Utah

UNIFORM APPLICATION
FY 2026/2027 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 05/28/2025 - Expires 01/31/2028
(generated on 07/31/2025 6.24.21 PM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

and

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

State Information

State Information

Plan Year

Start Year	2026
End Year	2027

State SUPTRS BG Unique Entity Identification

Unique Entity ID	1B08TI085836

I. State Agency to be the SUPTRS BG Grantee for the Block Grant

Agency Name	Utah Department of Health and Human Services
Organizational Unit	Office of Substance Use and Mental Health
Mailing Address	288 North 1460 West, 3rd Floor
City	Salt Lake City
Zip Code	84116

II. Contact Person for the SUPTRS BG Grantee of the Block Grant

First Name	Eric
Last Name	Tadehara
Agency Name	Office of Substance Use and Mental Health
Mailing Address	288 North 1460 West, 3rd Floor
City	Salt Lake City
Zip Code	84116
Telephone	801-669-0895
Fax	385-465-6040
Email Address	erictadehara@utah.gov

State CMHS Unique Entity Identification

Unique Entity ID	1B08TI085836

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

Agency Name	Utah Department of Health and Human Services
Organizational Unit	Office of Substance Use and Mental Health
Mailing Address	288 N 1460 W, Third Floor
City	Salt Lake City
Zip Code	84116

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

First Name	Leah
Last Name	Colburn
Agency Name	Office of Substance Use and Mental Health
Mailing Address	288 N 1460 W, Third Floor
City	Salt Lake City
Zip Code	84116
Telephone	385-285-6146
Fax	385-465-6040
Email Address	lacolburn@utah.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

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

From

To

V. Date Submitted

Submission Date

Revision Date

VI. Contact Person Responsible for Application Submission

First Name	Shanel
Last Name	Long
Telephone	801-885-7372
Fax	385-465-6040
Email Address	shlong@utah.gov

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
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Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

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

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or

attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

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

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

State: _____

Name of Chief Executive Officer (CEO) or Designee: Tracy Gruber

Signature of CEO or Designee[1]: _____

Title: Executive Director of Utah Dept. of Health and Human Services

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

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

Fiscal Year 2026

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Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**

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10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State

management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

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

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

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

3. Certifications Regarding Lobbying

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

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

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

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

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

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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

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

Name of Chief Executive Officer (CEO) or Designee: Tracy Gruber

Signature of CEO or Designee[1]: _____

Title: Executive Director of Utah Dept. of Health and Human Services

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Name

Tracy Gruber

Title

Executive Director of Utah Dept. of Health and Human Services

Organization

Utah State Department of Health and Human Services

Signature: Date:

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Steps

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

Narrative Question

Provide an overview of the state's prevention system (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public 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 SMHA, the SSA, and other state agencies with respect to the delivery of mental health and SUD services. States should also include a description of regional, county, tribal, and local entities that provide mental health and SUD services or contribute resources that assist in providing these services. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

1. Please describe how the public mental health and substance use services system is currently organized at the state level, differentiating between child and adult systems.

The Department of Health and Human Services Executive Director is a member of the Governor's Cabinet Council along with all other Department heads. Under the Executive Director there are four branches; Clinical Services, Operations, Health Care Administration and Community Health and Well-Being. There are three Operational Units that fall under Healthcare Administration; Aging and Adult Services, Services for People with Disabilities and Integrated Healthcare. Integrated Healthcare includes Behavioral Health and Medicaid. The Office of Substance Use and Mental Health (SUMH) is part of the Behavioral Health Operational Unit. The Department of Health and Human Services is one of the largest departments in the Utah State government. Child and Family Services, Family Health, Recovery Services, Population Health, Juvenile Justice and Youth Services and Utah Public Health Laboratory are located under the Community Health and Well-being branch. (See table 1 of attachment)

SUMH is responsible for providing and overseeing the majority of the public Substance Use and Mental Health services across the lifespan to include adults and children. The Utah Office of Substance Use and Mental Health is authorized under Utah State Code Annotated §26B-5-102 as the single state authority for mental health and substance use in Utah. Utah Statutes require the State Office of Substance Use 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 26B, Chapter 5, Section 104 "Authority and Responsibilities") and that SUMH "…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 26B-5-102. "Division -- Creation – Responsibilities").

SUMH oversees mental health, substance use treatment and prevention, recovery support service provision through contracted providers for youth, transitional aged youth and adult services. The Local Authorities (LAs) are responsible for providing these services to individuals within their catchment areas.

There are coordinated efforts Utah Department of Health and Human Services to support service access for the lifespan Division of Services for Persons with Disabilities, Adult and Aging Services, and youth specific agencies such as Juvenile Justice and Youth Services, Population Health, Child and Family Services, Family Health and also provide and contract behavioral health services for adults, families, adolescents and youth.

2. Please describe the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of mental health and substance use services.

The Office of Substance Use and Mental Health (SUMH) is the SMHA and SSA for Utah. SUMH has two assistant directors who serve as the SSA and SMHAs, and as such oversees the provision of public behavioral health services for children and adults in Utah. SUMH carries out its statutory obligations by contracting with Local Substance Abuse and Mental Health Authorities collectively known as the Local Authorities (LAs) for the delivery of Behavioral Health services. The State Prevention team is also located within SUMH. 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 for providing prevention services throughout the entire LSAA.
SUMH distributes federal and state funds through contracts (counties are required to provide matching funds), and monitors the LA's 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.
SUMH also provides leadership and coordination with other state agencies, the state legislature and advocacy groups. (See Table 2 of attachments)

3. Please describe how the public mental health and substance use services system is organized at the regional, county, tribal, and local levels. In the description, identify entities that provide mental health and substance use services, or contribute resources that assist in

providing these services. This narrative must include a description of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

Utah's public behavioral health system for children and adults have the same organizational structure. The 29 counties in Utah have organized themselves into 13 Local Substance Abuse and Mental Health Authorities, collectively Local Authorities (LA's). Currently all but 1 local authorities are joint behavioral health agencies and are able to provide Mental Health and Substance use services within the same agency. In 2026 all 13 local authorities will be co-located. 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 Office of Substance Use and Mental Health (SUMH). LA's are required to outline in their annual area plan how they are planning to provide mental health, substance abuse treatment and prevention and recovery support services to this population as well as the adult population. This plan is based on statutory requirements and Office Directive that is provided each year to the local authorities shortly after the Legislative Session ends in March. The current Office Directives are located on SUMH's website. Contracts with the LA's and their funding allocations are approved only after the Area Plans have been approved by the SUMH Director.

Local Authorities set the priorities to meet local needs, but at a minimum must provide eleven (11) 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 SUMH annually. Plans also include priority populations, levels of care, These plans become the foundation of contracts between SUMH and each of the LA's. Utah is home to 8 distinct tribal nations. Since planning for and providing services is the county responsibility, each county and or LA is tasked with the requirement to include Native Americans as well as other minority and underserved groups in their planning process.

Utah State Statute Utah Code 17-43-301, specifically mandates the Local Substance Abuse Authorities (LSAA) provide a "continuum of services for Adolescents and Adults" aimed at substance use disorders, prevention and treatment; and requires Local Mental Health Authorities (LMHA) to provide mandatory services for individuals with serious mental illness or severe emotional disturbance. Thus, Utah's LA's are given the responsibility to provide mental health services to their citizens. Utah utilizes MHBG and SAPT Block Grant funds, along with State General Funds, other State and Federal appropriations and the counties' 20% funding match to fulfill these requirements to provide for services required by federal and state statutes. State and federal funds are allocated to LA's 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.

Utah uses braided State and Federal funding to support behavioral health services. SUMH has prioritized integrated behavioral health services to address behavioral health and physical health needs of the individual. Screening and assessments are used to identify and diagnose behavioral health needs and treatment placement. SUD uses ASAM levels to ensure the correct level of care. Ongoing assessments are performed to address any needs that may come up during treatment.

Utah has focused on providing co-occurring disorder services for several years, understanding the importance to treat the individual where they are at. Although there is still a necessary need to set a primary diagnosis each agency is able to provide co-occurring services.

Priority populations:
Substance use treatment: Priority populations and populations served include pregnant women and women with dependent children, persons who inject drugs, persons in need of recovery support services for SUD (PRSUD), Individuals with a co-occurring mental health and SUD, Persons experiencing homelessness, Persons with SUD at Risk for Tuberculosis (TB), Persons with SUD at Risk for HIV (EIS/HIV), Individuals in Need of Primary Substance Use Prevention (PP).

Pregnant Women and Women with Dependent Children (PWWDC). Every local authority has the ability to provide services to pregnant women and women with dependent children directly or through contracted service providers. There are 6 women with children residential facilities, 1 women's only residential treatment facility, 13 outpatient women's treatment programs and 1 fathers with children outpatient programs. Individuals can access all levels of care through inter-agreements with treatment providers across the state.

Persons Who Inject Drugs (PWID) is set as a priority population and providers are required to meet priority population requirements at first contact when the individual is identified as such. If health concerns are identified with individuals such as high risk behaviors or other health concerns and risk such as increased risk of HIV/EIS or TB individuals will be referred for additional physical health screenings and services. Utah is not a designated state.

Each of the LAs has the ability to provide non-clinical recovery support services to persons in need of recovery support services for SUD directly or through contracted service providers. SUMH recognized the importance of wrap-around non-clinical services in order to support an individual in their own recovery.

Primary Prevention: Primary substance use prevention is carried out through contracts with the 13 Local Authorities. About half of prevention providers are housed at local health departments, separate from the rest of behavioral health, while the other half are

housed at one of the behavioral health agencies.
Utah code, administrative rules, and office directives outline prevention requirements for the state. Prevention efforts are conducted at a local community level through community engagement and coalition work. Each of the 13 areas have at least one community coalition that develops community partnerships and follows the Strategic Prevention Framework to implement effective prevention. Many of the more urban areas utilize a “cone” structure focused on developing coalitions around a high school and all of the schools/communities that feed into that particular high school. Utah has coined this local prevention effort as Community Centered Evidence Based Prevention.
SUMH directly funds the LA’s, who in turn fund community coalitions. Most LA’s are the fiscal agent for community coalitions and employ the coalition coordinator. Occasionally local coalitions have gained significant support at the local level and an agency outside of the LA employs the coalition coordinator and is the fiscal agent for the coalition. In these instances the LA often subcontracts some funding to the coalition's fiscal agent.
The state supports the 13 LA’s and community coalitions through a Regional Director (RD) position. The RD is assigned to a few of the 13 areas and is responsible to provide training and technical assistance to each area specific to that area's needs. RDs do not provide direct services and do not direct the prevention efforts of the LAs or local coalitions. They provide support to help areas progress through the Strategic Prevention Framework and to enhance the over quality and ability of the prevention workforce.

For adults with serious mental illness (SMI) and children with serious emotional disturbance (SED)- The LA system provides a full continuum of mandated mental health services in accordance with Utah Code 17-43-301 to support individuals with SMI and SED receiving services in their community. Local Authorities must provide 11 statutorily mandated mental health services as well as peer support services mandated through Medicaid contract, 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 SUMH annually. These plans become the foundation of contracts between SUMH and each of the Local Authorities. LA’s additionally provide a service array based on their community needs which may include additional services as indicated in the LA area plan documents.The LA system prioritizes individuals with SED and SMI. This includes but is not limited to individuals with intellectual and developmental disabilities, older adults, first episode psychosis, youth with complex behavioral health needs.

Crisis services: One of the mandated services identified in Utah Code 17-43-301 is “24 hour crisis care and services”. All 13 LA’s provide mobile crisis outreach teams (MCOT).

First episode psychosis (FEP): FEP treatment through coordinated speciality care (CSC) is not a mandated service, however requirements for the service provision for the LA’s who provide this care are outlined in the Office Directives mentioned in this section.

The Utah State Hospital (USH) provides statewide inpatient mental health services, is a 24-hour psychiatric facility located in Provo, Utah, and is organized as a part of the SUMH. USH provides active psychiatric treatment for children with SED and adults with SMI. USH has 154 forensic beds (22 at the crisis recovery unit at the Salt Lake County jail), 152 civil beds assigned to LAs, 2 beds held for the Department of Corrections and 72 pediatrics beds. 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. USH 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 SUMH is responsible for establishing a bed allocation formula, which is based on the percentage of state population within each LAs catchment area and a rural differential. The LAs monitor USH treatment and provide follow-up coordination and care in the community for those under their bed allocation.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Table 1- Department of Health and Human Services Organizational Chart

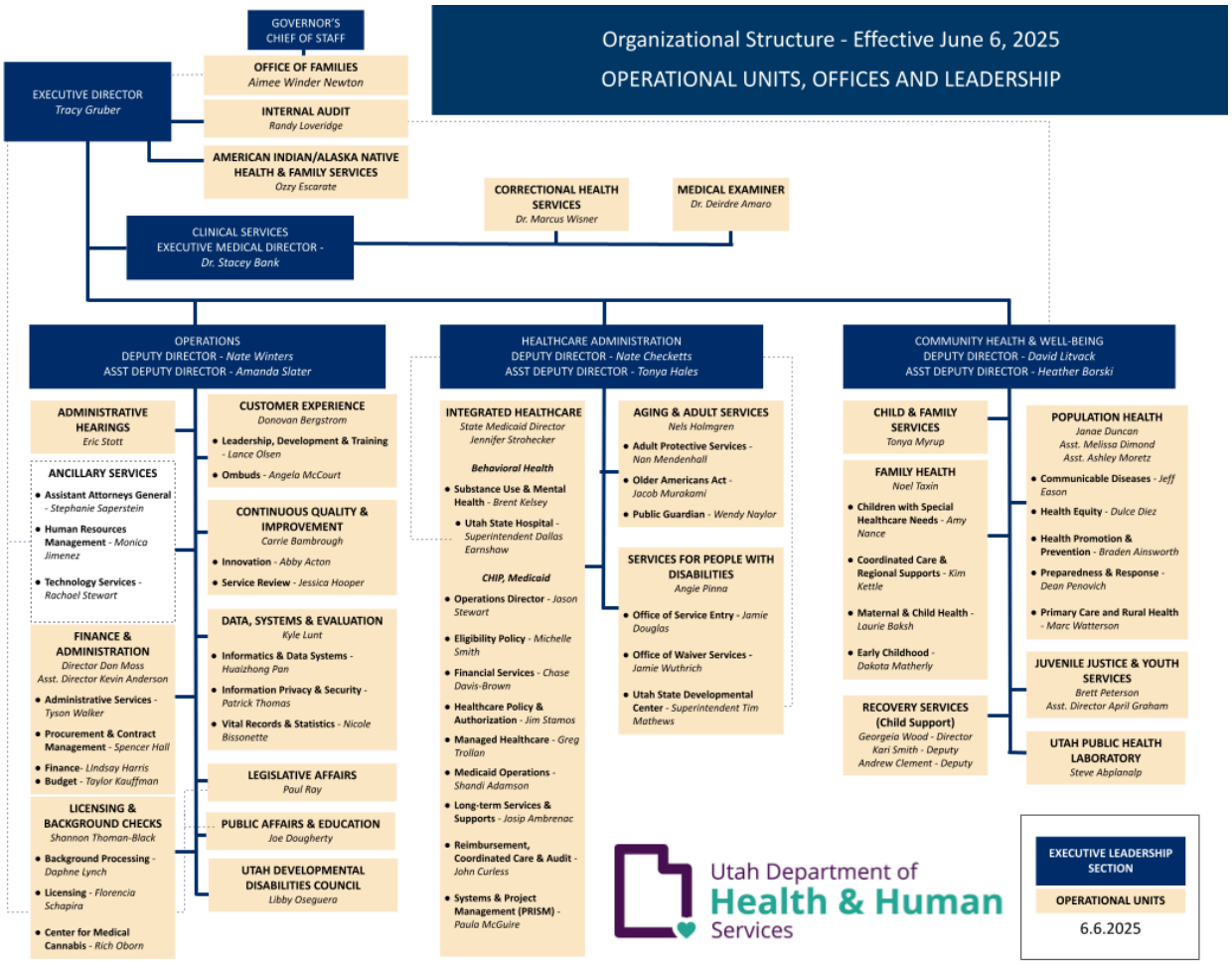

Table 2 - Office of Substance Use and Mental Health Public System Chart

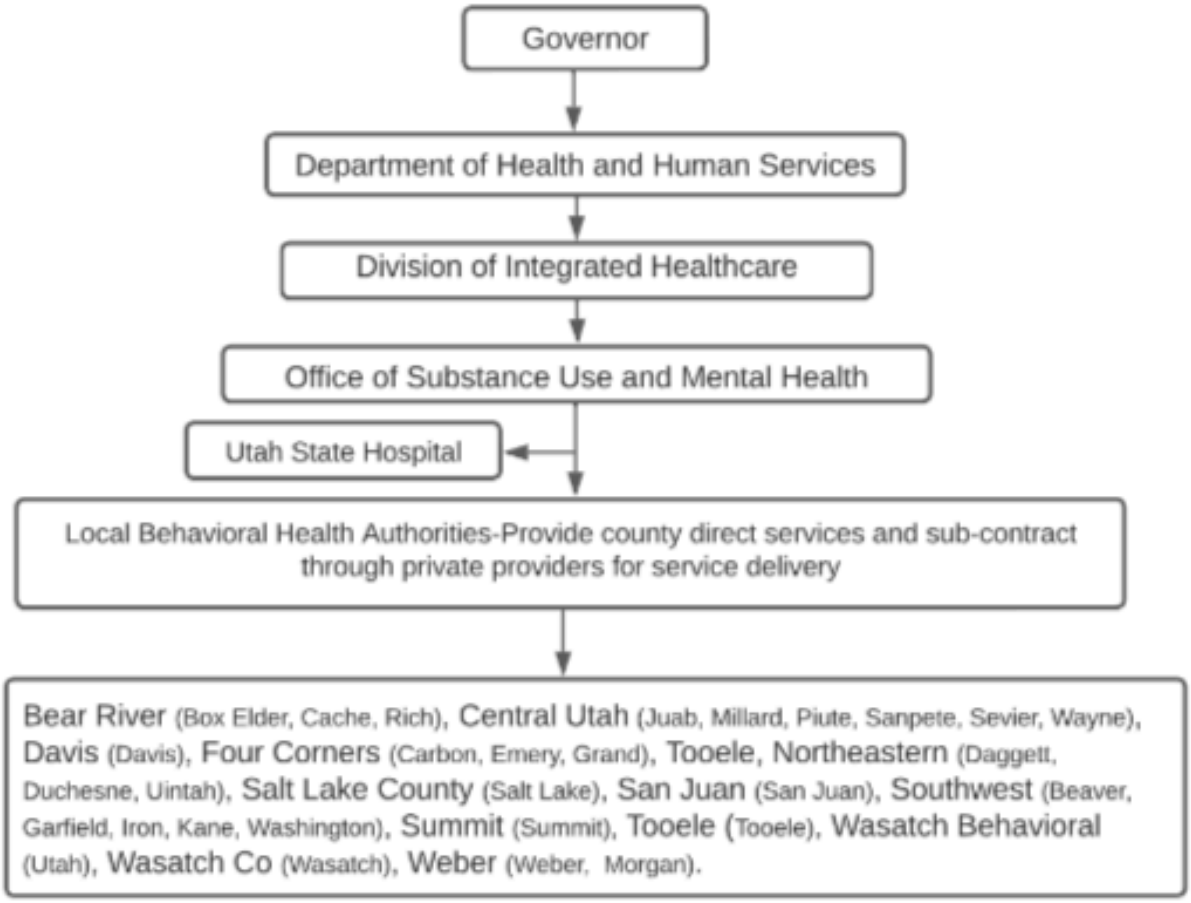

Table 3 - Local Authority Map

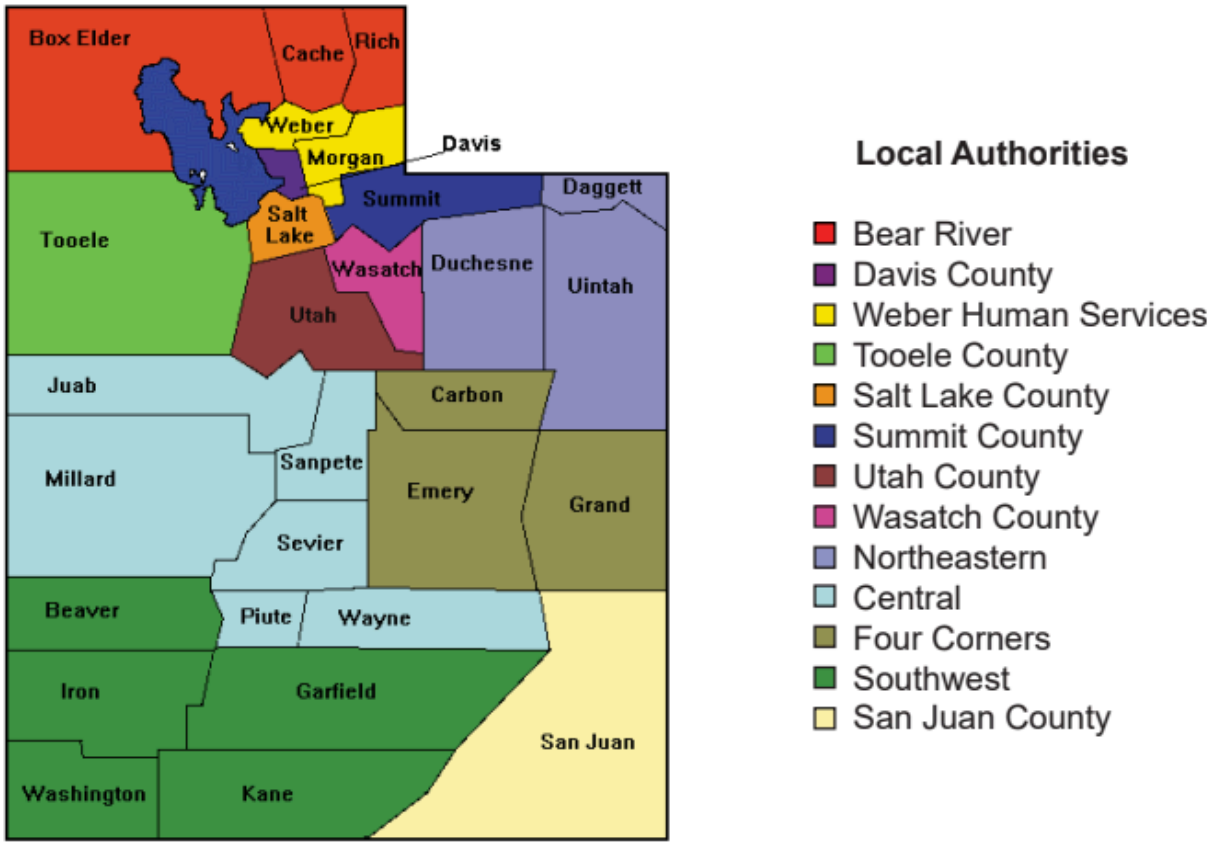

Table 4 - Utah's Eight District Tribal Nations

CONFEDERATED TRIBES OF GOSHUTE

HC 61 Box 6104
195 Tribal Center Road
Ibapah, Utah 84034

Amos Murphy, Chairman
amos.murphy@ctgr.us
Phone: (435) 234-1138
FAX: (435) 234-1162

