalitions implementing Communities that Care model**  
**Objective 1.6.4 Increase access to person-centered prevention services** | **Indicator:** Decrease the percentage of adults 18+ who report using prescription drugs non-medically (NSDUH)  
Baseline: 4.33% (12 and older)  
Target: 2.10% (12 and older)  
Timeframe: 2013-2023  
Responsible: Prevention Program Administrator (Craig PoVey)  
**Indicator:** Decrease the percentage of any non medical prescription drug use lifetime, youth  
Baseline: 6.4%, all grades, 2013  
Target: 3.2%, all grades, 2023  
Timeframe: 2013-2023  
Responsible: Prevention Program Administrator (Craig PoVey) |
Visits to UOAD
Pounds drugs
Take back events
# CTC Coalitions in Utah
# Selective, indicated Prevention

Goal: 1.7 Reduce overdose deaths

Objective 1.7.1 Educate the general public on ways to reduce overdose deaths

Objective 1.7.2 Educate the general public on Naloxone Project

Objective 1.7.3 Incorporate education, 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

Objective 1.7.4 Raise public awareness of opioid overdose using STO campaign and other resources

Objective 1.7.5 Educate the general public on ways to reduce overdose deaths

Objective 1.7.6 Increase availability and usage of Naloxone

Indicator: Opiate Overdose Deaths
Baseline: 274, 2013
Target: 250, 2019
Timeframe: 2013-2023
Responsible: Prevention Program Administrator (Craig PoVey)

OUTCOMES - UPDATES:
2014: 289 (Increase)

Visits to Opidemic.org
# of people trained as Naloxone end users
# of Naloxone kits distributed
# of documented reversals
<table>
<thead>
<tr>
<th>Goal 2.1 Engage community stakeholders and prevention coalitions in suicide prevention and mental health promotion efforts statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1 Train community members in Gatekeeper awareness and evidence-based trainings</td>
</tr>
<tr>
<td>2.1.2 Engage workplaces in suicide prevention by using the Action Alliance Blueprint for Workplace Suicide Prevention and by training using Working Minds model</td>
</tr>
<tr>
<td>2.1.3 Engage Institutes of Higher Education in suicide prevention using the Jed Foundation Campus Model</td>
</tr>
<tr>
<td>COMPLETED OBJECTIVES:</td>
</tr>
<tr>
<td>2.1.4 Subcontract with a minimum of 13 local coalitions through Prevention by Design. FY 2016 subcontracted with 24 coalitions statewide for suicide prevention/mental health promotion</td>
</tr>
</tbody>
</table>

**Indicator:** Number of engaged community prevention coalitions
**Baseline:** # of prevention coalitions engaging in suicide prevention efforts
**Target:** Increase # of prevention coalitions engaged by 10%
**Time frame:** 2015-2017
**Responsible:** Suicide Prevention Coordinator (Kim Myers)

**OUTCOMES - UPDATES:**
22 Coalitions engaged in Prevention by Design/Suicide Prevention activities statewide with the following activities:

**Data Outcomes**
Outcome data from the skills based trainings included an evaluation score measuring change in participant’s knowledge, understanding and confidence surrounding the skills presented in the training. These scores are recorded, averaged and stated as a percentage of those who responded either a 4 or 5 on the Likert scale. This percentage is termed the “Evaluation Score.” The higher the percentage, the greater the change in knowledge, understanding and confidence. The Evaluation Score for all reported skills based interventions was 94.2%.6

**Process Outcomes:**
- Skills trainings (e.g. Mental Health First Aid, QPR, ASIST):
  - Number of trainings: 417
  - Number of persons certified: 10,9833
- Trainer for trainer (T4T) (e.g. QPR, SafeTALK):
  - Number of persons certified as trainers: 51
<table>
<thead>
<tr>
<th>Goal 2.2</th>
<th>Develop broad based support through public/private partnerships dedicated to implementing and sustaining suicide prevention efforts</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.1 Sustain and strengthen collaborations across agencies and public/private partners to advance suicide prevention</td>
<td></td>
</tr>
<tr>
<td>2.2.2 Provide ongoing leadership to collaborate and coordinate the Utah Suicide Prevention Coalition, including the Executive Committee and relevant workgroups</td>
<td></td>
</tr>
<tr>
<td>2.2.3 Update current state suicide prevention plan for 2017</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 2.3</th>
<th>Improve the ability of health providers (including Behavioral Health) to better support individuals who are at risk of suicide through adoption of Zero</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3.1 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 services and support to defined patient populations</td>
<td></td>
</tr>
<tr>
<td>2.3.2 Promote the adoption of universal screening for suicide risk within the public behavioral health care system</td>
<td></td>
</tr>
<tr>
<td>2.3.3 Promote same day safety planning for individuals who screen</td>
<td></td>
</tr>
</tbody>
</table>

**Media and Events (e.g. interviews, articles, flyers etc.):**
- Media and Events (e.g. interviews, articles, flyers etc.):
  - Articles: 64
  - Community Events: 69
  - Flyers: 120,520
  - Take back events: 15
  - Gun safety (i.e. gun locks and other resources): 1312

**School based activities (e.g. NAMI’s Hope for Tomorrow and Hope Squads):**
- Number of schools: 48
- Total number of students involved: 1193

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

**2.2.1** Sustain and strengthen collaborations across agencies and public/private partners to advance suicide prevention

**2.2.2** Provide ongoing leadership to collaborate and coordinate the Utah Suicide Prevention Coalition, including the Executive Committee and relevant workgroups

**2.2.3** Update current state suicide prevention plan for 2017

**Indicator:** Participation in Suicide Prevention Coalition meetings

**Baseline:** 15 stakeholders represented at meetings

**Target:** Maintain or increase number of stakeholders engaged

**Time frame:** 2015-2017

**Responsible:** Suicide Prevention Coordinator (Kim Myers)

**OUTCOMES - UPDATES:**
DSAMH continues to provide leadership to the coalition. Coalition meets every other month with approximately 40 participants at each meeting. Objective will continue. In process of revising current state plan.

**Goal 2.3**
Improve the ability of health providers (including Behavioral Health) to better support individuals who are at risk of suicide through adoption of Zero

**2.3.1** 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 services and support to defined patient populations

**2.3.2** Promote the adoption of universal screening for suicide risk within the public behavioral health care system

**2.3.3** Promote same day safety planning for individuals who screen

**Indicator:** Universal Screening Rates in public mental health system

**Baseline:** Dependent on Local Authority

**Target:** Increase screening rates by 25%

**Time frame:** 2015-2018

**Responsible:** Suicide Prevention Coordinator (Kim Myers)

**OUTCOMES - UPDATES:** 2016 first implementation year for LA PIP, 2015 was baseline year. Will update end of
<table>
<thead>
<tr>
<th>Suicide framework</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>positive for suicide risk</td>
<td>Indicator: Same-day safety planning for individuals screened as at risk for suicide</td>
</tr>
<tr>
<td>2.3.4 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means</td>
<td>Baseline: Dependent on Local Authority</td>
</tr>
<tr>
<td>2.3.5 Provide training to community and clinical service providers on the prevention of suicide and related behaviors</td>
<td>Target: Increase same day safety plans by 25%</td>
</tr>
<tr>
<td>2.3.6 Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid followup after discharge</td>
<td>Time frame: 2015-2018</td>
</tr>
<tr>
<td>2.3.7 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide</td>
<td>Responsible: Suicide Prevention Coordinator (Kim Myers)</td>
</tr>
<tr>
<td><strong>OUTCOMES - UPDATES:</strong></td>
<td></td>
</tr>
<tr>
<td>2016 first implementation year for LA PIP, 2015 was baseline year. Will update end of 2016</td>
<td></td>
</tr>
<tr>
<td>All LMHA participating in suicide prevention PIP- includes universal screening, same day safety planning including reducing access to lethal means.</td>
<td></td>
</tr>
<tr>
<td>Zero Suicide Academy- 19 health/behavioral health care organizations represented</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2.4 Promote effective programs and practices that increase protection from suicide risk.</th>
<th>2.4.1 Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4.2 Develop and disseminate guidance for journalism and mass communication schools regarding how to address consistent and safe messaging on suicide and related behaviors in their curricula</td>
<td>Indicator: Number of media stories following safe messaging guidelines and providing crisis resources</td>
</tr>
<tr>
<td>2.4.3 Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk</td>
<td>Baseline: TBD</td>
</tr>
<tr>
<td>2.4.4 Partner with firearm dealers and gun owner groups to incorporate suicide awareness as a basic tenet of firearm safety and</td>
<td>Target: Decrease percentage of media stories using unsafe messaging by TBD</td>
</tr>
<tr>
<td></td>
<td>Time frame: 2016-2021</td>
</tr>
<tr>
<td></td>
<td>Responsible: Suicide Prevention Coordinator (Kim Myers)</td>
</tr>
<tr>
<td></td>
<td>Indicator: Number of concealed carry instructors using the firearm safety module in their training</td>
</tr>
<tr>
<td></td>
<td>Baseline: 0%</td>
</tr>
<tr>
<td></td>
<td>Target: Increase to 25% of Utah instructors using training</td>
</tr>
</tbody>
</table>
responsible firearm ownership

2.4.5 Complete a Suicide Prevention and Gun Study

**Strategic Initiative #3 – Promote Recovery**

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
<th>METRICS</th>
</tr>
</thead>
</table>
| Goal 3.1 Promote and establish Peer Support Services | 3.1.1 Provide Training for Mental Health (MH) and Substance Use Disorders (SUD) Peer Specialists including evidence-based practices, peer-to-peer cessation training, Certified Peer Support Specialist (CPSS) training and support for the annual Peer Support conference.  
  - Revision of CPSS basic training, including the development of a statewide curriculum
  - 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 | Indicator: CPSSs who desire work are able to find CPSS-related employment  
Baseline: Year one - determine % of CPSS currently employed in a CPSS position  
Baseline (Jan 2016): 29% of survey respondents were certified and employed, 4% were volunteers  
Target: Year two - Increase % CPSS employed by 10%  
Timeframe: 2015-2017  
Responsible: Cami Roundy |

|              | 3.1.2 Educate and Promote the availability of trained PSS to Local Authorities and other potential employers (public and private MH, SUD and health care providers) on benefits of using Peer Support Specialists. 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. | OUTCOMES - UPDATES:  
April 2016 - 3.1.5 - CPSS trainings have been held by OptumHealth and by USU. Sixty-eight (68) CPSS have been certified. The Peer Support Conference is scheduled for June 10, 2016.  
January 2017 -  
- 3.1.1 - CPSS trainings have been held by OptumHealth and Utah State University. One hundred and fifty three (153) were certified.  
  - Twenty two (22) individuals were trained in Peer Support Whole Health and Resiliency in September, 2016.  
  - Wellness Recovery Action Plan training was held |
### Goal 3.2 Promote and establish employment and maintenance

<table>
<thead>
<tr>
<th>Objective 3.2.1</th>
<th>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>Indicator:</td>
<td>Increase integrated and competitive employment opportunities through Supported Employment (SE)/Individual Placement and Support (IPS)</td>
</tr>
</tbody>
</table>

- 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

- for CPSS in November, 2016, eleven (11) CPSS were trained.
  - Twenty two (22) Individuals were trained and certified as Peer Support Specialists in April 2017.
  - A CPSS training is scheduled for July 10-14, 2017.

- 3.1.2 - 49% of survey respondents were certified and employed (increase of 20%), 8% were volunteers (increase of 4%)
  - CPSS services were reviewed with each Local Authority during DSAMH monitoring visits in SFY16-17.
  - Peer Support Supervision training has been scheduled for February, 2017.

- 3.1.3 - TANF Peer Support Specialist grant was approved and contract was drafted for the implementation of CPSS or FRF in each LA.
  - CPSS job opportunities are sent to CPSS via e-mail. CPSS job opportunities are also posted on jobs.utah.gov with pwdnet.

- April 2017
  - Twenty two (22) Individuals were trained by USU and certified as Peer Support Specialists in April 2017.
  - A CPSS training by USU is scheduled for July 10-14, 2017.
| education services statewide | Objective 3.2.2 Increase engagement of employment services for individuals in recovery

Objective 3.2.3 Work with Medicaid to expand services through various funding mechanisms

Objective 3.2.4 Increase the number of SUD participants employed/attending school |

| Baseline: Two LMHAs engaged in SE/IPS providing services to approximately 100 individuals per year |
| Target: Engage two rural LMHAs and two accredited Clubhouses to provide SE/IPS services to approximately 25 additional individuals |
| Timeframe: 2014-2018 |
| Responsible: Supported Employment Program Manager (Sharon Cook) |

Education Baseline: Increase measured from admit to discharge

OUTCOMES - UPDATES:
April 2016
- LMHAs engaged in SE are providing IPS services to six Eastern Utah counties (Duchesne, Dagget, Uintah, Carbon, Emery, and Grand) and will serve approximately 25 individuals, including transition-aged youth.

January 2017
- 3.2.1 - Action steps for the SE/IPS Strategic Plan address progress toward overcoming barriers and are continually updated.
- 3.2.2 - Total of six LMHAs are providing SE/IPS services.
  - SE/IPS trainer provided all employment specialists with quarterly training for FY17.
  - Four Corners Behavioral Health and Davis Behavioral Health Center’s employment specialist completed Rockville Institute, Westat Inc.’s (formerly Dartmouth) online IPS Practitioner training in November 2016. The employment specialists received on-site IPS
training with the IPS statewide trainer in FY16.

- 3.2.3 - Psychoeducational services billing is being explored with Medicaid as a funding method to sustain SE/IPS.

**Update June 2017**

- 3.2.1 - The Supported Employment Coordinating Committee (SECC) will form subcommittees to address the action steps for the SE/IPS Strategic Plan, focusing on overcoming barriers.

- 3.2.2 - Total of six LMHAs are continuing to provide SE/IPS services and one accredited Clubhouse is in the start-up process to provide SE/IPS services.
  - Davis Behavioral Health Center is scheduled for a baseline fidelity review in August 2017.
  - Alliance House will hire an FTE IPS Trainer and will provide IPS training for accredited Clubhouses and Clubhouse-like programs.
  - All employment specialists have received online IPS practitioner training and continue to receive quarterly training from the statewide IPS trainer.
  - All employment specialists have received ACRE certification to become vendors for job coaching services.
  - A Supported Employment/IPS Summit will be held in September 2017 to increase employment services for Youth...
and Young Adults with mental illness and co-occurring substance disorders.

- 3.2.3 - Psychoeducational services and Targeted Case Management billing is being explored with Medicaid as a funding method to sustain SE/IPS.
- 3.2.4 - The Supported Employment/IPS Summit in September 2017 will have a focus on substance use prevention. In addition to integrated MH meetings, employment specialists are participating in integrated SUD meetings at LHMA.

<table>
<thead>
<tr>
<th>Goal 3.3</th>
<th>Provide MH and SUD services in a trauma informed environment for clients and staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 3.3.1</td>
<td>Review Division Directives and contracts to include the provision of services in a trauma informed environment</td>
</tr>
<tr>
<td>Objective 3.3.2</td>
<td>Provide increased training and technical assistance for Local Authorities. Through the CABHI Grant, providing evidence based training on Trauma Informed Care (TIC)</td>
</tr>
<tr>
<td>Objective 3.3.3</td>
<td>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>
</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:**  
**April 2016:**  
- Review Division Directives completed  
- DHS EDO has developed a Trauma-Informed Care (TIC) Committee, which Ming Wang (DHS EDO) Chairs. Becky King (SUD) and Eric Tadehara (MH) represent DSAMH on this committee. This Committee is currently working on sharing TIC information, protocols and training opportunities offered by DHS, which can be shared with the UBHC Clinical Directors, LSAA/LMHA, DHS Programs and community partners
to inform them on policy, procedures and funding strategies to move to a TIC system.

**December 2016:**
Funding through the CABHI Grant has provided onsite trauma informed services for homeless outreach and housing. Four LMHAs (Wasatch, Salt Lake County, Davis and Weber) were provided on-site training in March and August, as well as conference calls in September. Training for state-wide community partners was provided in October as a part of the Annual Homeless Summit.

**June 2017:**
The following statewide trauma-informed and gender responsive training events were held in 2017 for Local Authority and Private SUD and MH Providers:

- **Seeking Safety Training**  
  May 24-25, 2017

- **Helping Men Recover and Exploring Trauma Training**  
  October 30 - November 2, 2017

- **Seeking Safety Training**  
  November 7-8, 2017

<table>
<thead>
<tr>
<th>Goal 3.4</th>
<th>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</th>
<th>Indicator: Increase recovery oriented support services to clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop array of non-clinical services designed to provide necessary supports for individuals seeking recovery or</td>
<td>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</td>
<td>Baseline: Scorecard history of recovery oriented services including: employment, housing, and peer support related services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Target: Increase recovery oriented support services provided by 5%</td>
</tr>
</tbody>
</table>
| **Objective 3.4.3** | **Timeframe:** SFY18  
**Responsible:** (Pam Bennett, Shanel Long)  
**OUTCOMES - UPDATES:**  
**April 2016**  
- Contract with Latino Behavioral Health Services, Inc., to increase diversity of Peer Support/Recovery Support services in Spanish.  
**November 2016**  
- 3.4.1 RSS Division Directive language was approved  
**December 2016**  
- 3.4.1 LA contract amendments with new language and RSS funding allocations were completed  
**January 2017**  
- 3.4.3 Contract with WSU and SLCC in collaboration with SLC VAMC, to increase veteran peer support to students  
- 3.4.4 RSS data specs roll out in the SAMHIS system.  
- 3.4.4 RSS service list including service description, rate, unit was approved and sent to LA’s.  
- 3.4.4 TANF RSS grant application approved and contract received for signature (Peer Support Specialists for LA’s).  
**June 2017**  
- 3.4.5 TANF RSS contract with SouthWest for CPSS  
- 3.4.5 Proposal from USARA for TANF RSS  
- 3.4.5 Contract with USARA for CRAFT  
- 3.4.5 Expanded services provided under PATR, JRI and Drug Court  
**Continual:** 3.4.3 ROSC committee continues to meet monthly to review processes and standards. |
|---|---|
| **Objective 3.4.4** | **in early recovery**  
Objective 3.4.4 Recovery Support data specifications reported from 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 |  
| **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 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** |
| **Goal 3.5** | **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 | **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 |
| --- | --- | --- |
| **Goal 3.6** | **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 number of certified JRI providers  
**Baseline:** 0 providers certified  
**Target:** Development of certification process and continual certification of new and current providers  
**Timeframe:** July 1, 2016 = precertification, Area plan review by June 30, 2017.  
**Responsible:** Shanel Long |

**OUTCOMES - UPDATES:**

| **3.5.1** | Received applications for 169 sites representing 68 private agencies and all 13 Local Authorities.  
| **3.5.2** | Provisionally certified 148 sites including Local Authorities, 6 prison programs, 13 jail programs, 22 |

*NEW GOAL: APRIL, 2016*
Adult Probation and Parole Programs.

3.6.2
Held 3 outreach informational trainings in FY16.
- Booth at Generations conference March 2016
- Presented at Utah SA Fall Conference September 2016
- Presented to 4th District Justice Courts September 2016
- Presented to Utah County Public Defender’s Organization October 2016.
Held 2 presentations at Salt Lake County Provider Network.
There is ongoing dialogue and communication regarding JRI concerns.

November 2016
- Participated in RSAT (Residential Substance Abuse Treatment - federal grant) site visit with the Sanpete County Sheriff’s Office/Jail in conjunction with CCJJ.

December, 2016
- DSAMH presented a 1 hour JRI certification and provider list training at the Justice Court Winter Workshop held at the U of U Marriott.
- DSAMH has representation on all DOC ASCENT committees

3.6.3
Local Authorities have all submitted Area Plans that outline the local JRI committees and program plans.
Currently conducting monitoring visits to review Area Plans and JRI committee and programs.

3.6.4
Rule 4 is treatment standards for all private and public providers.
Rule 15 is JRI certification rule.
R523-4 has been reviewed and update to include treatment standards for all private and public providers.
and JRI certification requirements.

3.6.5

Trauma informed care- October 2016 and 2017
Seeking safety- May and November 2017
MRT- March, April, May 2016 and February 2017
Helping Men Recover October and November 2017

June 2017

3.6.1

- Received applications for 184 sites representing 82 private agencies and all 13 Local Authorities.
- Provisionally certified 161 sites with 123 private agencies and 38 LA sites, 6 prison programs, 14 jail programs, 22 Adult Probation and Parole Programs.

Objective 3.6.2 Promote JRI throughout the State also identify and address barriers

- Developed a Justice Certification Private Provider Committee to review and recommend future training needs, future rule enhancements, review and recommend changes to the certification process, and provide recommendations of performance outcome data and collection.

Objective 3.6.3 Require each local authority to develop an annual plan that identifies their JRI committee and implementation plans

The FY 2017 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.

- The FY 2018 annual review of Local Authority area plans was completed and all Local Authorities are have implementation committee written into their plans.
| Goal 3.7 | Improve outcomes related to mental health treatment  
**NEW GOAL: SEPT, 2016** |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 3.7.1 - Demonstrate client’s self-report improved functioning after mental health services</td>
</tr>
</tbody>
</table>

| Goal 3.8 | Expand access and participation in evidence-based treatment services |
| --- |
| 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 3.6.4 Develop treatment standards for all public and private facilities and promote compliance of those standards to all providers |

- DSAMH has been working with the DHS/Office of Licensing to ensure appropriate standards and expectation were included in the updated Outpatient Treatment Rule

ASAM- contracting for 2018

| 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:**  
January 2017  
3.7.1 - FY 17 site monitoring to date has included a review of OQ administration and use as an intervention.

<table>
<thead>
<tr>
<th>Objective 3.8.1 - Number of Qualified Prescribers in Utah</th>
</tr>
</thead>
</table>
| Indicator: Increased number of qualified prescribers who can prescribe medications to treat opioid use disorders  
Baseline: 393 Suboxone Private Providers |
<table>
<thead>
<tr>
<th>Objective 3.8.3</th>
<th>Objective 3.8.4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase access and use of Naltrexone, Vivitrol, and Buprenorphine</td>
<td>Increase use and training of SBIRT</td>
</tr>
<tr>
<td>Objective 3.8.5</td>
<td>Objective 3.8.6</td>
</tr>
<tr>
<td>Increase participation in evidence-based behavioral health treatments for opioid use disorders</td>
<td>Improve treatment retention for individuals with opioid use disorders</td>
</tr>
<tr>
<td>Objective 3.8.7</td>
<td>Objective 3.8.8</td>
</tr>
<tr>
<td>Increase number and percent of clients with opioid use disorder who complete treatment successfully</td>
<td>Increase number of clients with public/private insurance</td>
</tr>
<tr>
<td>Objective 3.8.9</td>
<td></td>
</tr>
<tr>
<td>Increase the number of individuals voluntarily participating in activities of benefit to their community</td>
<td></td>
</tr>
</tbody>
</table>

**Target:** Increase the number of Suboxone providers in Rural Areas by 1%

**Timeframe:** May 1, 2017 - May 1, 2018

**Responsible:** (Becky King, Shanel Long)

**Objective 3.8.2 - Number of Participants in OTP**

| Indicator: | Increased number of participation in Opioid Treatment Programs |
| Baseline: | 3429 |
| Target: | Increase participation by 1% |
| Timeframe: | May 1, 2017 - May 1, 2018 |
| Responsible: | (Becky King, Shanel Long) |

**Objective 3.8.3 - Number of Participants Using Naltrexone, Vivitrol and Buprenorphine**

| Indicator: | Increase in the number of participants using Naltrexone, Vivitrol and Buprenorphine (MAT) |
| Baseline: | (5722 Opioid clients/181 receiving MAT) |
| Target: | Increase the number of participants using MAT by 5% |
| Timeframe: | May 1, 2017 - May 1, 2018 |
| Responsible: | (Becky King, Shanel Long) |

**Objective 3.8.4 - Number of SBI Codes Billed**

<p>| Indicator: | Increase number of SBI Codes billed to Medicaid and Commercial Insurance by physical and behavioral health care provider clinics |
| Baseline: | Establish Baseline |
| Target: | Receive no less than two SBI billings towards Medicaid and Commercial Insurance |
| Timeframe: | May 1, 2017 - May 1, 2018 |
| Responsible: | (Becky King, Shanel Long) |</p>
<table>
<thead>
<tr>
<th>Objective 3.8.4 - Number of SBIRT Training</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong> Provide 2 SBIRT Trainings each year for physical and behavioral health care providers</td>
<td></td>
</tr>
<tr>
<td><strong>Baseline:</strong> Establish Baseline</td>
<td></td>
</tr>
<tr>
<td><strong>Target:</strong> Provide no less than 2 SBIRT trainings each year</td>
<td></td>
</tr>
<tr>
<td><strong>Timeframe:</strong> May 1, 2017 - May 1, 2018</td>
<td></td>
</tr>
<tr>
<td><strong>Responsible:</strong> (Becky King, Shanel Long)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 3.8.5 EBP Treatment in LSAAs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong> Increase the use of fidelity measures for evidenced based practices in the LSAA’s for individuals with opioid use disorders.</td>
<td></td>
</tr>
<tr>
<td><strong>Baseline:</strong> Establish Baseline</td>
<td></td>
</tr>
<tr>
<td><strong>Target:</strong> Implement at least 1 fidelity measure for one EBP</td>
<td></td>
</tr>
<tr>
<td><strong>Timeframe:</strong> May 1, 2017 - May 1, 2018</td>
<td></td>
</tr>
<tr>
<td><strong>Responsible:</strong> (Becky King, Shanel Long)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 3.8.6 - Treatment Retention - LSAA Scorecard</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong> Improve treatment retention for individuals with opioid use disorders</td>
<td></td>
</tr>
<tr>
<td><strong>Baseline:</strong> Percent of clients retained in treatment 60 or more days. State Average (2016) - 67.3%</td>
<td></td>
</tr>
<tr>
<td><strong>Target:</strong> State Average of 70%</td>
<td></td>
</tr>
<tr>
<td><strong>Timeframe:</strong> May 1, 2017 - May 1, 2018</td>
<td></td>
</tr>
<tr>
<td><strong>Responsible:</strong> (Becky King, Shanel Long)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 3.8.7 - Percent of Clients That Complete Treatment Successfully</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong> Improve treatment completion for individuals with opioid use disorders</td>
<td></td>
</tr>
<tr>
<td><strong>Baseline:</strong> Successful Treatment Episode Completion is</td>
<td></td>
</tr>
<tr>
<td>Objective 3.8.8 - Percent of Clients With Public/Private Insurance</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Indicator:</strong> Increase the number of clients with public/private insurance</td>
<td></td>
</tr>
<tr>
<td><strong>Baseline:</strong> (Establish a Baseline) UHPP contract.</td>
<td></td>
</tr>
<tr>
<td><strong>Target:</strong> Expand eligibility and enrollment services through Navigators and Behavioral Health Care Providers</td>
<td></td>
</tr>
<tr>
<td><strong>Timeframe:</strong> May 1, 2017 - May 1, 2018</td>
<td></td>
</tr>
<tr>
<td><strong>Responsible:</strong> (Becky King, Shanel Long)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective 3.8.9 - Recovery Support Community Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong> Increase the number of individuals voluntarily participating in recovery support activities in their community. Recovery Support Activities can include 12-step groups, social, spiritual, recreational or any activity that promotes health, wellness and recovery.</td>
</tr>
<tr>
<td><strong>Baseline:</strong> Establish baseline</td>
</tr>
<tr>
<td><strong>Target:</strong> Increase recovery community activities through contracted providers by 2%</td>
</tr>
<tr>
<td><strong>Timeframe:</strong> May 1, 2017 - May 1, 2018</td>
</tr>
<tr>
<td><strong>Responsible:</strong> (Becky King, Shanel Long)</td>
</tr>
<tr>
<td>GOALS</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Goal 4.1 Promote Community Based Services (Systems of Care Values) through increasing accountability of states placing youth in Residential Treatment Centers (RTC) in Utah</td>
</tr>
</tbody>
</table>
|                                                                      | Objective 4.1.2 Establish and utilize collaboratively developed procedures to ensure ICPC compliance | **Indicator**: Compliance with ICPC process  
**Baseline**: Numbers of out of state clients accessing State or County services without reimbursement from the sending state through the ICPC process  
**First Year Target**: Establish baseline  
**Second Year Target**: 20% reduction  
**Data Source**: Partner agencies, OL, DCFS, ICPC Local Authorities  
**Description of Data**: Research results, reports, Substance Abuse and Mental Health Information System (SAMHIS) and Outcome Data  
**Responsible**: Children, Youth, and Families Program Administrator (Eric Tadehara) |
|                                                                      | 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 | **OUTCOMES - UPDATES:**  
**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 |
| Goal 4.2 | Objective 4.2.1 Increase utilization of LMHA/LSAA supplied data regarding the provision of services and outcomes for adolescents with co-occurring substance use and mental health disorders | Indicator: Adolescent Dashboard for Co-Occurring Mental Health and Substance Use Disorders developed and used  
Baseline: None, this would be a newly developed Scorecard  
June 2017: Outcome measures agreed upon and collection methods established  
June 2018: Dashboard developed and published  
Data Source: SAMHIS, Local Authority Reports, Responsible: Children, Youth and Family Program Administrator and Business Analyst Supervisor (Eric Tadehara, Brenda Ahlemann)  
OUTCOMES - UPDATES: |
|---|---|---|
| Goal 4.3 | Objective 4.3.1 Train and recruit 24 private and public adolescent substance use disorder (SUD) treatment providers to become certified in the TRI Consumer Guide to Adolescent Substance Abuse Treatment for UTAH project  
Objective 4.3.2 Train and certify 5 Tier 1 and 4 Tier II Consumer Guide Assessors (CGAs) through three phases of proficiency exams, which require a passing score of 90 or above. The Consumer Guide Assessors will be responsible for evaluating the programs participating in the TRI Consumer Guide Project on the following 10 Key Elements of Effective Treatment:  
Screening/Assessment  
Attention to Mental Health  
Comprehensive Treatment  
Developmentally Informed Programming | Indicator: Certify private and public providers during the project period (January 1, 2016 - January 1, 2021).  
Baseline: 0 providers certified  
Target: Development of certification process with DSAMH and TRI, including continual certification of the providers in the project.  
Timeframe: January, 1, 2016 - January 1, 2021 (Initial Project Period). Quarterly and annual reports will be provided by TRI regarding the progress and effectiveness of this project.  
Responsible: SUD Administrator- Becky King  
OUTCOMES - UPDATES:  
Objective 4.3.1 - The TRI Kick-Off Meeting was held March 1, 2016, where all 46 public and private providers
<table>
<thead>
<tr>
<th>Family Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage and Retain Clients</td>
</tr>
<tr>
<td>Staff Qualifications/Training</td>
</tr>
<tr>
<td>Continuing Care/Recovery Support</td>
</tr>
<tr>
<td>Person-First Treatment</td>
</tr>
<tr>
<td>Program Evaluation</td>
</tr>
</tbody>
</table>

- **Objective 4.3.2** - The TRI Consumer Guide Assessor Training was held March 2-3, 2016 for 5 Tier I and 4 Tier II CGAs.
- **Objective 4.3.3** - A follow up webinar regarding the test scores and recommendations was held April 28, 2016 for the CGAs.
- **Objective 4.3.4** - In March of 2016, TRI begins to conduct TCI-D Director Interviews with participating Agency Directors.
- **Objective 4.3.5** - In June of 2016, the 5 CGAs performed a site visit and co-audit with a TRI representative as the last step of certification.