PAIUTE INDIAN TRIBE OF UTAH

440 North Paiute Dr.
Cedar City, Utah 84721

Corrina Bow, Chairwoman
corrina_bow@yahoo.com
Phone: (435) 586-1112
FAX: (435) 867-2659

SAN JUAN SOUTHERN PAIUTE TRIBE

P.O. Box 2950
Tuba City, Arizona 86045

Johnny Lehi, Jr., President
j.lehijr@sanjuanpaiute-nsn.gov
Phone: (928) 212-9794
Fax: (928) 233-8948

NORTHWESTERN BAND OF SHOSHONE NATION

2575 Commerce Way
Ogden, Utah 84401

Dennis Alex, Chairman
dalex@nwbshoshone.com
Phone: (435) 734-2286
FAX: (435) 734-0424

SKULL VALLEY BAND OF GOSHUTE

407 Skull Valley Road
Skull Valley, UT 84029

Phone: (435) 831-4079

UTE INDIAN TRIBE OF THE UINTAH AND OURAY RESERVATION

P.O. Box 190
Fort Duchesne, Utah 84026-0190

Julius Murray, Chairman
Phone: (435) 722-5141
FAX: (435) 722-2374

UTE MOUNTAIN UTE TRIBE

P.O. Box JJ
Towaoc, CO 81334

Manuel Heart, Chairman
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Table 5 - Utah Eight District Tribal Lands Map

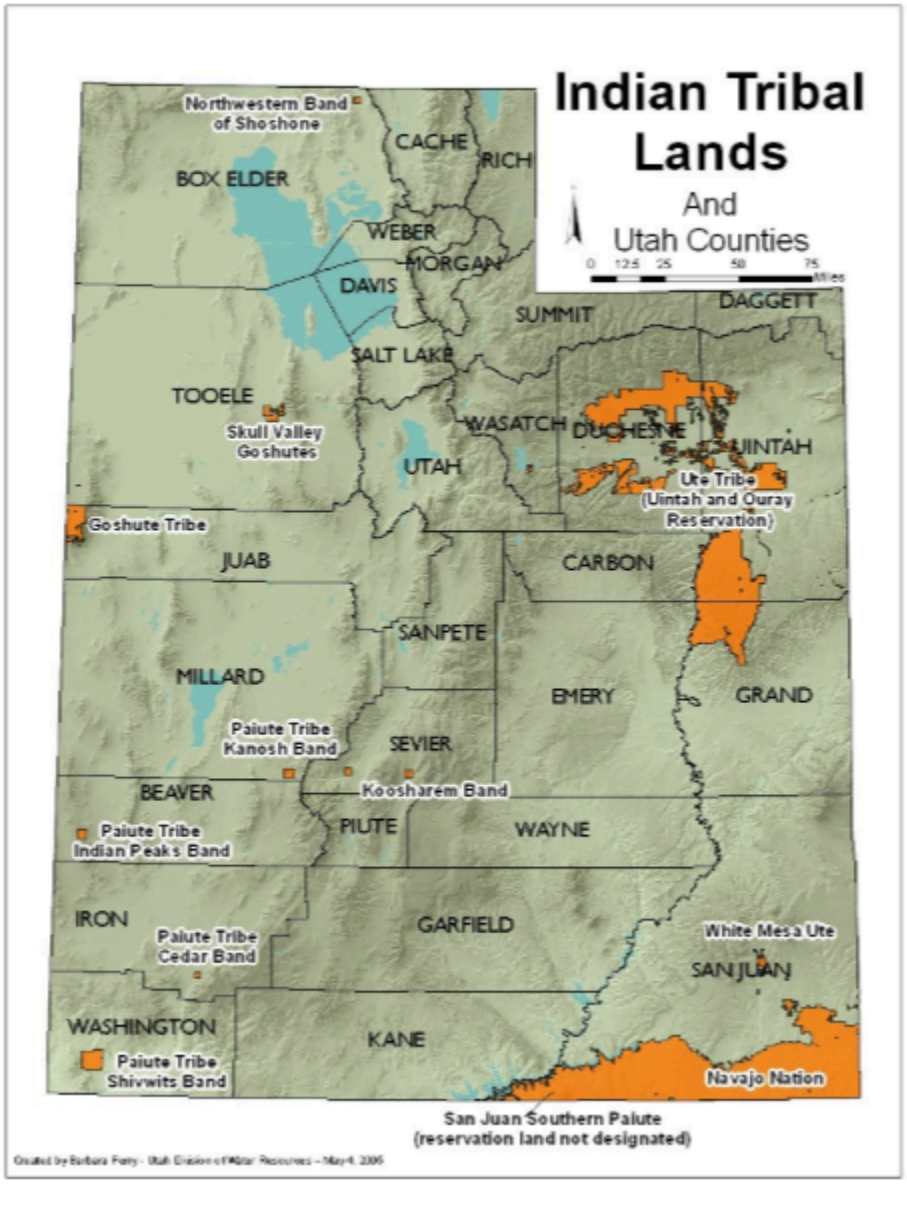

Table 6 - Women's Service Providers

		Local Authorities - Pregnant and Parenting Women's Services	
County	**Intermediary/MCO/ASO Name, Address, Telephone Number (if applicable)**	**Provider Name, Address, Telephone Number**	**Type of Program (e.g. PPW (for PPW indicate if they accept children), OTP, Residential, Outpatient, Detox, etc.)**
Cache County	Director - Jared Bohman	Bear River Health Department - 655 East 1300 North, Logan, Utah 84321; (435) 792-6500	PPW Outpatient - Accepts Children
Carbon County	Director - Melissa Huntington	Four Corners Behavioral Health - 105 West 100 North, Price, UT 84501; (435) 637-7200	PPW Outpatient - Accepts Children
Central Utah	Director - Nathan Strait	Central Utah Counseling - 152 North 400 West, Ephraim, Utah 84627-5549; (435) 283-8400	PPW Outpatient - Accepts Children
Davis County	Director - Brandon Hatch	Davis Behavioral Health -934 South Main, Layton, Utah 84041; (801) 773-7060	PPW Outpatient - Accepts Children
Salt Lake County	Director - Tim Whalen	Salt Lake County Behavioral Health - 2001 South State, Suite S2300, Salt Lake City, Utah 84190-2250; (385) 468-4707	PPW - Outpatient and Women and Children's Residential - Accepts Children (W&C Residential Contracts: House of Hope Salt Lake, Odyssey House of Utah & Valley Phoenix)
San Juan	Director - Tammy Squires	San Juan Counseling - 365 South Main, Blanding, Utah 84511; (435) 678-2992	PPW - Outpatient - Accepts Children
Washington County	Director - Mike Deal	Southwest Behavioral Health - 474 West 200 North, St. George, Utah 84770; (435) 634-5600	PPW - Outpatient and Women and Children's Residential - PPW Residential - Desert Haven - Accepts Children. Single Men / Women's Residential Treatment - Does not accept children.
Summit County	Director - Aaron Newman	Summit County - Huntsman Mental Health Instititue (HMHI) Park City - 1753 Sidewinder Drive, Park City, Utah 84770; (435)638-5461	PPW - Outpatient - Accepts Children

Tooele County	Director - Peter Clegg	Tooele County Department of Human Services - 47 South Main St. RM 114, Tooele, Utah 84074; (435) 843-3314	PPW - Outpatient - Accepts Children
Uintah Basin - Tri County	Director - Kyle Snow	Northeastern Counseling - 285 West 800 South, Roosevelt, Utah 84078; (435) 789-6300	PPW - Outpatient - Accepts Children
Utah County	Director - Randy Huntington	Wasatch Behavioral Health (WBH) - 750 N. Freedom Blvd, Provo, Utah 84601; (801) 373-4760	PPW - Outpatient - Accepts Children.
Utah County	Director - Amy Buehler	Wasatch Behavioral Health - Utah County Substance Use Disorder (SUD) Treatment -255 South Orem Blvd, Orem, UT 84058; (385) 268-5041	PPW - Outpatient and Women and Children's Residential - Accepts Children. PPW Residential - House of Hope Provo. PPW Intensive Outpatient - Promise North and South
Wasatch County	Clinical and Community Services Director - Elizabeth Feil, LCSW Clinical Director - Chad Shubin	Wasatch County Family Clinic - 55 South 500 East, Heber City, Utah 84032; (435) 654-3003	PPW - Outpatient - Accepts Children
Weber County	Director - Kevin Eastman	Weber Human Services - 237 26th Street, Ogden, Utah 84401; (801) 625-3847	PPW - Outpatient and Women and Children's Residential - PPW Residential - Tranquility Home - Accepts Children

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system, including state plans for addressing identified needs and gaps with MHBG/SUPTRS BG award(s)

Narrative Question

This narrative should describe your states needs assessment process to identify needs and service gaps for its population with mental or substance use disorders as well as gaps in the prevention system. A needs assessment is a systematic approach to identifying state needs and determining service capacity to address the needs of the population being served. A needs assessment can identify the strengths and the challenges faced in meeting the service needs of those served. A needs assessment should be objective and include input from people using the services, program staff, and other key community stakeholders. Needs assessment results should be integrated as a part of the state's ongoing commitment to quality services and outcomes. The findings can support the ongoing strategic planning and ensure that its program designs and services are well suited to the populations it serves. Several tools and approaches are available for gathering input and data for a needs assessment. These include use of demographic and publicly available data, interviews, and focus groups to collect stakeholder input, as well as targeted and focused data collection using surveys and other measurement tools.

Please describe how your state conducts needs assessments to identify behavioral health needs, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

Grantees must describe the unmet service needs and critical gaps in the state's current systems identified during the needs assessment described above. The unmet needs and critical gaps of required populations relevant to each Block Grant within the state's behavioral health system, including for other populations identified by the state as a priority should be discussed. Grantees should take a data-driven approach in identifying and describing these unmet needs and gaps.

Data driven approaches may include utilizing data that is available through a number of different sources such as the **National Survey on Drug Use and Health (NSDUH)**, **Treatment Episode Data Set (TEDS)**, **National Substance Use and Mental Health Services Survey (N-SUMHSS)**, the **Behavioral Health Barometer**, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the CDC mortality data, and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention, treatment, and recovery support services planning. States with current Strategic Prevention Framework - Partnerships for Success discretionary grants are required to have an active SEOW.

This step must also describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss their plan for implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations listed above, and any other populations, prioritized by the state as part of their Block Grant services and activities are addressed in these implementation plans.

1. Please describe how your state conducts statewide needs assessments to identify needs for mental and substance use disorders, determine adequacy of current services, and identify key gaps and challenges in the delivery of quality care and prevention services.

SUMH utilizes a number of resources to conduct needs assessments. Most recently, in 2024, Kem C Gardner Institute released the Behavioral Health Assessment and Road Map Report Masterplan for Utah. The goal was to conduct an environmental scan to understand current behavioral health initiatives; gaps in services; challenges, barriers, and inequities related to providing and accessing behavioral health services in Utah; and the changing and future needs of stakeholders connected to Utah's behavioral health systems. The Master Plan is a living document designed to address the needs and gaps in the state and provide a road map to improve services.

SUMH has also contracted or partnered with outside partners to complete the following needs assessments: a court-ordered services assessment; an analysis of a survey of the peer support workforce; and, and Early Childhood Mental Health needs assessment to inform early childhood (0-6) mental health needs statewide.

SUMH has also utilized partnership with universities to conduct needs service population specific needs assessments. The University of Utah College of Social Work research team is in the process of completing a needs assessment for youth experiencing homelessness in all counties except Salt Lake, which was completed in FFY23. This needs assessment will include information about access to mental health and substance use treatment services, in addition to. In July 2025,Utah closed a request for proposals for a needs assessment to address youth mental health statewide service access. SUMH completed a cost analysis for Individuals Placements and Support (IPS) and a cost analysis of the Coordinated Specialty Care (CSC) teams in Utah, which will be used to inform the incorporation of a team-based billing rate for Medicaid, SUMH partners with local hospital systems, local health departments, and other Utah DHHS operational units who conduct community health needs assessments whose results additionally inform opportunities to partner to address statewide gaps.

SUMH utilizes data analysis from NSUDH, TEDS, IBIS, YRBSS, Utah SAMHIS data set, the State SEOW, contracted needs assessment, SAMHSA Quality Assurance Visits and GPO state visits, Reports provided from Utah's population health, SHARP survey, State audits done by Legislative financial analysts and the Department of Health and Human Service auditors. There are other organizations that provide feedback regarding needs and gaps for our system including the Utah Behavioral Planning and Advisory Council (UBHPAC), the Utah Behavioral Healthcare Committee (UBHC) which includes directors, clinical directors, finance directors and data directors from each of the Local Authorities and the newly legislatively mandated Utah Behavioral Health Commission.
SUMH also reviews CDC mortality data and also our state Office of the Medical Examiner to review Utah mortality rates and SUMH is part of the fidelity review committee.

SUMH is contracted with the Administrative office of the Courts to provide annual drug court certifications and provide training and education. This includes addressing needs and gaps within the drug court system.

The SEOW contracts with an evaluation company to provide a person to carry out many of the functions of the SEOW. The SEOW is also composed of other state agency partners (those working in public health, and from the Utah Board of Education). There is prevention representation from state level staff, regional director staff, and local prevention coordinators. SUMH data folks round out the membership of the group. The SEOW, either through the contractor, or through the larger group provides analysis of data from local and national surveys, analyzes consumption and consequence data, and interprets data and packages that data in a user friendly manner. The SEOW is mostly utilized by the prevention system as a mechanism to better understand data for needs assessments.
A large way the SEOW contributes to the prevention system is through the upkeep of a social indicators website which houses data on use rates, consumption, and consequences. The SEOW contractor often provides training on how to use the social indicators website along with other data bases in the state. The SEOW also provides a quarterly data brief that dives deeper into prevention data to help prevention professionals better understand the data they are using for assessments. Annually the SEOW contractor pulls together an alcohol abuse tracking report that provides a comprehensive look at alcohol related data for the state. The report includes use rates, arrests, crashes, deaths, costs, etc.

2. Please describe the unmet service needs and critical gaps in the state's current mental and substance use systems identified in the needs assessment described above. The description should include the unmet needs and critical gaps for the required populations specified under the MHBG and SUPTRS BG "Populations Served" above. The state may also include the unmet needs and gaps for other populations identified by the state as a priority.

In the 2024 Kem C Gardner Behavioral Health Assessment and Road Map Report referenced above the following gaps and needs were identified:
1. Access to Services
-Continued need to increase access to behavioral health services. Many Utahns do not have access to the care they need. While data show utilization may have improved for some populations, nearly half of Utah's adults and youth with mental health needs do not receive services or treatment. Strengthening access to a full continuum of care including stabilization supports and wraparound services.
-Need for system level coordination and innovation: system fragmentation limits the ability to access the right care at the right place and at the right time. Many primary care providers lack the training and resources to engage in behavioral health screenings, early intervention, and treatment of mild-to-moderate behavioral health conditions.
-Insufficient funding to meet demands of necessary behavioral health services.
2. Stigma-behavioral health needs and certain targeted populations.
3. Payer-level integration of physical and behavioral health
-The inability for providers to treat co-occurring physical and behavioral health issues because of payor
-Lack of system-level coordination (Utah Medicaid ACOs cover medication management, county health departments oversee prevention-related activities, different state and federal funding sources for SUD vs. mental health services, etc
-Continuity of care in Medicaid. Another concern is the issue of "churn"—individuals moving between different Medicaid programs, different ACOs or prepaid mental health plans (PMHPs), and on and off Medicaid
4. Outpatient Specialty Services
-Limited access. The lack of access to outpatient specialty services stems from a myriad of issues, including more people needing behavioral health services due to the state's rapid population growth, Medicaid expansion, lessening stigma, improved access to crisis services (i.e., receiving centers and MCOT teams), workforce shortages (worsened by the COVID-19 pandemic), administrative burdens, limited reimbursement, lack of system coordination, and the creation of system siloes
-Increased co-occurring service needs and services for specialty needs such as eating disorders, geriatric.
4. Crisis/Diversion
-Rural-area crisis services
-Sustaining crisis and diversion services.
-Social detox services/facilities
-Lack of coordination with the criminal legal system
5. Subacute Care, Acute/Inpatient Care, and Residential Care
-Fixing the front end. Increase the lack of services for individuals needing more than crisis and diversion services, but something less than acute or inpatient care

-Lack of “step down” or aftercare services. Leading into need for long term recovery and inability to transition due to lack of step down services.
6. Stabilization Supports And Wraparound Services
-Care coordination, transition support, and patient navigation
-Housing and other recovery supportive services. Utah continues to suffer from a housing market shortage which is Utah’s number one issue as reported by the Kem C Gardner report.
7. Behavioral Health and Other Workforce
-Behavioral health providers across the care continuum.
-Non-traditional market entrants. Utah’s workforce shortages are exacerbated by the creation of siloed and sometimes competing initiatives such as EAPs and the emergence of online mental health/counseling platforms. As noted above, some of the main concerns with these siloes are that they are not always connected back into broader behavioral health systems.
-Increase training and education to behavioral health para-professionals and professionals to increase access and quality of service delivery.
-Duplication of efforts K-12 Mental Health (school based MH professionals were hired for other providers which caused workforce shortages in other practices).
-Full utilization of license potentials
-School funding being used on academics and not MH services
-Training needs
-School based MH lack of connection to BH providers or broader continuum of care.
-Lack of childcare providers for younger aged children
8. Other Supportive Services
-Tobacco cessation for youth- The nicotine dependency rate for individuals with behavioral health conditions is 2-3 times higher than the general population and the Utah Tobacco Quit Line reported 65% of total callers noted having a behavioral or mental health condition in 2022. This coupled with the high utilization rate of Utah’s cessation services among persons with behavioral health conditions is both an indicator of higher prevalence and interest in quitting tobacco.