**Goal 4.4**

**Improve outcomes related to mental health early intervention services**

**Objective 4.4.1** - Demonstrate client's improved functioning after mental health early intervention services (FRF, School-based, Mobile Crisis)

**Indicator**: Positive outcomes (stable, improved and in recovery) during treatment (or discharged?) as measured by OQ. Other Proxy outcomes: avoiding police involvement and out-of-home placement for those receiving mobile crisis outreach; improve GPA or DIBELS literacy score and reduce office disciplinary referrals for those receiving school based mental health services

**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%
- Reduced office of disciplinary referrals: 45.6%

**Target (DHS Targets)**: 69% (DHS target) of clients report positive outcomes
- Avoiding police involvement: 73%
<table>
<thead>
<tr>
<th>Avoiding out-of-home placement: 68%</th>
<th>Timeframe: 2016-2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved GPA: 14% or DIBELS: 42%</td>
<td>Responsible: Children, Youth, and Families Program Administrator (Eric Tadehara)</td>
</tr>
<tr>
<td>Reduced office of disciplinary referrals: 46%</td>
<td></td>
</tr>
</tbody>
</table>

**OUTCOMES - UPDATES:**

**FY16:** Reporting positive OQ outcomes - 85.6%
Children/Youth
Avoiding police involvement: 78.7%
Avoiding out-of-home placement: 68.5%
Improved GPA: 7.8% or DIBELS: 49.1%
Reduced office of disciplinary referrals: 38.11%

**Target (DHS Targets):** 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%

**Timeframe:** FY2016-FY2018
| Goal 4.5 Increase system knowledge and ability to provide services to children and youth with co-occurring mental health and intellectual/developmental disabilities | Objective 4.5.1 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  
Objective 4.5.2 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 | **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) |
|---|---|---|
| Goal 4.6 Improve collaboration among child serving entities and provide consultation for early childhood mental health | Objective 4.6.1 DSAMH will participate in statewide and inter-agency councils focused on early childhood health  
Objective 4.6.2 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  
**Baseline**: Limited collaboration among child serving entities for early childhood mental health  
**Timeframe**: SFY18-SFY20  
**Responsible**: Children, Youth, and Families Program Administrator (Eric Tadehara) |
<table>
<thead>
<tr>
<th>Goal 5.1</th>
<th>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 in SFY 2017</th>
</tr>
</thead>
<tbody>
<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>
</tr>
<tr>
<td></td>
<td>Objective 5.1.3 Local authorities will contract for services with FQHCs</td>
</tr>
<tr>
<td></td>
<td>Objective 5.1.4 Local authorities will contract for services with ACOs</td>
</tr>
<tr>
<td>Indicator:</td>
<td>Number of local authorities that submit integration area plan.</td>
</tr>
<tr>
<td>Baseline:</td>
<td>in SFY 2016, 100% of local authorities submitted integration plan.</td>
</tr>
<tr>
<td>Target:</td>
<td>100% in SFY 2017</td>
</tr>
<tr>
<td>Timeframe:</td>
<td>2015-2018</td>
</tr>
<tr>
<td>Responsible:</td>
<td>Shanel Long</td>
</tr>
</tbody>
</table>

**OUTCOMES - UPDATES:**

- **March, 2016**
  - Local Authorities received Area Plan training
- **November 2016**
  - IHC/DSAMH hosted a suboxone waiver training to local Health care clinics and medical professionals. 32 registered attendees.
- **January 2017**
  - 5.1.1 Collaboration meeting with Department of Health and other agencies regarding Opiate Crisis and Grant.
  - 5.1.3 A review of LAs indicates that all LAs have a formal or informal relationship with at least one FQHC/CMHC.
- **March 2017**
  - 5.1.2 Division Directives changed to require LA to contract with ACO, FQHC.
  - 5.1.3/5.1.4 Area Plan training reviewed requirements to contract with ACO, FQHC with LA’s
  - LA required to develop and submit in Area Plan plans to contract with ACO, FQHCs for Opioid STR grant.
- **June 2017**
Goal 5.2  
Services will address an individual's substance abuse, mental health, and physical healthcare needs

<table>
<thead>
<tr>
<th>Objective 5.2.1</th>
<th>Monitor weight (and height for children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 5.2.2</td>
<td>Provide or arrange for a diabetes/HIV/TB screening, as indicated</td>
</tr>
<tr>
<td>Objective 5.2.3</td>
<td>Identify tobacco use in the assessment and offer resources as indicated.</td>
</tr>
<tr>
<td>Objective 5.2.4</td>
<td>Provide services in a tobacco free environment</td>
</tr>
<tr>
<td>Objective 5.2.5</td>
<td>Evaluate all individuals who are Opioid or alcohol dependent for the use of Medication Assisted Treatment (MAT) and if appropriate: include the use of MAT in the treatment plan, and either provide the medications as part of the treatment, or refer the individual for Medication assisted treatment</td>
</tr>
<tr>
<td>Objective 5.2.6</td>
<td>Provide information to individuals on physical health concerns and ways to improve their physical health including referrals where needed</td>
</tr>
<tr>
<td>Objective 5.2.7</td>
<td>Incorporate wellness and physical care into individual person centered Recovery Plans as needed</td>
</tr>
<tr>
<td>Objective 5.2.8</td>
<td>Increase coordination of care between physical health providers and behavioral health providers</td>
</tr>
<tr>
<td>Objective 5.2.9</td>
<td>Provide targeted needle exchange to prevent/reduce</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 FY17- outcome data.  
Timeframe: SFY17  
Responsible: SUD Administrator- Shanel Long

% of medicaid restricted population in SUD treatment  
# of needles distributed

OUTCOMES - UPDATES:  
April 2016  
- DIMENSIONS: Peer-to-Peer Train-the-trainer Tobacco Cessation training completed  
April 2016  
- Collaboration with Department of Health for a National Behavioral Health Network for Tobacco and Cancer Control 2016 Community of Practice Application submitted April 12, 2016  
April 2016  
- Address smoking cessation and health screening/referrals during each LA during monitoring visit.  
December 2016  
- Completed Tobacco & Cancer Control Community of Practice project.
| HIV, HEP C, and other infectious diseases spread by IV drug use | January 2017  
- FY17 Site monitoring to date has included review of assessment of tobacco use, review of agency as a tobacco free zone, emphasis of physical health and wellness within the treatment plan, and have included screenings for need of MAT.  
February 2017  
- Opioid STR Grant submitted that will focus on prevention and treatment services regarding Opioid epidemic.  
June 2017  
- FY17 Monitoring reviews completed include review of tobacco use, tobacco free zones, physical health and wellness and MAT screenings/referrals.  
- Collaboration with Health Department to provide smoking cessation to youth.  
- DSAMH is working to transfer URL to Health Department.  
- 5.2.8 Addictions Update Conference held 6/17 to educate physical Health providers regarding behavioral health.  
- Needle exchange programs implemented in SLC and proposals for additional areas throughout State.  
- Fall Conference presenter to offer Needle Exchange presentation and harm reduction September 2017. |
Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required 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:

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 publically 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 publically funded system must be sustainable over time and be organized to provide a stable level of services.

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

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

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

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

As authorized in statute, the 29 counties in Utah have organized themselves into 13 Local Substance Abuse Authorities and 13 Local Mental Health Authorities. (See attached diagram) Also by statute, each local authority submits an Area Plan annually that must be approved by the DSAMH. The Area Plans are submitted in May of each year, and describe the Local Authority’s plan to provide services for the coming Fiscal Year. Each Area Plan describes what services will be provided and how Federal and State requirements will be met. This plan is based on statutory requirements and a Division Directive that is provided each year to the local authorities shortly after the Legislative Session ends in March. The current Division Directives are located at: http://www.dsamh.utah.gov. Contracts and with the Local Authorities and their funding allocations are approved only after the
2. Does your state provide the following services under comprehensive community-based mental health service systems?

   a) Physical Health  j) Services for persons with co-occurring M/SUDs
   b) Mental Health  k) Yes  m) No
   c) Rehabilitation services  l) Yes  n) No
   d) Employment services  i) Yes  o) No
   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 as needed (for example, best practices, service needs, concerns, etc)

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 consumer’s 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, Legal issues.

4. Describe activities intended to reduce hospitalizations and hospital stays.

   The Utah public mental health system provides an array of services that assure an effective continuum of care to target the mental health needs of individuals with serious mental illness to prevent hospitalizations and reduce hospital stays. Including the 10 mandated services, such as residential care, outpatient care, 24 hour crisis care, psychotropic medication management, case management, community supports and 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 stay stable in the community. In addition many of the local mental health authorities (LMHA) Provide Clubhouses which is a model of psycho-social 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 , purpose. Utah’s largest county provides a robust crisis response system including crisis lines, warm lines, mobile crisis outreach teams, receiving center, and residential crisis center to provide immediate support and stabilization with the goal of keeping people stable in the community. This system work 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 from peers in recovery to promote disconnectedness, social interaction, and encourage them to take responsibility for their treatment and recovery. Once hospitalized 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 re-
hospitalization.
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 behavioral health 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>4.8%</td>
<td>18%</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>12.5%</td>
<td>19%</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.
Narrative Question

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

**Criterion 3**

Does your state integrate the following services into a comprehensive system of care?

a) Social Services  Yes  No

b) Educational services, including services provided under IDEA  Yes  No

c) Juvenile justice services  Yes  No

d) Substance misuse prevention and SUD treatment services  Yes  No

e) Health and mental health services  Yes  No

f) Establishes defined geographic area for the provision of services of such system  Yes  No
Describe your state's targeted services to rural and homeless populations and to older adults

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.

The Local Mental Health Authorities, provide services; Specialized Rehab Services for individuals 55 and older in the community and Nursing Facilities depending on capacity. Array of services based on individual needs. The Division of Aging and Adult Services 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. Our goal is 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

The Aging Waiver with DOH, 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.

- 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
Narrative Question

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

DSAMH has developed a Crisis 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. 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. The DSAMH also contract to provide support to the Salt Lake County's and Lifeline Crisis Line.
Environmental Factors and Plan

11. 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
      jn Yes jn No
   b) Are you considering any of the following:
      Targeted services for veterans
      jn Yes jn No
      Expansion of services for:
      (1) Adolescents
      jn Yes jn No
      (2) Other Adults
      jn Yes jn No
      (3) Medication Assisted Treatment (MAT)
      jn Yes jn No
Narrative Question
Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

Criterion 2
Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  

   jn Yes jn No

2. Either directly or through and arrangement with public or private non-profit entities make perninal care available to PWWDC receiving services?  

   jn Yes jn 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?  

   jn Yes jn No

4. Does your state have an arrangement for ensuring the provision of required supportive services?  

   jn Yes jn No

5. Are you considering any of the following:

   a) Open assessment and intake scheduling  
      jn Yes jn No

   b) Establishment of an electronic system to identify available treatment slots  
      jn Yes jn No

   c) Expanded community network for supportive services and healthcare  
      jn Yes jn No

   d) Inclusion of recovery support services  
      jn Yes jn No

   e) Health navigators to assist clients with community linkages  
      jn Yes jn No

   f) Expanded capability for family services, relationship restoration, custody issue  
      jn Yes jn No

   g) Providing employment assistance  
      jn Yes jn No

   h) Providing transportation to and from services  
      jn Yes jn No

   i) Educational assistance  
      jn Yes jn 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.
**Criterion 4, 5 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program**

**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
   a) 90 percent capacity reporting requirement  [Yes] [No]
   b) 14-120 day performance requirement with provision of interim services  [Yes] [No]
   c) Outreach activities  [Yes] [No]
   d) Syringe services programs  [Yes] [No]
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation  [Yes] [No]

2. Are you considering any of the following:
   a) Electronic system with alert when 90 percent capacity is reached  [Yes] [No]
   b) Automatic reminder system associated with 14-120 day performance requirement  [Yes] [No]
   c) Use of peer recovery supports to maintain contact and support  [Yes] [No]
   d) Service expansion to specific populations (military families, veterans, adolescents, older adults)  [Yes] [No]

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 NIATx 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?  [Yes] [No]

2. Are you considering any of the following:
   a) Business agreement/MOU with primary healthcare providers  [Yes] [No]
   b) Cooperative agreement/MOU with public health entity for testing and treatment  [Yes] [No]
   c) Established co-located SUD professionals within FQHCs  [Yes] [No]

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 maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery?  [Yes] [No]
2. Are you considering any of the following:

   a) Establishment of EIS-HIV service hubs in rural areas

   b) Establishment or expansion of tele-health and social media support services

   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS

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)?

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?

   If yes, please provide a brief description of the elements and the arrangement.

The State Health Department conducts needle exchange with other funds and our Local Authorities that treat PWID all have existing relationships with the Health Departments. We also have Local Authorities that are working with community partners to provide syringe exchange services within their service area which is supported by other funds.
**Criterion 8,9&10**

**Syringe 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
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

2. Are you considering any of the following:
   
   a) Workforce development efforts to expand service access
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

   c) Establish a peer recovery support network to assist in filling the gaps
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

   d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

   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
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

   f) Explore expansion of service for:
   
   i) MAT
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

   ii) Tele-Health
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

   iii) Social Media Outreach
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

**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?
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

2. Are you considering any of the following:
   
   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

   b) Establish a program to provide trauma-informed care
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

   c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

**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)
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

2. Are you considering any of the following:
   
   a) Notice to Program Beneficiaries
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

   b) Develop an organized referral system to identify alternative providers
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

**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?
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

2. Are you considering any of the following:
   
   a) Review and update of screening and assessment instruments
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>

   b) Review of current levels of care to determine changes or additions
   
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>jn</td>
<td>jn</td>
</tr>
</tbody>
</table>
c) Identify workforce needs to expand service capabilities
   jn Yes jn No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background
   jn Yes jn No

Patient Records
1. Does your state have an agreement to ensure the protection of client records?
   jn Yes jn No
2. Are you considering any of the following:
   a) Training staff and community partners on confidentiality requirements
      jn Yes jn No
   b) Training on responding to requests asking for acknowledgement of the presence of clients
      jn Yes jn No
   c) Updating written procedures which regulate and control access to records
      jn Yes jn No
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure
      jn Yes jn 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?
   jn Yes jn 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. 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.
3. Are you considering any of the following:
   a) Development of a quality improvement plan
      jn Yes jn No
   b) Establishment of policies and procedures related to independent peer review
      jn Yes jn No
   c) Develop long-term planning for service revision and expansion to meet the needs of specific populations
      jn Yes jn No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?
   jn Yes jn No
   If YES, please identify the accreditation organization(s)
   i) b Commission on the Accreditation of Rehabilitation Facilities
   ii) b The Joint Commission
   iii) e 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. Are you considering 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 opertunity 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) Performance-based accountability  
      Yes  No
   d) Data collection and reporting requirements  
      Yes  No

2. Are you considering 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

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  
      Yes  No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

Footnotes:
Utah has an HIV waiver already in place.
12. Quality Improvement Plan- Requested

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?
   - [ ] Yes  [ ] No
   
   Does the state have any activities related to this section that you would like to highlight?
   
   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.

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

   None at this time.
See Attachments for Rules and Regulations and Agency Scorecard reports.
R495. Human Services, Administration.
R495-878-1. Authority and Purpose.
(1) This rule is authorized by Section 62A-1-111.
(2) The purpose of this rule is to provide for the prompt and equitable resolution of complaints alleging any violation of the nondiscrimination provisions of Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, or the Age Discrimination Act of 1975, by employees of the Department.

(1) "ADA" means Title II of the Americans with Disabilities Act of 1990.
(2) "ADA/Civil Rights/LEP/Section 504 Coordinator" means the employee assigned by the executive director to facilitate the prompt and equitable resolution of complaints alleging discrimination by employees of the Department.
(3) "Complainant" means an individual who has applied to receive services, is currently receiving services, or who has received services from the Department, or that individual's authorized representative.
(4) "Department" means the Department of Human Services created by Section 62A-1-102, and includes the divisions and offices created by Section 62A-1-105.
(5) "Division Coordinator" means an individual assigned by the executive director to investigate allegations of discrimination by employees of the Department.
(6) "Director" means the head of the division or office of the Department affected by a complaint filed under this rule.
(7) "Executive Director" means the executive director of the department.
(8) "LEP" means Limited English Proficiency.
(9) "Section 504" means Section 504 of the Rehabilitation Act of 1973.

R495-878-3. Filing of Complaints.
(1) A complainant may file a complaint alleging the violation of the nondiscrimination provisions of Title VI of the Civil Rights Act of 1964, Title II of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, or the Age Discrimination Act of 1975, by employees of the Department.
(2) A complainant shall file a complaint with the Department's ADA/Civil Rights/LEP/Section 504 Coordinator, unless the complaint includes allegations against the ADA/Civil Rights/LEP/Section 504 Coordinator, in which case the complaint shall be filed with the executive director.
(3) A complainant may file a written, oral, or electronic complaint to:
   ADA/Civil Rights/LEP/Section 504 Coordinator
   Department of Human Services
   Executive Directors Office-4th floor
   195 North 1950 West
To facilitate a thorough investigation, the complainant should file a written, oral, or electronic complaint with the Department ADA/Civil Rights/LEP/Section 504 Coordinator no later than thirty (30) days from the date of the alleged circumstances giving rise to the complaint. A complaint should include the following information (complaint form available online at http://hs.utah.gov/):

(a) A detailed description of the alleged circumstances which caused the complaint, including dates and locations;
(b) The names and contact information of any and all persons involved in those circumstances;
(c) A detailed description of any actions taken by the complainant to address the complaint; and
(d) The desired result or outcome that the complainant is seeking from the Department.

R495-878-4. Investigation of Complaints.

(1) Within ten (10) days after receipt of the complaint, the ADA/Civil Rights/LEP/Section 504 Coordinator will assign the investigation of the complaint to the applicable Division Coordinator.

(a) The ADA/Civil Rights/LEP/Section 504 Coordinator will retain a copy of the complaint in a central.

(b) Investigations shall be completed within sixty (60) days after receipt of the complaint by the applicable Division Coordinator.

(2) Within ten (10) days after receipt of the complaint from the ADA/Civil Rights/LEP/Section 504 Coordinator, the Division Coordinator will notify the complainant in writing or electronically that an investigation of the complaint has commenced and will provide the deadline upon which the complainant should receive correspondence regarding the outcome of the investigation.

(a) The ADA/Civil Rights/LEP/Section 504 Coordinator shall be provided a copy of this correspondence from the Division Coordinator.

(b) A copy of all correspondence will be included in the ADA/Civil Rights/LEP/Section 504 Coordinator's central file.

(3) The Division Coordinator, or designee under the direction of the Division Coordinator, will conduct the investigation into the complaint and draft a proposed response to the complaint.

(a) The Division Coordinator shall gather and document all available relevant information.

(b) If the Division Coordinator is unable to complete the investigation and make a recommendation within the deadline, the complainant and the ADA/Civil Rights/LEP/Section 504 Coordinator shall be notified of the reason and how much additional time is needed.

R495-878-5. Recommendation and Decision.

(1) Completion of the investigation will result in a decision that the alleged circumstances occurred, did not occur, or could not be substantiated.

(a) If the alleged circumstances did occur, then the recommendation will also include suggestions to address barriers in the future involving similar circumstances.

(b) If the alleged circumstances could not be substantiated,
but the Division Coordinator is able to identify areas where DHS practices may be improved, then suggestions may be made to address barriers in the future involving similar alleged circumstances.

(c) The Division Coordinator will be responsible for drafting the initial correspondence to the complainant.

(2) The correspondence will be sent by the Division Coordinator to the Director for final approval and mailing to the complainant.

(a) A copy of the correspondence will be sent to the ADA/Civil Rights/LEP/Section 504 Coordinator, and included in a central file.

(3) Within ten (10) business days after the conclusion of the investigation, the Division Coordinator will notify the complainant in writing concerning the outcome of the investigation.

(a) The Division Coordinator will log in the date that the written response is sent to the complainant to indicate that the complaint is completed.

(4) The Director shall take all reasonable steps to implement the recommendation, including the suggestions to ameliorate barriers in the future involving similar circumstances.

(5) Any of the foregoing deadlines may be reasonably extended for extenuating circumstances. Any extensions of time will be confirmed in writing to the complainant.

R495-878-6. Appeals.

(1) The complainant may appeal the Director's decision to the Executive Director within ten working days after the complainant's receipt of the Director's decision.

(2) The appeal shall be in writing.

(3) The Executive Director may name a designee to assist on the appeal. The ADA/Civil Rights/LEP/Section 504 Coordinator, Division Coordinator, Director, and Director's designee may not be the Executive Director's designee for the appeal.

(4) In the appeal the complainant shall describe in sufficient detail why the decision does not effectively address the complainant's needs.

(5) The Executive Director or designee shall review the Division Coordinator's recommendation, the Director's decision, and the points raised on appeal prior to reaching a decision. The Executive Director or designee may direct additional investigation as necessary. The Executive Director shall consult with representatives from other state agencies that may be affected by the decision, including the Office of Management and Budget, the Division of Risk Management, the Division of Facilities Construction Management, and the Office of the Attorney General before making any decision that would:

(a) involve an expenditure of funds beyond what is reasonably able to be accommodated within the applicable line item so that it would require a separate appropriation; or

(b) require facility modifications;

(6) The Executive Director or designee shall issue a final decision within 15 working days after receiving the complainant's appeal. The decision shall be in writing, and shall be delivered to the complainant.

(7) If the Executive Director or designee is unable to reach a final decision within the 15 working day period, the complainant shall be notified in writing why the final decision is being delayed.
and the additional time needed to reach a final decision.

**R495-878-7. Relationship to Other Laws.**

This rule does not prohibit or limit the use of remedies available to individuals under:

(a) the state Anti-Discrimination Complaint Procedures, Section 34A-5-107 and Section 67-19-32;

(b) the Federal ADA Complaint Procedures, 28 CFR 35.170 through 28 CFR 35.178; or

(c) any other Utah State or federal law that provides equal or greater protection for the civil rights of individuals, including but not limited to Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and Section 504 of the Rehabilitation Act of 1973

**KEY:** grievance procedures, disabled persons

**Date of Enactment or Last Substantive Amendment:** August 25, 2015

**Notice of Continuation:** December 13, 2016

**Authorizing, and Implemented or Interpreted Law:** 62A-1-111; 63G-3-201(3); 28 CFR 35.107
R137-1-1. Authority and Purpose of Rule for Grievance Procedures.
   (1) The authority for the rule on these grievance procedures is found at Section 67-19a-203.
   (2) This rule establishes official procedures and standardized practices for administering these grievance procedures.

R137-1-2. Definitions.
   Terms defined in Section 63G-4-103 of the Utah Administrative Procedures Act (UAPA) are incorporated by reference within this rule. In addition, other terms which are used in this rule are defined below:
   "Abandonment of Grievance" means either the voluntary withdrawal of a grievance or the failure by an employee to properly pursue a grievance through these grievance procedures.
   "Administrative Review of the File" means an informal adjudicative proceeding according to Subsection 67-19a-403(3)(b).
   "Administrator" means the person appointed under Subsection 67-19a-201(1).
   "Affidavit" means a signed and sworn statement offered for consideration in connection with a grievance proceeding.
   "Affirmative Defense" means a responsive answer asserting facts in addition to those alleged that are legally sufficient to rebut asserted allegations.
   "Appeal" means a formal request to a higher level of review of a lower level decision.
   "Appointing Authority" means the officer, board, commission, person or group of persons authorized to make appointments on personnel/human resource management matters in their respective agency.
   "Burden of Moving Forward" means a party's obligation to present evidence on a particular issue at a particular time. The burden of moving forward may shift back and forth between the parties based on certain legal principles.
   "Burden of Proof" means the obligation to prove affirmatively a fact or set of facts at issue between two parties.
   "CSRO" means the agency of state government that statutorily administers these grievance procedures according to Sections 67-19a-101 through 67-19a-406.
   "Closing Argument" means a party's final summation of evidence and argument, which is presented at the conclusion of the hearing.
   "Consolidation" means the combining of two or more grievances involving the same controversy for purposes of holding a joint hearing, proceeding, or administrative review.
   "Continuance" means an authorized postponement or adjournment of a hearing until a later date, whether the date is specified or not.
   "Declaratory Order" means a ruling that is explanatory in purpose; it is designed to clarify what before was uncertain or doubtful. A declaratory order constitutes a declaration of rights between parties to a dispute and is binding as to both present and future rights. It is an administrative interpretation or explanation of a right, statute, order or other legal matter under a statute, rule, or an order.
"Default" means an omission of or untimely failure to take or perform a required act in the processing of a grievance. It is the failure to discharge an obligation which results in a forfeiture.

"Deposition" means a form of discovery in which testimony of a witness is given under oath, subject to cross-examination, and recorded in writing, prior to the hearing.

"Discovery" means the prehearing process whereby one party may obtain from the opposing party, or from other individuals or entities, information regarding the witnesses to be called, the documents and exhibits to be used at the hearing, and the facts and information about the case.

"Evidentiary Hearing" means a proceeding of relative formality, though much less formal than a trial, in which witnesses may be heard and evidence is presented and considered. Specific issues of fact and of law are tried. Afterwards, ultimate conclusions of fact and of law are set forth in a written decision or order.

"Excusable Neglect" means a failure to take proper steps at the proper time, not in consequence of the person's own carelessness, inattention, or willful disregard in the processing of a grievance, but in consequence of some unexpected or unavoidable hindrance or accident.

"Extraordinary Circumstances" means factors not normally incident to or foreseeable during an administrative proceeding. It includes circumstances beyond a party's control that normal prudence and experience could not foresee, anticipate or provide for.

"File" means to submit a document, grievance, petition, or other paper to the CSRO as prescribed by these rules. The term "file" includes faxing and E-mailing.

"Filing Date" means the day that a document, grievance, petition, or other paper is recorded as having been received by the CSRO.

"Grievance Procedures" mean the grievance and appeal procedures codified at Sections 67-19a-101 through 67-19a-406 and promulgated through this rule.

"Grievant" means the person or party advancing one or more issues as a petitioner through these grievance procedures to the evidentiary/step 4 level.

"Group Grievance" means a grievance submitted and signed by two or more aggrieved employees. The term does not include "class action."

"Hearing" means the opportunity to be heard or present evidence in an administrative proceeding.

"Hearing Officer" means an impartial trier of facts appointed by the CSRO administrator and assigned to decide a particular grievance case at the evidentiary/step 4 level.

"Hearsay Evidence" means evidence not based upon a witness's personal knowledge as a direct observer of an event. Rather, hearsay evidence stems from the repetition of what a witness heard another person say. Hearsay's value rests upon the credibility of the declarant. Hearsay is a statement made outside of the hearing that is offered as evidence of the truth of matters asserted in the hearing.

"Initial Hearing" means a hearing conducted by the administrator to make an initial determination regarding timeliness, authority, jurisdiction, direct harm, standing and eligibility to advance a grievance issue to the evidentiary/step 4 level.

"Issuance" means the date on which a decision, order or ruling
is signed and dated; it is not the date of mailing, or the date of
the mailing certificate, nor the postal date. Date of issuance is
the date specified according to Subsection 63G-4-401, of the UAPA.

"Joint Hearing" means the uniting of two or more grievances
involving the same, similar, or related circumstances or issues to
carry out a single hearing; also see "Consolidation."

"Jurisdiction" means the legal right and authority to hear and
decide issues and controversies.

"Management Representative" means a person of managerial or
supervisory status who is not subject to exclusion. Legal counsel
is not included within the meaning of the term.

"Motion" means a request offered verbally or in writing for a
ruling or to take some action.

"Motion to Dismiss" means a motion requesting that a grievance
or appeal be dismissed because it does not state a claim for which
the CSRO provides a remedy, or is in some other way legally
insufficient.

"Notice" and "Notification" mean a proper written notice to the
parties involved in a grievance procedural hearing or conference,
setting forth date, time, location, and the issue to be considered.
"Pleadings" mean the formal written allegations of the parties
that set forth their respective claims and defenses.

"Presiding Hearing Officer" means either the Administrator or
designated evidentiary/step 4 hearing officer.

"Pro Se" means in one's own behalf. A person is represented pro
se in an administrative proceeding when acting without legal counsel
or other representation.

"Quash" means to cancel, annul, or vacate.

"Relevant" means directly applying to the matter in question;
pertinent, germane. It is evidence that tends to make the existence
of any facts more probable or certain than they would be without the
evidence; and tending to prove the precise fact at issue.

"Remand" means to send back, as for further deliberation and
judgment, to the presiding official or other tribunal from which a
grievance was appealed.

"Standard of Proof" means the evidentiary standard, which in
CSRO adjudications is the substantial evidence standard.

"Stay" means a temporary suspension of a case or of some
designated proceeding within the case. A stay is different than a
continuance or extension of time and can only be granted when agreed
to by the parties and when the administrator or assigned hearing
officer finds a stay necessary for judicial economy and the interest
of justice.

"Submit" means to commit to the discretion of another; to present
for determination.

"Subpoena" means a formal legal document issued under authority
to compel the appearance of a witness at an administrative proceeding,
the disobedience of which may be punishable as a contempt of court.

"Subpoena Duces Tecum" means a formal legal document issued under
authority to compel specific documents, books, writings, papers, or
other items.

"Substantial Evidence" means evidence possessing something of
substance and relevant consequence, and which furnishes substantial
basis of fact from which issues tendered can be reasonably resolved.
It is evidence that a reasonable mind might accept as adequate to support a conclusion, but is less than a preponderance.

"Summary Judgment" means a ruling made upon motion by a party or the presiding hearing officer when there is no dispute as to either material fact or inferences to be drawn from undisputed facts, or if only a question of law is involved. The motion may be directed toward all or part of a claim or defense.

"Transcript" means an official verbatim written record of an adjudicative proceeding or any part thereof, which has been recorded and subsequently transcribed by a certified court reporter.

"UAPA" means the Utah Administrative Procedures Act found at Sections 63G-4-102 through 63G-4-601.

"Withdraw" means to recall or retract a grievance from further consideration under these grievance procedures.

"Witness Fee" means an appearance fee and may also include a mileage rate established by statutory provision pursuant to Section 78B-1-119.

"Working Days" means for purposes of the time periods for filing a grievance, advancing an appeal or responding to an employee's grievance or appeal, all days except Saturdays, Sundays and recognized State holidays.

R137-1-3. Classification Jurisdiction.

The CSRO and the CSRO hearing officers have no jurisdiction over classification and reclassification grievances, appeals, and complaints nor over position schedule assignments, according to Section 67-19-31 and Subsections 67-19a-202(1)(a) and 67-19a-302(1), and Section R477-3-5.


(1) A public applicant for a position with the state's work force has no standing to submit a grievance and is precluded from using these grievance procedures, according to Subsection 67-19-16(6).

(2) A public applicant who alleges a violation of a legally prohibited practice based upon race, color, sex, pregnancy, childbirth, or pregnancy-related conditions, age, if the individual is 40 years of age or older, religion, national origin, or disability, is directed to Section R137-1-5 of these grievance procedures.


(1) Discrimination Claims. Claims alleged to be based upon a legally prohibited practice as set forth in Section 34A-5-106, including employment discrimination on the basis of race, color, sex, pregnancy, childbirth, or pregnancy-related conditions, age, if the individual is 40 years of age or older, religion, national origin, or disability, are not admissible under these grievance procedures. The CSRO and CSRO hearing officers have no jurisdiction over the preceding claims.

(2) Processing Discrimination Complaints. A public applicant, a probationary employee, a career service employee, or an exempt employee who alleges a violation of a legally prohibited practice pursuant to Section 34A-5-106, may file a timely complaint with the individual's respective department head. If the individual is not
satisfied with the department head's decision, or if the decision is not rendered within ten working days after submission of the complaint, the individual may then file a complaint with the Utah Anti-discrimination Division pursuant to Section 67-19-32.

(3) Filing Discrimination Complaints. Employees and applicants desiring to file a legally prohibited discrimination complaint may contact the Utah Anti-Discrimination Division.

R137-1-6. Filing Procedure.

The submission of correspondence, pleadings, grievance materials, and legal documents is subject to the following provisions:

(1) Filing/Receipt. Papers to be filed with the CSRO or the administrator are deemed filed on the date actually received, and are so date-stamped. The date on which papers are received and date-stamped is regarded as the date of filing.

(2) Time Periods. All papers, memoranda, petitions, grievances, pleadings, briefs, exhibits, and written motions to be filed with the administrator must be filed in the Career Service Review Office, 1120 State Office Building, Capitol Hill, Salt Lake City, Utah 84114, within the time limits prescribed either by law, by these rules, or by order of the administrator or by the designated CSRO hearing officer.

(a) All filing dates are based upon the CSRO's working days.

(b) Papers must be signed by the person filing the paper or by the person's authorized representative.

(c) Documents being submitted are to contain the name, business address, and telephone number of the representative, if a party or person is being represented.

(d) Copies of all filed papers shall be served upon the appropriate opposing party or person to grievance proceedings, with notice of service given to the administrator.

(e) Notice to a designated representative constitutes notice to the representative's client.

(f) Notice to an employee who is not represented shall be served at the address specified on the employee's statement of grievance or correspondence, or in the absence of such specification, at the last mailing address shown in the employing agency's personnel file.

R137-1-7. Subpoenas.

Subsection 63G-4-205(2) of the UAPA is incorporated by reference.

(1) Subpoena Power. Pursuant to Subsection 67-19a-204(2)(a)(ii), the administrator may issue subpoenas to witnesses and may obtain documents or other evidence in conjunction with any inquiry, investigation, hearing, or other proceedings.

(a) The aggrieved employee has the right to require the production of books, papers, records, documents and other items pertinent to the facts at issue that are within the control of the agency against which the grievance is lodged, and which are not held to be protected or privileged by law. Affidavits and ex parte statements offered during a hearing may be received and considered by the CSRO hearing officer.

(b) A person receiving a subpoena issued by the CSRO will find the title of the proceeding posted thereon, and the person to whom it is directed shall be compelled to attend and give testimony. A
subpoena duces tecum may be used to produce designated books, or other items at a specified time and place when these items are under an agency's or a person's control.

(c) A request by counsel or a party's representative to issue a subpoena must be reasonable and timely. At least five full working days' notice prior to a scheduled hearing must be given to the administrator, not counting preparation and delivery time. The requesting party shall simultaneously notify the opposing party of the request.

(d) The original of each subpoena is to be presented to the person named therein, and a copy shall be issued to the counsel or representative of each party.

(2) Service of Subpoenas. Service of subpoenas shall be made by the requesting party delivering the subpoena to the person named, unless the CSRO is requested to deposit the subpoena properly addressed and postage prepaid, with the U.S. Postal Service, or to send it by State Mail and Distribution Services, or to send it by E-mail, or to send it by facsimile transmission, or in any combination.

(3) Proof of Service. If service has not been acknowledged by the witness, the server may make an affidavit of service. Failure to make proof of service does not affect the validity of the service.

(4) Quashing. Subsection 67-19a-204(2)(a)(iii) governs the quashing of subpoenas by the administrator.


(1) Service by the Parties. The parties to a proceeding shall serve upon each other one copy of all pleadings filed with the administrator. Service of a pleading may be made by any of the following: personal delivery, U.S. Postal Service, postage prepaid, State Mail and Distribution Services, facsimile, or E-mail.

(a) Pleadings must be accompanied by a certificate of service or an affidavit of mailing, indicating how, where, when and to whom service is being made.

(b) It is the duty of a party or person or their representative to notify the administrator and the opposing party or representative in writing of any changes in names, addresses, or telephone numbers.

(2) Service of Subpoena. Service of subpoenas shall be executed in accordance with Section R137-1-7(2) above.

(3) Issuance of Decisions and Orders. A CSRO decision, order, ruling or other document shall be considered issued on the date that it is signed by its CSRO originator, rather than on other dates such as the date it is mailed, postmarked, received or distributed.

(a) All notices, decisions, orders and rulings by the administrator or by a CSRO hearing officer are to be distributed to the counsel or representatives of record and upon any person appearing pro se.

(b) The CSRO will retain the original notice, decision, order or ruling with the record of the proceedings. Distribution of a CSRO notice, decision, order or ruling is accomplished when any of the following occurs:

(i) deposit postage prepaid with the U.S. Postal Service,
(ii) deposit with State Mail and Distribution Services,
(iii) personal delivery,
(iv) facsimile transmission,
E-mail transmission.

A mailing certificate must be attached to the notice, decision, order or ruling bearing the date of mailing and the names and addresses of those persons to whom the notice, decision, order or ruling is originally distributed.

**R137-1-9. Hearing Dates, Continuance/Extension of Time.**

(1) Once the administrator has made an initial determination that the CSRO has authority to review or decide a grievance or appeal, the administrator shall set a date for the evidentiary/step 4 hearing that is:

(a) within 30 days of the administrator's determination; or
(b) if agreed to by the parties, no more than 150 days from the administrator's determination date.

(2) Notwithstanding Subsection (1), after the evidentiary hearing date has been set, each party may be granted one continuance or extension of time for the hearing provided there are extraordinary circumstances justifying such continuance or extension. A party desiring an extension of time or a continuance of the evidentiary hearing shall file a written request with the administrator or appointed hearing officer.

(a) Every petition for a continuance shall specify the reason for the requested delay.

(b) In considering a request for continuance, the administrator or the appointed CSRO hearing officer shall take into account:

(i) whether the request was timely made in writing; and
(ii) whether the request is based on extraordinary circumstances.

(3) Inattention or lack of preparation does not constitute extraordinary circumstances justifying a continuance or extension of time of the evidentiary hearing.

---

**R137-1-10. Eligibility to Grieve.**

(1) Standing. Only executive branch career service employees and reporting employees alleging retaliatory action, as defined by Subsections 67-19a-101(7) and 67-19a-101(8), may use these grievance procedures.

(a) Pursuant to Subsection 67-19-16(6) and Section 67-19a-301, the CSRO has no jurisdiction over grievance petitions filed by probationary employees, public applicants, exempt employees, noncareer service employees, public employees of the state's political subdivisions, public employees covered by other grievance systems, or employees of state institutions of higher education.

(2) Questionable Standing. Where a question or dispute exists whether an employee qualifies to use these grievance procedures, such controversies must be resolved through application of R137-1-17 by the administrator. The administrator's determination shall be final and subject to review only in the Utah Court of Appeals for formal adjudications and in the district court for informal adjudications according to Subsections 67-19a-301(2) and 67-19a-403(2)(a)(i), and Sections 63G-4-402 and 63G-4-403 of the UAPA.

(3) Class Action. Pursuant to Subsection 67-19a-401(8), class action grievances will not be admissible for consideration by the CSRO under these grievance procedures.
(4) Group Grievance. A group grievance is admissible provided that each aggrieved employee signs the grievance, according to Subsections 67-19a-401(8)(a) and (b).

All grievances shall be reviewed to determine:
(1) Whether the matters or issues raised in a grievance fall within the CSRO's limited jurisdiction as set forth in Subsections 67-19a-202(1)(a) and 67-19a-202(1)(6), or
(2) Whether any issues or components of a grievance were satisfactorily resolved at an earlier step in the grievance procedures. Matters or issues resolved at an earlier step in the grievance procedures may not be advanced to the CSRO.

R137-1-12. Employees' Rights.
(1) Representation. The state does not provide legal counsel or representation to aggrieved employees nor pay the fees for an employee's representation. Also, Subsection 67-19a-406(4)(a) precludes the CSRO from awarding fees or costs to an employee's attorney or representative. Pursuant to Subsection 67-19a-402.5(6)(a), an appellate court may award costs and attorney fees, accrued at the appellate court level, to a prevailing employee in a retaliatory action grievance.
(2) Pro Se Status. A party or person to a grievance proceeding may appear pro se. When a party or person appears pro se, the party or person is entitled to request the issuance of subpoenas, directly examine and cross-examine witnesses, make opening and closing statements, submit documentary evidence, summarize testimony, and in all respects fully present one's own case.
(3) No Reprisal. Pursuant to Subsection 67-19a-303(3), no appointing authority, director, manager, or supervisor may take action to retaliate against a grievant, a representative, or a witness who participates in or is scheduled to participate in a grievance proceeding.

(1) Automatic Processing. An agency's failure to reply in writing to an aggrieved employee's grievance within the prescribed time period automatically grants the aggrieved employee the right to advance the grievance to the next step of these grievance procedures listed in Section 14 (below). Pursuant to Subsection 67-19a-401(2), the parties may mutually agree to waive or extend steps 1, 2, or 3 or extend the statutory time period for those steps. Waivers of the statutory time periods by agency management and the aggrieved employee must be in writing and submitted to the administrator.
(2) Waiver. When the administrator finds that a grievance is one that an agency cannot resolve because of the nature of the grievance, the matter may be waived in writing to a higher level. Steps 1, 2, or 3 may be waived, but not step 4. Any waiver agreed to between the parties must be in writing, dated and submitted to the administrator according to Subsection 67-19a-401(2) and (3).
(3) Excusable Neglect. The standard of excusable neglect may be offered as a defense to lack of timeliness in processing a grievance
or for not appearing at a scheduled proceeding.

(a) The administrator or appointed CSRO hearing officer shall determine the applicability of the excusable neglect standard when offered as a defense to lack of timeliness or not appearing at a scheduled proceeding.

(b) All questions are to be resolved at the original level of occurrence.

(4) Abandonment of Grievance. In the event the administrator or CSRO hearing officer determines that a grievance claim has been withdrawn, abandoned, or otherwise neglected beyond either the established time lines or a reasonable period, the matter no longer qualifies for further processing through these grievance procedures. When withdrawal is intended, it should be accomplished in writing.

(5) Default. An employee who defaults in processing a grievance forfeits further rights granted by these rules and under Section 63G-4-209 of the UAPA, which is incorporated by reference.

(6) Transfer. The administrator may administratively transfer a grievance from the aggrieved employee's department to another, more appropriate department to respond as necessary to serve the ends of justice and fairness.

(7) Stay. Upon written request, the administrator or the CSRO hearing officer may grant a stay of a decision, order, ruling, remedy, or proceeding. However, stays may be granted only when agreed to by the parties and when the administrator or assigned hearing officer finds a stay necessary for judicial economy and the interest of justice.


Persons acting on grievances pursuant to Sections 67-19a-402 and 67-19a-402.5, and in accordance with these rules, shall conduct their filings through the following steps, or levels, of increasing accountability:

Step 1; A written grievance shall be submitted to the employee's immediate supervisor. A standard grievance form is available from the CSRO. Once submitted, the written grievance then becomes a formal complaint necessitating a response. Steps 2 and 3 also necessitate responses within time periods outlined in Section 67-19a-402. Such responses are to be issued by only one supervisor, director, etc. at each step.

Step 2; If the grievance is not resolved at step 1, the employee may advance their grievance to step 2. Step 2 requires the grievance be reviewed by the agency or division director or designee; Step 3; If the grievance is not resolved at step 2, the employee may advance their grievance to step 3. Step 3 requires the grievance be reviewed by the department head, executive director, commissioner or their designated representative.

Step 4; If the grievance is not resolved at step 3, the employee may advance their grievance to step 4. Step 4 is an evidentiary de novo hearing conducted before a CSRO hearing officer.

The purpose for the above steps, or levels, is to curtail employees from having to submit their grievances to persons in agency management not specified in the above steps or levels. Only the above-listed persons (or their designated representatives) in agency management are authorized to respond to state employees' grievances.

(1) An aggrieved employee who has been suspended without pay, demoted or dismissed by their respective department head (i.e., executive director or commissioner) may appeal the department head's action directly to the CSRO at the evidentiary step 4 level.
   (a) An appeal from discipline imposed by the department head is distinguishable from a grievance.
   (b) A grievance is filed at step 1 and proceeds through steps 2 and 3. Suspensions without pay that are not imposed by a department head shall proceed through the grievance procedures as a grievance.
   (c) When an appeal from discipline imposed by a department head occurs at the step 3 level, it may be appealed directly to the CSRO at the evidentiary/step 4 level.

(2) When appealed to the CSRO, the appeal must be filed within 20 working days from the date an aggrieved employee receives written notification from the department head who imposed the disciplinary action.

R137-1-16. Procedure for Appealing Reduction in Force or Abandonment of Position.

An aggrieved employee may appeal a reduction in force or abandonment of position according to the following:

(1) Upon receiving the department head's final, written decision, the employee may appeal from a reduction in force by filing a written appeal within 20 working days of receipt of the decision with the CSRO.

(2) An employee separated from employment for abandonment of position may appeal the department head's final written decision by filing a written appeal with the CSRO within 20 working days of receipt of the decision.

R137-1-17. Initial Review by Administrator.

When an employee advances a grievance to the CSRO or directly appeals a department head's decision to the CSRO, the administrator shall make an initial determination of whether the CSRO has authority to review or decide the grievance or appeal. In order to make this determination, the administrator may hold an initial adjudicative hearing in accordance with Subsections 67-19a-403(2), 67-19a-402.5(2)(b)(i) and Section 63G-4-206 or conduct an informal adjudicative review of the file in accordance with Subsections 67-19a-403(2), 67-19a-402.5(2)(b)(ii) and Section 63G-4-202 which are incorporated by reference.

(1) Procedural Issues. The administrator shall make an initial determination of the following: timeliness, direct harm, jurisdiction, standing, eligibility of the issues to be advanced, and any other procedural matters or jurisdictional controversies according to Sections 67-19a-402.5, 67-19a-403 and 67-19a-404.

(2) Determination. The administrator has authority to determine which types of grievances may be heard at the evidentiary/step 4 level. Those types of grievances found to have been resolved at a lower level or those that do not qualify for advancement to the evidentiary/step 4 level are precluded from further
(3)  Preclusion.  Those types of actions not listed in Subsections 67-19a-202(1)(a) or 67-19a-202(1)(b) and referenced in Subsection 67-19a-302(1) and 67-19a-302(3) are precluded from advancement to the evidentiary/step 4 level. When the grievance is precluded from the evidentiary/step 4 level, the matter under dispute shall be deemed as final at the level of the department head/step 3 according to Subsection 67-19a-302(2).

(4)  Reconsideration. A written request for reconsideration may be filed with the administrator. It must be filed within 20 days from the date the administrator issues a decision regarding whether the CSRO has authority to review or decide a grievance or appeal. Section 63G-4-302 of the UAPA incorporated by reference. The written reconsideration request must contain specific reasons why a reconsideration is warranted with respect to the factual findings and legal conclusions of the hearing decision or administrative review of the file decision. New or additional evidence may not be considered.

(5)  Judicial Review.
(a)  The aggrieved employee or the responding agency may appeal the administrator's initial adjudicative hearing decision and final agency action to the Utah Court of Appeals within 30 calendar days from the date of issuance according to Subsection 63G-4-401(3)(a) and Section 63G-4-403 of the UAPA which are incorporated by reference.
(b)  The aggrieved employee or the responding agency may appeal the administrator's informal adjudicative decision and final agency action of an administrative review of the file to the district court according to Sections 63G-4-402 and 63G-4-404 of the UAPA which are incorporated by reference.
(c)  A decision reached by the CSRO in reviewing a retaliatory action grievance from a reporting employee, as defined by Subsections 67-19a-101(7) and 67-19a-101(8), may be appealed to the Utah Court of Appeals.

(6)  Summary Judgment. The administrator or the (Presiding Officer, Utah Code Ann. Section 63G-4-103(1)(h)(i)) hearing officer may, pursuant to an administrative review of the procedural facts and circumstances of a grievance case, summarily dispose of a case on the ground that:
(a)  the matter is untimely;
(b)  the grievant has failed to appear at the properly scheduled date, time, and place pursuant to written notice;
(c)  the grievant lacks standing;
(d)  the grievant has withdrawn or otherwise abandoned the grievance;
(e)  the grievant has not been directly harmed;
(f)  the issue grieved does not qualify to be advanced beyond step 3; or
(g)  the requested remedy or relief exceeds the scope of these grievance procedures.

(7)  Transcription and Transcript Fees. If a party appeals the administrator's initial adjudicative hearing decision to the Utah Court of Appeals or to the district court, the appealing party is responsible for paying all transcription costs and any transcript fees. The CSRO does not participate in the payment of these fees when appeals are taken to the appellate or trial court. See Utah Rules
of Appellate Procedure, Rule 11, and Section 63G-4-403(3), regarding transcript costs from formal adjudications under the UAPA.


The provisions under this section pertain to initial administrative and evidentiary/step 4 proceedings before the CSRO.

(1) Purpose. A formal adjudicative proceeding provides a fair and impartial opportunity for the parties to be heard and to present their evidence. The adjudicative process allows the CSRO administrator or the CSRO hearing officer to be completely informed about the case. After having considered the parties' evidence, the CSRO administrator or the CSRO hearing officer may then render a proper determination based upon all of the facts, circumstances, and applicable laws, rules and policies.

(2) Types of Adjudications. For purposes of Section 63G-4-202 of the UAPA:

(a) All initial administrative and evidentiary/step 4 adjudications at the CSRO are formal adjudicative proceedings. Sections 63G-4-205 through 63G-4-209, 63G-4-401 and 63G-4-403 through 63G-4-405 of the UAPA are incorporated by reference within this rule and are applicable to these adjudicative proceedings.

(b) An administrative review of the file, pursuant to Subsections 67-19a-403(2) and 67-19a-402.5(2)(b)(2), is an informal adjudicative proceeding with Sections 63G-4-203, 63G-4-402, and 63G-4-404 of the UAPA incorporated by reference.

(3) Rules of Evidence/Procedure Inapplicable. The technical rules of evidence and the formal rules of civil procedure as observed in the courts of law are inapplicable to these grievance procedure proceedings, except for the rules of privilege as recognized by law and those specific references to the rules of evidence and procedure as set forth in the UAPA.

(4) Expelling. The presiding CSRO hearing officer may clear the proceeding of witnesses not under examination and may exclude any unruly or disruptive person. The hearing officer may also expel any persons whose presence is antagonistic, oppressive, intimidating or appears to have a chilling effect on the witness under examination.

(5) Presentation of Case. Each party is given the opportunity to make an opening statement and to present evidence. After the evidence is closed, each party may offer a closing argument. The moving party may offer one rebuttal. Continuous rebuttal is not permissible.

(6) Objections.

(a) When an objection is made as to the admissibility of evidence, the presiding CSRO hearing officer shall note the objection for the record and make a ruling or take the objection under advisement to be ruled upon later.

(b) The presiding CSRO hearing officer has discretion to exclude inadmissible evidence and to order that cumulative or repetitive evidence be discontinued.

(c) A party objecting to the introduction of evidence must state the precise grounds of the objection at the time such evidence is offered.

(7) Marking Exhibits. All exhibits shall be numerically marked and labeled in the order received into evidence, unless previously marked and labeled.
(8) Motion to Dismiss. The administrator or CSRO hearing officer may, upon a party's motion or upon their own motion, dismiss the grievance or appeal before the CSRO.

(9) Consolidation of Grievances. Grievances of the same or of a sufficiently similar context may be consolidated by the administrator for purposes of conducting a single or joint hearing.

(10) Standard of Proof. In all CSRO adjudicative proceedings, the standard of proof is the substantial evidence standard according to Subsections 67-19a-406(2) and 67-21-3.5.

(11) Hearsay Evidence. Hearsay evidence is admissible in CSRO formal adjudicative proceedings as qualified by Subsection 63G-4-208(3) of the UAPA which is incorporated by reference.

(12) Discovery. The following rule provisions satisfy Section 63G-4-205 of the UAPA on discovery.

(a) Discovery shall be limited to that which is relevant and nonprivileged, and for which each party has a substantial, demonstrable need for supporting their respective claims or defenses.

(b) At the discretion and approval of the administrator or appointed CSRO hearing officer, parties to a dispute may obtain discovery. The CSRO administrator or hearing officer has discretion to entertain discovery motions on a case-by-case basis regarding the following:

(i) production of documents, records and things under Utah Rule 34 of Civil Procedure; and

(ii) depositions only when a proposed witness is unavailable for giving testimony at a scheduled hearing.

(c) No other form of discovery is permitted.

(d) Witness lists and copies of exhibits shall be offered by each party to the opposing party and to the presiding CSRO hearing officer during a prehearing/scheduling conference, unless the exchange is scheduled for a later date.

(i) Each party's list of witnesses shall contain a brief statement describing the nature of the proposed testimony to be offered by each witness.

(ii) A party may not surprise the opposing party with a witness or an exhibit at the hearing which was not made known at the prehearing/scheduling conference, or by a scheduled exchange date, unless the witness or exhibit is in direct rebuttal to admitted opposing evidence. Also refer to R137-1-7(1)(c).

(13) Page Limitation.

(a) Written motions, pleadings, briefs, and memoranda for all CSRO proceedings may not exceed 20 typed, double-spaced 8-1/2 x 11 inch pages, exclusive of any statement of facts. Reply briefs may not exceed ten pages.

(b) An application for an exception to the above-stated page limitation provisions must be timely filed in writing, and not more than ten double-spaced 8-1/2 x 11 inch pages in a 12-point font. The applicant party has the burden to offer sufficient justification for requests more than 20 and 10 pages respectively to the CSRO for the granting of any exceptions to the page limitation provision.

(c) The CSRO may weigh all requests to exceed the page limitation provision based upon the reasonableness and necessity of such requests in light of each case and its circumstances. The CSRO does not automatically grant exceptions simply on the basis of a request.

(1) Availability of State Employees to Testify. An agency shall be responsible for making available any of its employees who are subpoenaed to testify in a hearing.

(a) Off Duty Employees. Agencies are not responsible for making available an employee who is: off duty; on sick, annual or other approved leave; or who, for any other reason, is not at work during the time the hearing is in progress.

(b) Nondisruption. The parties and their representatives, the administrator and the CSRO hearing officer shall make every effort to avoid disruption to the operation of state government in the calling of state employees to testify in hearings under these grievance procedures.

(c) Witness Failure. If a requested witness does not appear at the scheduled hearing, the witness's failure to appear may not necessitate the postponement of any proceedings.

(d) Excessive Witnesses. If the number of witnesses requested by a party is excessive, the administrator or the CSRO hearing officer may require the party to justify the request or face denial of part or all of the request.

(e) Witness Fees and Mileage Fees. A witness fee and a mileage fee are available to nonstate employees and to state employees who use nonworking hours if their presence is required in a grievance proceeding as a witness according to Section 78B-1-119. The CSRO reserves the right to determine on an individual case basis whether it will authorize a travel fee, and to what extent, for an out-of-state witness called by a party.

(2) Hostile Witnesses. When the presiding CSRO hearing officer determines that a witness is uncooperative or even hostile, the witness may be examined by the party calling that witness as if under cross-examination. The party calling the witness may, upon showing that the witness was called in good faith but that the testimony is a surprise, proceed to impeach the witness by proof of prior inconsistent statements.

(3) Exclusion/Sequestering of Witnesses.

(a) The presiding CSRO hearing officer may sequester witnesses from the hearing until they are called to testify.

(b) Witnesses not presently testifying may be sequestered on motion by one or both parties or in the presiding hearing officer's discretion.

(c) The presiding CSRO hearing officer will counsel the witnesses not to discuss the case with those witnesses who have not yet testified.

(4) Management Representative. Prior to every hearing the agency may designate one person to serve as the agency's management representative. The agency's management representative is entitled to remain throughout the hearing to represent the agency at any proceeding even if called to testify, unless the hearing officer determines it is reasonable to expel the management representative for any or part of the hearing.

R137-1-20. Public Hearings.

A CSRO hearing is open to the public unless there are reasonable
grounds to justify an executive session for either part or all of a hearing. This provision does not apply to witnesses who are being called to testify according to R137-1-19.

(1) Closing Hearings. All grievance procedure hearings shall be open to the public except as follows:
   (a) The administrator or the CSRO hearing officer may close either a portion or an entire hearing based upon reasonable grounds.
   (b) An evidentiary/step 4 hearing may be closed in part or in its entirety when the proceeding involves discussion about a state employee's character, professional competence, or physical or mental health according to Subsection 52-4-205(1)(a) of the Open and Public Meetings statute.

(2) Sealing Evidence. The administrator or the CSRO hearing officer may seal the record when appropriate according to Subsection 67-19a-406(4)(c).

(3) Media Presence. All hearings at the jurisdictional and evidentiary/step 4 level are open to the media, unless closed pursuant to R137-1-20(1) above. However, television cameras are not permitted at the evidentiary/step 4 proceeding.

(4) Distribution of Decisions. Once the grievance process, including all administrative appeals, has been completed and if the agency's decision was sustained, the administrator may provide copies of legal decisions, orders, and rulings to the public upon request. Portions of or entire legal decisions and orders may be withheld if deemed to be legally privileged or protected under the state's Government Records Access and Management Act (GRAMA), or if the record is sealed according to the Open and Public Meetings statute.


(1) Authority of the CSRO Hearing Officer/Presiding Officer. The CSRO hearing officer/presiding officer is authorized to:
   (a) serve as the presiding officer at evidentiary/step 4 hearings as set forth at Subsection 63G-4-103(1)(h)(i) of the UAPA;
   (b) maintain order, ensure the development of a clear and complete record, rule upon offers of proof, receive relevant evidence, and assign the burden of proof according to Subsection 67-19a-406(2);
   (c) set reasonable limits on repetitive and cumulative testimony and sequester any witness whose later testimony might be colored by the testimony of another witness or any person whose presence might have a chilling effect on another testifying witness;
   (d) rule on any motions, discovery requests, exhibit lists, witness lists and proposed findings;
   (e) require the filing of memoranda of law and the presentation of oral argument with respect to any question of law;
   (f) compel testimony and order the production of evidence and the appearance of witnesses;
   (g) admit evidence that has reasonable and probative value; and
   (h) reopen the evidentiary record.

(2) Conduct of Hearings. A hearing shall be confined to those issues related to the subject matter presented in the original grievance statement.
   (a) An evidentiary proceeding may not be allowed to develop into a general inquiry into the policies and operations of an agency.
(b) An evidentiary proceeding is intended solely to receive evidence that either refutes or substantiates specific claims or charges. A proceeding may not be used as an occasion for irresponsible accusations, general attacks upon the character or conduct of the employing agency, agency management, or other employees. A hearing may not be used as a forum for making derogatory assertions having no bearing on the claims or specific matters under review.

(3) Evidentiary/Step 4 Hearing. An evidentiary/step 4 hearing shall be a hearing on the record according to Subsections 67-19a-406(1) and (2), held de novo, with both parties being granted full administrative process as follows:

(a) The CSRO hearing officer shall first make factual findings based solely on the evidence presented at the hearing without deference to any prior factual findings of the agency. The CSRO hearing officer shall then determine whether:

(i) the factual findings made from the evidentiary/step 4 hearing support with substantial evidence the allegations made by the agency or the appointing authority, and

(ii) the agency has correctly applied relevant policies, rules, and statutes.

(b) When the CSRO hearing officer determines in accordance with the procedures set forth above that the evidentiary/step 4 factual findings support the allegations of the agency or the appointing authority, then the CSRO hearing officer must determine whether the agency's decision, including any disciplinary sanctions imposed, is excessive, disproportionate or otherwise constitutes an abuse of discretion. In making this latter determination, the CSRO hearing officer shall give deference to the decision of the agency or the appointing authority. If the CSRO hearing officer determines that the agency's penalty is excessive, disproportionate or constitutes an abuse of discretion, the CSRO hearing officer shall determine the appropriate remedy.

(4) Discretion. Upon commencement, the CSRO hearing officer shall announce that the hearing is convened and is being held on the record. The CSRO hearing officer shall note appearances for the record and note the party having the burden of moving forward first.

(5) Closing the Record. After all testimony, documentary evidence, and arguments have been presented, the CSRO hearing officer shall close the record and terminate the proceeding, unless one or both parties agree to submit a posthearing brief or memoranda of law within a specified time.

(6) Posthearing Briefs. When posthearing briefs or memoranda of law are scheduled to be submitted, the record shall remain open until the briefs or memoranda are exchanged and received by the CSRO hearing officer and incorporated into the record, or until the time to receive these submissions has expired. After receipt of posthearing documents, or upon the expiration of the time to receive posthearing documents, the case is then taken under advisement, and the period commences for the issuance of the written decision.