Additionally SUMH has identified the following:
Primary prevention unmet needs and gaps:
-While everyone in the state lives within the area of a LA, not everyone lives in a community that has a community coalition that is addressing risk and protective factors.
-Communities without a coalition also leads to a gap in individuals not having access to evidence-based prevention programs, strategies, policies.
-Lack of connection of prevention to the rest of the continuum of care. There are opportunities to engage families that have a member in treatment or recovery in prevention programming.

Utah has identified services to individuals experiencing homelessness as a priority for the state. In 2023, the Utah Homelessness Council released Utah’s Strategic Plan to Address Homelessness. Data shows that an estimated 12,442 individuals enrolled in homeless services or housing projects in Utah as of April of 2022 and this number continues to grow. Single adults consist of approximately 48% of the people experiencing homelessness, while families make up 30%. Black individuals are only 1% of the state population but represent over 10% of those in the homeless care system. Hispanic or Latino individuals are only 14% of the state population but represent over 23% of those experiencing homelessness. Specific data regarding American Indian/Alaskan Native and Pacific Islander populations were not provided, but they were noted as "overrepresented in the homeless population in Utah." Males represent a majority of the homeless population in Utah at 57%. The median time from entry into the care system to placement in permanent housing is 92 days. Of those experiencing homelessness since 2018 and enrolled in the care system, over 55% had a history of being unsheltered. An estimated 39% of people newly entering the care system each year have experienced or will experience unsheltered homelessness.

Utah’s TB rates have remained stable since 2022 with 23 cases reported in 2023. Utah HIV diagnosis rate has continued to remain relatively stable over the past decade with 4.0 per 100,000 in 2021. Utah is not a designated state. Persons who inject drugs (IV) are a priority population and required to meet federal requirements. TB and HIV are priorities of the Division of Heath Promotion, most services are funded and provided by Health Promotions. The Local Authorities provide TB and HIV testing through collaboration efforts with Health Promotion or directly with their internal medical teams or other community partners.
Utah identifies pregnant women and women with dependent children as priority populations. The needs for this population continue to be preventive services, early identification and access to services, and providing integration of care for mother and child.

3. Please describe how the state plans to address the unmet service needs and gaps identified in the needs assessment. These plans should reflect specific services and activities allowable under the respective Block Grants. In describing services and activities, grantees must also discuss plans for the implementation of these services and activities. Special attention should be made in ensuring each of the required priority populations and any other populations prioritized by the state as part of the Block Grant services and activities are addressed in the implementation plan.

The commission was established in 2024 by Utah Code 26B-5-703 to address Utah Behavioral Health Master Plan findings. The

Utah Behavioral Health Commission is the central authority for coordinating behavioral health initiatives between state and local governments, health systems, and other interested persons, to ensure that Utah's behavioral health systems are comprehensive, aligned, effective, and efficient.The Commission maintains independence from the Department of Health and Human Services (DHHS) and the governor, such that the Commission can provide independent advice and recommendations, especially regarding proposed bills and policy considerations. SUMH partners with the Behavioral Health Commission to coordinate strategies for addressing needs to include public and private partners to ensure all Utahn's have access to care.

Adults with Serious Mental Illness (SMI) and Children with Serious Emotional Disturbance (SED) - SUMH will continue to take a coordinated approach to addressing mental health services for adults with SMI and children with SED by supporting the LA system in their service provision. SUMH will work with partners to target increased screening for mental health concerns, evidence based treatment access, increasing access to integrated care and community based care, and recovery supports such as peer support services. SUMH will continue to partner with other Utah DHHS divisions and offices, including Aging and Adult services, Division of Services for Persons with Disabilities, Division of Child and Family Services, Division of Juvenile Justice and Youth Services, Division of Family Health, and Correctional Health Services, to ensure access to care and warm transitions for individuals served by them. SUMH will continue to support increased care quality for individuals with co-occurring I/DD, those with perinatal mental health conditions, and early childhood mental health through partnership with service providers and training agencies. Block grant funds are allocated on formula to LAs for service provision to individuals with SED/SMI, and contracted to community agencies for training for evidence based practices and workforce development, suicide prevention, peer support training and technical assistance, needs assessments, and direct services for SED/SMI not served by the LAs.

Crisis services - For individuals needing access to crisis services, SUMH will continue to focus on increasing the knowledge and use of 988, the number of mobile crisis outreach teams (MCOT) statewide, and use of receiving centers. Block grant funds are allocated to Huntsman Mental Health Institute to support the statewide 988 crisis line, on formula to LAs, and for training law enforcement Crisis Intervention Teams.

First Episode Psychosis - Funds are used to support 5 LAs who are providing Coordinated Speciality Care (CSC) teams. SUMH will continue to use mental health block grant funds to increase the number of CSC teams in urban regions. In those rural and frontier areas that are unable to develop a CSC team to fidelity, SUMH will work to ensure provider training for screening and assessment of individuals with symptoms. Technical support will be provided to ensure the best possible care is available. Block grant funds are allocated to LAs and contracted providers to establish and maintain CSC teams.

Pregnant Women and Women with Dependent Children (PWWDC) - Increase screening, assessment and access to behavioral health and physical health services. Utah was awarded the CCBHC planning grant and was also selected as a Physical Health Integration Learning Collaborative. These efforts will help our state to move in the direction of becoming an integrated state. This will help improve behavioral health and physical health services to pregnant women and women with dependent children. Utah is working to improve affordable housing through the Utah Homelessness Council in partnership with the Office of Homeless Services. SUMH also supports sober supportive housing and additional efforts to provide non-clinical recovery support services.

Persons Who Inject Drugs (PWID)- increase early identification and access screening and assessments. Utah is working to improve early access to physical healthcare and behavioral healthcare by working with physical health providers to increase screenings and referrals to treatment by utilizing SBIRT. Utah is working towards a no-wrong door approach for easier access of services.

Persons in need of recovery support services for SUD (PRSUD)- Increase access to housing and other non-clinical recovery support services that support recovery. SUMH is expanding recovery support services for those with mental health issues. With the elimination of some federal funding, Utah has worked to ensure that all other eligible funding such as the SUPTRS and MH block grants are available to cover all eligible recovery support services. Utah also utilizes other funding sources such as state funds, SOR funding, discretionary grants, etc to help support these services.

Individuals with a co-occurring mental health and SUD- increase screenings and identification of co-occurring issues, integration models with new CCBHC planning grant and Physical Health Integration Learning collaborative. Increased educational and training on co-occruing disorders as indicated in the Kem C. Gardner report. Work with payors to identify ways to improve reimbursement rates for services.

Persons experiencing homelessness- Efforts outlined in the Utah Homelessness Council includes increasing accessibility to affordable housing and permanent housing opportunities for people experiencing homelessness, increase access to supportive services such as case management and other non-clinical services, expanding homeless prevention efforts and increase coordination of efforts, alignment of coordination across multiple systems which include behavioral health, housing authorities, criminal justice agencies, increase supported employment.

Persons with SUD at Risk for Tuberculosis (TB)- coordinated efforts with the Office of Health Promotions. Identifying at risk individuals, increasing access to testing and physical health care. Increase Integration of physical and behavioral health which will be supported by the CCBHC planning grant and the Physical Health Integration Learning Collaborative awarded in 2025.

Persons with SUD at Risk for HIV (EIS/HIV) Identifying at risk individuals, Increase Integration of physical and behavioral health which will be supported by the CCBHC planning grant and the Physical Health Integration Learning Collaborative awarded in 2025. Increase Integration of physical and behavioral health. Utah is not a designated state.

Individuals in Need of Primary Substance Use Prevention (PP) Increase the number of community coalitions across the state. Increase the quality of current coalitions in their ability to follow the Strategic Prevention Framework to implement evidence-based strategies. Increase the quality of prevention strategies implemented across the state by community coalitions. Increase prevention's connection with the rest of the continuum of care to increase the amount of individuals that have family members in treatment or recovery that access primary prevention.

Criminal Justice Involved- Increase collaboration with the Department of Correction, Adult Probation and Parole, Clinical Health Services, Juvenile Justice Services, the Courts, Administrative Office of the Courts, Local Counties and Jails, Prison, Law Enforcement. Increase data sharing, re-entry. Case Management, Peer services including forensic peer support, Recovery Support Services. Utah is currently working on several different initiatives to increase and improve collaboration with those involved with

the criminal justice system. SUMH is working on a contract with the Department of Corrections to provide Substance Use and Recovery Support services for individuals in need of services. Referrals will be made by the Department of Corrections to the Local Authority for services. The Local Authority and the Department of Corrections, Adult Probation and Parole, will work in coordination to provide client oversight, and coordination of care for the referred individual. SUMH is also working with Clinical Health Services to provide behavioral health services to prison inmates which include using a Medicaid justice waiver for prior release services and then re-entry services once the individual is released from the prison. SUMH is working on assisting with the coordination of care upon re-entry with the Local Authorities and other community partners.

Workforce Development- Increase training to behavioral health professionals, increase training and use of certified peer supports and family peer supports. The peer reimbursement rate was increased in 2025. Work with educational institutions to increase skill development within higher ed. Full utilization of licensing abilities. Workforce development and expansion to identified service levels without reducing workforce in others.

SUMH works with Health Promotions to provide smoking cessation. Local Authorities are partnered with local health departments to provide smoking cessation educational classes to clients. Clients also have access to the Utah Quit line that will provide nicotine replacement therapy (NRT) and counseling services. As indicated in the Kem C Gardner report SUMH will work with Health Promotions to target education and smoking cessation efforts to youth and transition aged youth. SUMH also has been utilizing the Fagerstrom scale to help identify nicotine dependence and also help establish appropriate use of NRT. SUMH and Health Promotions will look to address the appropriate use of the Fagerstom scale test for youth or establish other appropriate tools for youth.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Table 1- Department of Health and Human Services Organizational Chart

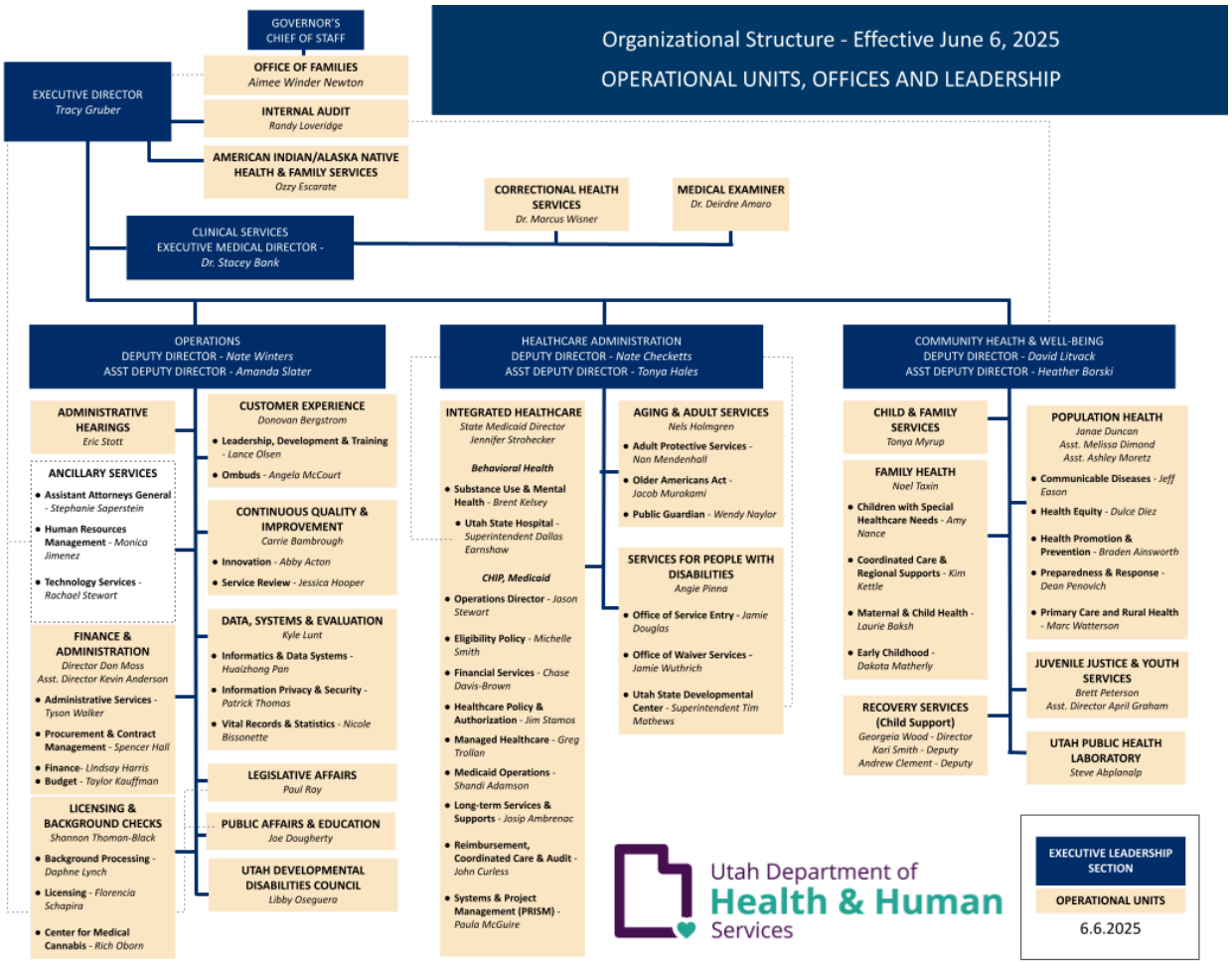

Table 2 - Office of Substance Use and Mental Health Public System Chart

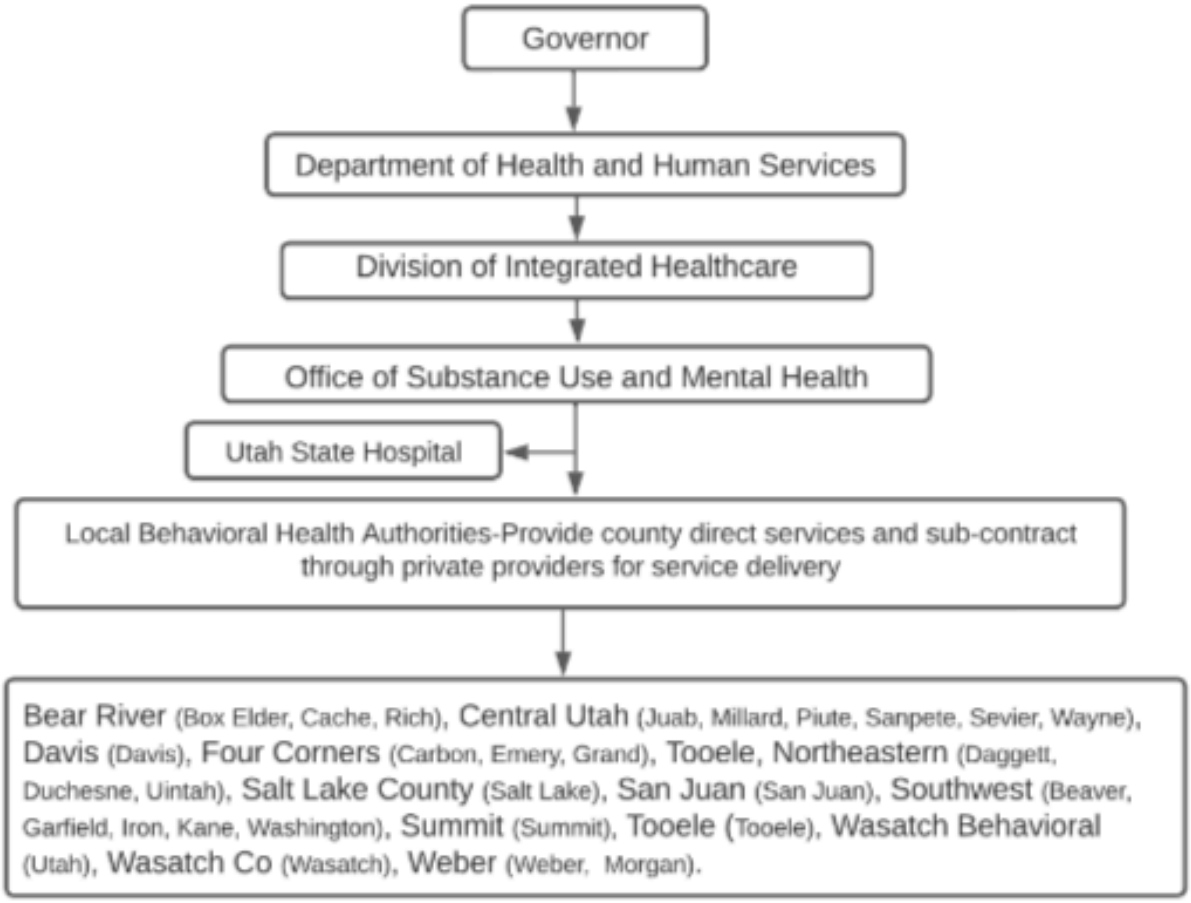

Table 3 - Local Authority Map

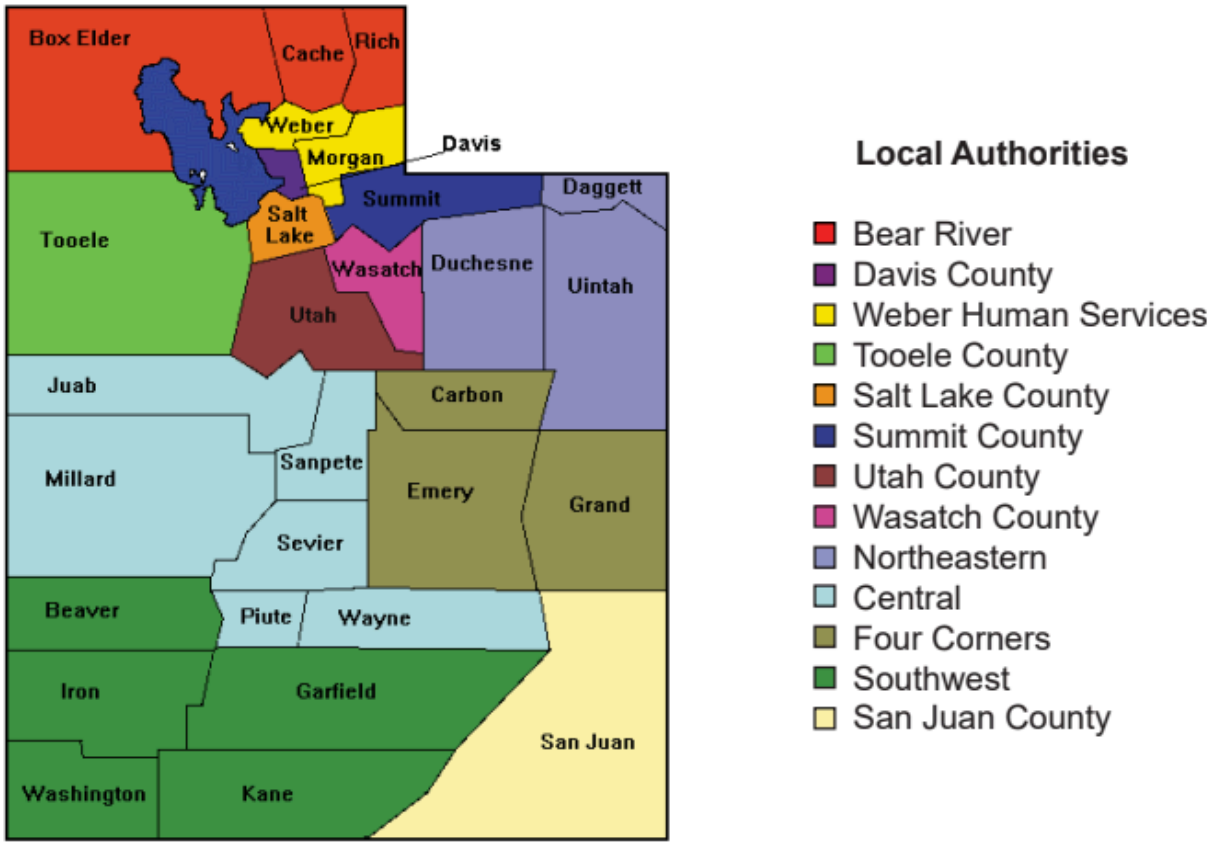

Table 4 - Utah's Eight District Tribal Nations

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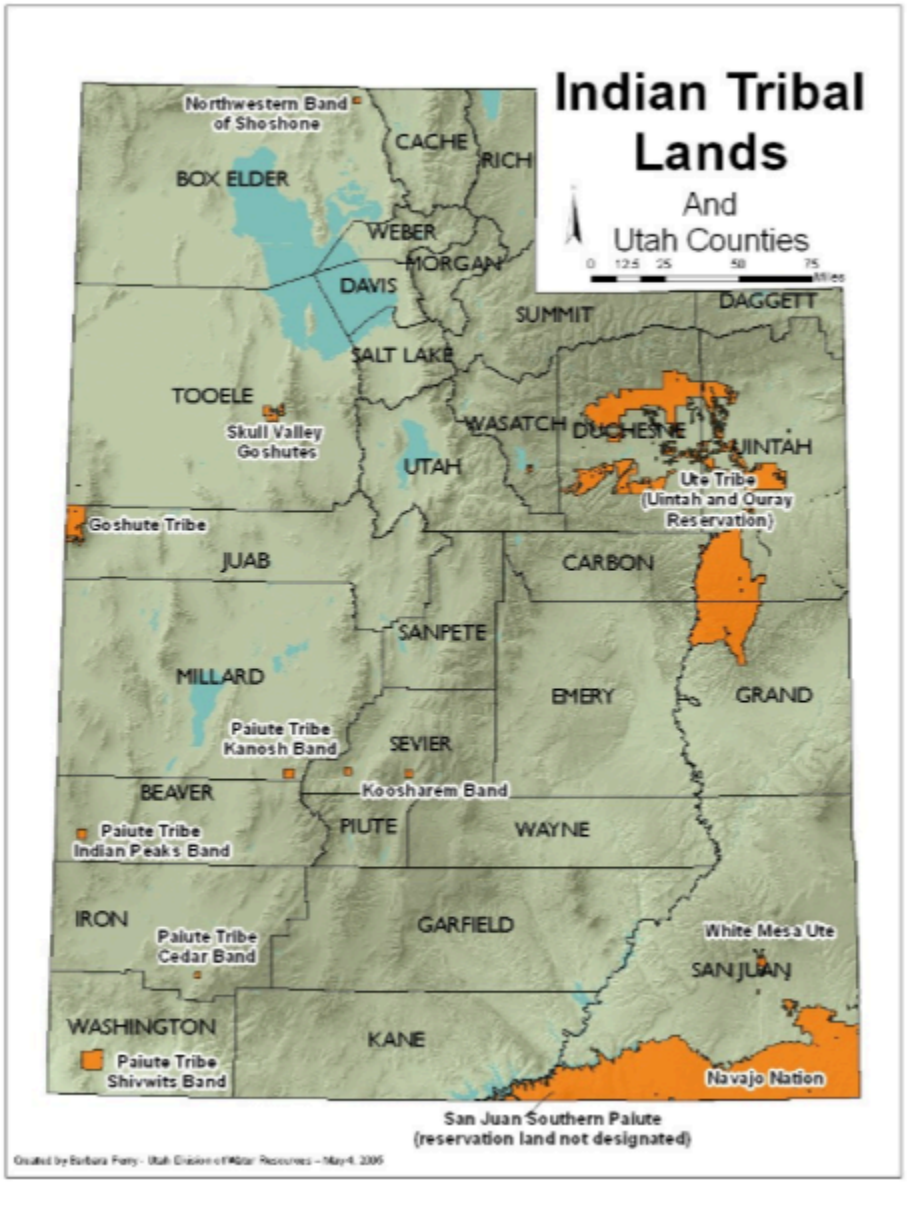

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Washington County	Director - Mike Deal	Southwest Behavioral Health - 474 West 200 North, St. George, Utah 84770; (435) 634-5600	PPW - Outpatient and Women and Children's Residential - PPW Residential - Desert Haven - Accepts Children. Single Men / Women's Residential Treatment - Does not accept children.
Summit County	Director - Aaron Newman	Summit County - Huntsman Mental Health Instititue (HMHI) Park City - 1753 Sidewinder Drive, Park City, Utah 84770; (435)638-5461	PPW - Outpatient - Accepts Children

Tooele County	Director - Peter Clegg	Tooele County Department of Human Services - 47 South Main St. RM 114, Tooele, Utah 84074; (435) 843-3314	PPW - Outpatient - Accepts Children
Uintah Basin - Tri County	Director - Kyle Snow	Northeastern Counseling - 285 West 800 South, Roosevelt, Utah 84078; (435) 789-6300	PPW - Outpatient - Accepts Children
Utah County	Director - Randy Huntington	Wasatch Behavioral Health (WBH) - 750 N. Freedom Blvd, Provo, Utah 84601; (801) 373-4760	PPW - Outpatient - Accepts Children.
Utah County	Director - Amy Buehler	Wasatch Behavioral Health - Utah County Substance Use Disorder (SUD) Treatment -255 South Orem Blvd, Orem, UT 84058; (385) 268-5041	PPW - Outpatient and Women and Children's Residential - Accepts Children. PPW Residential - House of Hope Provo. PPW Intensive Outpatient - Promise North and South
Wasatch County	Clinical and Community Services Director - Elizabeth Feil, LCSW Clinical Director - Chad Shubin	Wasatch County Family Clinic - 55 South 500 East, Heber City, Utah 84032; (435) 654-3003	PPW - Outpatient - Accepts Children
Weber County	Director - Kevin Eastman	Weber Human Services - 237 26th Street, Ogden, Utah 84401; (801) 625-3847	PPW - Outpatient and Women and Children's Residential - PPW Residential - Tranquility Home - Accepts Children

Planning Tables

Table 1: Priority Area and Annual Performance Indicators

Priority #: 1

Priority Area: Prevention and Early Intervention

Priority Type: SUP, SUT, MHS, ESMI

Population(s): SMI, SED, ESMI, PWWDC, PP, PWID, EIS/HIV, TB, PRSUD

Goal of the priority area:

Reduce the impact of substance use and mental disorders by implementing prevention and early intervention strategies.

Strategies to attain the goal:

1. TTA provided by Regional Directors
2. Training and support for coalition coordinators
3. Emphasize reducing risk and increasing protective factors through evidence-based prevention programs

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of communities with healthy developing or functioning substance misuse prevention coalitions.

Baseline measurement (Initial data collected prior to and during 2026): FY 25: 47 communities with a healthy developing or functioning coalition

First-year target/outcome measurement (Progress to the end of 2026): FY26: Increase by 10% from baseline

Second-year target/outcome measurement (Final to the end of 2027): FY27: Increase by 20% from baseline

Data Source:

Local Authority area plans and annual reports.

Description of Data:

A tool developed by our evaluator is used by the Local Authorities to rate communities and their coalitions all the way from no coalition exists to an established well function coalition exists. Local Authorities are asked to rate their communities twice a year, once on area plans for the upcoming state fiscal year (July 1 to June 30) and in an annual report collected in September capturing ratings at the end of the previous fiscal year.

Data issues/caveats that affect outcome measures:

While criteria is established to rate communities, there is some subjectivity that may lead to some differences between areas. Experience and turnover may also affect ratings and lead to slight differences year to year. Funding will also play a role in the number of communities that have coalitions and their ability to implement quality prevention.

Indicator #: 2

Indicator: Increase the number of individuals that area affected by prevention programs, strategies, and policies.

Baseline measurement (Initial data collected prior to and during 2026):

First-year target/outcome measurement (Progress to the end of 2026):

Second-year target/outcome measurement (Final to the end of 2027):

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures:

Indicator #:	3
Indicator:	Increase annual distribution of Naloxone kits
Baseline measurement (Initial data collected prior to and during 2026):	Baseline FY25: 63,686 kits distributed
First-year target/outcome measurement (Progress to the end of 2026):	FY26: Increase by 5% of baseline
Second-year target/outcome measurement (Final to the end of 2027):	FY27: Increase by 7% of baseline

Data Source:

contract reports by statewide organizations

Description of Data:

number of kits distributed

Data issues/caveats that affect outcome measures:

quality of reporting by contracted agencies, reduction in funding available for these services.

Indicator #:	4
Indicator:	Decrease Opioid Death Rate- annual (accidental and undetermined deaths)
Baseline measurement (Initial data collected prior to and during 2026):	Baseline FY2023 accidental and undetermined deaths in 2023 was 13.3 (n=458).
First-year target/outcome measurement (Progress to the end of 2026):	FY2026: Decrease by 2% of baseline
Second-year target/outcome measurement (Final to the end of 2027):	FY2027: Decrease by 4% of baseline

Data Source:

Utah Medical Examiner

Description of Data:

Estimates are based on occurrent deaths (deaths occurring in Utah, regardless of residence status). accidental and undetermined deaths
obtained from the Utah Medical Examiner Database for those ages 18 and older. Drug poisoning (overdose) deaths were defined as having an International Classification of Diseases, 10th Revision (ICD–10) underlying-cause-of-death code of X40–X44 (unintentional) or Y10–Y14 (undetermined intent). The following ICD-10 multiple-cause-of-death codes were included for opioid-related overdoses: opium (T40.0): heroin (T40.1); natural and semi-synthetic opioids (T40.2); methadone (T40.3); synthetic opioids other than methadone (T40.4); and other and unspecified narcotics (T40.6).

Data issues/caveats that affect outcome measures:

Data points may change as Medical Examiner reviews available data. Individual deaths may not be solely influences by the public behavioral health system but this is a priority for the Governor and our Department to reduce death rates.

Priority #: 2

Priority Area: Behavioral Health Crisis Reponse System

Priority Type: SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID

Goal of the priority area:

Increase services through the Behavioral Health Crisis Response System

Strategies to attain the goal:

Provide education and presentation's on the crisis response system
provide MCOT trainings on SUD and MH issues.
Expand MCOT services access across the state
Address and Improve workforce shortage issues.
Expand number of receiving centers across the state
Provide TA and support to receiving centers to ensure access and quality of services.
Improve referrals from crisis receiving centers to behavioral health services (create data to track referrals)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of Mobile Crisis Outreach Teams (MCOT) service recipients who receive MCOT follow-up services

Baseline measurement (Initial data collected prior to and during 2026): FY25; 53% of MCOT service recipients recieved follow up

First-year target/outcome measurement (Progress to the end of 2026): Increase by 10% from baseline

Second-year target/outcome measurement (Final to the end of 2027): Increase additional 10%

Data Source:

Utah Crisis Response Dashboard
Local Authority data submission into SAMHIS

Description of Data:

Data includes # MCOT services, # individuals served, # follow up services, # non-mobile responses

Data issues/caveats that affect outcome measures:

Timely and accurate data submission from the provider system

Indicator #: 2

Indicator: Increase Mobile Crisis Outreach services across the state

Baseline measurement (Initial data collected prior to and during 2026): FY24: 13,275 mobile response services provided

First-year target/outcome measurement (Progress to the end of 2026): Increase number of mobile crisis response services by 5%

Second-year target/outcome measurement (Final to the end of 2027): Increase number of mobile crisis response services by an additional 5%

Data Source:

Utah Crisis Response Dashboard
Local Authority data submission

Description of Data:

Data includes # MCOT services, # individuals served, # follow up services, # non-mobile responses

Data issues/caveats that affect outcome measures:

As more individuals are accessing 988 statewide, MCOT deployments may be impacted.
Workforce shortages have a significant impact on the number of MCOT teams, particularly in rural areas. In addition, rural and frontier areas are considering alternative models partnering with law enforcement after hours.

Indicator #: 3

Indicator: Increase access to information and resources in rural areas to normalize mental health conditions.

Baseline measurement (Initial data collected prior to and during 2026): FY24: 6,007 calls received by 988 from rural areas.

First-year target/outcome measurement (Progress to the end of 2026): 5% increase from baseline in calls to 988 from rural areas.

Second-year target/outcome measurement (Final to the end of 2027): 10% increase from baseline in calls to 988 from rural areas.

Data Source:

Huntsman Mental Health Institute (HMHI)

Description of Data:

HMHI provides quarterly data regarding 988 calls received separated by county.

Data issues/caveats that affect outcome measures:

Some rural local authorities maintain an after-hours number for high acuity clients. Therefor, the number of crisis may be under-reported.

Priority #: 3

Priority Area: Substance Use and Mental Health Treatment

Priority Type: SUP, SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PWID, EIS/HIV, TB, PRSUD

Goal of the priority area:

Increase access and improve quality of care for indviduals in SUD and MH services.

Strategies to attain the goal:

Provide training and education to behavioral health providers
Increase number of individuals receiving behavioral health services that are invovled in crimnal justice system, improvment of access to services, screening and assessments and appropriate placement.
Increase use of FDA approved MAT vie ensureing access to medications, early identification, screening and assessment and availability of medications.
Increase number of individuals receiving services that are pregnant through better access and early idetification and are referrals.
Women with Dependent children improved outcomes via proviing wrap around services, aftercare, family counceling, screenings for youth, childcare services, referrals and transfers to appropriate care, increased physical health access, etc.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Individuals admitted to SUD treatment services- all ASAM levels.

Baseline measurement (Initial data collected prior to and during 2026): baseline FY24: 16440 SUD served individuals

First-year target/outcome measurement (Progress to the end of 2026): FY26: Increase number of individuals served by 2% from baseline

Second-year target/outcome measurement (Final to the end of 2027): FY27: Increase number of individuals served by 4% from baseline

Data Source:

SAMHIS Teds data pull.

Description of Data:

Unduplicated data from SAMHIS TEDs data for # of individuals served unduplicated. This includes all ASAM levels of care and doe not include Assessments or Limited services such as Recovery Support services.

Data issues/caveats that affect outcome measures:

Data can be effected by funding sources available; individuals that move from one funding source to the other in relation to Medicaid, private pay, private insurance. OSUMH only collects data on individuals funded within our public behavioral health systems so as individuals move between funding and providers data may be effected.

Indicator #: 2

Indicator: Improve quality of care reported via positive service outcomes (SUD and MH) clients

Baseline measurement (Initial data collected prior to and during 2026): 2025 90% General Satisfaction overall (MHSIP Consumer Satisfaction Survey)

First-year target/outcome measurement (Progress to the end of 2026): FY26: Increase of 1% from baseline

Second-year target/outcome measurement (Final to the end of 2027): FY27: Increase of 2% from baseline.

Data Source:

Adult Consumer Satisfaction Survey Combined MH and SUD
Mental Health Statistics Improvement Program (MHSIP)

Description of Data:

Percent of clients reporting positive service outcomes. 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 use and mental health combined and is not a sum of the provider client counts.

Data issues/caveats that affect outcome measures:

Chart results are based on round numbers. Results are based on the number of surveys the LA receive. Some Local Authorities gather few surveys that result in insufficient sample sizes such that the rates are not statistically significant.

Indicator #: 3

Indicator: Increase number of individuals involved in the justice system receiving quality care.

Baseline measurement (Initial data collected prior to and during 2026): 2024 baseline: 1380 served

First-year target/outcome measurement (Progress to the end of 2026): Fy26: increase baseline by 2%

Second-year target/outcome measurement (Final to the end of 2027): Fy27: Increase baseline by 4%

Data Source:

SAMHIS data coming from SUD treatment file

Description of Data:

# of Unduplicated served that are justice involved. This includes clients involved in specialty court programs.

Data issues/caveats that affect outcome measures:

Individuals may be admitted into treatment services prior to having any justice involvement. This data may not be captured as the justice involved data is captured on the intake file based on referral source at intake.

Indicator #: 4

Indicator:	Increase the number of pregnant individuals served (priority population goal)
Baseline measurement (Initial data collected prior to and during 2026):	FY24: 247 pregnant individuals served.
First-year target/outcome measurement (Progress to the end of 2026):	Increase pregnant individuals served in treatment services by 1% from baseline.
Second-year target/outcome measurement (Final to the end of 2027):	Increase pregnant individuals served in treatment services by 2% from baseline.

Data Source:

State SAMHIS data, TEDs.

Description of Data:

Based on State SAMHIS data that is submitted monthly by the Local Authorities, using TEDs we can determine pregnant individuals that have accessed and been served in public treatment services.

Data issues/caveats that affect outcome measures:

With Utah's recent passed Medicaid expansion the majority of pregnant indiviudals seeking treatment services will qualify for Medicaid behavioral health benefits and can access those services through all Medicaid providers including private providers in which DSAMH does not collect that information and those clients accessing services will not be accounted for. Utah provides all levels of ASAM and a full continuum of care for Substance Use Disorder clients.

Indicator #:	5
Indicator:	Increase use of FDA approved medications for persons who inject drugs (Priority population) SUD
Baseline measurement (Initial data collected prior to and during 2026):	FY24: 3,778 person who inject drugs, 1,636 those that received MAT services.
First-year target/outcome measurement (Progress to the end of 2026):	FY26: Increase baseline by 2%
Second-year target/outcome measurement (Final to the end of 2027):	FY27: Increase baseline by 3%

Data Source:

SAMHIS and TEDs Data. Report from new Mobile Clinic contract for rural Utah

Description of Data:

Collection of data is based on client self-identifying reported information as being an IV user. Data is collected for for EBP as an MAT services indicator on episodes of care. IV or Intramuscular Injection (pri, sec, tert) (methadone or MAT EBP) as an EBP indicator. FY24: Those identified as IV users (Intramuscular and IV) served= 3,778. Those that received MAT services=1,636

Data issues/caveats that affect outcome measures:

Utah became a Medicaid Expansion state in 2019 which allows clients to get MAT and other clinical services through other agencies outside of our Local Authority network. The State Division does not collect data or outcomes from these outside Medicaid Providers which may affect our outcomes on clients served or receiving services since clients now have other options and avenues in which they can get services through.

Indicator #:	6
Indicator:	Number of women with dependent children served (SUD) priority population treatment completed successfully
Baseline measurement (Initial data collected prior to and during 2026):	FY24: of 3,058 women with dependent children served 815 completed treatment successfully or 48%
First-year target/outcome measurement (Progress to the end of 2026):	fy26: Increase by 2% from baseline
Second-year target/outcome measurement (Final to the end of 2027):	fy27: increase by 4% from baseline

Data Source:

SAMHSA data set

Description of Data:

SAMHIS data: gender pull with children in the home.
looked at FY24 Discharge data and out of 1,697 women with children that were discharged from treatment in FY24, 815...or 48%....discharge as "Treatment Completed."

Data issues/caveats that affect outcome measures:

Children aging out of the home. Individuals gaining or losing custody of children that were in the home may affect numbers reported. SUMH does not collect all Medicaid data such as private provider medicaid data so if the payor changes for women with dependent children the data does not follow transfers to private providers outside of the public behavioral health system. Clients with medicaid have a right to chose providers and are able to go to private providers which may result in completed treatment successfully data outcomes different as they change providers and may complete treatment at a different provider.

Indicator #: 7

Indicator: Increase access to mental health services for SMI/SED

Baseline measurement (Initial data collected prior to and during 2026): 59,632 individuals were served by the Local Authorities in FY24

First-year target/outcome measurement (Progress to the end of 2026): 1% increase in the number of individuals served by the Local Authorities

Second-year target/outcome measurement (Final to the end of 2027): 2% increase in the number of individuals served by the Local Authorities

Data Source:

Number of individuals receiving mental health assessments through local authorities
Number of adults served
Number of children and youth served

Description of Data:

The Local Authority scorecards are published each year with the information about number of individuals served in the Local Authority system.
The information is also available on the Utah OSUMH data portal. https://sumh.utah.gov/data-reports/data-portal-home

Data issues/caveats that affect outcome measures:

There was a decrease in individuals served in the public mental health system with post pandemic unwinding. Efforts are being made to ensure that individuals with SMI are not impacted by the change. Utah youth have lower rates of medicaid (approx 10%) compared to commerical insurance coverage (approx 75%) thus youth even with SMI have a wide range of options for clinical services.