(7) Findings of Fact, Conclusions of Law. Notwithstanding R137-1-21(1)(h) above, following the closing of the record, the CSRO hearing officer shall write a decision containing findings of fact and conclusions of law according to Section 67-19a-406 and Section 63G-4-208 of the UAPA, which is incorporated by reference. When the
CSRO hearing officer's decision and order is filed with the administrator it then becomes the decision and order of the evidentiary/step 4 hearing.

(8) Distribution of Decisions. The administrator shall distribute copies of the evidentiary/step 4 decision and order to the persons, parties and representatives of record.

(9) Past Work Record. In those proceedings where a disciplinary penalty is at issue, the past employment record of the employee is relevant for purposes of either mitigating or sustaining the penalty when substantial evidence supports an agency's allegations.

(10) Compliance and Enforcement. State agencies, department heads, division directors and officials are expected to comply with decisions and orders issued by the CSRO hearing officer. Enforcement measures available to the CSRO include:

(a) petitioning the governor, who may remove his appointed state officers with or without cause, and with respect to those who can only be removed for cause, refusal to obey a lawful order may constitute sufficient cause for removal;
(b) a mandamus order to compel the official to obey the order;
(c) the charge of a Class A misdemeanor according to Section 67-19-29; and
(d) seeking enforcement of a legal decision, order or ruling through civil enforcement in the district court according to Subsection 63G-4-501(1) of the UAPA which is incorporated by reference.

(11) Rehearings. Rehearings are not permitted.

(12) Reconsideration.

(a) Section 63G-4-302 of the UAPA is incorporated by reference within this rule, and requests for reconsideration of an evidentiary/step 4 decision will be conducted in accordance with that section, except for the time period which is stated below.

(b) The written reconsideration request must contain specific reasons why a reconsideration is warranted with respect to the factual findings and legal conclusions of the evidentiary/step 4 decision. The same CSRO hearing officer shall decide the propriety of a reconsideration. A request for reconsideration is filed with the administrator. To be timely the written request for reconsideration shall be filed within twenty days after the evidentiary/step 4 decision is issued as provided at Section 63G-4-302.

(13) Appeal to the Utah Court of Appeals. To appeal to the Utah Court of Appeals, a party must file with the court within 30 calendar days from the date of issuance of the evidentiary/step 4 decision and final agency action according to Sections 63G-4-401 and 63G-4-403 of the UAPA, which are incorporated by reference. The dates of mailing, postmarking and receipt are not applicable to filing with the court.

(14) Transcript Fee. The party petitioning the Utah Court of Appeals for a review must bear all costs of transcript production for the evidentiary/step 4 decision. The CSRO may not share any cost for a transcript or transcription of the evidentiary/step 4 hearing.

**R137-1-22. Declaratory Orders.**

This rule provides a procedure for the submission and review
of requests for and disposition of declaratory rulings pertaining to the applicability of statutes, administrative rules, and orders either governing or issued by the administrator, the previous Career Service Review Board or a CSRO hearing officer. Section 63G-4-503 of the UAPA is incorporated by reference.

1. Applicability. The applicability of a declaratory order refers to the determination of whether a statute, rule, or order should be applied, and if so, how the law should be applied to the facts.

2. Petition Procedure. Any person or agency with proper standing may petition for a declaratory ruling.
   (a) The petition must be addressed and delivered to the CSRO.
   (b) The petition shall be date-stamped upon receipt in the CSRO.

3. Petition Form. The petition shall:
   (a) be clearly designated as a request for a declaratory order;
   (b) identify the statute, rule, decision or order to be reviewed;
   (c) describe the circumstances in which applicability is to be reviewed;
   (d) describe the reason or need for the applicability review;
   (e) include an address and telephone number where the petitioner can be reached during regular work days; and
   (f) be signed by the petitioner.

4. Petition Review and Disposition. As appropriate the administrator:
   (a) shall review and consider the petition;
   (b) shall prepare a declaratory ruling, stating:
      (i) the applicability or nonapplicability of the statute, rule, or order at issue;
      (ii) the reasons for the applicability or nonapplicability of the statute, rule, decision or order; and
      (iii) any requirements imposed on a petitioning person or agency, or any other person according to the ruling; and
   (c) may:
      (i) interview the petitioner or the agency representative;
      (ii) hold a public hearing on the petition;
      (iii) consult with legal counsel or the Attorney General; or
      (iv) take any action that the administrator deems necessary to provide the petition with an adequate review and due consideration.

5. Time Period and Issuance. The administrator shall prepare the declaratory ruling without unnecessary delay. The CSRO shall issue a copy of the ruling to the petitioner by depositing it with the U.S. Postal Service, postage prepaid, or by depositing it with State Mail and Distribution Services, by faxing it or E-mailing it, as appropriate. In the event of a necessary delay, the CSRO must issue a notice of progress to the petitioner within 30 days of receipt of the petition.

6. Records. The CSRO shall retain the petition and the original of the declaratory ruling in its records.

7. Statutory Construction. Questions requiring the construction of statutory provisions may be submitted to the Attorney General for a formal or informal letter opinion.

8. Refusal. The administrator may refuse to issue a declaratory order if the question in issue is one that is being contested in a case currently before the CSRO.
KEY: grievance procedures, reconsiderations
Date of Enactment or Last Substantive Amendment: July 22, 2013
Notice of Continuation: July 11, 2016
RATIONALITY: It is the policy of the Department of Human Services that all Divisions, Offices, and Institutions must develop, maintain and exercise plans for the continuity of business operations in the event of a crisis. Whatever the situation, the Department’s agencies must be able to carry out their responsibilities to employees, clients, customers, vendors and the public of the State of Utah. Plans must address a range of resources including personnel, workspace, vehicles, telecommunications and data processing.

A security/safety crisis is the most common event for the Department but other emergencies may arise as the result of earthquake, fire, flood, or some other human-caused event such as a power outage. The level of service to be provided in an emergency event must be determined based on the resources available and the mission of the affected agencies.

SCOPE: This policy applies to all Divisions, Offices and Institutions within the Department of Human Services. Agency management will assess the preparedness of all organizational groups and report annually to the Executive Director. The assessment will include the quantification and qualification of continued service delivery of critical business processes, life/safety controls, and other areas deemed appropriate by agency management.

PURPOSE: The purpose of this policy is to formalize the Business Continuity/Crisis Management Program of the Department of Human Services and provide guidelines for the development, maintenance, and exercising of Business Continuity/Crisis Management Plans. More importantly, the policy seeks to provide for the continuation and resumption of time sensitive business operations in accordance with pre-established time frames; recovery of less time sensitive business operations as required; and, ultimately the restoration of a permanent operating environment.

CONTINUITY PLANNING PROGRAM

The leadership team of the Department of Human Services has recognized the potential exposures associated with service interruptions and the importance of maintaining viable Emergency Response, Resumption, Recovery, and Restoration Strategies.

The Business Continuity/Crisis Management Planning Program is intended to provide a framework for constructing plans to ensure the safety of clients and employees with the continuation and resumption of time sensitive operations and services in the event of an emergency such as a fire, flood, power or telecommunications blackout, earthquake, civil disturbance, etc. The plans resulting from this Program will include detailed descriptions of when they are to be implemented, who is responsible for their execution, and where their secondary or back-up operations will be located in an effort to maintain business continuity.

Although the Program provides guidance and documentation on which to base emergency response, business resumption, recovery, and restoration efforts, it is not intended to substitute for informed decision making. Division/Office/Institution Directors and Managers must identify and prioritize functions and services, for which a disruption will result in scaling back or curtailing less critical business functions. Plans must detail responsibilities and tasks for use in responding to emergencies and resuming operations based upon pre-defined time frames.
RESPONSIBILITY

1. **Crisis Management Team** - The Crisis Management Team will provide management direction for Business Continuation, Resumption and Recovery in the event of an emergency, such as a security threat, fire, earthquake, flood, power outage, hazardous materials spill or other event that causes a disruption of normal business operations. Individuals comprised of the Crisis Management Team will have the necessary emergency training as required by the State EOC (i.e. National Incident Management System (NIMS), at a minimum the 100 and 200 series upon appointment) in order to provide proper direction and guidance. The Crisis Management Team will be assembled upon the direction of the Executive Director’s Office depending upon the type, size and scope of the event and the Division/Office/Institution programs affected. The Crisis Management Team will be co-located in the MASGOB building. The Crisis Management Team will, in turn, activate the relevant Division/Office/Institution’s Business Continuity/Crisis Management Plans.

2. **Office of Administrative Support** - The Bureau of Administrative Support will establish the organization and methodology for developing, maintaining, and exercising Department-wide Business Continuity/Crisis Management Plans that support the continuity of Department of Human Services operations and ensure compliance with this policy.

   a. The Bureau of Administrative Support’s responsibilities include:

      (1) Develop a methodology and framework that will guide all areas of the Department in the development of specific agency continuity plans.

      (2) Provide a comprehensive Business Continuity/Crisis Management Strategy to ensure proper coordination of all continuity plans and coordination of response, resumption, recovery, and restoration efforts under one Business Continuity/Crisis Management Program.

      (3) Maintain a web-based inventory of all Agency plans to ensure that the relationship among plans is workable.

      (4) Ensure that an annual exercise plan is conducted that will examine the basic functions and responsibilities of all Agency plans and participants.

      (5) Report annually on the effectiveness of the Department’s preparedness to the Executive Director and Leadership Team.

      (6) Provide a methodology to follow in the event of a loss of property or personnel for recording, tracking, accountability and the necessary reporting to the Crisis Management Team and to the Division of Risk Management in accordance to their policy and procedures.

      (7) Coordinate with the State’s Continuity Planning entities to ensure that the Department’s plans support the overall efforts of the State.
(8) Coordinate with other Departments with whom Human Services has a working relationship to ensure that continuity plans do not conflict.

(9) Coordinate with the Department’s contract providers and vendors to ensure that continuity plans do not conflict and can be supported.

(10) Document and report the effectiveness of plan and preparedness after service interruptions, drills and exercises.

3. **Division/Office/Institution Directors** - Division/Office/Institution Directors will assure overall compliance with the Department’s Business Continuity/Crisis Management Program’s guidelines.

   a. The **Division/Office/Institution Director** will:

      (1) Identify and prioritize business critical processes and services.

      (2) Designate an Office Emergency Coordinator at each location to coordinate the continuity planning for that location.

      (3) Review and approve Business Continuity Plans at each location and notify the appropriate BAS Regional Manager when staff changes are made.

   b. The **Office Emergency Coordinator** will:

      (1) Coordinate the continuity planning efforts for the Office.

      (2) Document and present plan status to Division/Office/Institution Director.

      (3) Activate plans and then promptly notify the Crisis Management Team.

      (4) Report the effectiveness of the plans to the BAS Regional Manager after any service interruption, drill or exercise.

      (5) Identify emergency response/business continuity shortfalls and establish minimally acceptable levels of service for all critical Business Processes and Services.
4. **Plan Maintenance** - As a minimum, each Division/Office/Institution will:

a. Review all plans at least annually to ensure that they meet the needs of the Agency.

b. Document and submit all plan changes as they occur to the BAS Region Manager for inclusion in the Facility Information Tracking System (FiTS) database.

c. Conduct drills, tabletops or other exercises in lieu of an actual service disruption event at least annually.

---

Lisa-Michele Church, Executive Director  
Department of Human Services  
DATE: 06-10-10
Utah Department of Human Services
Division of Substance Abuse and Mental Health (DSAMH)
Comprehensive Emergency Management Plan
July 2015

Section I - Base Plan
July 21, 2015

Letter of Promulgation

The Division of Substance Abuse and Mental Health is committed to protect individuals being served by the Utah Public Mental Health and Substance Use 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; and
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

DSAMH, 195 North 1950 West, Salt Lake City, Utah 84116
Telephone (801) 538-3939 • facsimile (801) 538-9892 • www.dsamh.utah.gov
### COMPREHENSIVE EMERGENCY MANAGEMENT PLAN UPDATE/REVIEW LOG

<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>1</td>
<td>Entire Plan</td>
<td>July 30, 2015</td>
<td>Planning Team</td>
<td>Plan Creation</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.,</td>
<td>801-538-3939</td>
<td>Robert Snarr/Doug</td>
</tr>
<tr>
<td>Secondary: Utah State Hospital</td>
<td>1300 E Center St, Provo, UT 84603</td>
<td>801-344-4400</td>
<td>Dallas Ernshaw</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 Ernstrum</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 84627</td>
<td>435-283-8400</td>
<td>Brian Whipple</td>
</tr>
<tr>
<td>Davis Behavioral Health</td>
<td>934 South Main, Layton, Utah 84041</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 84078</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 84190-2250</td>
<td>801-468-2009</td>
<td>Tim Whalen</td>
</tr>
<tr>
<td>San Juan Counseling</td>
<td>356 South Main, Blanding, Utah 84511</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 84770</td>
<td>435-634-5600</td>
<td>Mike Deal</td>
</tr>
<tr>
<td>Valley Behavioral Health - Summit</td>
<td>1753 Sidewinder Drive, Park City, Utah 84124</td>
<td>435-649-8347</td>
<td>Gary Larcenaire</td>
</tr>
<tr>
<td>Valley Behavioral Health - Tooele</td>
<td>100 South 1000 West, Tooele, Utah</td>
<td>435-843-3520</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 37 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: 12
During normal operations, DSAMH operates as an administrative/oversite 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. This 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 mental/behavioral health services.
- Staff and residents will sustain injuries of varying degrees of severity.
- Security issues will arise.
- Support from outside the facility will be limited for the first 72 hours.
- Staff have been trained in emergency protocols and procedures.
- Staff will have emergency resources, including food/water cache and medical supplies.
- Facility evacuation will have to be coordinated with outside agencies through the use of a Memorandum of Understanding or Memorandum of Agreement.
- Communication systems are redundant and operable during an event.

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. Identify primary functions of facility and determine which functions can be continued under the circumstances. Food preparation capability, water flowing, etc.
4. Ensure appropriate staffing is in place, and coverage is available for ongoing crisis situation. Prioritize staff duties and what will be needed.
5. Prioritize all programming and activities for essential operations. Keep as normal a schedule as possible in regards to DSAMH functions.
6. Schedule times for briefing communications with the DSAMH Administrator in the Emergency Operations Center.
7. Schedule times for briefing communications with facility staff.
8. Outline clear procedures for internal and external communication with special consideration given to staff and their families, state, counties, and the general public.
9. 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.

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 Incident Commander (IC) for all emergency events. They will be in contact with the facility Assistant Director (AD) and or the Program Administrator for Crisis in a disaster, will report to the Crisis Management Team at the Emergency Operations Center (EOC), and 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 (SCO) will be in control of all operations at the facility and will work out of the Incident Command Post (ICP). The SCO will coordinate all operations and needs with the Incident Commander at the EOC. The role of the SCO will be executed by the Assistant Director (AD) at the facility.

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 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 the Department of Human Services PIO for all media inquiries and public information releases.

Critical Infrastructure Protection
In an effort to protect critical infrastructure after a disaster event, DSAMH has purchased or has access to mobile equipment stocked with emergency shelters, bedding, basic medical equipment, generators, and hygiene supplies. The staff maintains enough food to continue feeding staff for one week after an emergency and emergency water is regulated through the control operator.

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 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 Emergency Operations Center (EOC). The AD will provide information to the EOC 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 EOC 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 Incident Commander (IC) and general staff coordinate on-scene operations.

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 facility and will coordinate with the DSAMH Administrator at the EOC. The role of the SCO will be executed by the Assistant Director at the facility.

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.

The Memorandum of Understanding is attached as Appendix C

F. Information Collection, Analysis, and Dissemination

The facility will collect emergency contact information from the parent/guardian as well as two alternates who would be allowed to pick up the youth in an emergency that required depopulation of the facility. This information will be kept in the youth’s file and readily available for facility evacuation. Medical information will be stored on an encrypted hard-drive that is portable and readily accessible. These files will be kept up-to-date in Control at each facility and taken upon facility evacuation.

Personal and medical information will only be accessed and shared by those responsible for the care of the youth remaining in custody. This includes the evacuating and receiving facility.

Dissemination of information to parents/guardians of youth regarding evacuation, conditional release, or any other critical information will take place as soon as possible. Additional information on dissemination of information with Parents/Guardians is covered in section G below. The Scene Control Officer will take an active role in the information collection process to ensure they have all pertinent information to properly analyze the situation and make the proper decision for protective actions. This will require ongoing situational assessments to be completed by all staff and the development of both short-term and long-term goals for the emergency operations.

G. Communications - External/Internal

Communication with Parents/Guardians
During the Intake Process at each facility, the Facility Emergency Plan will be reviewed with the Parent/Guardian of the youth being admitted. The facility will discuss:

- The plans in place aimed at keeping the child safe in an emergency
- How the plan will work
- Options for Conditional Release in an emergency
- The alternate facilities for evacuation
- How and when the parent/guardian will be notified
- Why the youth would be evacuated
- When they evacuated
- Where they would be evacuated to
- Method of transportation and notification of safe arrival
- Any injuries to report
- When and where new information will be available
- When and how contact with child can occur
- Can parent/guardian visit child at the alternate facility

The facility will collect emergency contact information from the parent/guardian as well as two alternates who would be allowed to pick up the youth in an emergency that required depopulation of the facility. This information will be kept in the youth’s file and readily available for facility evacuation, as stated in section F.

Communications with Youth/Clients
After an emergency event, youth in custody may experience emotional trauma or show symptoms of Post Traumatic Stress Disorder. Facility staff will continuously communicate with youth to monitor emotional stress and potential for shock. Medical and mental health professionals will be utilized as needed and notification of needs will be communicated upon arrival at the receiving facility. Staff will also address the evacuated youth upon arrival at the receiving facility to allow for youth to contact family members and communicate safe and well status.

Internal Communications
Facilities will coordinate with one another to ensure that each facility has at least three alternate facilities. This will take place through discussions with the Program Director and the Assistant Program Directors who administrate the facilities. Alternate facilities will be chosen with forethought regarding needs for space, food, water, and accessibility. Transportation routes with alternates will be decided and logged into the facility’s Functional Emergency Response Plan.

Plans will be communicated to all employees and employees will utilize the plans in all exercises and emergency events. The AD and Control will keep an up-to-date call tree of all employees to ensure staff can be contacted during times of emergency. Program Directors and Assistant Program Directors will also be aware of what situations will require facility evacuation and which scenarios will require the facility to shelter in place.

Communication will take place with Youth Court Judges regarding emergency release of youth offenders during an emergency event. Administration will create a formalized written Risk Assessment document for an emergency release plan. Assistant Program Directors will keep on file a list of all youth in the facility and coordinate with the Youth Court Judges which youth are able
to be given a conditional release to parents/guardians without involvement from the Youth Court during an emergency event. This coordination and assessment must be done at intake to ensure the form is in place before an emergency event.

Assistant Program Directors will coordinate with the kitchen staff at their facility to ensure that the facility has emergency food and water rations capable of feeding the youth and staff at the facility for no less than one week. The kitchen staff will keep a list of all food kept for emergency use and rotate stock to ensure that the food is within its expiration date.

During an emergency event, communication with Staff will be completed at shift turnover. If staff are required to work for extended shifts, the Incident Commander will complete a situation brief with staff to coordinate needs and answer all questions. IC will communicate staff needs to the Emergency Operations Center. IC will allow for staff to ensure that family is safe and communicate with staff to ensure that staff’s mental and emotional state is clear and focused on what needs to be completed at the facility to ensure continuity of operations. IC will address physical and emotional fatigue issues and direct breaks for decompression as needed. IC will also brief staff on the continuance of salary payments.

If evacuation is required, all injuries will be logged and triaged enroute to the accepting facility. Upon arrival at the accepting facility, triaged patients will be treated first according to severity of injury. Medical staff at the facility will treat the injured and arrange for further transport and treatment if required. If injured are in dire need of advanced medical care, staff will call ahead to arrange for emergency medical services to meet at the accepting facility.

Communications with Media
The Division of Substance Abuse and Mental Health does not employ a Public Information Officer for the Division. As such, ALL communications with Media/Reporters regarding the Division will go 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
- Intercom
- 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 landline 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 facility 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.

H. Administration, Finance, and Logistics
Administration and Finance Management will ensure that there are funds available for the purchase of extra food and water storage in the facilities and that the food is rotated through normal use to ensure all food is within expiration dates. Kitchen Staff and Assistant Program Directors will coordinate to ensure that the facility has the food capacity to feed staff and youth for a period of one week during an emergency event.

Administration and Finance Management will dedicate $10,000 per year for emergency equipment purchases/maintenance. The Division owns three trailers dedicated for emergency response and temporary housing/feeding. The Division will continue to expand these emergency trailers until each region has one.

An additional $5,000 per year will be allocated for use of emergency trailer resources during training exercises and emergency trailer maintenance. A Preventative Maintenance Schedule will be created and completed for each piece of emergency equipment.

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.
I. 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 shall remain the Plan Maintenance Team and consist of the following positions:

- DSAMH Deputy Director
- DSAMH Administrative Services Managers
- Correctional Facility Administrator
- DSAMH Correctional Facilities Program Director
- DSAMH Correctional Facilities Assistant Program Director
- DSAMH Correctional Facilities Supervisor
- DSAMH Early Intervention Services Assistant Program Director
- DSAMH Early Intervention Services Supervisor
- DSAMH Training Manager
- DHS BAS Director
- DHS BAS Emergency Planner/Risk Manager

Tests, Training and 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.

J. Authorities and References

The legal basis for all day to day and emergency operations are authorized by Utah State 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](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.

62A-7-101. Definitions
62A-7-102. Creation of division -- Jurisdiction
62A-7-103. Division director -- Qualifications -- Responsibility
62A-7-104. Division responsibilities
62A-7-104.5. Appropriation and funding of receiving centers
62A-7-105.5. Information supplied to division
62A-7-106.5. Annual review of programs and facilities
62A-7-107.5. Contracts with private providers
62A-7-108.5. Records -- Property of division
62A-7-109.5. Restitution by youth offender
62A-7-111.5. Cost of support and maintenance of youth offender -- Responsibility
62A-7-201. Confinement -- Facilities -- Restrictions
62A-7-202. Location of detention facilities and services
62A-7-203. Detention -- Physical facilities
62A-7-401.5. Secure facilities
62A-7-402. Aiding or concealing youth offender -- Trespass -- Criminal penalties
62A-7-403. Care of pregnant youth offender
62A-7-404. Commitment -- Termination and review
62A-7-501. Youth Parole Authority -- Expenses -- Responsibilities -- Procedures
62A-7-502. Youth Parole Authority -- Parole procedures
62A-7-503. Administrative officer of Youth Parole Authority
62A-7-504. Parole revocation -- Hearing -- Procedures
62A-7-505. Conditions of parole
62A-7-506. Discharge of youth offender
62A-7-507. Appeal regarding parole release or revocation
62A-7-601. Youth services for prevention and early intervention -- Program standards -- Program services
62A-7-701. Community-based programs
62A-7-702. Case management staff

Section II - Functional Annexes
These annexes are variations of functional annexes tailored to the EOP format used by each facility. 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. Direction, Control, and Coordination
This section describes detailed measures on how the direction, control, and coordination of incident management is to take place.

B. Continuity of Operations
Continuity of operations (COOP) may have a separate plan from the EOP. If a separate COOP plan is used, it should be identified in the EOP.

(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.

D. 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.

E. 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.

F. External Affairs / Emergency Public Information
(1) Identify and describe the actions that will be taken to provide continuous and accessible public information about the disaster (e.g., media briefings, press releases, cable interruptions, EAS, text messages, door-to-door warnings), secondary effects, and recovery activities.
(2) Identify and describe the actions that will be taken to ensure that information provided by all sources includes the content necessary to enable reviewers to determine its authenticity and potential validity.
(3) Identify and describe plans, programs, and systems to control rumors by correcting misinformation rapidly.
(4) Identify and describe the actions that will be taken to inform individuals with sensory, intellectual, or cognitive disabilities; individuals with limited English proficiency; and others with access and functional needs in the workplace, public venues, and in their homes.
(5) Describe the role of a public information officer and the actions this person will take to coordinate public information releases (e.g., working with media at the scene, using a Joint Information Center, coordinating information among agencies/elected and appointed officials), including household pet evacuation and sheltering information.
(6) Describe how responders/local officials will use and work with the media during an emergency (e.g., schedule press briefings; establish media centers on-scene; control access to the scene, responders, and victims).

(7) Include prepared public instructions for identified hazards, including materials for managers of congregate care facilities, such as childcare centers, group homes, assisted living centers, and nursing homes.

(8) Identify and describe the actions that will be taken to manage

G. Population Protection

(1) Identify and describe the actions that will be taken to coordinate evacuations and sheltering-in-place for all segments of the population, including children, individuals with disabilities, and others with access and functional needs.

(2) Describe the protocols and criteria used to decide when to recommend evacuation or sheltering-in-place.

(3) Describe the conditions necessary to initiate an evacuation or sheltering-in-place and identify who has the authority to initiate such action.

(4) Identify and describe the actions that will be taken to conduct the evacuation (e.g., of high-density areas, neighborhoods, high-rise buildings, subways, airports, schools, special events venues, areas with a high concentration of children and individuals with disabilities) and to provide security for the evacuation area.

(5) Identify and describe the actions that will be taken to perform advanced/early evacuation, which is often necessary to accommodate children and others with mobility issues.

(6) Identify and describe the actions that will be taken to provide safe evacuation/transportation assistance to unaccompanied minors.

(7) Identify and describe the actions that will be taken to track unaccompanied minors and to reunite children with their families.

(8) Identify and describe the actions that will be taken to protect target at-risk groups and/or facilities (e.g., racial, ethnic, religious) in the event of a terrorism alert.

(9) Describe the plan for receiving those evacuated as a result of hazards in neighboring jurisdictions, including household pets and service animals.

(10) Describe the methods used to keep children and others with disabilities with their caregivers, mobility devices, other durable medical equipment, and/or service animals during an evacuation.

H. Mass Care, Emergency Assistance, Housing, and Human Services

(1) Identify and describe the actions that will be taken to identify, open, and staff emergency shelters, including temporarily using reception centers while waiting for shelters to open officially.

(2) Describe the agencies and methods used to provide essential care (e.g., food, water) to promote the well-being of evacuees throughout the entire process (including household pets and service animals).

(3) Describe the partnership between the jurisdiction’s emergency management agency, the animal control authority, the mass care provider(s), and the owner of each proposed congregate household pet sheltering facility.

(4) Describe the agencies and methods used to provide care and support for institutionalized populations (e.g., long-term care and assisted living facilities, group homes), individuals with disabilities, and others with access and functional needs (e.g., medical and prescription support, personal assistance services, durable medical equipment, consumable medical supplies, childcare,
transportation [including accessible transportation, foreign language interpreters], including their caregivers.

(5) Describe how the jurisdiction will ensure physical and programmatic accessibility of shelter facilities, effective communication using multiple methods, full access to emergency services, and reasonable modification of programs or policies where needed.

(6) Identify and describe the actions that will be taken to ensure that the Americans with Disabilities Act Accessibility Guidelines govern shelter site selection and operation.

(7) Describe the method for ensuring adequate shelter space allocation is provided for children, as well as individuals with disabilities and others with access and functional needs who may need additional space for assistive devices (e.g., wheelchairs, walkers).

(8) Identify and describe the actions that will be taken to provide alternate shelter accommodations for evacuees from domestic violence shelters.

I. Public Health and Medical Services

(1) Describe the agencies and methods used to maintain efficient surveillance systems supported by information systems to facilitate early detection, reporting, mitigation, and evaluation of expected and unexpected public health conditions.

(2) Describe the agencies and methods used to identify the public health issues created by the disaster (e.g., food / water safety, biological concerns) and to prioritize how the issues will be managed, including how this process is coordinated with the incident command post/EOC (e.g., issue vaccinations, establish quarantines).

(3) Describe the agencies and alternate methods used to provide potable water, bulk water, and temporary water distribution systems to the jurisdiction when the water systems are not functioning (e.g., private sources, boil orders, private wells).

(4) Describe the agencies and methods used to provide alternate sources for human waste disposal (e.g., arrange portable latrines, encourage sharing with those who have their own septic systems).

(5) Identify the lead agency for providing health and medical support to individuals with disabilities and others with access and functional needs.

(6) Describe the mechanisms or processes to effectively identify children and families who will need additional assistance, as well as individuals with disabilities and others with access and functional needs, with their specific health-related needs in advance of, during, and following an emergency.

(7) Identify and describe the actions that will be taken to secure medical records to enable children with disabilities and/or other special health care needs, as well as individuals with disabilities and others with access and functional needs, to receive health care and sustained rehabilitation in advance of, during, and following an emergency.

(8) Identify and describe the actions that will be taken to assess and provide mental health services for the general public (including individuals with disabilities and others with access and functional needs) impacted by the disaster.

(9) Identify and describe the actions that will be taken to assess and provide vector control services (e.g., insect and rodent controls, biological wastes/contamination, use of pesticides). (10) Identify and describe the actions that will be taken to assess and provide food production and agricultural safety services (e.g., conducting a coordinated investigation of food and agricultural events or agricultural or animal disease outbreaks).

J. 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.

K. Critical Infrastructure Restoration
(1) Identify and describe the actions that will be taken to determine qualified contractors offering recovery / restoration services.
(2) Identify and describe the actions that will be taken to coordinate credentialing protocols so personnel have access to critical sites following an incident.
(3) Identify and describe the actions that will be taken to identify, prioritize, and coordinate the work to repair/restore local roads, bridges, and culverts (e.g., along city, county, township, state, interstate, and U.S. routes).
(4) Identify and describe the actions that will be taken to repair/restore local water and wastewater systems (e.g., water / waste treatment plants, water/sewer lines, public/private wells), including providing temporary water distribution and wastewater collection systems until normal operations resume.

L. 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.

M. Firefighting
(1) Describe the process used to detect and suppress wildland, rural, and urban fires resulting from, or occurring coincidentally with, an incident response.
(2) Describe existing interstate and intrastate firefighting assistance agreements.
(3) Describe the methods by which situation and damage assessment information will be transmitted through established channels.

N. 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.
(7) Describe strategies for transporting materials through restricted areas, quarantine lines, law enforcement checkpoints, and so forth that are agreed upon by all affected parties.
O. Search and Rescue
(1) Identify and describe the actions that will be taken to conduct structural collapse (urban) search and rescue, waterborne search and rescue, inland/wilderness search and rescue, and aeronautical search and rescue operations.
(2) Identify and describe the actions that will be taken to monitor distress, communications, location of distressed personnel, coordination, and execution of rescue operations including extrication or evacuation along with the provisioning of medical assistance and civilian services through the use of public and private resources to assist persons and property in potential or actual distress.