Priority #: 4

Priority Area: Recovery and Resiliency

Priority Type: SUP, SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB, PRSUD

Goal of the priority area:

Partner with people in recovery and their family members to foster health and resilience.

Strategies to attain the goal:

Increase number of certified peer support specialisits (training, education, certifcation)
Allow flexabilty of funding for Recovery Support services to include MH
Provide training and education on Recovery Support Services, data collection of recover support services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase availability of peer support services for adults and youth

Baseline measurement (Initial data collected prior to and during 2026): In FY24, Mental health 2,588 adults, 453 youth received peer support services (PSS) SUD in FY24 247 individuals received PSS

First-year target/outcome measurement (Progress to the end of 2026): Increase % of individuals served by PSS by 2%

Second-year target/outcome measurement (Final to the end of 2027): Increase % of individuals served by PSS by 3% from baseline in second year.

Data Source:

SAMHIS data
TEDs data
SUMH data portal - https://sumh.utah.gov/data-reports/data-portal-home
SUMH Local Authority scorecards

Description of Data:

Number of substance use clients receiving peer support services
Number of adult mental health clients receiving peer support services
Number of mental health clients under 18 years old receiving peer support services

Data issues/caveats that affect outcome measures:

Peer services provided by community based organizations are not always collected by the Local Authorities. The number of individuals served is therefore higher than the reported numbers.

Indicator #: 2

Indicator: Increase the use of Recovery Support Services in Mental Health

Baseline measurement (Initial data collected prior to and during 2026): New measure: Establish Baseline in FY26

First-year target/outcome measurement (Progress to the end of 2026): Establish baseline in FY26

Second-year target/outcome measurement (Final to the end of 2027): FY27: Increase baseline by 10%

Data Source:

Recovery Support File spec that is submitted to SUMH. Tableau report

Description of Data:

Use of Recovery Support service data to establish # of services being provided. Use Mental Health contract to look at the Mental Health service counts.

Data issues/caveats that affect outcome measures:

New Data spec has to be developed and set up in each of the provider EHR records, reporting to SUMH through the RSS data file needs to be submitted each month. Baseline needs to be established in order to get outcomes for this new measure.

Indicator #: 3

Indicator: Increase number of Recovery Support Services to SUD clients

Baseline measurement (Initial data collected prior to and during 2026): FY24: 2,025 clients received recovery support services

First-year target/outcome measurement (Progress to the end of 2026): FY26: Increase baseline by 2%

Second-year target/outcome measurement (Final to the end of 2027): FY27: Increase baseline by 4%

Data Source:

SAMHIS Recovery Support file.

Description of Data:

Data is looking at all SUD contracts, all provders, all services per fiscal year.

Data issues/caveats that affect outcome measures:

Correct data entry by providers. We will be updating the data specs to include addtional recovery support services for Mental health, the numbers may changes based on primary diagnosis and if the client is Mental health, Substance Use or co-occuring on where the data is entered. Also funding identified for Recovery Support Services was reduced in FY26 due to elimination of supplemental and federal ARPA funding which will lead to reduced number recovery support services being provided to individuals and services.

Priority #: 5

Priority Area: Substance Use and Mental Health Training and Educational Opportunities

Priority Type: SUP, SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID, EIS/HIV, TB, PRSUD

Goal of the priority area:

Provide substance use and mental health training that improves the health and wellbeing of individuals and communities

Strategies to attain the goal:

1) Train and certify individuals to work in the behavioral health system
2) Provide training to the behavioral health workforce on evidence based practices, trauma-informed care and cultural and linguistic competence.
3) Provide training for the community to reduce stigma and promote understanding of substance use and mental health disorder
4) Provide EBP trainings (i.e, Motivation Interviewing, GateKeeper trainings, etc)

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of individuals trained in MH and I/DD co occurring best practices

Baseline measurement (Initial data collected prior to and during 2026): no individuals trained

First-year target/outcome measurement (Progress to the end of 2026): FY26: Increase number of individulas trained by 50 from baseline

Second-year target/outcome measurement (Final to the end of 2027): FY27: Increase number of individuals trained by 100 from baseline

Data Source:

Contract quarterly and annual training reports

Description of Data:

Number of individuals trained in accordance to number of trainnigs pervided and attendees.

Data issues/caveats that affect outcome measures:

Reduction of funding awaded on contract could affect the number of trainings provided and the number of attendees.

Indicator #: 2

Indicator: Number of individuals trained in Suicide Prevention Gatekeeper trainings (EBP)

Baseline measurement (Initial data collected prior to and during 2026): 143 indivudals trained in FY25

First-year target/outcome measurement (Progress to the end of 2026): Train 150 individuals as gatekeeper instructors.

Second-year target/outcome measurement (Final to Train 150 individuals as gatekeeper instructors.

the end of 2027):

Data Source:

registration data from the following Question-Persuade-Refer, VitalCog, Mental Health First Aid

Description of Data:

registration numbers from the following Question-Persuade-Refer, VitalCog, Mental Health First Aid

Data issues/caveats that affect outcome measures:

Individuals that do not show to the training, individuals that do not complete all required segments of the trainings.

Indicator #:	3
Indicator:	Number of agencies participating in Trauma Informed care cohort trainings (EBP)
Baseline measurement (Initial data collected prior to and during 2026):	FY2025: 10 agencies particiapte in first cohort
First-year target/outcome measurement (Progress to the end of 2026):	FY2026: Increase by 2 providers from baseline
Second-year target/outcome measurement (Final to the end of 2027):	FY2027: Increase by 4 providers from baseline

Data Source:

Contract with Trauma Informed Utah

Description of Data:

Number of agencies partcipating in the trauma informed training program.

Data issues/caveats that affect outcome measures:

Contract expires in 2027 and funding was reduced on this contract in fy25/26 due to ending of CARES act funding. Baseline numbers established in 2025 were based on full amount of funding awared on contract. Funding was reduced for the following years of this contract which will affect the overall number of participating agencies.

Indicator #:	4
Indicator:	Increase teams trained on Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)
Baseline measurement (Initial data collected prior to and during 2026):	5 teams are currently trained for CSC
First-year target/outcome measurement (Progress to the end of 2026):	Increase number of teams trained with CSC by 1 team.
Second-year target/outcome measurement (Final to the end of 2027):	Increase number of teams trained with CSC by a second team.

Data Source:

SUMH transition aged youth team

Description of Data:

SUMH provides funding and works with the University of Oregon (EASA) to provide training and technical assistance.

Data issues/caveats that affect outcome measures:

Workforce shortages have impacted the ability of the CSC teams to obtain and remain fully staffed. Agencies are hesitant to bring on programs that involve a larger number of team members.

Indicator #:	5
Indicator:	Train Local Authorities to implement the PRIME screening tool

Baseline measurement (Initial data collected prior to and during 2026):	5 teams currently utilize the PRIME screening tool to identify possible psychosis symptoms
First-year target/outcome measurement (Progress to the end of 2026):	3 additional Local Authorities will train staff to implement the PRIME screening tool with youth and young adults
Second-year target/outcome measurement (Final to the end of 2027):	3 additional Local Authorities will train staff to implement the PRIME screening tool with youth and young adults.

Data Source:

SUMH transition aged youth team

Description of Data:

# of sites who have implemented the PRIME screening tool with youth and young adults
# of providers who have been trained in implemented the PRIME screening tool with youth and young adults

Data issues/caveats that affect outcome measures:

system readiness to treat following screening may impact willingness to engage in training

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Indicator #:	6
Indicator:	Increase number of providers trained in Diagnostic Classification for young children 0-5 (DC 0-5)
Baseline measurement (Initial data collected prior to and during 2026):	no individuals trained
First-year target/outcome measurement (Progress to the end of 2026):	Increase by 100 from baseline
Second-year target/outcome measurement (Final to the end of 2027):	Increase by 200 from baseline

Data Source:

Contract reporting

Description of Data:

# of individuals trained

Data issues/caveats that affect outcome measures:

New training, providers willing to sign up for training may impact numbers.

Indicator #:	7
Indicator:	Number of individuals trained in peer support (PS) (Adult and family)
Baseline measurement (Initial data collected prior to and during 2026):	FY25 1220 of certified peer supports
First-year target/outcome measurement (Progress to the end of 2026):	Increase number by 10% from baseline
Second-year target/outcome measurement (Final to the end of 2027):	Increase number by 15% from baseline

Data Source:

Contracts for PS training

Description of Data:

# of individuals trained in Adult Peer Support
# of individuals trained in Family Peer Support

Data issues/caveats that affect outcome measures:

Providers choose to not host training, attendees do not complete training.

Indicator #:	8
Indicator:	Improving the intersection between homeless services and behavioral health services.
Baseline measurement (Initial data collected prior to and during 2026):	There is no specific training specific to areas that intersect homeless and behavioral health services.
First-year target/outcome measurement (Progress to the end of 2026):	Coordination and resource training will be developed for paraprofessionals working with unhoused individuals needing behavioral health services.
Second-year target/outcome measurement (Final to the end of 2027):	Area-specific coordination trainings will be held with paraprofessionals.

Data Source:

Local homeless councils, housing authorities, local authorities, homeless resource providers

Description of Data:

Resources for specific areas of the state will be gathered from local authorities and key partners .

Data issues/caveats that affect outcome measures:

Urban regions have complex networks of providers for both behavioral health and homeless services. Ongoing maintenance of resource lists are always a challenge as provider information changes.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 2: SUPTRS BG Planned State Agency Budget for Two State Fiscal Years (SFY)

ONLY include funds budgeted by the executive branch agency (SSA) administering the SUPTRS BG. This includes only those activities that pass through the SSA to administer substance use primary prevention, substance use disorder treatment, and recovery support services for substance use disorder.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds
1. Substance Use Disorder Prevention[a] and Treatment	$14,498,467.65		$35,962,359.00	$1,257,006.00	$21,873,547.00	$5,967,688.00	$3,692,170.00	
a. Pregnant Women and Women with Dependent Children (PWWDC)[b]	$3,119,511.95		$14,512,629.00	$262,577.00	$6,206,025.00	$1,201,426.00	$858,698.00	
b. All Other	$11,378,955.70		$21,449,730.00	$994,429.00	$15,667,522.00	$4,766,262.00	$2,833,472.00	
2. Recovery Support Services[c]	$1,000,000.00		$740,043.00	$128,378.00	$3,562,841.00	$1,877,802.00	$316,508.00	
3. Primary Prevention[d]	$7,210,696.00		$0.00	$234,927.00	$3,002,628.00	$583,192.00	$1,853,751.00	
4. Early Intervention Services for HIV[e]	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	
5. Tuberculosis	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00	
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)								
7. State Hospital								
8. Other Psychiatric Inpatient Care								
9. Other 24-Hour Care (Residential Care)								
10. Ambulatory/Community Non-24 Hour Care								
11. Crisis Services (5 percent Set-Aside)								
12. Other Capacity Building/Systems Development[f]	$1,524,583.00		$0.00	$738,025.00	$221,804.00	$0.00	$0.00	
13. Administration[g]	$1,275,460.35		$0.00	$0.00	$0.00	$0.00	$0.00	
14. Total	**$40,007,674.65**		**$72,664,761.00**	**$3,615,342.00**	**$50,534,367.00**	**$14,396,370.00**	**$9,554,599.00**	

[a] Prevention other than primary prevention.

[b] Grantees must plan expenditures for Pregnant Women and Women with Dependent Children in compliance with Women's Maintenance of Effort (MOE) over the two-year planning period.

[c] This budget category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of planned expenditures allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only plan RSS for those in need of RSS from substance use disorder.

[d] Row 3 should account for the 20 percent minimum primary prevention set-aside of SUPTRS BG funds to be used for universal, selective, and indicated substance use prevention activities.

[e] The most recent AtlasPlus HIV data report 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 SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[f] Other Capacity Building/Systems development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**

[g] Per **45 CFR § 96.135** Restrictions on expenditure of the SUPTRS BG, the state involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Utah is not a designated state.

Planning Tables

Table 2: MHBG Planned State Agency Budget for Two State Fiscal Years (SFY)

States are asked to present their projected two-year budget at the State Agency level, including all levels of state and applicable federal funds to be expended on mental health and substance use services allowable under each Block Grant. When planning their budgets, states should keep in mind all statutory requirements outlined in the application Funding Agreement/Certifications and Assurances.

Table 2 addresses funds budgeted to be expended during State Fiscal Years (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027).Table 2 includes columns to capture state planned budget of BSCA funds (MHBG only)

Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

Activity	Source of Funds							
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. Bipartisan Safer Communities ACT Funds[a]
1. Substance Use Disorder Prevention and Treatment								
a. Pregnant Women and Women with Dependent Children (PWWDC)								
b. All Other								
2. Recovery Support Services								
3. Primary Prevention								
4. Early Intervention Services for HIV								
5. Tuberculosis								
6. Evidence-Based Practices For Early Serious Mental Illness including First Episode Psychosis (10 percent of total MHBG award)[b]		$1,876,071.00						$36,206.00
7. State Hospital								
8. Other Psychiatric Inpatient Care			$38,445,388.00		$11,860,306.00	$2,494,814.00	$2,214,816.00	
9. Other 24-Hour Care (Residential Care)		$0.00	$3,108,384.00		$13,856,786.00	$3,623,136.00	$5,758,860.00	$0.00
10. Ambulatory/Community Non-24 Hour Care		$15,008,566.00	$239,888,292.00		$40,143,769.00	$52,799,298.00	$17,095,052.00	$0.00
11. Crisis Services (5 percent Set-Aside)[c]		$938,035.00	$9,548,212.00	$2,365,002.00	$26,622,092.00	$1,316,334.00	$9,987,184.00	$318,611.00
12. Other Capacity Building/Systems Development								
13. Administration		$938,036.00		$48,265.00				$7,241.00
14. Total		**$18,760,708.00**	**$290,990,276.00**	**$2,413,267.00**	**$92,482,953.00**	**$60,233,582.00**	**$35,055,912.00**	**$362,058.00**

[a]The expenditure period for the 3rd and 4th allocations of Bipartisan Safer Communities Act (BSCA) supplemental funding will be from **September 30, 2024 through September 29, 2026** (3rd increment), **September 30, 2025 through September 29, 2027** (4th increment). Column H should reflect the state planned expenditure for this planning period (FY2026 and FY2027) [July 1, 2025 through June 30, 2027, for most states].

[b]Row 6 in Columns B and H: per statute, states are required to set-aside 10 percent of the total MHBG and BSCA awards for evidence-based practices for Early Serious Mental Illness (ESMI), including Psychotic Disorders.

[c]Row 11 in Columns B and H: per statute, states are required to set-aside 5 percent of the total MHBG and BSCA awards for Behavioral Health Crisis Services (BHCS) programs.

[d]Per statute, administrative expenditures for the MHBG and BSCA funds cannot exceed 5 percent of the fiscal year award.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 3: Persons in Need of/Receiving SUD Treatment – Required for SUPTRS BG Only

This table allows states to present their estimated current need and baseline reach of the priority populations laid out in the SUPTRS BG statute. This information is intended to assist the state in demonstrating the unmet need of these populations that informs their plans for FY2026 - 2027. The estimates provided should represent the unmet need at the time of the application.

To complete the Aggregate Number Estimated in Need (Column A), please refer to the most recent edition of the **National Survey on Drug Use and Health** (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment (Column B), please refer to the most recent edition of the **Treatment Episode Data Set** (TEDS) data prepared and submitted to the Behavioral Health Services Information System (BHSIS).

States should contact their federal points of contact for assistance in drawing these estimates from national and state survey data.

Estimates should utilize the most recent data from NSDUH, TEDS, and other data sources.

	A. Aggregate Number Estimated in Need of SUD Treatment	B. Aggregate Number in SUD Treatment
Pregnant Women	3505	247
Women with Dependent Children	25000	3058
Individuals with a co-occurring M/SUD	120000	7348
Persons who inject drugs	9000	3778
Persons experiencing homelessness	3869	4083

Please provide an outline of how the state made these estimates, including data sources and values used for each row. For any cell which the state is

unable to estimate the need or number in treatment, please provide an explanation for why these estimates could not be drawn.
A: Pregnant Women in need of SUD treatment - National Library of Medicine, Utah's Women Health Review. 7.8% of pregnant women in need of SUD treatment based of a fertility rate of 59.6 per 1,000 women. Persons experiencing homelessness - Utah Workforce Services Homelessness Annual Report point in time survey. Women with dependent children - No reliable data source. Through TEDS data and Utah IBIS, estimate based off of a conservative estimate of 75,000 women in Utah having dependent children and one-third needing SUD treatment. Individuals with a co-occurring m/SUD - No reliable data source. Aligning with NSDUH methodology, an estimated 120,000 Utah residents (12 +) are likely to have a co-occurring disorder and classified as needing SUD treatment. Persons who inject drugs - No reliable data source. Estimate based off of Harm Reduction providers in Utah. 300,000 individuals needing SUD treatment in Utah. 3% of those inject drugs and need treatment. B: SUD treatment data collected in the Utah public county based local authority system.
OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Page 2 of 2

Planning Tables

Table 4: SUPTRS BG Planned Award Budget by Federal Fiscal Year

In addition to projecting planned budget by State Fiscal Year (Table 2b), states must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations and expenditure categories. Therefore, Plan Table 4b must be completed for the SUPTRS BG awarded for Federal Fiscal Year (FFY) 2026 and FFY 2027. The totals for each FFY planning year should match the SUPTRS BG Final Allotments for the state in that award year.

Note: The FFY presented in the table is that of the award year, however states have up to two years to expend the award received. For example, the FFY 2026 award may be expended from October 1, 2025 through September 30, 2027.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Expenditure Category	FFY 2026 SUPTRS BG Award
1 . Substance Use Disorder Prevention[a] and Treatment	$14,498,467.65
2 . Recovery Support Services[b]	$1,000,000.00
3 . Substance Use Primary Prevention[c]	$7,210,696.00
4 . Early Intervention Services for HIV[d]	$0.00
5 . Tuberculosis Services	$0.00
6 . Other Capacity Building/Systems Development[e]	$1,524,583.00
7 . Administration[f]	$1,275,460.35
8. Total	**$25,509,207.00**

Page 1 of 142

[a]Prevention other than primary prevention. The amount in this row should reflect the planned budget for direct services during the planning period. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[b]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023 and includes an aggregate of budget allowable under the 2023 guidance, "Allowable Recovery Support Services (RSS) Expenditures through the SUBG and the MHBG." Only present the estimated budget for RSS for those in need of RSS from substance use disorder. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[c]This row should reflect the state's planned budget of direct primary prevention activities that are intended to meet the SUPTRS BG 20 percent set aside. Activities include those used for universal, selective, and indicated substance use prevention activities. The budget for direct activities in this row should match the total budget planned in Table(s) 5a and 5b. Do not include budgeted funds for other capacity building/systems development, those are required to be presented in Row 6 of this table.

[d]The most recent AtlasPlus HIV data report 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 SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment.

[e]Other Capacity Building/System Development include those activities relating to substance use per **45 CFR §96.122 (f)(1)(v)**. The amount presented here should reflect the total found in Planning Table 6 across treatment, recovery, and primary prevention.

[f]Per **45 CFR §96.135** Restrictions on expenditure of grant, the State involved will not expend more than 5 percent of the BG to pay the costs of administering the SUPTRS BG.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Utah is not a designated state.

Planning Tables

Table 4: MHBG State Agency Planned Budget

Table 4 addresses the planned budget for MHBG. Please use this table to capture your estimated budget for MHBG-funded services and programs over a 24-month period (for most states, it is July 1, 2025 - June 30, 2027).