P. Oil and Hazardous Materials Response
(1) Describe the actions to prevent, minimize, or mitigate an oil or hazardous materials release. (2) Describe the methods to detect and assess the extent of contamination (including sampling and analysis and environmental monitoring).
(3) Describe the methods to stabilize a release and prevent the spread of contamination.
(4) Describe the options for environmental cleanup and waste disposal; implementation of environmental cleanup; and storage, treatment, and disposal of oil and hazardous materials.

Q. Agriculture and Natural Resources
(1) Describe the process to determine nutrition assistance needs, obtain appropriate food supplies, and arrange for delivery of the supplies.
(2) Describe the plan to respond to animal and plant diseases and pests, including an outbreak of a highly contagious or economically devastating animal / zoonotic disease or an outbreak of a harmful or economically significant plant pest or disease.
(3) Describe the methods to ensure the safety and security of the food supply.
(4) Describe the response actions to preserve, conserve, rehabilitate, recover, and restore natural and cultural resources and historic properties.

R. Energy
(1) Describe the process to address significant disruptions in energy supplies for any reason, whether caused by physical disruption of energy transmission and distribution systems, unexpected operational failure of such systems, or unusual economic or international political events.
(2) Describe the process to address the impact that damage to an energy system in one geographic region may have on energy supplies, systems, and components in other regions relying on the same system.
(3) Describe/identify the energy-centric critical assets and infrastructures, as well as the method to monitor those resources to identify and mitigate vulnerabilities to energy facilities.

S. Public Safety and Security
(1) Describe the method by which public safety and security resources will be provided to support incident operations, including threat or pre-incident and post-incident situations.
(2) Describe the process to determine public safety and security requirements and to determine resource priorities.
(3) Describe the process to maintain communication with supporting agencies to determine capabilities, assess the availability of resources, and track resources.

T. Long – Term Community Recovery
(1) Describe the coordination mechanisms and requirements for post-incident assessments, plans, and activities.
(2) Describe the methods of identifying long-term recovery needs of special needs populations and incorporating these needs into recovery strategies.
(3) Describe the methods of identifying long-term environmental restoration issues.
(4) Describe the method of coordination with animal welfare and agricultural stakeholders and service providers in long-term community recovery efforts.

U. 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.

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

W. 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.

X. 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).

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

Z. Prevention and Protection
This process is used to identify prevention activities designed to reduce the risk of terrorism.
(1) Describe the process for managing and ensuring operational and threat awareness among government organizations and sectors.
(2) Describe the process for sharing information between the fusion center(s) and the EOC(s). (3) Describe the integration of prevention activities in support of response and recovery operations. This process is used to identify protection activities designed to reduce the risk of terrorism.
(1) Describe the process for managing the Critical Infrastructure identification and protection efforts involving all threats and hazards.
(2) Describe the integration of protection activities in support of response and recovery operations.

Section III – Hazard-, Threat-, or Incident Specific Annexes
b. DHS may also request Transportation Services by making a request through the Davis, Salt Lake, Utah, Weber Counties' Emergency Operations Center or through Utah State's Emergency Operations Center.

c. Division of Juvenile Justice Services will require law enforcement to assist in escorting and may request officers from UTA or other area law enforcement agencies.

5. Tracking and Reporting of Resources

A DHS facility utilizing UTA's Transportation Services will provide an inventory report of the Transportation Services furnished by UTA when requested to do so, but not more than annually.

6. Reimbursement of Resources

UTA may seek reimbursement costs for services. UTA shall provide an invoice for the reasonable cost of providing Transportation Services DHS, which shall pay the invoiced amount within thirty (30) days of receipt.

7. Termination

This MOU may be terminated by either party at any time by providing written notice of its intent to terminate.

8. Contact Information

To request transportation services contact Transit Communication Center 801-287-3937

The designated primary contacts for the Parties are:

For the Department of Human Services,
Name(s) Tyson Walker, Emergency Planner/Risk Management
Address 195 North 1950 West, Salt Lake City, UT 84116
Phone 385-290-5288
Fax 801-538-4317
Email tysonwalker@utah.gov

For Utah Transit Authority
Name(s) Jerry Benson, Chief Operating Officer
Address 669 W 200 S Salt Lake City, UT 84101
Phone 801-287-2318
Fax 801-741-8896
Email jbenson@rideuta.com

2
Mack McDonald  Date
Director
Bureau of Administrative Support

Jerry Benson  Date
Chief Operating Officer

Dave Goeres  Date
Chief Safety Officer

Approved as to form:

UTA Legal Counsel
Appendix D

Department of Human Services Prepares:

Internal Pandemic Flu
Work Group Report

January 4, 2007
Updated: October 8, 2009

By

Jennifer Anderson, Office of Recovery Services
Chuck Bruder, Division of Services for People with Disabilities
Nicole Christiansen, Office of Human Resources
Karen Clark, Developmental Center
Joy Diamond, Utah State Hospital
Joyce Foster, Utah State Hospital
Lori Gauf, Office of Public Guardian
Jack Green, Division of Child and Family Services
Janice Knaphus, Office of Licensing
Karen Linke, Office of Services Review
Alan Ormsby, Division of Aging and Adult Services
John Rokich, Office of Financial Operations
Robert Snarr, Division of Substance Abuse and Mental Health
Brian Whitesides, Office of Technology
Purpose Statement

Pandemic flu has the potential to be a serious crisis for the Department of Human Services and our clients. The Department’s Internal Pandemic Flu Work Group was created by Lisa-Michele Church, our Executive Director, to address specific internal concerns for our employees and clients. This task force was not asked to develop a “comprehensive” or “state-wide” pandemic flu response plan (the Governor has assembled such a task force); rather, we were asked to address specific goals, as follows:

Pandemic Flu Work Group Goals

From Lisa-Michele Church:

1. Inform DHS clients of the steps to take on preparedness (supplies, info, etc.)

2. Prepare our facilities for the unique demands of potentially lengthy absenteeism due to staff and loved ones being sick

3. Communicate with DHS providers as to their responsibilities in the crisis

4. Figure out DHS absenteeism policies if 30-40% of employees must stay home for six weeks

5. Investigate whether we can restrict face-to-face contact in DHS case management

6. UPDATED - October 8, 2009: Describe the Department’s strategy for disseminating ongoing information to employees about pandemic flu

Other Goals (developed by the Work Group):

1. Identify and prioritize highly vulnerable, highly dependent populations who rely on DHS and to whom we have a legal obligation to provide for their health and safety

Pandemic Flu Work Group Tasks

1. Prepare a simple, easy to read one-page information sheet to be delivered to all DHS clients. “Clients” include all individuals (whether receiving services directly from DHS employees or through our contracted providers), their parents if a minor, caregivers and/or guardians who are currently receiving DHS services or are on a waiting list for such services. We estimate 40,000 clients.
2. Prepare a template for a provider information packet and list of provider responsibilities that can easily be adapted for diverse providers.

3. Develop a report to Lisa-Michele Church with the following data:
   - Guidelines for preparing our DHS facilities (masks, sanitizer, etc.)
   - Recommendations for HR policy changes relating to absenteeism, overtime (real money or improved comp time) and telecommuting
   - Surge capacity guidelines
   - Recommended language to reinforce provider responsibility in their contracts
   - Prioritized descriptions of highly vulnerable, highly dependent populations

4. UPDATED - October 8, 2009: Post information about the 2009 H1N1 Flu to the Department’s website. Keep employees well-informed and encourage them to take proper steps to minimize exposure and disruption due to the 2009 H1N1 Flu.
Report and Recommendations

1. Client Information Sheet

The first task the Work Group addressed was preparing a simple, one-page (front and back) information sheet for all DHS clients. This information sheet is on the next two pages (pp. 5 and 6). All documents within this report are available electronically. The information sheet is updated as of October 8, 2009.

There was considerable discussion relating to the definition of “clients.” We wanted the definition to be broad enough to include all of the individuals we serve and their family members, as appropriate, but not so broad that it included everyone in Utah.

We propose the following definition: “Clients” include all individuals (whether receiving services directly from DHS employees or through our contracted providers), their parents if a minor, caregivers and/or guardians who are currently receiving DHS services or are on a waiting list for such services. We estimate 40,000 clients.

We developed the information sheet with a simple question and answer format. An effort was made to avoid “panic” or overreaction to the information. We also designed the information sheet to meet the needs of the average DHS client, recognizing that certain agencies within the Department may need to adapt the information sheet for their clients. The information sheet is updated with the most current recommendations from the CDC as of October 8, 2009.

Recommendation:

1. If a pandemic flu appears to be imminent, agencies within the Department should review the information sheet, update it and adapt it as necessary, and then distribute it to their clients.
Pandemic Flu Information & Checklist – Updated October 8, 2009

What is 2009 H1N1 (Swine Flu)? The 2009 H1N1 flu is a strain of influenza A that has appeared throughout the United States and in other countries. The World Health Organization has declared it a pandemic. For the latest information, go to: [http://www.cdc.gov/swineflu/](http://www.cdc.gov/swineflu/) or [http://health.utah.gov/epi/h1n1flu/](http://health.utah.gov/epi/h1n1flu/)

What are the symptoms of 2009 H1N1? Symptoms are similar to seasonal influenza. Typical symptoms of influenza include fever, chills, muscle aches, headache, stuffy or runny nose, cough, sore throat, and general weakness. Swine flu symptoms may also include nausea and vomiting. These symptoms usually appear one to five days after a person is exposed to the virus.

Is there a vaccine for 2009 H1N1? Yes, it is available now for some priority populations, and it should be available generally soon. You can check with your local health department to find out about its availability.

You can prepare for 2009 H1N1 now. You can take action now to help lessen the impact of influenza on you and your family. This checklist will help you gather the information and resources you may need in case of a flu outbreak in Utah.

1) To plan for a pandemic:
   - Store a two week supply of water and food. During a pandemic, if you cannot get to a store, or if stores are out of supplies, it will be important for you to have extra supplies on hand. This can be useful in other types of emergencies, such as power outages or disasters.
   - Have any non-prescription drugs and other health supplies on hand, including pain relievers, stomach remedies, cough and cold medicines, fluids and electrolytes, and vitamins.
   - Talk with family members and loved ones about how they would be cared for if they get sick, or what will be needed to care for them in your home.
   - Volunteer with local groups to prepare and assist with emergency response.
   - Get involved in your community as it works to prepare for an influenza pandemic.

2) Limit the spread of germs and prevent infection:
   - Wash hands frequently with soap and water. Alcohol based hand wipes and gel sanitizers work well to kill germs and the flu virus.
   - Teach your children to cover coughs and sneezes with tissues and throw the tissues away. If you do not have a tissue, cough or sneeze into your elbow.
   - Teach your children to stay away from others as much as possible if they are sick. Stay home from work or school if sick.
Here is a list for the Emergency Supply Kit:

**Water**
- Store 1 gallon per person per day
- Keep at least a three day supply of water

**Food**
- Preferably, store foods that can be kept at room temperature and are easy to prepare such as:
  - Canned fish, meats, vegetables, fruits, soups
  - Cereal
  - Peanut butter
  - Dried beans, rice and pasta
  - Processed cheese
  - Ramen noodles
  - Crackers
  - Dried milk
  - Food for infants or those on special diets
- Try to have a two-week supply of food in your house
  *Note: many of these foods can be high in sodium, eat them in moderation*

**First Aid**
- Sterile adhesive bandages (such as Band-Aids)
- Antiseptic lotion
- Pain reliever, stomach remedies, vitamins
- Thermometer
At least a two-week supply of all your prescription medicines and other medical supplies

For more information:
- Please watch TV and listen to the radio
- Visit: www.pandemicflu.gov
- Call: The Centers for Disease Control and Prevention (CDC) hotline, 1-800-CDC-INFO (1-800-232-4636), is available in English and Spanish, 24 hours a day, 7 days a week. TTY: 1-888-232-6348. Questions can be e-mailed to cdcinfo@cdc.gov.
- Visit: www.pandemicflu.utah.gov
2. **Provider Information and Provider Responsibilities**

The next task the Work Group addressed was addressing our providers and their responsibilities. We approached this issue in three ways: First, we wanted to provide providers with a very simple information sheet, since most providers will have their own information about pandemic flu and since the Department of Human Services is not an “expert” on pandemic flu. Thus, we believe the same information sheet that we developed for clients should be used for providers.

Second, we developed a comprehensive “Provider Pandemic Flu Planning Checklist.” This checklist is on the next page, p. 8. This document should be given to providers to assess their readiness to deal with pandemic flu. It describes fifteen critical tasks or steps providers should take to prepare for pandemic flu. These tasks were taken from a variety of national publications. We envision each Division giving their providers a copy of the checklist and then following through with them to obtain a completed checklist and all of the required documentation.

Finally, we developed model contract language that clearly describes a provider’s duty to maintain critical services during a pandemic Flu. The model contract language is on pages 9 and 10, and recommended changes are underlined. This language could be added to all existing state contracts with providers.

**Recommendations:**

1. If a pandemic flu appears to be imminent, agencies within the Department should review the information sheet, adapt it as necessary, and then distribute it to their clients.

2. Agencies should have their providers fill out and return the “Provider Pandemic Flu Planning Checklist” and obtain all supporting documentation.

3. Our internal Bureau of Contracts Management should review the proposed model contract language and consider adding this language to state contracts with providers.
## Provider Pandemic Flu Planning Checklist

<table>
<thead>
<tr>
<th>Task</th>
<th>Complete</th>
<th>In Process</th>
<th>Not Started</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Designate a flu pandemic coordinator and/or team.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name(s):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Describe your business continuity plan in light of flu pandemic, with up to 40% of your workforce unavailable for six weeks or more.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan: (Attach documentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Identify essential employees and describe your plan if they are unavailable.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name(s):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan: (Attach documentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Identify core services you will continue to provide regardless of the scope and duration of flu pandemic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Core Services: (Attach documentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Identify services that may need to be suspended due to flu pandemic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suspended Services: (Attach documentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Identify critical sub-contractors and other inputs required to maintain operations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Describe your plan to maintain operations if your critical sub-contractors and other inputs are disrupted for up to six weeks.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan: (Attach documentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Train and prepare employees and critical subcontractors with respect to flu pandemic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Review and assess your supplies of hygiene supplies such as hand sanitizer.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Describe your plan to minimize face-to-face contact during flu pandemic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan: (Attach documentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Describe your emergency communications plan, including how you will communicate with DHS and your employees.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan: (Attach documentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Review and update emergency calling trees.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Identify individuals, including employees and clients with special needs who will need extra assistance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Review human resources policies such as sick leave, flex time and flex locations, travel, and employee hygiene in light of flu pandemic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Describe your plan to coordinate and collaborate with local public health and/or emergency responders.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan: (Attach documentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EMERGENCY MANAGEMENT AND BUSINESS CONTINUITY PLAN: The Contractor shall use qualified personnel to perform all services in conformity with the requirements of this Contract and generally recognized standards. The Contractor's performance shall not be excused by force majeure. The Contractor represents that it has identified the critical functions or processes of its business operations essential for providing the services required in this Contract. The Contractor also represents that it has developed an emergency management and business continuity plan that will allow the Contractor to continue to operate those critical functions or processes during or following an emergency. The Contractor further represents that its emergency management and business continuity plan addresses at least the following areas as they pertain to the services Contractor is providing: 1. Evacuation procedures; 2. Temporary or alternate living arrangements, including arrangements for isolation or quarantine; 3. Vital supplies, including food, water, clothing, first aid supplies, client medications, and other medical necessities, etc.; 4. Communications (with Contractor staff, the appropriate government agency, and clients' families); 5. Transportation; and, 6. Recovery and maintenance of client records. In addition, the Contractor represents that it provides at least annual training for its staff on its emergency management and business continuity plan and it acknowledges that DHS and DHS/_____ may rely upon this and the other representations of the Contractor in this paragraph.

The Contractor shall evaluate its emergency management and business continuity plan at least annually, and shall modify the plan as appropriate. The Contractor shall provide DHS or DHS/_____ with a copy of its current plan upon request.

EMERGENCY MANAGEMENT AND BUSINESS CONTINUITY PLAN: The Contractor shall use qualified personnel to perform all services in conformity with the requirements of this Contract and generally recognized standards. The Contractor's performance shall not be excused by force majeure. The Contractor represents that it has identified the critical functions or processes of its business operations essential for providing the services required in this Contract. The Contractor also represents that it has developed an emergency management and business continuity plan that will allow the Contractor to continue to operate those critical functions or processes during or following an emergency. The Contractor further represents that its emergency management and business continuity plan addresses at least the following areas as they pertain to the services Contractor is providing: 1. Evacuation procedures; 2. Temporary or alternate living arrangements, including arrangements for isolation or quarantine; 3. Vital supplies, including food, water, clothing, first aid supplies, client medications, and other medical necessities, etc.; 4. Communications (with Contractor staff, the appropriate government agency, and clients' families); 5. Transportation; and, 6. Recovery and maintenance of client records; 7. Staffing plans to allow for maintenance of functions deemed to be critical for both short-term as well as longer-term (greater than 6 weeks) emergencies or disruptions of normal business; 8. Personnel policies including leave and
recall policies that present fair and equitable options for employees unable to work for extended periods because of illness during periods of declared pandemic in Utah; 9. Maintenance, inspection and replenishment of current and adequate supplies necessary for infection control or hazardous material protection; and, 10. Policies and procedures to ensure the timely discharge of financial obligations including payroll and contractor payments during times of extended disruption of normal business operations during periods of declared pandemic in Utah. In addition, the Contractor represents that it provides at least annual training for its staff on its emergency management and business continuity plan and it acknowledges that DHS and DHS/DJJS may rely upon this and the other representations of the Contractor in this paragraph.

The Contractor shall evaluate its emergency management and business continuity plan at least annually, and shall modify the plan as appropriate. The Contractor shall provide DHS or DHS/DJJS with a copy of its current plan upon request. All such plans are subject to the review and approval of DHS or DHS/DJJS, and plans will be modified upon request of DHS or DHS/DJJS until such time as approval is granted.
3. **Internal Department of Human Services Preparation**

   The Department itself will need to prepare for a pandemic flu outbreak. Absenteeism will likely be 30 to 40%. Many critical staffing concerns will occur as a result, such as surge capacity. Human Resources policies need to be reviewed and possibly amended with incentives to encourage healthy employees to stay at work.

   Since every Division, Office and Bureau will have unique challenges, we drafted an “Internal Pandemic Influenza Planning Checklist.” The checklist is found on page 12.

   Each organization within the Department should fill out the checklist and return them to the Executive Director’s office for review. Most organizations will need to work to successfully complete the tasks on the checklist.

**Guidelines for Facemasks, Hand Sanitizer, etc:**

   Our research revealed that masks are not effective for preventing healthy people from getting the flu. The most current guidance on masks can be found at: [http://www.cdc.gov/h1n1flu/masks.htm](http://www.cdc.gov/h1n1flu/masks.htm). In any event, the Department should not supply masks or compel employees to wear them.

   Employees who have flu-like symptoms, especially fever, should stay at home until 24-hours after their last fever. There is good evidence that proper hand washing does prevent the spread of disease, including flu. Each employee should be encouraged to wash their hands regularly, and offices should have hand sanitizer available. Additionally, Utah’s Department of Health has advised that anti-bacterial sprays such as Lysol are effective, so offices may want to consider having anti-bacterial spray on hand.

**Recommendations:**

1. Each Division, Office or Bureau within the Department should fill out the “Internal Pandemic Influenza Planning Checklist” and return it to the Executive Director’s office; if gaps in planning are identified, organizations should address those gaps.

2. The Executive Director, in conjunction with the Governor’s office and the Department of Human Resources, should review human resources policies to create incentives for healthy employees to stay at work during a pandemic flu.

3. Each office should consider their need for hand sanitizer and anti-bacterial spray, and should purchase an adequate supply.
<table>
<thead>
<tr>
<th>Task</th>
<th>Complete</th>
<th>In Process</th>
<th>Not Started</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Designate an influenza pandemic coordinator and/or team. Name(s):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Describe your business continuity plan in light of an influenza</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pandemic, with up to 40% of your workforce unavailable for up to six</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>weeks or more. Plan: (Attach documentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Describe how you have addressed surge capacity to include:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The minimum number and categories of personnel needed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Responsibility for assessing day-to-day staffing needs Plan:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Attach documentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Development of a written influenza pandemic plan:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surveillance (Including coordination with local public health)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication (with DHS and employees)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education and training of personnel and tracking of that training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rapid training for non-facility staff brought in during surge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>capacity Plan:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility access plan (criteria for limiting visitors/closing facility)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational health (criteria for vaccine delivery, detecting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>symptomatic personnel before they report for duty, policy for</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>managing healthcare personnel with symptoms of or documented</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pandemic influenza)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Describe your plan to maintain operations if critical sub-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>contractors/vendors or other inputs are disrupted for up to six</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>weeks, include emergency numbers for sub-contractors/vendors.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan: (Attach documentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Review and assess hygiene supplies such as hand sanitizer and anti</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>bacterial spray.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Describe your plan to minimize face-to-face contact during an</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>influenza pandemic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan: (Attach documentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Identify individuals, including employees and clients with special</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>needs who will need extra assistance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Review human resources policies such as sick leave, flex time and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>flex locations, travel, and employee hygiene in light of influenza</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pandemic.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Describe your plan to maintain financial obligations to providers,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>employees, and sub-contractors/vendors.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Describe your information technology plan to back up critical data</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>offsite.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan: (Attach documentation)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. **UPDATED October 8, 2009 – Plan for On-going Information**

Employees will need on-going information and regular updates during a flu pandemic. Management will need frequent status reports and keep an eye on capacity issues. The Department will need information about the extent of confirmed cases and which offices are being impacted.

The Department has designated Alan Ormsby (801-538-4135, akormsby@utah.gov) to serve as the key point for disseminating information about the H1N1 flu. Department-wide e-mails have already been sent out reminding employees about ways to help minimize flu, like proper hand-washing and social distancing. A department-wide e-mail has also been sent asking managers and supervisors to consider additional cross-training to meet capacity demands.

The Department will continue to work closely with the Health Department to get the latest information and will disseminate it as necessary throughout flu pandemic.
5. **Highly Vulnerable, Highly Dependent Populations**

Finally, the Work Group developed a goal to identify and prioritize our highly vulnerable, highly dependent populations. These are individuals who will face tremendous risk in any emergency situation. These people rely on the Department or our providers, and we have a legal obligation to provide for their health and safety.

On the next several pages, we describe, by agency, the vulnerable populations and the number of individuals.

**Recommendations:**

1. Each Division, Office or Bureau within the Department should fill out the “Internal Pandemic Influenza Planning Checklist” and return it to the Executive Director’s office; if gaps in planning are identified, organizations should address those gaps.
Department of Human Services
Vulnerable Populations: Listed in order of priority
within each Division or Office.
Prepared by the Flu Pandemic Task Force
(All numbers are approximate and are subject to fluctuation)

Division of Child and Family Services
1. Children in state custody in group homes, treatment facilities and shelters where there may be several children at one time. (723)
2. Children and adults in domestic violence shelters. (260)
3. Children in foster homes where there are fewer children (one to four in a sibling group). (1211)
4. Older children in independent living situations where they are not living with an older adult. Could be in an apartment or group home. (51)
5. Children in their own home on a trial basis with goal of reuniting with parents. (142)
6. Children and adults in their own home where there has been a problem of abuse/neglect but not serious enough to remove the child but court has ordered in-home services. (2304)
7. Children and adults with whom the division is working on a voluntary basis to improve the family relationship due to allegations/instances of abuse/neglect. (558)

Note: These are point-in-time numbers as of June 1 and would fluctuate from day to day.

Division of Aging and Adult Services
1. Waiver Clients - appx. 450 in any month. Totally dependant, meet SNF level of care.
2. APS Clients with active investigation and unresolved protective need - appx. 15 - 30. These people would be at extreme risk for abuse, neglect, or exploitation.
3. Alternatives Clients - appx. 700 in any month. Most will be OK for 48 hours or so, then at extreme risk. But all need help with ADL and IADL.
4. Meals on Wheels Clients - appx. 3000 per month. All are homebound. Most will be OK for 48 hours, then at extreme risk for hunger, dehydration and malnutrition.
Division of Substance Abuse and Mental Health

1. Utah State Hospital

Patients admitted to State Hospital in FY 2005 = 770.
Current number of pts. in State Hospital = 290.

2. Other related vulnerable populations:

- Any person requiring regular medication. The medication issue is significant in that presently a person is unable to received more then a 30 day supply of medication at one time. In case of a pandemic, medication may become scarce or the person is unable to get to a pharmacy to get their medication. This is esp. critical for diabetics, seizure pts., anyone on immunosuppressive drugs (transplant) to name a few.

- Homeless - people that go to many different areas with the potential to spread disease as they often don't seek or receive medical care in a timely manner.

Division of Services for People with Disabilities

(Based upon 2005 FY data)

1. Physical Disabilities Population - Total individuals - 109

- This program serves approximately 109 individuals with severe physical disabilities due to spinal cord injuries, multiple sclerosis, muscular dystrophy or other severe degenerative diseases. These individuals typically live in their own apartments in the community and received limited community living supports for Direct Care staff on a daily basis. These individuals do not receive night support. Some individuals also received very limited (1 to 3 hours per day) of Home Health supports through the Health Department.

2. Acquired Brain Injury / Intellectual Disabilities Community Supported Living - Total individuals = 819

- This program serves approximately 73 people who have brain injury due to a head injury, stroke, and loss of oxygen to the brain or brain tumor in this program. These individuals live in their own apartments in the community and receive less than 24-hour supervision from provider Direct Care staff. Typically this population does not have night supervision.

- This program serves approximately 746 people who have mental retardation, autism, cerebral palsy and other conditions related to mental retardation. These individuals live
in their own apartments in the community and receive less than 24-hour supervision from provider Direct Care staff. Typically this population does not have night supervision.

3. Acquired Brain Injury / Intellectual Disabilities Residential Community Living Supports in a Group Home (4 plus individuals) / Certified setting (3 or less individuals) – Total individuals = 1,362
   - This program serves approximately 14 people who have brain injury due to a head injury, stroke, and loss of oxygen to the brain or brain tumor in this program. These individuals live in Group Home or Certified Living residential settings in the community and receive 24-hour supervision from provider Direct Care staff.
   - This program serves approximately 1,348 people who have mental retardation, autism, cerebral palsy and other conditions related to mental retardation. These individuals live in Group Home or Certified Living residential settings in the community and receive 24-hour supervision from provider Direct Care staff.

4. Utah State Developmental Center – Total individuals = 230
   - The Developmental Center provides medical and behavioral critical care to 230 individuals with severe cognitive/developmental disabilities in a 24-hour residential setting. Many residents are medically fragile. The Developmental Center admits those individuals with the most profoundly complex array of medical, emotional and behavioral psychiatric symptoms. Providing a comprehensive array of treatment interventions including medical, psychiatric and dental evaluation and treatment, physical and occupational therapies, speech and communication therapy, job-skills development skills, social habilitation and critical efforts to reduce the incidence of criminal behaviors. The Center is prepared for Emergencies with their own Emergency Disaster Plan. However, in the event of an emergency, they may be overwhelmed with new placements coming from community providers who would not be able to meet the needs of the individual in the community. This could result in a serious staffing and appropriate housing problem.

5. Individuals residing with their Families - Total individuals = 1,353
   - This program serves approximately 14 people who have brain injury due to a head injury, stroke, and loss of oxygen to the brain or brain tumor in this program. These individuals live with their parents and/or caretaker’s in their own apartment / homes in the community. We have limited contact with these individuals through a Division Support Coordinator and provider Direct Care staff.
   - This program serves approximately 1,339 people who have mental retardation, autism, cerebral palsy and other conditions related to mental retardation. These individuals live with their parents and/or caretaker’s in their own apartment / homes in the community. We have limited contact with these individuals through a Division Support Coordinator and provider Direct Care staff.
Incident Response Checklist*

Gather Information Quickly

‰ What happened? .................................................................
‰ Internal event? Where? .....................................................
‰ External to organization? ....................................................
‰ When? Where? Who? ..........................................................

‰ Is it over or still in progress? .............................................
‰ Who is the target victim group? ...........................................
‰ What is the estimated number of people who are seriously injured and/or with high exposure to trauma? ..............................
‰ Are vulnerable populations involved (e.g., children, disabled)? .................................................................
‰ How bad is it? .................................................................
‰ Is there current or future danger? (Take action to protect.) .................................................................

‰ Property damage? ..........................................................
‰ Business disruption? .....................................................

Find Out What Is Being Done

‰ What responders are already on scene? ..............................
‰ Are you in communication with them? ..............................
‰ Are evacuations needed? ...................................................
‰ Are there injury or death notifications that need to be made?

‰ Is there a need to secure site? .............................................
‰ Has an Incident Command been established? Who is in charge? ...............................................................

-Credit-
Verify

☐ Is information accurate? 

☐ Is additional information needed?