Planning Period Start Date: 7/1/2025 Planning Period End Date: 6/30/2027

MHBG-Funded Services	MHBG Funds Budgeted for This Item
1. Services for Adults	
1a. EBPs for Adults	337001.00
1b. Crisis Services for Adults	844231.00
1c. CSC/ESMI program for Adults	1500856.00
1d. Other outpatient/ambulatory services for Adults	4251696.00
1e. *Other Direct Services for Adults	
2. Subtotal of Services for Adults	6933784.00
3. Services for Children	
3a. EBPs for Children	158588.00
3b. Crisis Services for Children	93804.00
3c. CSC/ESMI program for Children	375214.00
3d. Other outpatient/ambulatory services for Children	4251696.00
3e. *Other Direct Services for Children	
4. Subtotal of Services for Children	4879302.00
5. Other Capacity Building/Systems Development[a]	6009586.00
6. Administrative Costs[b]	938036.00
7. *Any Other Cost	
8. Total MHBG Allocation[c]	**18760708.00**

Please provide brief explanation for services with an asterisk* below:

[a] This row for Other Capacity Building/Systems Development should be equal to the total of your planned budget in Table 6

[b] Administrative Costs should not exceed 5 percent of total MHBG allocation

[c] The total budget should be equal to your MHBG allocation for the next two years.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 5a: SUPTRS BG Primary Prevention Planned Budget by Strategy and Institutes of Medicine (IOM) Categories

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	IOM Classification	FFY 2026 SUPTRS BG Award
1. Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
2. Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
3. Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
	Universal	
	Selective	

5. Community-Based Processes	Indicated	
	Unspecified	
	Total	**$0**
6. Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
7. Section 1926 (Synar)-Tobacco	Universal	$0
	Selective	$0
	Indicated	$0
	Unspecified	$0
	Total	**$0**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Budget		**$0**
Total Award [a]		**$25,509,207**
Planned Primary Prevention Percentage		**0.00%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 5b: SUPTRS BG Planned Primary Prevention Budget by Institutes of Medicine (IOM) Categories

States should identify the planned budget for primary prevention disaggregated by IOM Categories the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 and FFY 2027 SUPTRS BG allotments.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Strategy	FFY 2026 SUPTRS BG Award
1. Universal Direct	$2,550,656
2. Universal Indirect	$2,675,079
3. Selective	$808,745
4. Indicated	$186,633
5. Column Total	**$6,221,113**
6. Total SUPTRS Award[a]	**$25,509,207**
7. Primary Prevention Percentage	**24.39%**

[a] Total SUPTRS BG Award is populated from Plan Table 4 SUPTRS BG Planned Award Budget by Federal Fiscal Year

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 5c: SUPTRS BG Planned Primary Prevention Priorities

States should identify the categories of substances the state plans to prioritize with primary prevention set-aside dollars from the FFY 2026 SUPTRS BG award.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Priority Substances	FFY 2026 SUPTRS BG Award
Alcohol	☑
Tobacco/Nicotine-Containing Products	☑
Cannabis/Cannabinoids	☑
Prescription Medications	☑
Cocaine	☑
Heroin	☑
Inhalants	☑
Methamphetamine	☑
Fentanyl or Other Synthetic Opioids	☑
Other	☐
Priority Populations	
Students in College	☑
Military Families	☑
American Indian/Alaska Native	☑
African American	☑
Hispanic	☑
Persons Experiencing Homelessness	☑
Native Hawaiian/Pacific Islander	☑
Asian	☑
Rural	☑

Footnotes:

Planning Tables

Table 6: SUPTRS BG Other Capacity Building/Systems Development Activities

Please enter the total amount of the SUPTRS BG budgeted for each activity described above, by treatment, recovery support services and primary prevention. In budgeting for each activity, states should break down the row budget by funds planned for SSA activities and those planned to be contracted out under other subrecipient contracts. States should plan their budgets on a single Federal Fiscal Year (FFY), specified in the table below.

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Activity	FFY 2026		
	A. SUPTRS Treatment	B. SUPTRS Recovery Support Services	C. SUPTRS Primary Prevention
1. Information Systems	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
2. Infrastructure Support	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$205,000.00	$0.00	$620,000.00
a. Single State Agency (SSA)	$205,000.00	$0.00	$620,000.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
4. Planning Council Activities	$0.00	$0.00	$0.00
a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$50,000.00	$0.00	$0.00
a. Single State Agency (SSA)	$50,000.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00

a. Single State Agency (SSA)	$0.00	$0.00	$0.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
7. Training and Education	$280,000.00	$0.00	$369,583.00
a. Single State Agency (SSA)	$280,000.00	$0.00	$369,583.00
b. All other subrecipient contracts	$0.00	$0.00	$0.00
8. Total	**$535,000.00**	**$0.00**	**$989,583.00**

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Planning Tables

Table 6: MHBG Other Capacity Building/Systems Development Activities

MHBG Plan 6 address MHBG funds to be expended on other capacity building /systems development during State Fiscal Year (SFY) 2026 and 2027 (for most states, the 24-month period is July 1, 2025, through June 30, 2027). This table includes columns to capture planned state budget for BSCA supplemental funds. Please use these columns to capture how much the state plans to expend over a 24-month period. Please document the planned uses of BSCA funds in the footnotes section.

MHBG Planning Period Start Date: 01/01/2026 MHBG Planning Period End Date: 01/01/2027

Activity	A. MHBG[1]	B. BSCA Funds[2]
1. Information Systems	$1,039,000.00	
2. Infrastructure Support	$2,163,680.00	$7,241.00
3. Partnerships, Community Outreach, and Needs Assessment	$555,025.00	
4. Planning Council Activities	$48,000.00	
5. Quality Assurance and Improvement	$171,600.00	
6. Research and Evaluation	$424,979.00	
7. Training and Education	$1,607,302.00	
8. Total	**$6,009,586.00**	**$7,241.00**

[1] The standard MHBG planned expenditures captured in column A should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025 – June 30, 2027**, for most states].

[2] The expenditure period for the 3rd and 4th allocations of the Bipartisan Safer Communities Act (BSCA) funding is **September 30, 2024 – September 29, 2026** (3rd increment) and **September 30, 2025 – September 29, 2027** (4th increment). Column B should reflect the state planned budget for this planning period (SFYs 2026 and 2027) [**July 1, 2025, through June 30, 2027** for most states].

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required for MHBG & SUPTRS BG

Narrative Question

Across the United States, significant proportions of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not have access to or do not otherwise access needed behavioral healthcare. **States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it**. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral health needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by **ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections**. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **The Essential Aspects of Parity: A Training Tool for Policymakers**; **Approaches in Implementing the Mental Health Parity and Addiction Equity Act: Best Practices from the States**.

The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1] Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. **States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings**. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. **States should develop systems that vary the intensity of care coordination support based on the severity and complexity of individual need**. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve **access to care for mental disorders, substance use disorders, and co-occurring disorders**, including details on efforts to increase access to services for:

a) Adults with serious mental illness (SMI)

b) Adults with SMI and a co-occurring intellectual and developmental disabilities (I/DD)

c) Pregnant women with substance use disorders

d) Women with substance use disorders who have dependent children

e) Persons who inject drugs

f) Persons with substance use disorders who have, or are at risk for, HIV or TB

g) Persons with substance use disorders in the justice system

h) Persons using substances who are at risk for overdose or suicide

i) Other adults with substance use disorders

j) Children and youth with serious emotional disturbances (SED) or substance use disorders

k) Children and youth with SED and a co-occurring I/DD

l) Individuals with co-occurring mental and substance use disorders

a) Adults with serious mental illness
The Local Authority (LA) system provides a full continuum of services for adults with SMI in accordance with Utah Code 17-43-301 There are five Prevention and Recovery of Early Psychosis (PREP) teams in Utah that provide Coordinated Specialty Care (CSC) to youth and young adults. Four of the five teams provide services to youth and young adults with Clinical High Risk for Psychosis (CHRP) or First Episode Psychosis (FEP), with the fifth team in the building phase and currently providing CSC to youth and young adults with FEP. The CSC treatment model provides therapy, medication management, case management, peer support, psychoeducation, and occupational therapy. The treatment team is focused on early identification and intervention of psychosis symptoms in order to support the young adult managing those symptoms and preventing relapse. Four of the PREP teams are located in the most populated areas of the state, with one team in a rural area building services in five rural counties. The SUMH is working to expand services to other non-metro areas of the state.

b) SUMH meets with Local Authorities (LAs) quarterly to discuss system needs; resources are provided by the state to address any gaps or needs for adults with SMI and co occurring I/DD. Since SYF23, SUMH has focused on improving the mental health workforce's ability to provide mental health treatment to the I/DD community. SUMH provides semi-annual I/DD and mental health training for mental health clinicians; this training focuses on ethical considerations in mental health treatment for individuals with I/DD; completing a thorough bio-psycho-social mental health assessment; and adapting evidence-based treatments. Quarterly consultations are available to training attendees. SUMH has also provided a monthly introductory webinar series for mental health professionals to increase knowledge of I/DD and the I/DD system of care. Beginning in SFY26, the SUMH will provide semi-annual skilled workshops to mental health clinicians. The Office of Substance Use and Mental Health and the Division of Services People With Disabilities, Utah's home and community based services agency, meet bi-monthly to discuss system needs and develop strategic plans to address needs.

c) Pregnant women with substance use disorders
The 13 Local Authority Substance Use and Mental Health Providers ensure that pregnant women with substance use disorders (SUD) have access to a continuum of gender-responsive, trauma-informed services, including prevention / early intervention, outpatient, intensive outpatient and residential treatment services. There are currently no waiting lists for outpatient services and minimal waiting lists for residential treatment services. Individuals on waiting lists for residential treatment services receive interim services until a bed is available.

There are 6 Statewide Parents and Children's Residential Treatment Programs where the children are allowed to live with their parents in the program and receive treatment services. Since these programs are Statewide, they will accept parents and their children in their program who are from other counties.

SUMH requires that the 13 Local Authority Providers ensure pregnant women are given preference with admission treatment facilities or make available interim services within 24 hours, including prenatal care. Below is Utah Statute that requires this:
Substance Abuse Treatment for Pregnant Women and Pregnant Minors Representative State Statute (Hutchings' H.B. 316) requires:
(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.
See Table 6 attachment for provider inventory list

c) Women with substance use disorders who have dependent children
The 13 Local Authority Substance Use and Mental Health Providers ensures that women with substance use disorders (SUD) have access to a continuum of gender-responsive, trauma-informed services, including prevention / early intervention, outpatient, intensive outpatient and residential treatment services. There are currently no waiting lists for outpatient services and minimal waiting lists for residential treatment services. Individuals on waiting lists for residential treatment services receive interim services until a bed is available. See attachment Table 6 for provider inventory list

d) Persons who inject drugs
SUMH identifies individuals who inject drugs as a priority population. Upon intake, clients are asked if they have a history of IV use, and they are prioritized for intake appointments or are provided walk-in appointments. Individuals are screened and assessed, and placed into treatment services using ASAM placement criteria. Early identification sites such as receiving centers,

local hospitals and clinics to try and identify clients earlier in order to increase earlier access to care.
OSUMH works with the Utah Syringe Exchange Network. The Utah Syringe Exchange Network (USEN) is a coalition of over 30 community agencies, state and local governments, law enforcement, medical providers and other stakeholders working together to collaborate on comprehensive Harm Reduction services for people who use drugs in Utah. Syringe exchange became legal in Utah in May 2016 and is overseen by the Department of Health and Human Services. All syringe service programs are required to provide linkage to substance use treatment, provide sterile syringe and injection equipment and offer vaccination, testing and linkage to care and treatment for infectious diseases. This is not funded by block grant funds but through the health department or other funding sources.

e) Persons with substance use disorders who have, or are at risk for, HIV or TB
The Local Substance Abuse Authorities along with the Local Health Departments work under the direction of the Department of Health and Human Services, Office of Communicable Disease to ensure that screening, testing and linking to treatment for HIV, HCV and TB is happening at the local level throughout the state. The Health Department, local clinics or internal medical staff provide testing for clients.

f) Persons with substance use disorders in the justice system
OSUMH so working with the University of Utah, the Administrative Office of the Courts, the Utah Department of Corrections and private for profit SUD treatment providers to create a unified identification process that would allow all courts, corrections agencies, and private and publicly funded programs to understand where an individual has received previous services so that releases of information can be used to gather data on how types of treatment and how effective treatment was in the past. OSUMH was once tasked by the legislature to certify SUD treatment providers and create a list of those providers for courts to distribute to persons seeking court order SUD treatment. This mandate has been removed, but the office has maintained a good working relationship with about 60 for profit providers and meets with them quarterly to pass on information about EBPs that are supported by the state and to help them network with the Utah Department of Corrections. Also, OSUMH has a contract with the University of Utah to provide one-on-one support to local authorities and private providers in tracking date outcomes and increasing the use of EBPs within their treatment offerings. This contract includes a review of gender specific screening, assessment, and treatment for women who enter the justice system.

g) Persons using substances who are at risk for overdose or suicide
OSUMH has a small suicide prevention team that works in partnership with other public and private sector organizations to promote and train both clinical providers and community members. Training for clinical and health care providers include all providers, in physical, behavioral health and integrated settings, both outpatient and inpatient. These trainings include safety planning, crisis response and means safety. Trainings for community members focus on recognizing warning sides of suicide ideation, identifying individuals who are at risk of suicide and the interventions and resources available to individuals and their families and supporters. The area of postvention planning and services is addressed with both clinical and community members, as well as businesses and schools. Substance use prevention and treatment is addressed in all suicide prevention trainings.

h) Other adults with substance use disorders
Reduction of waiting lists by providing walk-in appointments, target funding in order to increase funding to services that are identified as a need. Ensure appropriate screening and assessment in order to place in appropriate levels of care. Continued assessments including ASAM for SUD clients. Ensure access to a full continuum of care across the state. Contract with Juvare for a bed registry that will improve access and referrals to care, currently this is being piloted with the hospitals for MH clients but we are looking to expand to SUD treatment services as we grow the use of the bed registry across the behavioral health system.

i) Children and youth with serious emotional disturbances or substance use disorders
The LMHA and LSAA provides MH and SUD services for children and youth. Following screening and assessment each youth is offered the opportunity to engage in services which will appropriately support mental health symptom reduction and or substance use. The LMHA/LSAA provides a full continuum of mental health and substance use services to youth and their families in the community. OSUMH continues to work with the LAs to address service capacity. Utah State Board of Education (USBE) partners with OSUMH, while Local Education Agencies (LEA) partner regionally to support mental health screening activities in school with referrals to community mental health providers to support early identification activities. OSUMH partners to enhance education and provider training on early childhood mental health and intellectual and developmental disabilities.

j) Individuals with co-occurring mental and substance use disorders
Reduction of waiting lists by providing walk-in appointments, target funding in order to increase services that are identified as needs and gaps within certain target populations or areas of need. We have used data to identify areas of need and worked in collaboration to ensure services are being provided that can address SUD and MH disorders. Ensure appropriate screening and assessment in order to place in appropriate levels of care. Continued assessments including ASAM for SUD clients. Ensure access to a full continuum of care across the state.
Utah focuses services around a recovery system of care approach when addressing individual and family needs whether there are adults or youth.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance **parity enforcement and increase awareness of parity protections** among the public and across the behavioral and general health care fields.

SUMH has recently hired a Medicaid Policy Assistant Director and policy team to help address behavioral health policy within the behavioral health system, this would include efforts to address parity.

During the Utah 2021 Legislative session, a bill was passed requiring a merger between the Department of Health and the Department of Human Services to form the Utah Department of Health and Human Services. The Office of Substance Use and Mental Health was incorporated into the Division of Integrated Healthcare that also includes the Medicaid office. This promotes a close partnership with Medicaid including continual conversations and discussion on how to improve parity across behavioral health and general health services. An example of this are weekly internal meetings with Medicaid and SUMH staff and biweekly meetings with Medicaid, SUMH, and community stakeholders. SUMH has also contracted with Utah Health Policy Project (UHPP) that provides technical assistance, training and awareness regarding behavioral health coverage.

3. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders.

Yes, Utah provides evidence-based integrated treatment for co-occurring disorders. The state's behavioral health system has shifted away from bifurcated services delivery. When an individual seeks help at a local authority, they receive screening and coordinated treatment services that address their needs concurrently.

Utah was awarded the CCBHC planning grant in 2025. Utah is working towards physical and behavioral health integration. Utah was also selected to participate in the Physical Health Integration Learning Collaborative in 2025.
The 13 Local Authorities are all combined Mental Health and Substance Use Authorities, with only one that was a separate entity but is currently under integration efforts which should be completed by 2026. Most Local Authorities use a combination of screening and assessment tools to identify the specific mental health and substance use services that are needed. There are ongoing efforts to continually address issues, concerns or new diagnosis that may arise during their services. Local Authorities use an individualized person-centered planning that addresses the individual's needs whether it is Substance Use, Mental Health or both. The Local Authorities have the ability to transition the individual to the needed services and provide full continuum of care as indicated. This allows for the individuals to receive services based on need. SUD utilizes ASAM to address appropriate levels of care. Non-clinical recovery support services are also provided based on need and when available and also support co-occurring services. Utah focuses services around a recovery system of care approach when addressing individual and family needs whether there are adults or youth.

a. Please describe how this system differs for youth and adults.

Utah focuses on 3 target age groups; Youth, transitional aged youth and adults. Prevention plays a key role when it comes to addressing youth across the state. Efforts focus around schools and community engagement in order to engage you where they are most likely at. For youth and transitional aged youth, schools are a focal point of engagement in order to identify individuals in need of SUD and MH services early on. Most of Utah's schools have counselors and also collaborate with the Local Authorities (LAs) to provide screenings, assessments and further services when indicated. The LAs work closely with the schools to ensure the students have access to Substance Use and mental health services. Utah also uses the SHARP survey to show indications of additional services, education, etc for particular areas of the state. Prevention also works with higher education to provide education and engagement opportunities for students. Youth and transitional aged youth have access to screenings, assessment and integrated physical health services much the same way that adults do. Youth are provided screening and assessments and recommendations for levels of services are made. Physical health needs are identified as part of the screening and assessment process, furthermore ongoing screenings and assessments may identify additional needs for psychological testing or additional physical health needs. The LAs all have internal physical health facilities or access to a physical health provider in order to address any physical health need. For youth and transitional aged youth, family services and needs are addressed as well.
Adults are typically referred for services through the Justice system which would include involvement with Adult Probation and Parole, pending or post criminal charges, Division of Child and Family Services, etc. Others coming in for services typically have other pressures for services such as employment, family or friend involvement, etc. Adults are screened and assessed in the same way and behavioral health as well as physical health needs are addressed at screening and intake and then again as ongoing screening and assessment are performed or as there are other indicators that may arise during treatment. Peer engagement can also help to identify when there is a need for further screening and assessment is needed.

b. Does your state provide evidence-based integrated treatment for co-occurring disorders (IT-COD), formerly known as IDDT? Please explain.

Yes, Utah provides evidence-based integrated treatment for co-occurring disorders. The state's behavioral health system has shifted away from bifurcated services delivery. When an individual seeks help at a local authority, they receive screening and coordinated treatment services that address their needs concurrently.
Utah was awarded the CCBHC planning grant in 2025. Utah is working towards physical and behavioral health integration. Utah was also selected to participate in the Physical Health Integration Learning Collaborative in 2025.
The 13 Local Authorities are all combined Mental Health and Substance Use Authorities, with only one that was a separate entity but is currently under integration efforts which should be completed by 2026. Most Local Authorities use a

combination of screening and assessment tools to identify the specific mental health and substance use services that are needed. There are ongoing efforts to continually address issues, concerns or new diagnosis that may arise during their services. Local Authorities use an individualized person-centered planning that addresses the individual's needs whether it is Substance Use, Mental Health or both. The Local Authorities have the ability to transition the individual to the needed services and provide full continuum of care as indicated. This allows for the individuals to receive services based on need. SUD utilizes ASAM to address appropriate levels of care. Non-clinical recovery support services are also provided based on need and when available and also support co-occurring services. Utah focuses services around a recovery system of care approach when addressing individual and family needs whether there are adults or youth.

c. How many IT-COD teams do you have? Please explain.

The most formal use of integrated treatment is found within Utah's seven Assertive Community Treatment (ACT) teams. These high-fidelity teams are specifically designed to treat individuals with the most severe and persistent co-occurring mental health and substance use disorders, providing comprehensive, wrap-around services that include housing and employment support.
Beyond these seven specialized ACT teams, the local authorities offer robust peer support services, which are integral to supporting long-term recovery. Looking forward, Utah's active pursuit of the Certified Community Behavioral Health Clinic (CCBHC) model, for which the state has a planning grant, is poised to significantly increase the formal availability and fidelity of integrated services for individuals with co-occurring disorders.

d. Do you monitor fidelity for IT-COD? Please explain.

Yes, Utah monitors fidelity, with the most formal process applied to our highest-intensity services. Specifically, the state's five ACT teams undergo a formal fidelity review on an annual basis. For the broader public behavioral health system, fidelity is promoted and monitored through other key mechanisms. Adherence is supported through state-sponsored training on evidence-based practices, technical assistance, and continuous quality improvement (CQI) initiatives at the provider level. The monthly supervision for Certified Peer Support Specialists is another component of our quality assurance framework, ensuring this important element of the recovery model is delivered effectively. As Utah advances its implementation of the Certified Community Behavioral Health Clinic (CCBHC) model, these requirements for fidelity monitoring and outcomes reporting are expected to become even more standardized and robust across the system.

e. Do you have a statewide COD coordinator? ○ Yes ◉ No

4. Describe how the state **supports integrated behavioral health and primary health care**, including services for individuals with mental disorders, substance use disorders, co-occurring M/SUD, and co-occurring SMI/SED and I/DD. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

d) How the state provides integrated treatment for individuals with co-occurring disorders

a) Access to behavioral health care facilitated through primary care providers - Several LAs have agreements with local healthcare providers to allow LA staff to provide services in physical healthcare settings, including primary and pediatric care. On site behavioral healthcare is targeted for mild to moderate symptomology. Patients with more complex needs are referred to services at the LA or other provider as clinically identified.
b) Efforts to improve behavioral health care provided by primary care providers - SUMH is in the early stages of developing support programming for behavioral health providers who are currently working in, or interested in working in physical healthcare settings. Currently, the priority for SUMH is supporting behavioral health providers with implementing physical healthcare.
c) Efforts to integrate primary care into behavioral health settings - SUMH is in the process of creating a framework document for the LAs focused on integrating care at four different levels. This framework will include guidance on programming, staffing, and billing. SUMH is also in the middle of a SAMHSA CCBHC planning grant. CCBHC efforts will lead to increased physical health screening and monitoring at the CCBHC provider sites.
d) How the state provides integrated treatment for individuals with co-occurring disorders - LAs provide integrated care for individuals with mental health conditions and co-occurring substance use disorders through a coordinated system that combines clinical, community, and recovery supports. Local authorities offer assessments, therapy, medication management, and case management based on evidence-based practices, including the ASAM criteria and DSM diagnoses. Services are delivered in outpatient, intensive outpatient, residential, and inpatient settings.

*****Require LAs to address integrated care including plans for expansion when they write their area plans.

5. Describe how the state **provides care coordination**, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness (SMI)

b) Adults with substance use disorders

c) Adults with SMI and I/DD

d) Children and youth with serious emotional disturbances (SED) or substance use disorders

e) Children and youth with SED and I/DD

SUMH is responsible for designing and supporting the infrastructure for care coordination across the behavioral health system. This includes setting standards, providing training and guidance, and ensuring services align with state and federal requirements.

a)For adults with SMI and SUD, SUMH staff is responsible for certifying case managers, peer support specialists, and crisis workers to ensure care coordination is provided in a uniform way with high standards for adults with SMI and/or SUD. SUMH staff also works with other state agencies in high complexity case staffings to support individuals with the most intensive needs. Designated examiners, forensic evaluators, and PASRR evaluators are trained by SUMH and the Utah State Hospital. Designated examiners assist with civil commitment assessments and coordinate care between the emergency rooms, inpatient psychiatric wards, and the district courts. Forensic evaluators assess competency for individuals with SMI who have charges. These evaluators work with the treatment community, Utah State Hospital and the courts. PASRR evaluators review mental health needs for individuals with SMI to determine appropriate placement and need for mental health specialized services when clients are being placed at skilled nursing facilities.

b) For adults Substance Use Disorders (SUD), SUMH staff provides oversight by certifying case managers, peer support specialists, and crisis workers. Adults with SUD receive screening and assessments to determine appropriate placement and to identify service needs. Needs for the coordination of care is based on screening, assessment and individualized care. Coordination efforts include, physical health coordination to include primary care, medications, wound care, or other medical needs, efforts, peer coordination, MAT, identification of co-occurring, disorders, IDDs, coordination with justice services or legal involvement, etc. Collection of Releases of Information make it possible to share client specific information and to ensure coordination takes place and provides the best outcomes.

c) Adults with co-occurring SMI and Intellectual/Developmental Disabilities (I/DD) receive state-level care coordination primarily through Home and Community-Based Services (HCBS) waivers. Their care is also managed through high-level case staffings involving multiple state agencies.

d) Children and youth with Serious Emotional Disturbances (SED) or substance use disorders are served through Utah's system of care framework. This framework incorporates wraparound models and utilizes SAMHSA funding to support regional implementation. To ensure care is coordinated effectively across sectors, state staff develop and maintain interagency agreements with education, juvenile justice, and other child-serving systems.

e)Children and youth with Serious Emotional Disturbances (SED) and I/DD are served through Utah's system of care framework. This framework incorporates wraparound models and utilizes SAMHSA funding to support regional implementation. To ensure care is coordinated effectively across sectors, state staff develop and maintain interagency agreements with division of service for persons with disabilities, education, juvenile justice, and other child-serving systems.

6. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and substance use disorders**, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Utah utilizes a no wrong door principle where anyone seeking help is screened for both mental health and substance use conditions. Local authorities ensure that individuals receive a single, integrated treatment plan that addresses the whole person. The state supports this model by embedding these integrated care requirements in provider contracts and monitoring for compliance.
For adults, a person's care is managed by one clinical team that helps them work on mental health and substance use goals simultaneously. For those with the most severe challenges, the state supports highly intensive services like Assertive Community Treatment teams, which provide comprehensive care directly in the community.
The system for children and youth operates under a System of Care philosophy. The primary model is High-Fidelity Wraparound, a collaborative process that brings together a team from all parts of a child's life, such as family, school officials, and community supports, to create one coordinated plan. This ensures a child's behavioral health needs are met holistically, with support seamlessly integrated across home, school, and community.
Utah was awarded the CCBHC planning grant in 2025. Utah is working towards physical and behavioral health integration. Utah was also selected to participate in the Physical Health Integration Learning Collaborative in 2025.

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but is currently under integration efforts which should be completed by 2026. Most Local Authorities use a combination of screening and assessment tools to identify the specific mental health and substance use services that are needed. There are ongoing efforts to continually address issues, concerns or new diagnosis that may arise during their services. Utah focuses services around a recovery system of care approach when addressing individual and family needs whether their are adults or youth. Local Authorities use an individualized person-centered planning that addressed the individuals needs whether it is Substance Use, Mental Health or both. The Local Authorities have the ability to transition the individually to the needed services and provide full continuum of care as indicated. This allows for the individuals to receive services based on need. SUD utilizes ASAM to address appropriate level of care. Non-clinical recovery support services are also provided based on need and when available and also support co-occurring services.

Youth and transition aged youth services are provided in the same way. Although referrals and early identification may take place in a different setting such as school based. Local Authorities work closely with the local school district and the board of education to provide behavioral health services. Most schools have access to Mental Health counselors, psychologists or other behavioral health professionals. SUMH and the Local Authorities also work closely with the Division of Child and Family Services and Juvenile Justice System to coordinate care and provide services.

7. Describe how the state supports the provision of **integrated services and supports for individuals with co-occurring mental and intellectual/developmental disorders (I/DD)**, including screening and assessment for co-occurring disorders and integrated treatment that addresses I/DD as well as mental disorders. Please describe how this system differs for youth and adults.

SUMH meets with Local Authories (LAs) quarterly to discuss system needs; resources are provided by the state to address any gaps or needs. Since SYF23, SUMH has focused on improving the mental health workforce's ability to provide mental health treatment to the I/DD community. SUMH provides semi-annual I/DD and mental health training for mental health clinicians; this training focuses on ethical considerations in mental health treatment for individuals with I/DD; completing a thorough bio-psycho-social mental health assessment; and adapting evidence-based treatments. Quarterly consultations are available to training attendees. SUMH has also provided a monthly introductory webinar series for mental health professionals to increase knowledge of I/DD and the I/DD system of care. Beginning in SFY26, the SUMH will provide semi-annual skilled workshops to mental health clinicians. The Office of Substance Use and Mental Health and the Division of Services People With Disabilities, Utah's home and community based services agency, meet bi-monthly to discuss system needs and develop strategic plans to address needs. Beginning in SYF26, SUMH and the Division of Services People With Disabilities will meet quarterly with the state's crisis line provider to review shared clients to improve system collaboration and support. In SYF25, SUMH and the Division of Services People With Disabilities started an education project for behavioral health professionals focusing on mental health and substance use treatment services for I/DD. Since SYF24, SUMH has created annual aggregate data score cards for the LAs to review mental health services to people with I/DD; score cards are separated by age - 0-17 and 18+. In SYF25, SUMH and the Division of Services People With Disabilities began an all-payer claims database project to develop state baselines related to I/DD and mental health.

8. Please indicate areas of **technical assistance needs** related to this section.

Not at this time.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among individuals 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 as soon as possible following initial symptoms and reducing possible lifelong negative impacts such as loss of family and social supports, unemployment, incarceration, and increased hospitalizations *[Note: 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 SMI or SED].* The duration of untreated mental illness, defined as the time interval between the onset of symptoms and when an individual gets into appropriate treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be a negative prognostic factor. However, earlier treatment and interventions not only reduce acute symptoms but may also improve long-term outcomes.

The working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5TR (APA, 2022). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic, or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by the 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 experiencing first episode of psychosis (FEP). RAISE was a set of federal government- sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

States shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals experiencing 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.

Please respond to the following items:

1. Please name the evidence-based model(s) for ESMI, including psychotic disorders, that the state implemented using MHBG funds including the number of programs for each.

Model(s)/EBP(s) for ESMI	Number of programs
Coordinated Specialty Care (CSC)	5.00
	0.00
	0.00
	0.00

	0.00
	0.00

2. Please provide the total budget/planned expenditure for ESMI for FY 26 and FY 27 (only include MHBG funds).

FY2026	FY2027
938,035.40	938,035.40

3. Please describe the status of billing Medicaid or other insurances for ESMI services. How are components of the model currently being billed? Please explain.

Components of CSC include: therapy, medication management, case management, peer support, occupational therapy, psychoeducation (individual and family), multi-family group, and supported employment/Individual Placement and Support. The five sites facilitating Coordinated Specialty Care (CSC) bill Medicaid for allowable services such as therapy, medication management, and case management. There is not currently a bundled rate for CSC in Utah, although a cost analysis has been completed in order to inform the creation of a team-based rate in the state Medicaid plan. Services that are not Medicaid reimbursable are still facilitated by the CSC team to ensure fidelity to the model.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI.

The Utah Office of Substance Use and Mental Health (SUMH) uses the 10% set aside funds to contract with four Local Mental Health Authorities and one community service organization in the State of Utah to provide Coordinated Specialty Care (CSC) programs for individuals experiencing early serious mental illness. Weber Human Services (Weber County) was the pilot site for the 5% set aside, with expansion to Davis Behavioral Health (Davis County) and Wasatch Behavioral Health (Utah County) with the 10% set aside. Volunteers of America, Utah (Salt Lake County), a community service organization, implemented a CSC program two years ago. Within the last year, Southwest Behavioral Health Center (Iron County) has introduced CSC services in their community. Each of the sites providing CSC services include the following components: Medication Management, Individual and Group Psychotherapy, Dialectical Behavioral Therapy, Occupational Therapy, Supported Employment/Individual Placement and Support, Supported Education, Case Management, Peer Support, Multi or Single-Family Psychoeducation, and Recovery Oriented Cognitive Behavioral Therapy.

5. Does the state monitor fidelity of the chosen EBP(s)? (●) Yes ( ) No

6. Does the state or another entity provide trainings to increase capacity of providers to deliver interventions related to ESMI? (●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI.

The five Coordinated Specialty Care (CSC) teams provide essential services to those clients identified as having experienced a First-episode Psychosis (FEP). With targeted funding through SAMHSA, four of these sites also facilitate the CSC for clients meeting criteria for Clinical High-Risk of Psychosis (CHRP). The essential services provided include therapy, case management, medication management, supported education and employment, psychoeducation, peer support, multi-family group, and occupational therapy. Clients engaged with the CSC teams have participated in screening and assessment to ensure early identification and intervention for psychosis and psychosis-risk symptoms. Outcomes are improved as clients and their natural supports engage in early intervention services designed to address symptoms and provide tools to manage and decrease symptoms. Tools include evidence-based practices (DBT, CBT, CT-R) as well as individualized relapse prevention plans. These tools are utilized with the goal of each client participating in services for approximately two years. If a client meets criteria for CHRP and experiences a first episode of psychosis, they continue receiving services from the same treatment team and interventions are adjusted to address the psychosis symptoms.

****Need to add in using the SIPS to identify need.

8. Please describe the planned activities in FY2026 and FY2027 for your state's ESMI programs.

Programs at the primary pilot site (Weber Human Services) and the expansion sites (Davis Behavioral Health, Wasatch Behavioral Health, Volunteers of America, Utah, and Southwest Behavioral Health Center) will continue to be developed and refined. Ongoing training, coaching, technical assistance, and monitoring are provided at least monthly to ensure that EBPs and the CSC model are provided to fidelity, and that an array of treatment services and recovery supports are being offered. Fidelity reviews will be completed with all teams during the FY2026 and FY2027 time frame.
The state-level administrators plan to work with the program sites to engage graduates of the CSC programs in building a Youth Advisory Board. This Board will provide helpful oversight to the existing teams and give feedback to improve services for existing clients.

Strategic Plan for FFY 2026 and FFY 2027
Goal I: Early psychosis is well understood and accepted by the community.
Objective 1: School personnel, including post-secondary education, understand early psychosis and are able to identify, screen,

and refer youth and young adults for services.
Objective 2: High need communities as identified by data to understand early psychosis and are able to identify, screen, and refer youth and young adults for services.
Objective 3: First responders (mobile crisis, law enforcement) and medical personnel understand early psychosis and are able to identify, screen, and refer youth and young adults for services.
Objective 4: Criminal/juvenile justice system personnel understand early psychosis and are able to identify, screen, and refer youth and young adults for services.
Objective 5: Child welfare system personnel understand early psychosis and are able to identify, screen, and refer youth and young adults for services.
Objective 6: Intellectual, developmental, and physical disability system personnel understand early psychosis and are able to identify, screen, and refer youth and young adults for services.
Objective 7: Primary care physicians and coordinating teams understand early psychosis and are able to identify, screen, and refer youth and young adults for services.
Objective 8: Families, young people, and natural supports understand early psychosis and are able to identify and refer youth and young adults for services.
Objective 9: General public understands early psychosis and the stigma associated with it is reduced and/or eliminated.
Objective 10: The developed program logo and website will be utilized to create consistent statewide community education and outreach tools.
Goal II: Behavioral health providers have the capacity and capability to provide effective screening, assessment, interventions, and support through training and implementation consultation
Objective 1: Behavioral health providers are trained in early psychosis screening, assessment, interventions, and supports.
Objective 2: Behavioral health providers have the capacity to provide assertive outreach and engagement.
Objective 3: Behavioral health providers provide early psychosis screening, assessment, interventions, and supports to fidelity through implementation support

Goal III: Early psychosis service will be expanded to additional LMHA(s)
Objective 1: All LMHAs will implement the use of the PRIME screening tool for youth and young adults by the end of FFY2026.
Objective 2: Engage in conversations with LMHAs on integrating early psychosis services into the Mental Health Centers Area Plan by 2026
Objective 3: Expand fully structured early psychosis program to at least one additional LMHA by 2027

Specific planned activities for FY 2026 and 2027 are:
1.Collaborate with the Office of Medicaid Operations, Utah Department of Health and Human Services to enhance service arrays for ESMI.
2. Collaborate with the Office of Medicaid Operations, Utah Department of Health and Human Services to explore additional payment options for CSC (i.e. bundled rate), utilizing the completed CSC team costs analysis report.
3.Conduct annual fidelity review to the PREP Practice Guidelines.
4.Develop and implement LMHA-specific Continuous Quality Improvement plan based on the fidelity review results.
5.Incorporate early psychosis focus into the integrated health/behavioral health model.
6.Continue technical assistance with EASA.
7.Expand youth empowerment activities e.g., youth advocacy and youth-to-youth peer support services.

9. Please list the diagnostic categories identified for each of your state's ESMI programs.

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

10. What is the estimated incidence of individuals experiencing first episode psychosis in the state?

OnTrack NY created an FEP Cost Estimator Tool which illustrates costs and teams needed under low, medium, and high estimates of the number of persons served, which corresponds to various estimates of incidence, percentage of persons approached, percentage agreeing to services, number of clients served per team, and average months in treatment. For Utah, with a population of 3,564,000 the incidence rate per year ranges from 535 (low estimate) to 1069 (high estimate). Incidence of all psychoses are estimated at 27.1/100,000 (Kirkbride et al, 2009) and 31.6/100,000 (Baldwin et al, 2005). Incidence of non-affective psychoses (ICD 10 codes F20-F29 including schizophrenia, schizotypal disorder, delusional disorders, brief psychotic disorder, shared psychotic disorder, schizoaffective disorders, other psychotic disorder not due to a substance or known physiological condition, and unspecified psychosis not due to a substance or known physiological condition) are estimated at 16.7/100,000 (Kirkbride). Affective psychoses are estimated at 6.8/100,000 (Kirkbride) and 11.6/100,000 (Baldwin). Incidence of schizophrenia alone is estimated at 8.9/100,000 (Kirkbride) and 7.0/100,000 (Baldwin).

11. What is the state's plan to outreach and engage those experiencing ESMI who need support from the public mental health system?

Technical assistance focused on youth and young adults is coordinated with the local mental health authorities. Training addresses first-episode psychosis, including information about symptoms, diagnosis, treatment options, and appropriate evidence-based practices. Specific training for first-episode psychosis will include the PRIME screening tool, the Structured Interview for Psychosis-Risk Syndromes (SIPS), and the Structured Clinical Interview for DSM-5 (SCID-5). All three tools can be utilized to screen or assess first-episode psychosis and lead to appropriate treatment and referrals.

A logo and website for the Utah CSC teams were created in FFY2024 with the goal of ensuring consistent brand recognition for the teams. Community education and outreach tools will be created using the logo and website to ensure consistent messaging across the state and CSC teams.

12. Please indicate area of technical assistance needs related to this section.

Technical assistance needs are currently being met through a contract with the Early Assessment and Support Alliance (EASA). Additional technical assistance was requested from the ESMI TTA Center in FFY2024 to gather information regarding the team-based Medicaid billing rates

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Footnotes:

Environmental Factors and Plan

3. Person Centered Planning (PCP) – Required for MHBG, Requested for SUPTRS BG

Narrative Question

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. PCP resources may be accessed from **https://acl.gov/news-and-events/announcements/person-centered-practices-resources**

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.

3. Describe how the state engages people with SMI and their caregivers in making health care decisions, and enhances communication.

SUMH does not provide direct services to consumers. Office Directives created by SUMH and the Utah Preferred Practice Guidelines emphasize that an important aspect of effective treatment is the ability for providers to engage clients so that the client has hope for their recovery and desires to participate in treatment. One barrier to effective engagement is the belief that all elements of assessment and planning must be gathered at the very beginning of services. Therefore, these guidelines emphasize that assessment and planning are a process rather than an event, and should be balanced with the process of engagement. A more concerted focus on engagement results in improvements in client retention and improved treatment outcomes. SUMH monitors assessments and treatment plans to look for client and caregiver input in treatment decisions. This includes assessing whether goals and treatment are congruent with the client's stated reason for seeking care. Consumer satisfaction surveys (Mental Health Statistics Improvement Program) are collected system wide and reviewed annually. The Outcome Questionnaire (OQ) is used extensively throughout the mental health system to assess progress in treatment. Use of the OQ is monitored by the state, requiring that the tool be administered every 30 days and that the results of the tool be incorporated into treatment. The OQ is also available for children/youth and their parents, with a tool that clinicians can answer for individuals with psychosis. The Substance Use Recovery Evaluator (SURE) tool from King's College of London was implemented across our public behavioral health providers in 2023. This tool is used to monitor individual recovery needs and review progress over time allowing clinicians to engage with a client regarding their progress or lack thereof. It allows the clinical to watch trending patterns and intervene when trends change. Six sections are scored and can be monitored for change which allows the clinician an opportunity to engage and address the individual's needs and concerns. The OQ and SURE are available in English and Spanish (Spanish SURE is in progress now).