*Adapted from The Red Pages, www.jeffersonmentalhealth.org/redpages/redpagesmain.htm. Used with permission.
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**

Name: ____________________________  Cell: ____________________________

*Work*  E-mail: ____________________________  Phone: ____________________________

*Home*  E-mail: ____________________________  Phone: ____________________________

**Attorney**

Name: ____________________________  Cell: ____________________________

*Work*  E-mail: ____________________________  Phone: ____________________________

*Home*  E-mail: ____________________________  Phone: ____________________________

**Public Information Officer**

Name: ____________________________  Cell: ____________________________

*Work*  E-mail: ____________________________  Phone: ____________________________

*Home*  E-mail: ____________________________  Phone: ____________________________

**Disaster Coordinator**

Name: ____________________________  Cell: ____________________________

*Work*  E-mail: ____________________________  Phone: ____________________________

*Home*  E-mail: ____________________________  Phone: ____________________________

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

Name: ____________________________  Cell: ____________________________

*Work*  E-mail: ____________________________  Phone: ____________________________

*Home*  E-mail: ____________________________  Phone: ____________________________

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.asneeded)
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: ___________________________ Cell: __________________

Work  E-mail: ______________________ Phone: __________________

Home  E-mail: ______________________ Phone: __________________

Name: ___________________________ Cell: __________________

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

<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>

## Governor’s Office

<table>
<thead>
<tr>
<th>PIO:</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>

## State Health Department

<table>
<thead>
<tr>
<th>Director:</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>

## State Health Department

<table>
<thead>
<tr>
<th>PIO:</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>

## Substance Abuse Agency

<table>
<thead>
<tr>
<th>Director:</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>
## Substance Abuse Agency

**PIO:**

<table>
<thead>
<tr>
<th>Work E-mail</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home E-mail</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td></td>
</tr>
</tbody>
</table>

**Cell:**

<table>
<thead>
<tr>
<th>Work E-mail</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home E-mail</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td></td>
</tr>
</tbody>
</table>

## State Emergency Management Agency

**Director:**

<table>
<thead>
<tr>
<th>Work E-mail</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home E-mail</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td></td>
</tr>
</tbody>
</table>

**Cell:**

<table>
<thead>
<tr>
<th>Work E-mail</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home E-mail</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td></td>
</tr>
</tbody>
</table>

## State Police

**Director:**

<table>
<thead>
<tr>
<th>Work E-mail</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home E-mail</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td></td>
</tr>
</tbody>
</table>

**PIO:**

<table>
<thead>
<tr>
<th>Work E-mail</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home E-mail</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>________________</td>
<td></td>
</tr>
</tbody>
</table>
Contact

Home  E-mail: ___________________________ Phone: ___________________________

LocalPolice/CountyLawEnforcement

Chief Executive: ___________________________ Cell: ___________________________

Work  E-mail: ___________________________ Phone: ___________________________

Home  E-mail: ___________________________ Phone: ___________________________

LocalPolice/CountyLawEnforcement

PIO: ___________________________ Cell: ___________________________

Work  E-mail: ___________________________ Phone: ___________________________

Home  E-mail: ___________________________ Phone: ___________________________
District Attorney’s Office/Victims’ Assistance
District Attorney: ___________________________ Cell: ___________________________
Work E-mail: ___________________________ Phone: ___________________________
Home E-mail: ___________________________ Phone: ___________________________

Military Base
Key contact: ___________________________ Cell: ___________________________
Work E-mail: ___________________________ Phone: ___________________________
Home E-mail: ___________________________ Phone: ___________________________

National Guard
Key contact: ___________________________ Cell: ___________________________
Work E-mail: ___________________________ Phone: ___________________________
Home E-mail: ___________________________ Phone: ___________________________

Reserves
Key contact: ___________________________ Cell: ___________________________
Work E-mail: ___________________________ Phone: ___________________________
Home E-mail: ___________________________ Phone: ___________________________

American Red Cross Chapter
Key contact: ___________________________ Cell: ___________________________
Work E-mail: ___________________________ Phone: ___________________________
Home E-mail: ___________________________ Phone: ___________________________

National Mental Health Association Chapter
Key contact: ___________________________ Cell: ___________________________
Work E-mail: ___________________________ Phone: ___________________________
Home E-mail: ___________________________ Phone: ___________________________

National Alliance on Mental Illness Chapter
Key contact: ___________________________ Cell: ___________________________
Work E-mail: ___________________________ Phone: ___________________________
Home E-mail: ___________________________ Phone: ___________________________
<table>
<thead>
<tr>
<th>Key contact:</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>

**SAMHSA**

<table>
<thead>
<tr>
<th>Key contact:</th>
<th>Cell:</th>
</tr>
</thead>
<tbody>
<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>
Content Experts Emergency Contacts List

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)
Name: ____________________________ Cell: ____________________________
Work E-mail: _______________________ Phone: _________________________
Home  E-mail: _______________________ Phone: _________________________
Areas of Expertise: ____________________________

Content.Expert
Name: ____________________________ Cell: ____________________________
Work E-mail: _______________________ Phone: _________________________
Home  E-mail: _______________________ Phone: _________________________
Areas of Expertise: ____________________________

Content.Expert
Name: ____________________________ Cell: ____________________________
Work E-mail: _______________________ Phone: _________________________
Home  E-mail: _______________________ Phone: _________________________
Areas of Expertise: ____________________________

Content.Expert
Name: ____________________________ Cell: ____________________________
Work E-mail: _______________________ Phone: _________________________
Home  E-mail: _______________________ Phone: _________________________
Areas of Expertise: ____________________________
Content.Expert
Name: __________________________  Cell: __________________________
Work  E-mail: __________________________  Phone: __________________________
Home  E-mail: __________________________  Phone: __________________________
Areas of Expertise: __________________________________________________________

Content.Expert
Name: __________________________  Cell: __________________________
Work  E-mail: __________________________  Phone: __________________________
Home  E-mail: __________________________  Phone: __________________________
Areas of Expertise: __________________________________________________________

Content.Expert
Name: __________________________  Cell: __________________________
Work  E-mail: __________________________  Phone: __________________________
Home  E-mail: __________________________  Phone: __________________________
Areas of Expertise: __________________________________________________________

Content.Expert
Name: __________________________  Cell: __________________________
Work  E-mail: __________________________  Phone: __________________________
Home  E-mail: __________________________  Phone: __________________________
Areas of Expertise: __________________________________________________________
Media Contacts List

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></td>
</tr>
<tr>
<td>Cell:</td>
<td></td>
</tr>
<tr>
<td>Work E-mail:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Personal 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></td>
</tr>
<tr>
<td>Cell:</td>
<td></td>
</tr>
<tr>
<td>Work E-mail:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Personal 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></td>
</tr>
<tr>
<td>Cell:</td>
<td></td>
</tr>
<tr>
<td>Work E-mail:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Personal E-mail:</td>
<td></td>
</tr>
<tr>
<td>News deadlines:</td>
<td></td>
</tr>
<tr>
<td>Notes:</td>
<td></td>
</tr>
</tbody>
</table>
"If your agency or key partner has access to commercial media database software, you may be able to compile these lists for "health," "crime" or other categories of journalists by media type, state or other elements."
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:

| Print date: 8/1/2017 3:59 PM | Page: 252 of 299 |
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: __________________________
* Any agency with access to commercial media software may want to have staff log all notes in a searchable field that can be saved to a shared database.
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

<table>
<thead>
<tr>
<th>Staff who took call:</th>
<th>Date and time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of caller:</td>
<td>Phone:</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</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>Staff who took call:</th>
<th>Date and time:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of caller:</td>
<td>Phone:</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</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>
UTAH DIVISION OF SUBSTANCE ABUSE & MENTAL HEALTH
CALL DOWN LIST FOR ALERT NOTIFICATION OR STATE EMERGENCY OPERATIONS CENTER ACTIVATION

* * * * * * * * * * *

Important: This list is confidential Information is not to be distributed without permission.

* * * * * * * * * * *

When the need arises for the Utah Departments of Government to be on alert to respond to a disaster, the Utah Department of Human Services Risk Management, Mack McDonald will call:

Doug Thomas, Director
Utah Division of Substance Abuse & mental Health
(801) 538-4298 Office
(801) 707-6729 Work Cell
(801) 913-0755 Cell
(435) 840-0241 Home Cell

AND/OR

Robert Snarr, Adult Project Manager
Utah Division of Substance Abuse & Mental Health
(801) 538-4080 Office
(801) 647-5756 Cell
(801) 243-6904 Personal Cell

If neither Doug nor Robert is available, then contact:

Brent Kelsey, Assistant Director – Substance Use
Utah Division of Substance Abuse & Mental Health
(801) 538-4305 Office
(801) 487-0139 Home
(801) 540-5242 Cell

Jeremy Christensen, Assistant – Adult Mental Health
Utah Division of Substance Abuse & Mental Health
(801) 538-4390 Office
(801) 419-3192 Cell

AND

Dallas Earnshaw, Superintendent
Utah State Hospital (USH)
(Dallas will inform USH Staff)
(801) 344-4290 Office
(801) 361-2926 Cell
(801) 489-0710 Home

In the event that no one is available, begin contacts with first person available as follows:

Ruth Wilson, Assistant Director Children’s Behavioral Health
(801) 538-4032 Office
(801) 989-7217 Cell

Heather Rydalch
Contracts Analyst
(801) 538-4319 Office
(801) 688-9217 Cell

Jeff Marrott
Training Manager
(801) 538-4410 Office
(801) 631-6122 Cell

WHO WILL THEN BE RESPONSIBLE FOR CONTACTING DSAMH’s Supervisors who will be responsible to contact their staff (see attached chart):
### Adult Consumer Satisfaction Survey 2016 combined MH and SA Clients

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River Health Dept.</td>
<td>671</td>
<td>147</td>
<td>80</td>
<td>9.2%</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Bear River Mental Health</td>
<td>1,719</td>
<td>458</td>
<td>522</td>
<td>30.4%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Central Utah</td>
<td>996</td>
<td>337</td>
<td>249</td>
<td>25.0%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Davis Behavioral</td>
<td>3,375</td>
<td>919</td>
<td>435</td>
<td>12.9%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Four Corners</td>
<td>1,319</td>
<td>289</td>
<td>253</td>
<td>19.2%</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Northeastern</td>
<td>1,712</td>
<td>437</td>
<td>482</td>
<td>28.2%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>14,879</td>
<td>2,305</td>
<td>3,263</td>
<td>15.2%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>San Juan</td>
<td>430</td>
<td>110</td>
<td>82</td>
<td>19.1%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Southwest</td>
<td>1,981</td>
<td>250</td>
<td>280</td>
<td>14.1%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Summit Co.</td>
<td>483</td>
<td>42</td>
<td>161</td>
<td>33.3%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Tooele Co.</td>
<td>1,222</td>
<td>26</td>
<td>146</td>
<td>12.2%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Utah Co. - Wasatch Mental Health</td>
<td>5,219</td>
<td>1,008</td>
<td>576</td>
<td>11.0%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Utah County Substance Abuse</td>
<td>908</td>
<td>303</td>
<td>205</td>
<td>22.6%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Wasatch Co.</td>
<td>431</td>
<td>94</td>
<td>51</td>
<td>11.8%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Weber</td>
<td>3,839</td>
<td>808</td>
<td>819</td>
<td>21.3%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>State</td>
<td>38,586</td>
<td>7,528</td>
<td>6,607</td>
<td>17.1%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td><strong>National (2015)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
</tbody>
</table>

### Adult Consumer Satisfaction Survey 2016 MH Clients

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River Mental Health</td>
<td>1,719</td>
<td>458</td>
<td>522</td>
<td>30.4%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Central Utah</td>
<td>681</td>
<td>268</td>
<td>217</td>
<td>31.9%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Davis Behavioral</td>
<td>2,624</td>
<td>693</td>
<td>306</td>
<td>11.3%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Four Corners</td>
<td>937</td>
<td>188</td>
<td>170</td>
<td>18.1%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Northeastern</td>
<td>1,445</td>
<td>337</td>
<td>363</td>
<td>25.1%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>9,268</td>
<td>1,342</td>
<td>832</td>
<td>11.0%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>San Juan</td>
<td>389</td>
<td>87</td>
<td>72</td>
<td>18.9%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Southwest</td>
<td>1,482</td>
<td>162</td>
<td>192</td>
<td>13.0%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Summit Co.</td>
<td>238</td>
<td>17</td>
<td>103</td>
<td>43.3%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Tooele Co.</td>
<td>947</td>
<td>10</td>
<td>115</td>
<td>12.1%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Utah Co. - Wasatch Mental Health</td>
<td>5,218</td>
<td>1,008</td>
<td>576</td>
<td>11.0%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Wasatch Co.</td>
<td>389</td>
<td>61</td>
<td>27</td>
<td>6.3%</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Weber</td>
<td>2,971</td>
<td>557</td>
<td>548</td>
<td>18.4%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>State</td>
<td>27,830</td>
<td>5,188</td>
<td>4,041</td>
<td>14.5%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td><strong>National (2015)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
</tbody>
</table>

### Adult Consumer Satisfaction Survey 2016 SA Clients

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River Health Dept.</td>
<td>671</td>
<td>147</td>
<td>80</td>
<td>9.2%</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Central Utah</td>
<td>996</td>
<td>337</td>
<td>249</td>
<td>25.0%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Davis Behavioral</td>
<td>3,375</td>
<td>919</td>
<td>435</td>
<td>12.9%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Four Corners</td>
<td>1,319</td>
<td>289</td>
<td>253</td>
<td>19.2%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Northeastern</td>
<td>1,712</td>
<td>437</td>
<td>482</td>
<td>28.2%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>14,879</td>
<td>2,305</td>
<td>3,263</td>
<td>15.2%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>San Juan</td>
<td>430</td>
<td>110</td>
<td>82</td>
<td>19.1%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Southwest</td>
<td>1,981</td>
<td>250</td>
<td>280</td>
<td>14.1%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Summit Co.</td>
<td>483</td>
<td>42</td>
<td>161</td>
<td>33.3%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Tooele Co.</td>
<td>1,222</td>
<td>26</td>
<td>146</td>
<td>12.2%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Utah Co. - Wasatch Mental Health</td>
<td>5,219</td>
<td>1,008</td>
<td>576</td>
<td>11.0%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>Wasatch Co.</td>
<td>389</td>
<td>61</td>
<td>27</td>
<td>6.3%</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Weber</td>
<td>2,971</td>
<td>557</td>
<td>548</td>
<td>18.4%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td>State</td>
<td>38,586</td>
<td>7,528</td>
<td>6,607</td>
<td>17.1%</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
<tr>
<td><strong>National (2015)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>↑</td>
<td>*</td>
</tr>
</tbody>
</table>
### Youth Satisfaction Survey 2016 (Youth Ages 12-17)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Number Served FY2015</th>
<th>Number of Forms Returned 2015</th>
<th>Number of Forms Returned 2016</th>
<th>Percent of Clients Served FY2015</th>
<th>Percent of Clients Served FY2016</th>
<th>General Satisfaction</th>
<th>Good Service Access</th>
<th>Cultural Sensitivity</th>
<th>Participation in Treatment Planning</th>
<th>Positive Service Outcomes</th>
<th>Wellness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River Health Dept.</td>
<td>77</td>
<td>20</td>
<td>9</td>
<td><strong>11.7%</strong></td>
<td><strong>11.7%</strong></td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Bear River Mental Health</td>
<td>574</td>
<td>112</td>
<td>196</td>
<td>34.1%</td>
<td>34.1%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Central Utah</td>
<td>272</td>
<td>100</td>
<td>66</td>
<td>24.3%</td>
<td>24.3%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Davis Behavioral</td>
<td>1,020</td>
<td>44</td>
<td>151</td>
<td>14.8%</td>
<td>14.8%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Four Comers</td>
<td>257</td>
<td>5</td>
<td>45</td>
<td>17.5%</td>
<td>17.5%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↓</td>
</tr>
<tr>
<td>Northeastern</td>
<td>454</td>
<td>90</td>
<td>137</td>
<td>30.2%</td>
<td>30.2%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↓</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>3,178</td>
<td>670</td>
<td>616</td>
<td>19.4%</td>
<td>19.4%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>San Juan</td>
<td>141</td>
<td>41</td>
<td>30</td>
<td>14.2%</td>
<td>14.2%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Southwest</td>
<td>884</td>
<td>101</td>
<td>123</td>
<td>13.9%</td>
<td>13.9%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Summit Co.</td>
<td>116</td>
<td>5</td>
<td>41</td>
<td>35.3%</td>
<td>35.3%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↓</td>
</tr>
<tr>
<td>Tooele Co.</td>
<td>343</td>
<td>0</td>
<td>27</td>
<td>7.9%</td>
<td>7.9%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↓</td>
</tr>
<tr>
<td>Utah Co. - Wastach Mental Health</td>
<td>1,961</td>
<td>435</td>
<td>446</td>
<td>22.7%</td>
<td>22.7%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Utah County Substance Abuse</td>
<td>44</td>
<td>8</td>
<td>6</td>
<td><strong>13.6%</strong></td>
<td><strong>13.6%</strong></td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Wastach Co.</td>
<td>82</td>
<td>30</td>
<td>21</td>
<td>25.6%</td>
<td>25.6%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Weber</td>
<td>877</td>
<td>194</td>
<td>234</td>
<td>26.7%</td>
<td>26.7%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>State</td>
<td>10,106</td>
<td>1,858</td>
<td>2,138</td>
<td>21.2%</td>
<td>21.2%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>National (2015)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>86</td>
<td>85</td>
<td>93</td>
<td>87</td>
<td>87</td>
<td>70</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Insufficient sample rate.

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

Green = Percentage meets or exceeds National Average for MHSSIP (except Wellness) or Statewide Average for the YSS and YSS-F Surveys.

Yellow = Percentage between 75% of the National Average and the National Average for MHSSIP (except Wellness) or 75% of the Statewide Average and the Statewide Average on YSS and YSS-F.

Red = Percentage below 75% of the National Average for the MHSSIP (except Wellness) or of the Statewide Average for the YSS and YSS-F.

↑ ↓ Indicates change in color from prior year.  No change from prior year.

Chart results are based on round numbers.

Client served counts for each provider are unduplicated for that provider and across substance abuse and mental health combined.

State client served count is unduplicated across substance abuse and mental health combined and is not a sum of the provider client counts.

---

### Youth Satisfaction Survey (Family) 2016

| Agency                                | Number Served FY2015 | Number of Forms Returned 2015 | Number of Forms Returned 2016 | Percent of Clients Served FY2015 | Percent of Clients Served FY2016 | General Satisfaction | Good Service Access | Cultural Sensitivity | Participation in Treatment Planning | Positive Service Outcomes | Social Connec-
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River Health Dept.</td>
<td>77</td>
<td>12</td>
<td>7</td>
<td>9.1%</td>
<td>9.1%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Bear River Mental Health</td>
<td>1,419</td>
<td>200</td>
<td>241</td>
<td>17.0%</td>
<td>17.0%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Central Utah</td>
<td>537</td>
<td>147</td>
<td>104</td>
<td>19.4%</td>
<td>19.4%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Davis Behavioral</td>
<td>2,015</td>
<td>490</td>
<td>337</td>
<td>16.7%</td>
<td>16.7%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Four Comers</td>
<td>532</td>
<td>10</td>
<td>34</td>
<td>7.9%</td>
<td>7.9%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Northeastern</td>
<td>847</td>
<td>120</td>
<td>140</td>
<td>16.5%</td>
<td>16.5%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>6,638</td>
<td>625</td>
<td>728</td>
<td>11.0%</td>
<td>11.0%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>San Juan</td>
<td>197</td>
<td>38</td>
<td>53</td>
<td>26.9%</td>
<td>26.9%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Southwest</td>
<td>1,790</td>
<td>197</td>
<td>251</td>
<td>11.9%</td>
<td>11.9%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Summit Co.</td>
<td>171</td>
<td>12</td>
<td>43</td>
<td>25.1%</td>
<td>25.1%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Tooele Co.</td>
<td>665</td>
<td>0</td>
<td>38</td>
<td>5.7%</td>
<td>5.7%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Utah Co. - Wastach Mental Health</td>
<td>3,764</td>
<td>549</td>
<td>771</td>
<td>20.5%</td>
<td>20.5%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Utah Co. Substance Abuse</td>
<td>44</td>
<td>3</td>
<td>28</td>
<td>7.9%</td>
<td>7.9%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Wastach Co.</td>
<td>163</td>
<td>28</td>
<td>17</td>
<td><strong>18.4%</strong></td>
<td><strong>18.4%</strong></td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>Weber</td>
<td>1,841</td>
<td>251</td>
<td>251</td>
<td>13.6%</td>
<td>13.6%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>State</td>
<td>20,370</td>
<td>2,682</td>
<td>2,968</td>
<td>14.5%</td>
<td>14.5%</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
<td>↓</td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td>National (2015)</td>
<td></td>
<td></td>
<td></td>
<td>86</td>
<td>85</td>
<td>93</td>
<td>87</td>
<td>87</td>
<td>70</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Insufficient sample rate.

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

Green = Percentage meets or exceeds National Average for MHSSIP (except Wellness) or Statewide Average for the YSS and YSS-F Surveys.

Yellow = Percentage between 75% of the National Average and the National Average for MHSSIP (except Wellness) or 75% of the Statewide Average and the Statewide Average on YSS and YSS-F.

Red = Percentage below 75% of the National Average for the MHSSIP (except Wellness) or of the Statewide Average for the YSS and YSS-F.

↑ ↓ Indicates change in color from prior year.  No change from prior year.

Chart results are based on round numbers.

Client served counts for each provider are unduplicated for that provider and across substance abuse and mental health combined.

State client served count is unduplicated across substance abuse and mental health combined and is not a sum of the provider client counts.
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Near River</td>
<td>231</td>
<td>261</td>
<td>484</td>
<td>536</td>
<td>971</td>
<td>1,049</td>
<td>142</td>
<td>165</td>
</tr>
<tr>
<td>Central Utah</td>
<td>1,028</td>
<td>1,041</td>
<td>1,009</td>
<td>1,072</td>
<td>555/30/15/0</td>
<td>55/33/16/0</td>
<td>630</td>
<td>662</td>
</tr>
<tr>
<td>Four Corners</td>
<td>517</td>
<td>610</td>
<td>535</td>
<td>561</td>
<td>516/33/15/10</td>
<td>52/52/10/12</td>
<td>114</td>
<td>124</td>
</tr>
<tr>
<td>Northeastern</td>
<td>282</td>
<td>291</td>
<td>397</td>
<td>458</td>
<td>516/55/50/10</td>
<td>88/14/0/0</td>
<td>163</td>
<td>172</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>7,295</td>
<td>8,174</td>
<td>7,463</td>
<td>8,278</td>
<td>3,915/20/16/0</td>
<td>2,710/16/30</td>
<td>925</td>
<td>983</td>
</tr>
<tr>
<td>San Juan County</td>
<td>81</td>
<td>92</td>
<td>90</td>
<td>76</td>
<td>95/50/4/0</td>
<td>100/0/0/0</td>
<td>72</td>
<td>100</td>
</tr>
<tr>
<td>Southwest Center</td>
<td>613</td>
<td>654</td>
<td>639</td>
<td>619</td>
<td>436/31/20/0</td>
<td>44/35/21/0</td>
<td>372</td>
<td>257</td>
</tr>
<tr>
<td>Summit County</td>
<td>167</td>
<td>177</td>
<td>317</td>
<td>360</td>
<td>78/80/0/10</td>
<td>72/12/0/0</td>
<td>163</td>
<td>151</td>
</tr>
<tr>
<td>Tooele County</td>
<td>382</td>
<td>387</td>
<td>478</td>
<td>476</td>
<td>173/37/0/0</td>
<td>37/73/1/0</td>
<td>159</td>
<td>148</td>
</tr>
<tr>
<td>Utah County</td>
<td>1,271</td>
<td>1,301</td>
<td>1,406</td>
<td>1,412</td>
<td>161/88/15/10</td>
<td>100/0/0/0</td>
<td>109</td>
<td>100</td>
</tr>
<tr>
<td>Weber Human Services</td>
<td>1,363</td>
<td>1,372</td>
<td>1,354</td>
<td>1,370</td>
<td>303/12/5/0</td>
<td>31/81/4/0</td>
<td>109</td>
<td>100</td>
</tr>
<tr>
<td>State Average/Total</td>
<td>14,530</td>
<td>15,111</td>
<td>15,049</td>
<td>14,722</td>
<td>4,462/10/21/0</td>
<td>4,962/10/31</td>
<td>1,149</td>
<td>1,149</td>
</tr>
<tr>
<td>State Urban Average/Total/Non - White</td>
<td>12,305</td>
<td>12,588</td>
<td>10,922</td>
<td>10,038</td>
<td>43/21/11/25</td>
<td>42/22/11/25</td>
<td>5,797</td>
<td>4,969</td>
</tr>
<tr>
<td>State Rural Average/Total/Non - White</td>
<td>2,575</td>
<td>2,523</td>
<td>3,519</td>
<td>3,052</td>
<td>73/21/6/20</td>
<td>74/21/6/20</td>
<td>1,867</td>
<td>2,016</td>
</tr>
<tr>
<td>National Average/Benchmark</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Outcome Measures

<table>
<thead>
<tr>
<th></th>
<th>Increased Alcohol Abstinence (Percent Decrease)</th>
<th>Increased Drug Abstinence (Percent Decrease)</th>
<th>Increased Drug Abstinence (Percent Increase in those reporting other drugs)</th>
<th>Increased Stable Housing (Percent Increase in homeless clients admission to discharge)</th>
<th>Increased Employment (Percent Increase in those employed)</th>
<th>Decreased Use and Completing Modality (Percent Decrease)</th>
<th>Social Support Recovery (Percent Increase in those completing treatment)</th>
<th>Decreased Tobacco Use (Percent decrease in number of clients using tobacco)</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2015</td>
<td>158.6%</td>
<td>146.1%</td>
<td>316.7%</td>
<td>307.1%</td>
<td>4.9%</td>
<td>3.3%</td>
<td>18.3%</td>
<td>19.8%</td>
</tr>
<tr>
<td>FY2016</td>
<td>155.8%</td>
<td>145.6%</td>
<td>316.3%</td>
<td>307.6%</td>
<td>4.6%</td>
<td>3.3%</td>
<td>18.7%</td>
<td>19.9%</td>
</tr>
</tbody>
</table>

For more information, see the FY2016 Utah Substance Abuse Treatment Outcomes Measures Scorecard for all clients.
### FY 2016 Mental Health Scorecard for Adults

**November 2, 2016**

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Number of Clients Served</th>
<th>Estimated Need of Treatment (SMI)</th>
<th># in Need of Treatment SMI</th>
<th>% in Need of Treatment SMI</th>
<th># SMI Need Served</th>
<th>% SMI Need Served</th>
<th># SMI Served</th>
<th>Unfunded</th>
<th>Supported Housing</th>
<th>Jail Services</th>
<th>Supported Employment</th>
<th>% Employed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rural Counties</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bear River</td>
<td>1,802</td>
<td>1,871</td>
<td>6.17%</td>
<td>7,435</td>
<td>20.5%</td>
<td>1,490</td>
<td>1,523</td>
<td>37</td>
<td>22</td>
<td>205</td>
<td>240</td>
<td>9.9%</td>
</tr>
<tr>
<td>Central</td>
<td>682</td>
<td>684</td>
<td>5.09%</td>
<td>2,776</td>
<td>21.7%</td>
<td>605</td>
<td>602</td>
<td>121</td>
<td>114</td>
<td>24</td>
<td>29</td>
<td>6.6%</td>
</tr>
<tr>
<td>Four Corners</td>
<td>985</td>
<td>1,030</td>
<td>5.09%</td>
<td>1,509</td>
<td>47.8%</td>
<td>813</td>
<td>721</td>
<td>430</td>
<td>408</td>
<td>11</td>
<td>26</td>
<td>75%</td>
</tr>
<tr>
<td>Northern Pan</td>
<td>1,483</td>
<td>1,617</td>
<td>6.17%</td>
<td>2,437</td>
<td>14.0%</td>
<td>339</td>
<td>364</td>
<td>514</td>
<td>251</td>
<td>28</td>
<td>20</td>
<td>61%</td>
</tr>
<tr>
<td>San Juan</td>
<td>393</td>
<td>403</td>
<td>5.09%</td>
<td>545</td>
<td>14.9%</td>
<td>92</td>
<td>81</td>
<td>89</td>
<td>80</td>
<td>1</td>
<td>2</td>
<td>12%</td>
</tr>
<tr>
<td>Southwest</td>
<td>1,482</td>
<td>1,691</td>
<td>5.09%</td>
<td>8,169</td>
<td>11.4%</td>
<td>903</td>
<td>932</td>
<td>251</td>
<td>321</td>
<td>39</td>
<td>32</td>
<td>48%</td>
</tr>
<tr>
<td>Summit Co.</td>
<td>238</td>
<td>241</td>
<td>1.67%</td>
<td>1,808</td>
<td>6.9%</td>
<td>89</td>
<td>62</td>
<td>14</td>
<td>186</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Tooele Co.</td>
<td>947</td>
<td>981</td>
<td>6.17%</td>
<td>2,563</td>
<td>38.0%</td>
<td>600</td>
<td>624</td>
<td>7</td>
<td>376</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Washoe Co.</td>
<td>391</td>
<td>332</td>
<td>6.17%</td>
<td>1,214</td>
<td>15.3%</td>
<td>185</td>
<td>193</td>
<td>90</td>
<td>62</td>
<td>0</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>8,260</td>
<td>8,874</td>
<td>5.62%</td>
<td>28,450</td>
<td>1,703</td>
<td>1,561</td>
<td>1,546</td>
<td>7,045</td>
<td>2,132</td>
<td>358</td>
<td>595</td>
<td>81%</td>
</tr>
<tr>
<td><strong>Urban Counties</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Davis</td>
<td>3,624</td>
<td>3,925</td>
<td>4.87%</td>
<td>10,958</td>
<td>22.0%</td>
<td>2,120</td>
<td>2,411</td>
<td>1,738</td>
<td>1,717</td>
<td>82</td>
<td>100</td>
<td>948%</td>
</tr>
<tr>
<td>Salt Lake Co.</td>
<td>9,268</td>
<td>10,446</td>
<td>4.99%</td>
<td>39,717</td>
<td>15.4%</td>
<td>6,350</td>
<td>6,102</td>
<td>1,408</td>
<td>2,644</td>
<td>154</td>
<td>129</td>
<td>15%</td>
</tr>
<tr>
<td>Utah Co. - Washat MTH</td>
<td>6,766</td>
<td>6,387</td>
<td>5.28%</td>
<td>19,866</td>
<td>18.8%</td>
<td>3,409</td>
<td>3,728</td>
<td>510</td>
<td>795</td>
<td>185</td>
<td>163</td>
<td>1,807</td>
</tr>
<tr>
<td>Weber</td>
<td>4,276</td>
<td>4,343</td>
<td>4.73%</td>
<td>8,536</td>
<td>24.3%</td>
<td>1,909</td>
<td>2,073</td>
<td>666</td>
<td>420</td>
<td>10</td>
<td>45</td>
<td>42%</td>
</tr>
<tr>
<td>Total</td>
<td>27,877</td>
<td>28,907</td>
<td>5.09%</td>
<td>56,190</td>
<td>38.3%</td>
<td>13,565</td>
<td>14,184</td>
<td>4,158</td>
<td>5,690</td>
<td>463</td>
<td>474</td>
<td>43,432</td>
</tr>
<tr>
<td><strong>State</strong></td>
<td>81,431</td>
<td>32,963</td>
<td>5.16%</td>
<td>107,505</td>
<td>17.9%</td>
<td>18,666</td>
<td>19,200</td>
<td>6,541</td>
<td>7,517</td>
<td>591</td>
<td>606</td>
<td>4,751</td>
</tr>
</tbody>
</table>

**Notes for page 2:**

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

*Estimate of Need—Substance Abuse and Mental Health Services Administration. (2014). Substate Estimates of Substance Use and Mental Disorders from the 2010-2012 National Surveys on Drug Use and Health: Results and Detailed Tables. Rockville, MD http://media.samhsa.gov/data/NSDUH/substate2k12/AgeGroupTabs/NSDUHsubstateAgeGroupTabs2012.htm

**Utilization:** Percent of all clients receiving services. Total Outpatient number of clients served is an unduplicated count by provider of any client receiving an outpatient service.

**Median Length of Stay:** Median length of time for all clients who received that service. Median is the middle value in a list of numbers.

**Average Length of Stay:** Average length of time for all clients who received that service. Average or mean is the total number of time for that service divided by the number of clients receiving that service.

**Inpatient includes MHE service code 170**

**Residential includes MHE service codes 171 and 173**

**Medication Management includes MHE service codes 61**

**Psychosocial Rehabilitation includes MHE service codes 70, 80, 100, and 160**

**Case Management includes MHE service code 120 and 130**

**Respite includes MHE service code 150**

**Assessment includes MHE service code 22 Diagnosis and Assessment**

**Testing is not shown on the scorecard but is included in Total Outpatient**

**Treatment Therapy includes MHE service code 30 Individual Therapy, 31 Electroconvulsive Therapy, 35 Individual Behavior Management, 40 Family Therapy, and 50 Group Therapy**

**Total Outpatient includes all MHE service codes except those reported on the same day as a bed day (170 Inpatient, 171 Residential, and 173 Residential Support)**

**Emergency includes all service codes with emergency indicator set to “yes.”**

**Peer Support services includes MHE service code 130 Peer Support.**

**State Hospital data used to calculate utilization, median and average number of days in the state hospital during the fiscal year only.**

**Data for services provided in Jail are not included.**
## FY 2016 Mental Health Scorecard for Adults Continued

### Local Authority

#### Total Outpatient Services

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>State Hospital</th>
<th>Community Inpatient</th>
<th>Residential</th>
<th>Medication Management</th>
<th>Psychosocial Rehabilitation</th>
<th>Case Management</th>
<th>Respite</th>
<th>Assessment</th>
<th>Treatment</th>
<th>Total Outpatient</th>
<th>Emergency</th>
<th>Peer Support</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River</td>
<td>10</td>
<td>83.6%</td>
<td>45</td>
<td>25.5%</td>
<td>795</td>
<td>44.3%</td>
<td>255</td>
<td>12.2%</td>
<td>636</td>
<td>35.5%</td>
<td>1</td>
<td>0.1%</td>
<td>961</td>
</tr>
<tr>
<td>Central</td>
<td>9</td>
<td>1.3%</td>
<td>0</td>
<td>0%</td>
<td>310</td>
<td>45.5%</td>
<td>99</td>
<td>14.5%</td>
<td>98</td>
<td>16.0%</td>
<td>0</td>
<td>0%</td>
<td>329</td>
</tr>
<tr>
<td>Four Corners</td>
<td>8</td>
<td>0.9%</td>
<td>38</td>
<td>4.2%</td>
<td>358</td>
<td>39.7%</td>
<td>128</td>
<td>14.2%</td>
<td>441</td>
<td>48.1%</td>
<td>1</td>
<td>0.1%</td>
<td>331</td>
</tr>
<tr>
<td>Northeastern</td>
<td>9</td>
<td>0.8%</td>
<td>22</td>
<td>2.1%</td>
<td>687</td>
<td>42.1%</td>
<td>197</td>
<td>10.3%</td>
<td>107</td>
<td>18.4%</td>
<td>0</td>
<td>0%</td>
<td>840</td>
</tr>
<tr>
<td>San Juan</td>
<td>1</td>
<td>0.3%</td>
<td>4</td>
<td>1.0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>17</td>
<td>53.3%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
</tr>
<tr>
<td>Southwest</td>
<td>23</td>
<td>1.4%</td>
<td>81</td>
<td>40%</td>
<td>531</td>
<td>249%</td>
<td>159</td>
<td>23%</td>
<td>388</td>
<td>48%</td>
<td>1</td>
<td>0.1%</td>
<td>905</td>
</tr>
<tr>
<td>Summit Co.</td>
<td>2</td>
<td>0.8%</td>
<td>77</td>
<td>11%</td>
<td>897</td>
<td>249%</td>
<td>573</td>
<td>24%</td>
<td>254</td>
<td>23%</td>
<td>1</td>
<td>0.1%</td>
<td>260</td>
</tr>
<tr>
<td>Tooele Co.</td>
<td>5</td>
<td>0.6%</td>
<td>25</td>
<td>2.8%</td>
<td>460</td>
<td>51.4%</td>
<td>96</td>
<td>16%</td>
<td>147</td>
<td>24%</td>
<td>0</td>
<td>0.1%</td>
<td>438</td>
</tr>
<tr>
<td>Wasatch Co. - Heber</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>160</td>
<td>50%</td>
<td>48</td>
<td>14%</td>
<td>127</td>
<td>38%</td>
<td>0</td>
<td>0%</td>
<td>160</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>0.8%</td>
<td>268</td>
<td>31%</td>
<td>152</td>
<td>1.5%</td>
<td>125</td>
<td>12%</td>
<td>203</td>
<td>23%</td>
<td>4</td>
<td>0.1%</td>
<td>422</td>
</tr>
</tbody>
</table>

#### Time in Service for Mandated Services (Days or hours for only clients receiving service)

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>State Hospital</th>
<th>Community Inpatient</th>
<th>Residential</th>
<th>Medication Management</th>
<th>Psychosocial Rehabilitation</th>
<th>Case Management</th>
<th>Respite</th>
<th>Assessment</th>
<th>Treatment</th>
<th>Total Outpatient</th>
<th>Emergency</th>
<th>Peer Support</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River</td>
<td>184.00</td>
<td>384.99</td>
<td>4.00</td>
<td>6.81</td>
<td>22.00</td>
<td>57.67</td>
<td>2.75</td>
<td>3.49</td>
<td>19.21</td>
<td>61.57</td>
<td>1.84</td>
<td>5.10</td>
<td>2.92</td>
</tr>
<tr>
<td>Central</td>
<td>193.00</td>
<td>246.11</td>
<td>0.00</td>
<td>36.00</td>
<td>28.25</td>
<td>63.87</td>
<td>3.33</td>
<td>5.00</td>
<td>99.86</td>
<td>216.74</td>
<td>4.43</td>
<td>7.32</td>
<td>6.00</td>
</tr>
<tr>
<td>Four Corners</td>
<td>85.50</td>
<td>145.75</td>
<td>13.56</td>
<td>21.71</td>
<td>31.00</td>
<td>83.85</td>
<td>1.67</td>
<td>3.33</td>
<td>94.62</td>
<td>210.75</td>
<td>1.79</td>
<td>8.60</td>
<td>2.16</td>
</tr>
<tr>
<td>Northeastern</td>
<td>176.50</td>
<td>134.00</td>
<td>12.35</td>
<td>17.00</td>
<td>32.20</td>
<td>61.94</td>
<td>1.70</td>
<td>3.70</td>
<td>17.27</td>
<td>46.09</td>
<td>1.83</td>
<td>4.85</td>
<td>1.50</td>
</tr>
<tr>
<td>San Juan</td>
<td>835.00</td>
<td>835.00</td>
<td>6.25</td>
<td>7.25</td>
<td>0.00</td>
<td>91.00</td>
<td>1.91</td>
<td>3.01</td>
<td>59.17</td>
<td>121.32</td>
<td>12.18</td>
<td>16.94</td>
<td>0.00</td>
</tr>
<tr>
<td>Southwest</td>
<td>148.00</td>
<td>277.96</td>
<td>5.00</td>
<td>6.70</td>
<td>54.00</td>
<td>73.95</td>
<td>1.83</td>
<td>2.40</td>
<td>5.36</td>
<td>46.26</td>
<td>4.26</td>
<td>23.38</td>
<td>0.66</td>
</tr>
<tr>
<td>Tooele Co.</td>
<td>143.00</td>
<td>189.50</td>
<td>10.00</td>
<td>9.84</td>
<td>19.00</td>
<td>62.31</td>
<td>1.75</td>
<td>2.13</td>
<td>46.75</td>
<td>275.45</td>
<td>3.17</td>
<td>7.94</td>
<td>0.00</td>
</tr>
<tr>
<td>Wasatch Co. - Heber</td>
<td>0.00</td>
<td>0.00</td>
<td>6.00</td>
<td>63.00</td>
<td>22.50</td>
<td>33.23</td>
<td>2.25</td>
<td>2.38</td>
<td>22.50</td>
<td>33.23</td>
<td>1.25</td>
<td>0.56</td>
<td>0.00</td>
</tr>
<tr>
<td>Total</td>
<td>169.50</td>
<td>161.50</td>
<td>6.00</td>
<td>9.71</td>
<td>30.00</td>
<td>72.71</td>
<td>1.82</td>
<td>2.85</td>
<td>23.77</td>
<td>108.56</td>
<td>2.33</td>
<td>1.13</td>
<td>1.58</td>
</tr>
</tbody>
</table>

#### Urban Counties

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>State Hospital</th>
<th>Community Inpatient</th>
<th>Residential</th>
<th>Medication Management</th>
<th>Psychosocial Rehabilitation</th>
<th>Case Management</th>
<th>Respite</th>
<th>Assessment</th>
<th>Treatment</th>
<th>Total Outpatient</th>
<th>Emergency</th>
<th>Peer Support</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davis</td>
<td>528.00</td>
<td>1036.42</td>
<td>4.00</td>
<td>5.95</td>
<td>15.00</td>
<td>23.89</td>
<td>1.75</td>
<td>2.68</td>
<td>8.59</td>
<td>84.41</td>
<td>2.50</td>
<td>13.08</td>
<td>30.00</td>
</tr>
<tr>
<td>Salt Lake Co.</td>
<td>503.00</td>
<td>1053.29</td>
<td>7.00</td>
<td>13.00</td>
<td>101.88</td>
<td>2.00</td>
<td>3.15</td>
<td>6.00</td>
<td>31.80</td>
<td>275.73</td>
<td>3.75</td>
<td>1.97</td>
<td>5.92</td>
</tr>
<tr>
<td>Utah Co. - Wasatch MH</td>
<td>410.00</td>
<td>912.41</td>
<td>6.00</td>
<td>9.91</td>
<td>70.00</td>
<td>131.49</td>
<td>2.00</td>
<td>3.52</td>
<td>9.00</td>
<td>168.69</td>
<td>1.75</td>
<td>6.26</td>
<td>5.00</td>
</tr>
<tr>
<td>Weber</td>
<td>361.00</td>
<td>694.04</td>
<td>5.00</td>
<td>9.48</td>
<td>12.50</td>
<td>21.04</td>
<td>2.25</td>
<td>4.29</td>
<td>9.00</td>
<td>58.46</td>
<td>6.50</td>
<td>19.20</td>
<td>2.00</td>
</tr>
<tr>
<td>Total</td>
<td>443.00</td>
<td>691.36</td>
<td>10.26</td>
<td>20.36</td>
<td>17.95</td>
<td>2.00</td>
<td>3.30</td>
<td>7.25</td>
<td>56.81</td>
<td>92.90</td>
<td>2.25</td>
<td>10.90</td>
<td>5.00</td>
</tr>
</tbody>
</table>
### FY 2016 Mental Health Scorecard for Adults

**November 2, 2016**

#### OQ Measures

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Stable</th>
<th>Positive Outcomes</th>
<th>Positive Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Episodes</td>
<td>% of Episodes</td>
<td>% of Episodes</td>
<td>% of Episodes</td>
</tr>
<tr>
<td>Improved</td>
<td>In Recovery*</td>
<td>Total</td>
<td>Deteriorated</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Discharged (Subset of Treatment)</th>
<th>Stable</th>
<th>Positive Outcomes</th>
<th>Positive Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Episodes</td>
<td>% of Episodes</td>
<td>% of Episodes</td>
<td>% of Episodes</td>
</tr>
<tr>
<td>Improved</td>
<td>In Recovery*</td>
<td>Total</td>
<td>Not Recovered</td>
</tr>
</tbody>
</table>

#### Local Authority

<table>
<thead>
<tr>
<th>Rural Counties</th>
<th>Valid OQ Clients Served FY2016</th>
<th>Unduplicated Number of Clients Participating</th>
<th>Percent Unduplicated Clients Participating</th>
<th>Percent of Clients Matching to SAMHIS **</th>
<th>Positive Outcomes</th>
<th>Discharged (Subset of Treatment)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River</td>
<td>1,327</td>
<td>1,071</td>
<td>80.7%</td>
<td>99.1</td>
<td>42.98</td>
<td>19.65</td>
</tr>
<tr>
<td>Central</td>
<td>594</td>
<td>466</td>
<td>100.0%</td>
<td>94.0</td>
<td>42.27</td>
<td>20.04</td>
</tr>
<tr>
<td>Four Corners</td>
<td>785</td>
<td>527</td>
<td>67.1%</td>
<td>84.4</td>
<td>50.89</td>
<td>13.23</td>
</tr>
<tr>
<td>Northeastern</td>
<td>1,370</td>
<td>1,000</td>
<td>73.0%</td>
<td>97.5</td>
<td>44.94</td>
<td>15.52</td>
</tr>
<tr>
<td>San Juan</td>
<td>351</td>
<td>99</td>
<td>26.2%</td>
<td>97.1</td>
<td>47.37</td>
<td>14.74</td>
</tr>
<tr>
<td>Southwest</td>
<td>1,281</td>
<td>537</td>
<td>41.5%</td>
<td>96.9</td>
<td>41.98</td>
<td>20.75</td>
</tr>
<tr>
<td>Summit Co.</td>
<td>321</td>
<td>154</td>
<td>48.0%</td>
<td>91.6</td>
<td>50.46</td>
<td>15.60</td>
</tr>
<tr>
<td>Tooele Co.</td>
<td>816</td>
<td>323</td>
<td>39.6%</td>
<td>94.0</td>
<td>40.40</td>
<td>22.00</td>
</tr>
<tr>
<td>Wasatch Co. - Heber</td>
<td>288</td>
<td>262</td>
<td>91.0%</td>
<td>96.6</td>
<td>36.02</td>
<td>19.35</td>
</tr>
<tr>
<td>Total</td>
<td>7,118</td>
<td>4,639</td>
<td>65.2%</td>
<td>95.0</td>
<td>43.82</td>
<td>18.21</td>
</tr>
</tbody>
</table>

#### Urban Counties

| Davis         | 2,499                          | 1,915                                        | 76.6%                                     | 95.5                                       | 49.38              | 15.69                            | 18.60            | 83.67                           | 16.33              | 50.37                          | 17.21              | 18.95                          | 86.53              | 13.47                          |
| Salt Lake Co. | 9,379                          | 3,344                                        | 35.7%                                     | 86.9                                       | 50.84              | 12.67                            | 19.10            | 82.60                           | 17.40              | 55.60                          | 11.20              | 18.24                          | 85.03              | 14.97                          |
| Utah Co. - Wasatch MH | 4,226                     | 2,894                                        | 68.5%                                     | 97.6                                       | 44.75              | 19.08                            | 19.92            | 83.74                           | 16.26              | 42.78                          | 19.77              | 22.37                          | 84.92              | 15.08                          |
| Weber         | 2,075                          | 1,559                                        | 74.2%                                     | 98.8                                       | 44.16              | 19.97                            | 22.29            | 86.43                           | 13.57              | 45.25                          | 19.61              | 22.28                          | 88.14              | 11.86                          |
| Total         | 18,040                         | 9,692                                        | 53.7%                                     | 92.7                                       | 47.78              | 16.21                            | 19.72            | 84.6                            | 15.38              | 49.50                          | 16.01              | 20.22                          | 86                 | 14.27                          |
| State         | 25,021                         | 14,331                                       | 57.3%                                     | 93.5                                       | 46.71              | 16.75                            | 20.95            | 84.40                           | 15.60              | 48.26                          | 16.45              | 21.18                          | 85.89              | 14.11                          |

**Red: Minimum requirements not met.**

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

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

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

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

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

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

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

Recovery: If a client’s score drops below the empirically derived cutoff between clinical scores and community normative scores and there has been * Clinically Significant change during the mental health treatment. The RCI is the amount by which a client’s total score must increase (deterioration) or decrease (improvement) from intake to be considered clinically significant. Changes in the total score that are less than the RCI are not statistically significant (i.e. no change). Outcomes are not calculated until there has been reliable change within a given instrument.

Outcomes; Improved, Stable, Recovered, and Deteriorated are calculated by episode.
### FY 2016 Mental Health Scorecard for Children and Youth (age 17 and younger)

#### November 2, 2016

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Number of Clients Served</th>
<th>Number of Clients Served (ages 5-17)</th>
<th>Estimated Need of Treatment for Children/Youth (ages 5-17)</th>
<th>% in Need of Treatment</th>
<th># SED Served</th>
<th>Unfunded</th>
<th>Youth Enrolled in School</th>
<th>Youth Employed</th>
<th>Justice Services</th>
<th>Family Resource Facilitators Peer Support Services</th>
<th>Clients Served in Wraparound Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rural Counties</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bear River</td>
<td>1,419</td>
<td>1,590</td>
<td>1,569</td>
<td>19.0%</td>
<td>926</td>
<td>981</td>
<td>298</td>
<td>312</td>
<td>1,230</td>
<td>1,397</td>
<td>16 20</td>
</tr>
<tr>
<td>Cache</td>
<td>500</td>
<td>525</td>
<td>500</td>
<td>12.6%</td>
<td>276</td>
<td>364</td>
<td>46</td>
<td>33</td>
<td>464</td>
<td>487</td>
<td>0 5 2 0 193 122 99 56</td>
</tr>
<tr>
<td>Four Corners</td>
<td>511</td>
<td>457</td>
<td>434</td>
<td>14.1%</td>
<td>436</td>
<td>360</td>
<td>177</td>
<td>122</td>
<td>415</td>
<td>415</td>
<td>7 11 2 5 47 17 28 15</td>
</tr>
<tr>
<td>Northern Wayne</td>
<td>3,546</td>
<td>2,976</td>
<td>2,063</td>
<td>21.6%</td>
<td>1,165</td>
<td>1,337</td>
<td>166</td>
<td>115</td>
<td>740</td>
<td>919</td>
<td>20 73 125 49 17 18 14 10</td>
</tr>
<tr>
<td>San Juan</td>
<td>184</td>
<td>208</td>
<td>192</td>
<td>9.9%</td>
<td>20</td>
<td>47</td>
<td>29</td>
<td>20</td>
<td>175</td>
<td>191</td>
<td>5 2 14 14 51 44 50 42</td>
</tr>
<tr>
<td>Southwest</td>
<td>1,731</td>
<td>1712</td>
<td>1,608</td>
<td>14.5%</td>
<td>1,087</td>
<td>1,052</td>
<td>190</td>
<td>123</td>
<td>1,590</td>
<td>1,563</td>
<td>25 19 1 1 240 195 56 68</td>
</tr>
<tr>
<td>Summit Co.</td>
<td>152</td>
<td>237</td>
<td>228</td>
<td>21.9%</td>
<td>74</td>
<td>72</td>
<td>12</td>
<td>103</td>
<td>141</td>
<td>224</td>
<td>25 21 14 16 86 24 19 13</td>
</tr>
<tr>
<td>Tooele Co.</td>
<td>636</td>
<td>525</td>
<td>489</td>
<td>17.3%</td>
<td>463</td>
<td>323</td>
<td>42</td>
<td>174</td>
<td>376</td>
<td>462</td>
<td>3 3 3 0 132 192 58 31</td>
</tr>
<tr>
<td>Wasatch Co.</td>
<td>227</td>
<td>172</td>
<td>175</td>
<td>25.2%</td>
<td>161</td>
<td>162</td>
<td>165</td>
<td>160</td>
<td>702</td>
<td>694</td>
<td>1 0 391 220 21 9</td>
</tr>
<tr>
<td>Total</td>
<td>6,121</td>
<td>5,342</td>
<td>5,973</td>
<td>14.4%</td>
<td>3,569</td>
<td>3,378</td>
<td>1976</td>
<td>1,066</td>
<td>5,438</td>
<td>5,874</td>
<td>156 34 78 90 200 717 361 302</td>
</tr>
<tr>
<td><strong>Urban Counties</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Davis</td>
<td>1,935</td>
<td>2,154</td>
<td>2,051</td>
<td>13.9%</td>
<td>1,549</td>
<td>1,720</td>
<td>335</td>
<td>363</td>
<td>1,781</td>
<td>1,941</td>
<td>12 11 8 11 605 486 34 48</td>
</tr>
<tr>
<td>Salt Lake Co.</td>
<td>5,990</td>
<td>6,752</td>
<td>6,176</td>
<td>16.1%</td>
<td>4,527</td>
<td>4,465</td>
<td>281</td>
<td>706</td>
<td>5,319</td>
<td>6,032</td>
<td>41 63 2 6 433 921 343 172</td>
</tr>
<tr>
<td>Weber</td>
<td>1,976</td>
<td>1,773</td>
<td>1,857</td>
<td>18.5%</td>
<td>1,346</td>
<td>1,400</td>
<td>172</td>
<td>175</td>
<td>1,540</td>
<td>1,546</td>
<td>35 3 4 1 129 182 23 53</td>
</tr>
<tr>
<td>Total</td>
<td>13,274</td>
<td>14,274</td>
<td>13,938</td>
<td>19.5%</td>
<td>9,117</td>
<td>9,653</td>
<td>1,252</td>
<td>1,410</td>
<td>13,105</td>
<td>13,728</td>
<td>214 21 1 1 1,137 1,248 332 334</td>
</tr>
<tr>
<td><strong>State</strong></td>
<td>19,275</td>
<td>20,465</td>
<td>19,063</td>
<td>15.1%</td>
<td>13,792</td>
<td>13,924</td>
<td>1,933</td>
<td>2,520</td>
<td>17,155</td>
<td>18,275</td>
<td>245 255 106 121 2,237 1,957 693 636</td>
</tr>
</tbody>
</table>

Note: For page 2:

- FY 2015 Mental Health Scorecard for Children and Youth
- Notes for page 2:
  - Urban Counties
  - Rural Counties

**Utilization:** Percentage of all clients receiving services. Total Outpatient number of clients served is an unduplicated count by provider of any client who receives an outpatient service. Total number of time for all clients who received that service. Median is the middle value in a list of numbers.

- Average Length of Stay: Average length of time for all clients who received that service. Average or mean is the total number of time for that service divided by the number of clients receiving that service.

- Inpatient includes MHE service code 170 Housing.

- Residential includes MHE service code 171 and 173

- Medication Management includes MHE service code 61

- Psychosocial Rehabilitation includes MHE service codes 70, 80, 100, and 160

- Case Management includes MHE service codes 120 and 130

- Respite includes MHE service code 150

- Medication Management includes MHE service code 61

- Psychosocial Rehabilitation includes MHE service codes 70, 80, 100, and 160

- Case Management includes MHE service codes 120 and 130

- Respite includes MHE service code 150

- Assessment includes MHE service code 22 Diagnosis and Assessment

- Testing is not shown on the scorecard but is included in Total Outpatient Treatment Therapy includes MHE service codes 30 Individual Therapy, 31 Electroconvulsive Therapy, 35 Individual Behavior Management, 40 Family Therapy, and 50 Group Therapy

- Outpatient includes all MHE service codes except 170 Inpatient, 171 Residential, 173 Residential Support, and 174 Housing

- Emergency includes all services codes with emergency indicator set to “yes.” Peer Support Services includes MHE service code 130 Peer Support Service

- In-Home and School-Based Services are based on service location code.

- State Hospital data used to calculate utilization, total and average days of service during the fiscal year. Data for services provided in Jail are not included.
### Utilization of Mandated Services (Percent of clients receiving services)

#### Outpatient Services

<table>
<thead>
<tr>
<th>Local Authority</th>
<th># of Clients</th>
<th>Percent</th>
<th># of Clients</th>
<th>Percent</th>
<th># of Clients</th>
<th>Percent</th>
<th># of Clients</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salt Lake Co.</strong></td>
<td>2,782</td>
<td>98.2%</td>
<td>305</td>
<td>10.7%</td>
<td>133</td>
<td>4.8%</td>
<td>48</td>
<td>1.7%</td>
</tr>
<tr>
<td><strong>Utah Co. - Wasatch MH</strong></td>
<td>879</td>
<td>99.6%</td>
<td>17</td>
<td>1.9%</td>
<td>17</td>
<td>1.9%</td>
<td>17</td>
<td>1.9%</td>
</tr>
<tr>
<td><strong>Webber</strong></td>
<td>1,220</td>
<td>98.7%</td>
<td>19</td>
<td>1.5%</td>
<td>19</td>
<td>1.5%</td>
<td>19</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,187</td>
<td>98.3%</td>
<td>133</td>
<td>2.3%</td>
<td>133</td>
<td>2.3%</td>
<td>133</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

#### In-Home Services

<table>
<thead>
<tr>
<th>Local Authority</th>
<th># of Clients</th>
<th>Percent</th>
<th># of Clients</th>
<th>Percent</th>
<th># of Clients</th>
<th>Percent</th>
<th># of Clients</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salt Lake Co.</strong></td>
<td>2,782</td>
<td>98.2%</td>
<td>305</td>
<td>10.7%</td>
<td>133</td>
<td>4.8%</td>
<td>48</td>
<td>1.7%</td>
</tr>
<tr>
<td><strong>Utah Co. - Wasatch MH</strong></td>
<td>879</td>
<td>99.6%</td>
<td>17</td>
<td>1.9%</td>
<td>17</td>
<td>1.9%</td>
<td>17</td>
<td>1.9%</td>
</tr>
<tr>
<td><strong>Webber</strong></td>
<td>1,220</td>
<td>98.7%</td>
<td>19</td>
<td>1.5%</td>
<td>19</td>
<td>1.5%</td>
<td>19</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,187</td>
<td>98.3%</td>
<td>133</td>
<td>2.3%</td>
<td>133</td>
<td>2.3%</td>
<td>133</td>
<td>2.3%</td>
</tr>
</tbody>
</table>

### Time in Service for Mandated Services (Days or hours for clients receiving services)

#### Outpatient Services

<table>
<thead>
<tr>
<th>Local Authority</th>
<th># of Days</th>
<th>Average</th>
<th>Median</th>
<th>Average</th>
<th>Median</th>
<th>Average</th>
<th>Median</th>
<th>Average</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salt Lake Co.</strong></td>
<td>2,782</td>
<td>98.2%</td>
<td>305</td>
<td>10.7%</td>
<td>133</td>
<td>4.8%</td>
<td>48</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td><strong>Utah Co. - Wasatch MH</strong></td>
<td>879</td>
<td>99.6%</td>
<td>17</td>
<td>1.9%</td>
<td>17</td>
<td>1.9%</td>
<td>17</td>
<td>1.9%</td>
<td></td>
</tr>
<tr>
<td><strong>Webber</strong></td>
<td>1,220</td>
<td>98.7%</td>
<td>19</td>
<td>1.5%</td>
<td>19</td>
<td>1.5%</td>
<td>19</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,187</td>
<td>98.3%</td>
<td>133</td>
<td>2.3%</td>
<td>133</td>
<td>2.3%</td>
<td>133</td>
<td>2.3%</td>
<td></td>
</tr>
</tbody>
</table>

#### In-Home Services

<table>
<thead>
<tr>
<th>Local Authority</th>
<th># of Days</th>
<th>Average</th>
<th>Median</th>
<th>Average</th>
<th>Median</th>
<th>Average</th>
<th>Median</th>
<th>Average</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Salt Lake Co.</strong></td>
<td>2,782</td>
<td>98.2%</td>
<td>305</td>
<td>10.7%</td>
<td>133</td>
<td>4.8%</td>
<td>48</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td><strong>Utah Co. - Wasatch MH</strong></td>
<td>879</td>
<td>99.6%</td>
<td>17</td>
<td>1.9%</td>
<td>17</td>
<td>1.9%</td>
<td>17</td>
<td>1.9%</td>
<td></td>
</tr>
<tr>
<td><strong>Webber</strong></td>
<td>1,220</td>
<td>98.7%</td>
<td>19</td>
<td>1.5%</td>
<td>19</td>
<td>1.5%</td>
<td>19</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5,187</td>
<td>98.3%</td>
<td>133</td>
<td>2.3%</td>
<td>133</td>
<td>2.3%</td>
<td>133</td>
<td>2.3%</td>
<td></td>
</tr>
</tbody>
</table>

---

### Footnotes

- **State**: All Urban and Rural Counties combined.