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, culturally aware, and trauma-informed manner. Person-centered and strengths-based questions 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 SUMH includes chart reviews, which focus on person-centered planning and evidence of client voice in the treatment choices. When client voice is not evident in goals and objectives, SUMH offers technical assistance to treatment providers, requiring that treatment and recovery efforts are modified to ensure services are person-centered. Implementation of the SURE also helps to address areas of concern and allows engagement to address them.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as **A Practical Guide to Psychiatric Advance Directives**)?

SUMH monitors all Local Authorities annually, including a review of the clinical charts. These reviews often include questions related to creation of a Psychiatric Advance Directive, although this has not been a focus of the monitoring in the past. OSUMH is including this question specifically in the monitoring process beginning in the SFY26 season.

6. Please indicate areas of technical assistance needs related to this section.

Not at this time.

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Footnotes:

Environmental Factors and Plan

4. Program Integrity – Required for MHBG & SUPTRS BG

Narrative Question

There is a strong emphasis on ensuring that Block Grant funds are expended in amanner consistent with the statutory and regulatory framework. This requires that the federal government and the states have a strong approach to assuring program integrity. Currently, the primary goals of the federal government's 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, states are reminded of restrictions on the use of Block Grant funds outlined in **42 U.S.C. § 300x–5** and **42 U.S.C § 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)**, there are periodic site visits to MHBG and SUPTRS BG 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 SUPTRS BG funds can only be used for individuals with or at risk for SUD. The 20% minimum primary prevention set-aside of SUPTRS BG funds should be used for universal, selective, and indicated substance use prevention. Guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through private and public insurance. In addition, the federal government and states need to work together to identify strategies for sharing data, protocols, and information to assist Block Grant program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based substance use primary 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 SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and SUD benefits; (3) ensuring that consumers of mental health and SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of mental health and SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

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

(●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

(●) Yes ( ) No

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

SUMH has a dedicated audit team that monitors the Local Authorities (LAs) annually. Governance and oversight review is a component of the monitoring visit, with deviation from expectations included as findings in the audit report. LAs are required to complete a corrective action plan to address findings and ensure that program requirements are being maintained.
Utah has ongoing meetings with the Utah Behavioral Health Committees (UBHC) which represent our public behavioral health system. The committees include the UBHC Executive Directors committee, UBHC Clinical Directors committee, UBHC Data committee, and the UBHC Finance Directors committee. The committees meet monthly to address any changes or updates on budgets and finance, contracts, federal or state policy, data, etc. The collaborative efforts of these ongoing meetings help ensure that the Utah behavioral health system continues to move in a coordinated, positive forward approach to service delivery, with improved access, treatment and outcomes for the community.

4. Please indicate areas of technical assistance needs related to this section.

Not at this time.

Footnotes:

Environmental Factors and Plan

5. Primary Prevention – Required for SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend a minimum of 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment which programs (A) educate and counsel the individuals on substance use and substance use disorders; and (B) provide for activities to reduce the risk of substance use and substance use disorders by the individual. 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 primary 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 SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

1. ***Information dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, misuse and substance use disorders on individuals families and communities.
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5. ***Community-based processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the use 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 serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

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):

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☐ Other (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Rural communities

i) ☐ Other (please list)

4. Does your state use data from the following sources in its primary prevention needs assesment? (check all that apply):

a) ☑ Archival indicators (Please list)

Juvenile arrest data, children in protective custody, adult arrest data, medical examiner morbidity and mortality reports.

b) ☑ National survey on Drug Use and Health (NSDUH)

c) ☑ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

e) ☑ Monitoring the Future

f) ☑ Communities that Care

g) ☑ State-developed survey instrument

h) ☐ Other (please list)

5. Does your state use needs assessment data to make decisions about the allocation of SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, (please explain in the box below)

Utah puts out the majority of the allocated SUPTRS BG primary prevention funds via a formula process. However, the state does take into account assessment information and can make changes to allocated amounts when assessments identify a need. The state takes into account the capacity of areas, in particular capacity related to the rural nature of the sub-recipient, along with substance use data and trends, when determining to allocate additional funding to an area.

b) If no, please explain how SUPTRS BG funds are allocated:

Narratve Question

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Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe.

Through the Association of Utah Substance Abuse Professionals, Utah prevention workers have the opportunity to become licensed with the International Certification and Reciprocity Consortium (IC&RC).
Outside of the IC&RC prevention licensure, the Office of Substance Use and Mental Health requires that all prevention specialists in the state complete a Prevention Skills Training within the first year of hire. Prevention specialist must recertify by completing the training every 3 years.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? (●) Yes ( ) No

a) If yes, please describe mechanism used.

The Office of Substance Use and Mental Health (OSUMH) provides training and technical assistance to the prevention workforce in the state of Utah. This includes contracted trainings including motivational interviewing for prevention professionals, Applied Prevention Science International training series, and Communities that Care Facilitator training. OSUMH also provides a prevention skills training (SAPSTs) at least quarterly. Other TTA needs are provided through our Regional Director system. 5 regional directors are assigned a few of our local provider areas, and meet with the prevention folks from those areas often to assess and provide necessary TTA to help the area through the Strategic Prevention Framework. OSUMH also hosts an annual behavioral health conference which includes a specific prevention track.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) If yes, please describe mechanism used.

OSUMH supports the use of the Tri Ethnic Center's Community Readiness for Community Change tool for assessing community readiness to address substance misuse issues. The office has partnered with other entities like SPTAC to provide trainings on how to utilize the tool, and RDs often provide assistance where needed to local communities that are

conducting the readiness surveys.

Narratve Question

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The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must serve both the general population and sub-groups that are at high risk for substance use. The program must include, but is not limited to, the following strategies:

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Planning

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

If yes, please attach the plan in WebBGAS

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

- [x] Yes
- [ ] No
- [ ] Not applicable (no prevention strategic plan)

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) Does the composition of the Advisory Council represent the demographics of the State? (●) Yes ( ) No

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

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

Utah's Evidence-Based Workgroup has developed a tool that places programs in 1 of 4 levels depending on the quality of research and outcomes associated with the program. Programs that reach a level 3 or 4 are deemed to be evidence-based for our state and are eligible for prevention funding. To reach level 3 programs must have a least 1 quasi-experimental design evaluation, along with an additional study showing positive outcomes. The EBW reviews locally developed programs who have conducted their own evaluations, along with programs that have peer-reviewed research but do not show up on the blue prints programs registry.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG 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 SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Brain science messaging campaign, family nights, Gray Matters campaign, Know Your Script campaign, Parents Empowered campaign, Parents Learn to See campaign, school presentations, Red Ribbon Week, community presentations, social norms campaign, townhalls, Everyday Strong presentation.

b) Education:

All Stars, Botvin LifeSkills, Catch my Breath, Circle of Security Parenting, Clearing the Vapor, Good Behavior Game, Guiding Good Choices, InShape Prevention Plus Wellness, Keepin' it REAL, Learning to Breathe, Life Skills Training, Living Skills,

Living Well with Chronic Pain, Love and Logic, Mindfulness-based Stress Reduction, MindUP, Parenting Wisely, Personal Empowerment Program, Physician Education, Positive Action, Prime for Life, Project Toward no Drug Abuse, Protecting You Protecting Me, Second Step, SPORT Program, Staying Connected with your Teen, STEP, Strengthening Families, Student Athlete Prevention Program, Too Good for Drugs and Violence, VOICES, Why Try.

c) Alternatives:

Big Brothers Big Sisters, Sober Socials, Spy Hop Teen Prevention Program, Check and Connect Mentoring.

d) Problem Identification and Referral:

Assessment and referral to Prime for Life

e) Community-Based Processes:

Community Schools, family bonding events, Governing Youth Council, Social Development Strategy, Youth Coalitions, Community Coalitions.

f) Environmental:

Alcohol and tobacco compliance checks, DEA 360 community table talks, policy work, shoulder tap, social host law, take back events.

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) Yes (if so, please describe)

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

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that serve 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 primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in WebBGAS

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as prioritized benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [x] Includes 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 describe):
- **g)** [x] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** [x] Numbers served
- **b)** [ ] Implementation fidelity
- **c)** [ ] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [x] Attendance
- **f)** [x] Demographic information
- **g)** [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy alcohol use
- **c)** ☑ Binge alcohol use
- **d)** ☑ Perception of harm
- **e)** ☑ Disapproval of use
- **f)** ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- **g)** ☐ Other (please describe):

Footnotes:

SUMH Prevention Strategic Plan

FY2026

SUMH Vision: Is healthy individuals, families and communities

SUMH Mission: Is to promote health, hope, and healing

SUMH Result Statement: Children, adults, families, and communities experience improved health and social functioning, and a reduction in the harms associated with substance use and mental health challenges.

Experience of the Result:

1. All Utahns have fair and equitable access to a broad array of prevention, mental health and substance use disorder services where and when they are needed.
2. Local substance use and mental health authorities use evidence-based practices, integrate mental and physical health care, and demonstrate improved outcomes.
3. Fewer Utah youth use alcohol and drugs, and fewer Utahns of all ages are negatively affected by mental health symptoms and substance use disorders.
4. Fewer Utahns experience suicidal ideation, attempts, or death. Utahns in crisis have someone to talk to, someone to respond, and a place to go.

Strategic Initiative #1 – Reduce Substance Misuse **Who is responsible: Rob (SUD prevention team)**			
Goals	**Objectives**	**Metrics**	**Outcome**
1. Increase the number and quality of coalitions addressing substance	1. Enhanced TTA through RDs 2. Enhanced prevention skills training (USAPST) 3. Coalition coaching support	Increase the number of communities with healthy developing or functioning substance misuse prevention coalitions. (coalition rating tool, area plans, annual reports)	Reduction in substance misuse by 2035 As measured by: Underage drinking Underage marijuana Underage tobacco (including vaping)

misuse (CCEBP)		**Baseline**: 47 E and G communities at start of FY26 **Target**: 35% increase by FY30	Underage prescription drug misuse
2. Increase the quality and reach of prevention strategies that address risk and protective factors	1. Formalize the review process of prevention strategies between Regional Directors and Local Authorities 2. Training on quality/fidelity 3. Prevention specialists are USAPSTs trained	Increase the number of individuals that are receiving universal direct and selective prevention services. (DUGS data) **Baseline**: 19,921 FY24 **Target**: 30% increase by FY30	
3. Enhance the stature and role of the SUD prevention system in the Behavioral Healthcare Continuum	1. Complete National Prevention Policy Academy 2. Develop example connections across continuum 3. Develop a referral process linking Utah residents to various touch points across the continuum	Increase the number of family members of those receiving treatment or recovery services that participate in primary prevention strategies. **Baseline**: TBD **Target**: TBD	

SUMH Prevention Evaluation Plan

FY2026

Purpose: This plan is designed to systematically assess the effectiveness of prevention initiatives across the state, drawing data annually from the 13 Local Authorities (LAs) that oversee community prevention coalitions. This plan ensures a thorough assessment of community coalition status, implemented strategies, and measurable outcomes related to substance misuse, risk and protective factors, and local conditions.

Data Collection: Annual baseline data is established through each of the 13 Local Authorities submitting an annual area plan prior to the beginning of the state fiscal year in July. Outcome data is collected in an annual report called the Logic Model Review in September. SUMH utilizes an in-house system called DUGS to collect data on the number of individuals served with prevention programs, strategies, and policies.

Information from area plans, the Logic Model Review, and data collected in DUGS is combined in an annual scorecard. The scorecard provides a snapshot of the evaluation efforts conducted by SUMH.

1. **Annual progress of each CCEBP community/coalition**

Purpose: To assess the progress of coalitions as they develop and their ability to implement evidence-based prevention strategies. SUMH will track progress of coalitions as they work through established coalition milestones and benchmarks, along with progress through an in-house tool that assess the readiness of communities to have community coalitions and the quality of established coalitions.

CCEBP Community/Coalition	Starting Milestone/Benchmark	Coalition Status Rating from Area Plan	End of Year Coalition Status Rating	End of Year Milestone/Benchmark

2. Strategies implemented to address prioritized risk and protective factors

Purpose: To track prioritized risk/protective factors by coalitions and the strategies coalitions are implementing to address each risk/protective factor.

Coalition/Area	Programs, Strategies, policies	Risk/Protective Factor Addressed

3. Outcomes related to substance misuse, risk and protective factors, and local conditions by coalition

Purpose: To provide critical information on the effectiveness of prevention efforts, SUMH monitors the impact of strategies on substance misuse rates, risk/protective factors, and local conditions.

Issue (source)	Baseline Year	Baseline data	Current Year	Current Data	Change Flat, Pos, Neg	Goal Data	Goal Year
Coalition:							
Prioritized Substances							

Risk/Protective Factors							
Local Conditions							

4. **Scorecard:**

Purpose: To provide a snapshot by area of the data that has been collected throughout the year to easily be able to show progress and address any areas of concern.

Area	Area Plan							DUGS			
	Coalition	FY22 Rating	FY23 Rating	FY24 Rating	Milestone/Benchmark (from FY23 annual report)	Programs	Risk/Protective Factors	Programs	Universal Served	Selective Served	Percentage of data entered in compliance with contract terms Standard: Data

											entered within 45 days
Totals											

Annual Report							Compliance Checks			
Coalition	Beginning of year Rating	End of Year Rating	Milestone/Benchmark Beginning of Year	Milestone/Benchmark End of Year	Programs	Risk/Protective Factors	Number of EASY alcohol compliance checks Standard: Increase number of checks		Percent of retail establishments that refused to sell tobacco to minors (Fed Year) Standard: 90%	
							FY23	FY24	FFY 2023	FFY 2024

Substance misuse trend data

Environmental Factors and Plan

6. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Office of Substance Use and Mental Health (OSUMH) is Utah's public mental health and substance use authority. This office consults and coordinates with federal, state, and local partners regarding programs and services. The office also contracts for substance use and mental health programs funded with state and federal funds. SUMH anchors to the result that all children, adults, families, and communities experience improved health and social functioning, and a reduction in the harms associated with substance use and mental health challenges.
a. All Utahns have fair and equitable access to a broad array of prevention, mental health and substance use disorder services where and when they are needed.
b. Local substance use and mental health authorities use evidence-based practices, integrate mental and physical health care, and demonstrate improved outcomes.
c. Fewer Utah youth use alcohol and drugs, and fewer Utahns of all ages are negatively affected by mental health symptoms and substance use disorders.
d. Fewer Utahns experience suicidal ideation, attempts, or death. Utahns in crisis have someone to talk to, someone to respond, and a place to go.

Sub State Organization: Utah State Statute specifically mandates the Local Substance Abuse Authorities (LSAA) provide a "continuum of services for Adolescents and Adults" aimed at substance abuse prevention and substance use disorder treatment. Utah's Local Mental Health Authorities (LMHAs) are given the responsibility to provide mental health services to their citizens, including the 10 mandated services. Utah utilizes MHBG and SAPT Block Grant funds, along with State General Funds, other State and Federal appropriations, and the Counties' 20% funding match to fulfill the requirements to provide for services required by federal and state statutes.

As authorized in statute, the 29 counties in Utah have organized themselves into 13 Local Substance Abuse Authorities and 13 Local Mental Health Authorities. (See attached diagram). A Local Mental Health or Substance Abuse Authority is generally the governing body of a county i.e. a commissioner or council member. Many counties have joined together under inter-local agreements to create a single Local Authority where one commissioner representing each county holds a seat on the governing board. Services are delivered through contracts with Mental Health and Substance Abuse Providers, and in compliance with statute, administrative rule, and under the administrative direction of the Office of Substance Use and Mental Health. Short-term acute hospitalization is provided through contracts with local private hospitals in most areas. Local Authorities set the priorities to meet local needs, but at a minimum must provide ten statutorily mandated mental health services and a continuum of substance use disorder services either directly or through contracts and agreements.

State and federal funds are allocated to Local Authorities through a formula which takes into account the percent of the state's population residing within the county's boundaries and a rural differential. Each county is required to provide at least a 20% match on all state general funds. The majority of general and county funds allocated for mental health services are used to meet Medicaid match requirements. In the 2019 Legislative session, Senate bill 96 was passed that put Utah's Medicaid Expansion bill into law. This law expands Medicaid to parents and adults without dependent children earning up to 138% federal poverty level ($17,608 for an individual or $36,156 for a family of four). Expansion Medicaid functions as Fee For Service. In urban areas, Expansion Medicaid is managed by four managed care organizations. In rural areas, Expansion Medicaid is managed by the Local Mental Health Authorities.

Each local authority submits an Area Plan annually that must be approved by the SUMH. 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 Office Directives that are provided each year to the Local Authorities shortly after the Legislative Session ends in March. The current Office Directives are located at https://sumh.utah.gov/providers/contracts-and-monitoring. Area plans must outline services and priorities that emphasize care for individuals in the community, with efforts to ensure individuals are maintained outside of residential and inpatient settings whenever possible. These Plans become the foundation of contracts between the Office and each of the Local Authorities. Contracts with the Local Authorities and their funding allocations are approved only after the Area Plans have been approved by the Office Director.

Utah's public Behavioral Health system for child, youth/adolescent and family services has the same organizational structure as the adult system. Local Authorities are required to outline in their area plan how they are planning to provide mental health and substance abuse treatment and prevention services to this population as well as the adult population

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(●) Yes ( ) No
b)	Mental Health	(●) Yes ( ) No
c)	Rehabilitation services	(●) Yes ( ) No
d)	Employment services	(●) Yes ( ) No
e)	Housing services	(●) Yes ( ) No
f)	Educational services	(●) Yes ( ) No
g)	Substance use prevention and SUD treatment services	(●) Yes ( ) No
h)	Medical and dental services	(●) Yes ( ) No
i)	Recovery Support services	(●) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(●) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(●) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

SUMHs Office Directives require Local Authorities (LAs) to assess for physical health, mental health, and substance use disorders for individuals receiving treatment. This evaluation includes questions on primary care providers, all medication, current and desired state of employment and education (including accommodations), housing situation and need for support services. A case management needs assessment is completed to ensure coordination of care across multiple providers and to provide access to support services (Peer Support, Employment Services, Housing Providers).

3. Describe your state's case management services

Case managers (CM) are certified by SUMH and provide a Medicaid billable service to adults with SMI and children with SED. Case management provides coordination, advocacy, linking and monitoringfor individuals in treatment. It is a service that assists clients to gain access to needed healthcare(including behavioral health), social, educational, and other services that empower the service population to live successfully in the community based on their own needs and desires. The overall goal of case management services is not only to help clients to access needed services, but to ensure that services are coordinated among all agencies and providers. The need for case management will be determined by a formal needs assessment (typically the DLA-20) and may also consider the following factors: Consumer requests, preferences or right of refusal, consumer self direction, social resources and natural supports, safety, culture, co-occurring conditions and/or legal issues. Case management is a mandated Medicaid service and is provided by all the Local Authorities throughout the State of Utah.

SUMH has recently revised the case management rule to allow for more providers to be eligible for case management certification. These efforts include expansion of the case management system both inside and outside of the Local Authority system, and a standardization of expectations for case management care across more of the service system.

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

The Utah public mental health system provides an array of services that ensure an effective continuum of care to target the mental health needs of individuals with serious mental illness to prevent hospitalizations and reduce hospital stays. This includes the 11 mandated services, such as inpatient care, residential care, outpatient care, 24 hour crisis care, psychotropic medication

management, case management, community supports, services to unfunded individuals, consultation and education services, and services to people incarcerated in county jails or other county correctional facilities. These all provide the support necessary to help individuals with SMI remain stable in the community and to return to the community after a psychiatric crisis. In addition, many of the Local Authorities (LA) have Clubhouse or Clubhouse-like programs, a model of psychosocial rehabilitation where attendees are considered members and are empowered to function in a work-ordered day. They provide a pre-educational, pre-vocational environment where individuals with a history of mental illness can rebuild their confidence and purpose. Other LAs provide day programs with psychosocial rehabilitation programs for individuals with SMI.

Utah's provides a robust crisis response system including crisis lines, warm lines, mobile crisis outreach teams, and a receiving centers to provide immediate support and stabilization with the goal of keeping people stable in the community. This system works closely with law enforcement (CIT officers), Fire, and EMS to provide crisis response and to connect with outpatient services. All the crisis services utilize Peer Support Specialists (with Peers in recovery) to promote connectedness, social interaction, and encourage individuals to take responsibility for their treatment and recovery. If hospitalized, the Peer Bridger