---

**Source**: FY 2016 Mental Health Scorecard for Children and Youth (age 17 and younger) Continued.

**Date**: November 2, 2016.
## FY 2016 Mental Health Scorecard for Children and Youth (age 17 and younger) Continued

**November 2, 2016**

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Valid YOQ Clients Served through FY2015</th>
<th>Unduplicated Number of Clients Participating</th>
<th>Percent of Clients Matching to SAMHIS **</th>
<th>Percent of Clients Participating</th>
<th>Percent of Clients Matching to SAMHIS **</th>
<th>Percent of Clients Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River</td>
<td>1,310</td>
<td>942</td>
<td>71.9%</td>
<td>99.4</td>
<td>45.20</td>
<td>14.26</td>
</tr>
<tr>
<td>Central</td>
<td>411</td>
<td>375</td>
<td>91.2%</td>
<td>96.7</td>
<td>42.82</td>
<td>17.13</td>
</tr>
<tr>
<td>Four Corners</td>
<td>383</td>
<td>284</td>
<td>76.8%</td>
<td>91.3</td>
<td>40.63</td>
<td>11.30</td>
</tr>
<tr>
<td>Northeastern</td>
<td>718</td>
<td>623</td>
<td>86.8%</td>
<td>96.2</td>
<td>40.37</td>
<td>17.61</td>
</tr>
<tr>
<td>San Juan</td>
<td>163</td>
<td>72</td>
<td>44.2%</td>
<td>97.5</td>
<td>58.27</td>
<td>14.81</td>
</tr>
<tr>
<td>Summit Co.</td>
<td>294</td>
<td>124</td>
<td>60.8%</td>
<td>92.7</td>
<td>45.08</td>
<td>15.57</td>
</tr>
<tr>
<td>Totino Co.</td>
<td>424</td>
<td>169</td>
<td>36.0%</td>
<td>96.4</td>
<td>35.05</td>
<td>17.94</td>
</tr>
<tr>
<td>Wasatch Co. - Heber</td>
<td>147</td>
<td>119</td>
<td>81.0%</td>
<td>96.1</td>
<td>36.25</td>
<td>16.81</td>
</tr>
<tr>
<td>Total</td>
<td>5,025</td>
<td>3,495</td>
<td></td>
<td>96.9</td>
<td>43.50</td>
<td>16.44</td>
</tr>
</tbody>
</table>

### Urban Counties

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Valid YOQ Clients Served through FY2015</th>
<th>Unduplicated Number of Clients Participating</th>
<th>Percent of Clients Matching to SAMHIS **</th>
<th>Percent of Clients Participating</th>
<th>Percent of Clients Matching to SAMHIS **</th>
<th>Percent of Clients Participating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davis</td>
<td>1,667</td>
<td>1,673</td>
<td>100.0%</td>
<td>95.9</td>
<td>42.67</td>
<td>13.78</td>
</tr>
<tr>
<td>Salt Lake Co.</td>
<td>5,407</td>
<td>3,097</td>
<td>56.6%</td>
<td>85.1</td>
<td>42.83</td>
<td>20.56</td>
</tr>
<tr>
<td>Utah Co. - Wasatch MH</td>
<td>3,094</td>
<td>2,476</td>
<td>82.4%</td>
<td>98.0</td>
<td>37.66</td>
<td>17.43</td>
</tr>
<tr>
<td>Weber</td>
<td>1,315</td>
<td>1,276</td>
<td>97.0%</td>
<td>97.9</td>
<td>31.44</td>
<td>21.09</td>
</tr>
<tr>
<td>Total</td>
<td>11,386</td>
<td>8,522</td>
<td></td>
<td>92.9</td>
<td>40.00</td>
<td>18.46</td>
</tr>
<tr>
<td>State</td>
<td>16,306</td>
<td>12,016</td>
<td>73.7%</td>
<td>93.4</td>
<td>40.85</td>
<td>17.95</td>
</tr>
</tbody>
</table>

### Outcome Measures

<table>
<thead>
<tr>
<th>OQ Measures</th>
<th>Treatment Positive Outcomes</th>
<th>Discharged (Subset of Treatment)</th>
<th>Positive Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Stable</td>
<td>Improved</td>
<td>Deteriorated</td>
</tr>
<tr>
<td></td>
<td>% of Episodes</td>
<td>% of Episodes</td>
<td>% of Episodes</td>
</tr>
<tr>
<td>Rural Counties</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bear River</td>
<td>25.61</td>
<td>85.06</td>
<td>14.94</td>
</tr>
<tr>
<td>Central</td>
<td>24.03</td>
<td>83.38</td>
<td>16.02</td>
</tr>
<tr>
<td>Four Corners</td>
<td>21.93</td>
<td>83.00</td>
<td>16.94</td>
</tr>
<tr>
<td>Northeastern</td>
<td>29.57</td>
<td>83.98</td>
<td>12.46</td>
</tr>
<tr>
<td>San Juan</td>
<td>20.25</td>
<td>80.25</td>
<td>19.78</td>
</tr>
<tr>
<td>Southwest</td>
<td>18.09</td>
<td>85.30</td>
<td>14.70</td>
</tr>
<tr>
<td>Summit Co.</td>
<td>15.78</td>
<td>90.16</td>
<td>9.84</td>
</tr>
<tr>
<td>Totino Co.</td>
<td>17.94</td>
<td>84.24</td>
<td>15.74</td>
</tr>
<tr>
<td>Wasatch Co. - Heber</td>
<td>12.90</td>
<td>90.27</td>
<td>9.73</td>
</tr>
<tr>
<td>Total</td>
<td>15.27</td>
<td>85.31</td>
<td>14.69</td>
</tr>
</tbody>
</table>

| Urban Counties | | | | | | |
| Davis          | 29.31 | 87.02 | 12.80 | 44.07 | 13.65 | 29.31 |
| Salt Lake Co.  | 24.03 | 84.33 | 15.37 | 47.20 | 18.50 | 17.96 |
| Utah Co. - Wasatch MH | 29.57 | 84.59 | 15.41 | 38.70 | 15.43 | 32.45 |
| Weber          | 18.09 | 89.12 | 10.88 | 33.00 | 17.39 | 41.50 |
| Total          | 27.74 | 85.73 | 14.27 | 41.88 | 16.71 | 27.87 |

### Notes

- **Red**: Discharge requirements not met.
- **^**: Discharge includes clients who have been discharged in the current year or have not received any events of service for at least 7 months.
- **Valid YOQ Clients Served** excludes children 5 years of age and younger, and any client who receives only assessment or testing services or received services in Jail.
- **Percent of Clients Participating**: Minimum requirement is 50% or more.
- **Minimum requirement of matching clients with SAMHIS is 90%**, if results are in red it means the provider didn’t meet this requirement.
- **Clients and Episodes are included if there are 2 or more valid administrations per instrument where one or more was administered within the fiscal year.**
- **Deteriorated**: Clients who have had a *Clinically Significant increase in symptoms from intake.
- **Improved**: Clients who have **not** a Clinically Significant reduction in symptoms from intake.
- **Recovery**: If a client’s score drops below the empirically derived cutoff between clinical scores and community normative scores and has been **Clinically Significant change, then the client is classified as recovered.** This number does not include clients in Recovery who are only receiving medication services administration.

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

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

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

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

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

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

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

**Improved**: Clients who have **not** a Clinically Significant reduction in symptoms from intake.

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

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

**Outcomes; Improved, Stable, Recovered, and Deteriorated are calculated by episode.**
<table>
<thead>
<tr>
<th></th>
<th>Adult MH</th>
<th>CYF- MH</th>
<th>SA Treatment</th>
<th>SA Prevention</th>
<th>G &amp; O</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MONDAY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5:00 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Interviews – as available &amp; coordinated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TUESDAY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00 AM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opening Conference</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30 AM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined Managers Discussion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00 AM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Drug court staffing (if possible)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noon</td>
<td>Lunch</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:00 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>WEDNESDAY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00 AM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Program &amp; allied agency visits</td>
<td>Managers Discussion: 1.5 -2 hours</td>
<td>Records Review (if needed)</td>
<td>Records Review (if needed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11:00 AM</td>
<td>Continue visits</td>
<td>Case Staffing or Program/Allied Agency Visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Noon</td>
<td>Lunch</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:00 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Records Review (if needed)</td>
<td>Continue visits</td>
<td><strong>R&amp;R Manager</strong> – Consumer Feedback</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:00 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MONDAY</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3:30 PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exit Conference: Via telecommunications equipment from Salt Lake</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Printed: 8/1/2017 3:59 PM - Utah - OMB No. 0930-0168  Approved: 06/12/2015  Expires: 09/30/2020*
Environmental Factors and Plan

13. 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 behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

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

Please respond to the following items

1. Does the state have a plan or policy for behavioral health 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 behavioral health providers?  
   - Yes  
   - No

3. Does the state have a plan to build the capacity of behavioral health 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 trauma specific interventions, including the following: (1) Trauma Recovery and Empowerment Model (2) Beyond Trauma: A Healing Journey for Women; (4) Helping Women Recover: A Program for Treating Addiction. (5) Utah Trauma Academy provided by Gabriella Grant, MA. (6) Utah Fall Substance Abuse Conference; (7) Critical Issues Facing Children and Adolescents (8) Generations Conference (9) Troubled Youth Conference (10) TIC Training by DSAMH staff to various organizations. DSAMH hired Dr. Stephanie Covington to provide three day workshop on the Trauma-Informed Approach with the Utah Department of Human Services Directors and is currently working with Gabriella Grant, MA, Director of the Center of Excellence for Trauma-Informed Care / Certified Trainer for Seeking Safety to provide training and consultation on the Trauma-Informed Approach. Treatment Innovations will also be providing training and consultation for DSAMH on the Seeking Safety Model. DSAMH is working with the...
Utah Department of Human Services (DHS) 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. DHS is also looking into the development of a Utah Trauma Informed Care Center, where all TIC initiatives are handled.

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

None needed at this time.

Footnotes:
Environmental Factors and Plan

14. 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.62 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.63 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 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.

63 http://csgjusticecenter.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 behavioral health services? jn Yes jn No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health 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? jn Yes jn No

3. Does the state provide cross-training for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? jn Yes jn 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 SM HA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? jn Yes jn 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.

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

None at this time.

Footnotes:
Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

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)

FDA Approved Medications: (1) Drug Enforcement Agency (DEA) (2) Utah Division of Occupational Licensing - Pharmacy Board

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 contract with a provider to conduct Naloxone Trainings and Train the Trainer (TOT) education. Through the UT Opioid STR Grant Project, the State has hired a Project Director and Medical Consultant to collaborate closely with the Opioid Treatment Providers, Accountable Care Organizations, Federally Qualified 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.

Please indicate areas of technical assistance needed to this section.

None at this time.

*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

16. 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 behavioral health crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.64 SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises65,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

Please respond to the following items:

1. Crisis Prevention and Early Intervention
   a) b Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) e Psychiatric Advance Directives
   c) b Family Engagement
   d) b Safety Planning
   e) b Peer-Operated Warm Lines
   f) b Peer-Run Crisis Respite Programs
   g) b Suicide Prevention

2. Crisis Intervention/Stabilization
   a) b Assessment/Triage (Living Room Model)
   b) e Open Dialogue
   c) b Crisis Residential/Respite
   d) b Crisis Intervention Team/Law Enforcement
   e) b Mobile Crisis Outreach
   f) b Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support
   a) e WRAP Post-Crisis
   b) b Peer Support/Peer Bridges

64 http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848
Follow-up Outreach and Support

Family to Family Engagement

Connection to care coordination and follow-up clinical care for individuals in crisis

Follow-up crisis engagement with families and involved community members

Recovery community coaches/peer recovery coaches

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 first Mental Health Crisis Response Summit on April 26th, 2017. Attendees for this inaugural Summit were personally identified as influential stakeholders statewide from each of the above disciplines. The purpose of this Summit was 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. This proved a valuable opportunity to learn from the different disciplines, and identify more effective and efficient ways to assist those experiencing a mental health crisis. This first Mental Health Crisis Response Summit experienced a robust turnout from all agencies and there was an overwhelming response of positive feedback and appreciation for hosting this event, with the hope of continuing this Summit annually.

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 to this section.

None at this time.

**Footnotes:**
17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making.

The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual’s mental or substance use disorder. 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, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA’s Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

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, SAMHAs 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:
   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?  
      □ Yes □ No
   b) Required peer accreditation or certification?  
      □ Yes □ No
   c) Block grant funding of recovery support services.  
      □ Yes □ No
   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state’s M/SUD system?  
      □ Yes □ No

   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 use of Peer Support Specialists at each Local Authority. All Local Authorities have Peer Support Specialists and/or Family Resource Facilitators (FRF) on staff, and some use peer volunteers that assist with local M/H/SUD system evaluations and input. DSAMH conducts Clubhouse visits annually, including focus groups consisting of Peers who are encouraged to provide feedback regarding the M/H/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 VA Medical Center. Local Authorities will also host alumni groups for individuals that have completed treatment or Drug Court programs that request input.

2. Does the state measure the impact of your consumer and recovery community outreach activity?  
   □ Yes □ No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.
   Self-Direction and Recovery Support services have been a focal point for DSAMH for many years. DSAMH has put together a Recovery Oriented System of Care (ROSC) committee that meets monthly and addresses system changes toward a ROSC model. DSAMH has also focused efforts on individualized care and meeting the individuals where they are at in their recovery. All Local Authorities have included Peers/FRFs as part of their agencies that provide recovery services for Juveniles and Adults, and their families. The Local Authorities provide an array of Recovery Supports such as assistance with early intervention services, housing, employment, Peer Support, case management, payee services, skills development etc. DSAMH has also contracts with NAMI, LBHS, AFSP, USARA and Recovery Community Organization (RCO) to provide Recovery Support Services to those individuals with Behavioral Health disorders in need of assistance throughout the community.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.
   Self-Direction and Recovery Support services have been a focal point for DSAMH for many years. DSAMH has put together a Recovery Oriented System of Care (ROSC) committee that meets monthly and addresses system changes toward a ROSC model. DSAMH has also focused efforts on individualized care and meeting the individuals where they are at in their recovery. All Local Authorities have included Peers/FRFs as part of their agencies that provide recovery services for Juveniles and Adults, DSAMH has programs to assist with support and payment of recovery support services. These include: Individuals enrolled into a Drug Court program, parolees re-entering into the community and individuals compelled to treatment through the Justice Reinvestment Initiative. A portion of Local Authorities have chosen to use local County funds to assist with Recovery Support Services. DSAMH also contracts with Utah Supports Advocacy for Recovery Awareness (USARA) and Recovery Community Organizations (RCO) to provide Recovery Support Services to those individuals with Behavioral Health disorders in need of assistance throughout the community.

5. Does the state have any activities that it would like to highlight?
   Utah was awarded the ATR III grant (2010-2015) and has used the ATR model to continue offering Recovery Support services through other avenues. SAMHSA grants to develop employment (Supported Employment/Individual Placement and Support) and housing services (Collaborative Agreement to Benefit Homeless Individuals) were awarded in 2014 to improve the recovery supports for individuals in treatment. Utah saw the importance of Recovery Support services and continues to strive to provide
these services.

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

None at this time.

**Footnotes:**

Public committee meetings are posted on the Divisions website and public comment, feedback and input is received and reviewed.
Environmental Factors and Plan

18. 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 behavioral health 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 behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office 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.

Please respond to the following items
1. Does the state's Olmstead plan include:
   - housing services provided. Yes ☐ No ☐
   - home and community based services. Yes ☐ No ☐
   - peer support services. Yes ☐ No ☐
   - 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.
   - Does the state have any activities related to this section that you would like to highlight?
     - 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.

Footnotes:
Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHGB 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 10 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 20. 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 behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (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).

69 The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

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 behavioral health 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 behavioral health 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 Department of Education and Law Enforcement.

The Utah State Division of Substance Abuse and Mental Health (DSAMH) provides integrated services for mental health (MH) and substance use disorder (SUD) services for children and youth through the Local Authority Substance Use and Mental Health System and contracted providers. There are thirteen Local Authorities in Utah, which all provide integrated MH and SUD services, except two 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
The System of Care Expansion and Planning Grant, 2012 – Present (SAM HSA funding): DSAMH collaborates with all of the child serving agencies within the Utah Department of Human Services (DHS) including the Division of Child and Family Services (DCFS), Division of Juvenile Justice Services (DJJS), Division of Services for People with Disabilities (DSPD), and the Executive Director’s Office (EDO) who directly oversees System of Care in Utah to develop a comprehensive statewide strategic plan to improve and expand services using a system of care approach for children and youth from birth to 21 years of age who have, or are at risk of developing, serious mental health conditions.

The Division’s Children, Youth and Families team (CYF) helps shape and contribute to the system through policy development, technical assistance, monitoring and oversight. In FY18, 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 collaboratively work to ensure children, youth, and their families have their needs supported.

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 involvement activities 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 FY18, 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 2017, there are 109 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.

d. Increase the number of Certified Wraparound Facilitators through 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 at the beginning of FY18, there are 18 Certified Wraparound Facilitators. By June 30, 2019, the Division plans to increase that number to 25.

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 2018, School-Based Programs were accessible in 313 schools.

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 2018, DSAMH has supported LMHA school based work in 89 total 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, especially those with high rates of intergenerational poverty throughout the next two years.

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 sustain the programming and develop a statewide curriculum with the partnering agencies by June 2019.

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. Along with this technical assistance provided by Georgetown University, Utah is also receiving assistance from the National Association of State Mental Health Program Directors (NASMHPD) for the co-occurring mental health and intellectual/developmental/autism treatment.

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. One of the primary requests LMHAs have is for more assistance to better prepare and train their workforce when they are working within school settings and with school based populations.

c. Continued assistance for intellectual/developmental/autism disabilities and treating comorbid issues. Although the providers throughout Utah are able to sufficiently address the 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.

Footnotes:
Environmental Factors and Plan

20. Suicide Prevention - Required 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 behavioral health 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 through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health 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 that are 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 NSPL affiliate who also provides application based chat/text crisis support to youth needing support.
   DSAMH contracts with NAMI Utah and local coalitions statewide to help them review data and choose local suicide prevention strategies for implementation through an RFP process. We currently provide 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, began a comprehensive study of firearm suicide, partnered with our local Children's Hospital on an ED means restriction initiative, and is beginning a training program for firearm retailers.
   DSAMH works extensively on implementing the Zero Suicide 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 in July 2017 formal adoption of the aspirational goal of zero through the Zero Suicide model.
   DSAMH provides leadership to the Utah Suicide Prevention Coalition and Executive Committee. This diverse group of stakeholders helped with the Utah Suicide Prevention Plan, ongoing strategic planning, and implementation of strategies.

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 2016-FFY 2017 plan was submitted?  
   - Yes  
   - No

   If so, please describe the population targeted.
   DSAMH continues to build on our Zero Suicide Initiative and on community based efforts through coalitions. We have begun targeting suicide prevention -means reduction efforts on gun owning individuals and families and have initiatives to target military connected and veteran populations.

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

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

Footnotes: 
Environmental Factors and Plan

21. Support of State Partners - Required 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 behavioral health needs and/or impact persons with behavioral health conditions or consultation on the benefits available to any Medicaid populations;

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 public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and

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?

   Though there are not new relationships need recognized, over the years DSAM H has had varying levels of relationships with partners, in this past year DSAM H has recognized the need to strengthen relationships with the Courts at all levels, Prosecutor/Defense attorneys and organizations, State and County Corrections and Public Safety Agencies, Probation and Parole, Fire Authorities, police Dispatch, various levels of healthcare including community health workers in relationship to crisis, civil commitment, justice reinvestment and forensic competency issues that have been of increasing focus in Utah over the past year. 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 interceps 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, workgroups, coalitions and day to day collaboration with program managers and administrators of both internal and external organizations. Listed below are just a few of the ongoing partnerships that the division is currently involved in.

   a. Utah Substance Abuse Advisory Council (USAAV) is a committee established by statute to advise the Governor on Substance Use Disorder issues. The Division sits on the council and provides member ship to all four of the Council’s Committees.

   b. Office of Licensing: The Division has worked closely with the Office of Licensing to update rules and requirements for Opioid
Treatment programs as well as a workgroup that created a Recovery Residence Licensing process to assist in providing safe sober housing for individuals in recovery.

c. Criminal Justice: The Division has a long history of collaboration and cooperation with the Criminal Justice workers, to include the Administrative Office of the Courts, the Programming Division in the Department of Corrections which provides SUD services inside the prison system, with Adult Probation and Parole, and with the judges and other Drug Court Team Members. The collaboration with the Department of Corrections and the Commission on Criminal and Juvenile Justice (CCJJ) has already been discussed in section 12.

d. Department of Education (DOE)

e. University of Utah. The Division conducts quarterly meetings with three key departments of the University of Utah to continue the partnership established over many years.

f. Recovery Support: The Division contracts with and meets with the following Recovery support organizations on numerous issues on a monthly basis.

National Alliance for Mental Illness (NAMI)
Utah Support Advocates for Recovery Awareness (USARA)

Utah Department of Veterans Affairs and the Utah National Guard:

Latino Behavioral Health Services (LBHS)
Utah Support Advocates for Recovery Awareness (USARA)
National Alliance for Mental Illness (NAMI)

Recovery Plus (Tobacco Cessation)
Recovery Plus II (Disease Prevention and Control and collaboration with Local Authorities)
Prescription Drug Abuse Task Force
Narcan Distribution work group.
Care Management Workgroup.
Prevention Coalitions statewide

USAAV + and focus to include Mental Health issues

1) Recovery Plus (Tobacco Cessation)
2) Recovery Plus II (Disease Prevention and Control and collaboration with Local Authorities)
3) Prescription Drug Abuse Task Force
4) Narcan Distribution work group.
5) Care Management Workgroup.
6) Prevention Coalitions statewide
7) DSAM H 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

Criminal Justice: The Division has a long history of collaboration and cooperation with the Criminal Justice workers, to include the Administrative Office of the Courts, the Programming Division in the Department of Corrections which provides SUD services inside the prison system, with Adult Probation and Parole, and with the judges and other Drug Court Team Members. The collaboration with the Department of Corrections and the Commission on Criminal and Juvenile Justice (CCJJ) has already been discussed in another section.

Department of Education (DOE)

Universities throughout Utah. The Division conducts quarterly meetings with three key departments of the University of Utah to continue the partnership established over many years as well as other joint committees and efforts with other Universities.

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)

DSAM H Staff participate on the Veteran’s Affairs Committee, and 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.

Department of Health (DOH). A few of the committees and workgroups that the Division either attends with the DOH, cochairs with the DOH or has DOH membership on its committees are:

1) Recovery Plus (Tobacco Cessation)
2) Recovery Plus II (Disease Prevention and Control and collaboration with Local Authorities)
3) Prescription Drug Abuse Task Force
4) Narcan Distribution work group.
5) Care Management Workgroup.
6) Prevention Coalitions statewide
7) DSAM H 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

General: The Division is involved in numerous partnerships, committees, workgroups, coalitions and day to day collaboration with program managers and administrators of both internal and external organizations. Listed below are just a few of the ongoing partnerships that the division is currently involved in.

Utah Substance Abuse and Mental Health Advisory Council (USAAV+) is a committee established by statute to advise the Governor on substance use disorder and mental health issues. The Division sits on the council and provides membership to all four of the Council’s Committees. In 2016 the USAAV Council changed its name to USAAV + and focus to include Mental Health issues and incorporated the Utah Behavioral Health Planning and Behavioral Health Council (UBHPAC) as a sub council, elevating the UBHPAC’s visibility and impact with the Governor’s office and Legislature.

Office of Licensing: The Division has worked closely with the Office of Licensing to update rules and requirements for Opioid Treatment programs as well as a workgroup that created a Recovery Residence Licensing process to assist in providing safe sober housing for individuals in recovery.

Office of Licensing:

A few of the committees and workgroups that the Division either attends with the DOH, cochairs with the DOH or has DOH membership on its committees are:

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

General: The Division is involved in numerous partnerships, committees, workgroups, coalitions and day to day collaboration with program managers and administrators of both internal and external organizations. Listed below are just a few of the ongoing partnerships that the division is currently involved in.

Utah Substance Abuse and Mental Health Advisory Council (USAAV+) is a committee established by statute to advise the Governor on substance use disorder and mental health issues. The Division sits on the council and provides membership to all four of the Council’s Committees. In 2016 the USAAV Council changed its name to USAAV + and focus to include Mental Health issues and incorporated the Utah Behavioral Health Planning and Behavioral Health Council (UBHPAC) as a sub council, elevating the UBHPACs visibility and impact with the Governor’s office and Legislature.

Office of Licensing: The Division has worked closely with the Office of Licensing to update rules and requirements for Opioid Treatment programs as well as a workgroup that created a Recovery Residence Licensing process to assist in providing safe sober housing for individuals in recovery.

Criminal Justice: The Division has a long history of collaboration and cooperation with the Criminal Justice workers, to include the Administrative Office of the Courts, the Programming Division in the Department of Corrections which provides SUD services inside the prison system, with Adult Probation and Parole, and with the judges and other Drug Court Team Members. The collaboration with the Department of Corrections and the Commission on Criminal and Juvenile Justice (CCJJ) has already been discussed in another section.

Department of Education (DOE)

Universities throughout Utah. The Division conducts quarterly meetings with three key departments of the University of Utah to continue the partnership established over many years as well as other joint committees and efforts with other Universities.

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)

Utah Department of Veterans Affairs and the Utah National Guard: DSAM H Staff participate on the Veteran’s Affairs Committee, and 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.

Department of Health (DOH). A few of the committees and workgroups that the Division either attends with the DOH, cochairs
with the DOH or has DOH membership on its committees are:
Recovery Plus (Tobacco Cessation)
Recovery Plus II (Disease Prevention and Control and collaboration with Local Authorities)
Prescription Drug Abuse Task Force
Narcan Distribution work group.
Care Management Workgroup.
Prevention Coalitions statewide
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
Department of Workforce Services
Utah State Office of Rehabilitation
Insurance Commissioner
Opioid Treatment Programs
Private Health Care and Managed Care.
Department of Professional Licensing (DOPL)
Utah Behavioral Health Care Council (UBHC )

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

None needed at this time.

Footnotes:
Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating 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 a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council’s comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance 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 BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.72

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 behavioral health 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.

72http://beta.samhsa.gov/grants/block-grants/resources

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)
   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 will be distributed to members for continued discussion and feedback. Sub committees have been formed, including a prevention, treatment, and recovery Committee 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 the UBHPAC will be made aware via email as well as in our meetings, 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, fax number, or calling the DSAMH which was posted on website, and in hard copy.

      Here is a link the the UBHPAC page on our website with minutes: https://dsamh.utah.gov/provider-information/ubhpac/

      a) The Division provides guidance to all of the Local Substance Abuse Authorities (and Local Mental Health Authorities in late March, shortly after the end of the legislative session. (See: https://dsamh.utah.gov/pdf/contracts_and_monitoring/Division_Directives_FY17_Final.pdf)

      The Local Authorities use that guidance to develop their Area Plans, in conjunction with their local partners. Each Local Authority also has consumers involved in the development of their plans and priorities. As stated earlier, the Counties, represented by the Local Authorities, are responsible for planning for and providing MH and SUD services to the residents of their counties.

      b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into their work?

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

3. Please indicate 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.

   5) The Public Health Service Act (42 U.S.C.300x) mandates each state establish a State Mental Health Planning Council. The Council is required to review and provide feedback on the states Mental Health Block Grant (MHBG) application and submit any recommendations. The Council will Monitor, Review, and evaluate the allocation and adequacy of mental health services in their...
state; and serve as an advocate for adults with serious mental illness, children with serious emotional disturbances and other individuals with mental illness or emotional disturbances. The UBHPAC is comprised of mental health and substance use disorder providers, peers in recovery, and family members of individuals in recovery, and state agencies. From each member’s perspective, issues and concerns are brought up in this meeting and the council works together to better serve individuals with SMI and SED. Four subcommittees have been formed, Executive, Prevention, Treatment, and Recovery. Forming these committees have made it easier to develop priorities, discuss legislative issues, and review the block grant. One way in which the Council has advocated for Adults with SMI and Children with SED is by providing a letters of support. In FY16 the UBHPAC provided a letter supporting the Governor’s Healthy Utah version of Medicaid Expansion and sent it to representatives of the House and Senate. The Council has been active during the legislative period showing their support of Healthy Utah and other important legislative concerns affecting the care of individuals with SMI and SED. In FY17, a letter was written in support of the continuation of providing early prevention and intervention in schools in Utah. The council advocated for additional state funds for the continuation of the Crisis Intervention Team Program for law enforcement and the funds were granted on going.

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

The Utah Substance Abuse and Anti Violence Advisory Council to the Governor, made a decision to integrate with Mental Health and is now called the Utah Substance Abuse and Mental Health Advisory Council (USAAV +) and the UBHPAC has become a sub committee of USAAV +, this has given the UBHPAC a voice on this influential advisory council to the Governor. In addition the state has contracted with a peer run organization to provide administrative support the the UBHPAC, and sub committees, executive, prevention, treatment, and recovery have been formed to help fulfill the UBHPAC duties.

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

TBD

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.73

73There 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.

Footnotes:

link to UBHPAC minutes: http://dsamh.utah.gov/provider-information/ubhpac/

Link to Division Directives for question 1a: https://dsamh.utah.gov/pdf/contracts_and_monitoring/Division_Directives_FY17_Final.pdf
Environmental Factors and Plan

Behavioral Health Advisory Council Members

<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>
<tbody>
<tr>
<td>Owen Ashton</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dan Braun</td>
<td>Providers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ron Bruno</td>
<td>Others (Not State employees or providers)</td>
<td>Law Enforcement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lori Cerar</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>Allies with Families</td>
<td>505 East 200 South Salt Lake City UT, 84102 PH: 801-433-2595 FX: 801-521-0872</td>
<td><a href="mailto:lori@allieswithfamilies.org">lori@allieswithfamilies.org</a></td>
</tr>
<tr>
<td>Renee Chipmen</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jeremy Christensen</td>
<td>State Employees</td>
<td>Department of Human Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nelson Clayton</td>
<td>State Employees</td>
<td>Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cathy Davis</td>
<td>State Employees</td>
<td>Utah State Office of Education</td>
<td>250 East 500 South Salt Lake City UT, 84114 PH: 801-538-7727</td>
<td><a href="mailto:carol.landerson@schools.utah.gov">carol.landerson@schools.utah.gov</a></td>
</tr>
<tr>
<td>Liz Felt</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kevin Foote</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nicole Fraedrich</td>
<td>State Employees</td>
<td>Utah State Office of Rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valerie Fritz</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td></td>
<td></td>
<td><a href="mailto:valfritz123@gmail.com">valfritz123@gmail.com</a></td>
</tr>
<tr>
<td>Kimbal Gardner</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>NAMI-Utah</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jacqueline Gomez-</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Latino Behavioral Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anas</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Title/Role</td>
<td>Organization</td>
<td>Email</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>----------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Peggy Hostetter</td>
<td>Others (Not State employees or providers)</td>
<td>Advocate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LeAnne Huff</td>
<td>State Employees</td>
<td>Division of Substance Abuse and Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taylor Joseph</td>
<td>Others (Not State employees or providers)</td>
<td>Salt Lake City Police Department</td>
<td></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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jenifer Lloyd</td>
<td>Others (Not State employees or providers)</td>
<td>Association for Utah Community Health</td>
<td><a href="mailto:jenifer@auch.org">jenifer@auch.org</a></td>
<td></td>
</tr>
<tr>
<td>Mary Jo McMillen</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>USARA</td>
<td><a href="mailto:maryjo@usara.us">maryjo@usara.us</a></td>
<td></td>
</tr>
<tr>
<td>Teresa Molina</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>James Howard Park</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td></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></td>
<td></td>
<td></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>USARA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Robert Snarr</td>
<td>State Employees</td>
<td>Housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Christina Zidow</td>
<td>Providers</td>
<td>Odyssey House of Utah</td>
<td><a href="mailto:czidow@odysseyhouse.org">czidow@odysseyhouse.org</a></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes:**
Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018  End Year: 2019

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Membership</td>
<td>26</td>
<td></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>
<td></td>
</tr>
<tr>
<td>Family Members of Individuals in Recovery* (to include family members of adults with SMI)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Parents of children with SED*</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Vacancies (Individuals and Family Members)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Others (Not State employees or providers)</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total Individuals in Recovery, Family Members &amp; Others</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>State Employees</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Providers</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Federally Recognized Tribe Representatives</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Vacancies</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total State Employees &amp; Providers</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Persons in recovery from or providing treatment for or advocating for substance abuse services</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Several presentations were providing by the State Liaison to the UBHPAC leading up to August 1 (day of posting) to discuss the block grant: by breaking down the sections, discussing funding, and budget and then working in sub committees so the members feel like they understand it enough to provide feedback. In addition, A copy of the last years block grant and current application were given to members for further review, and if they had questions to bring the questions back to subsequent UBHPAC meetings. The application will be posted on August 1st for feedback by the public.

Footnotes:
Environmental Factors and Plan

23. 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
   c) Other (e.g. public service announcements, print media) Yes No

 If yes, provide URL:

Footnotes: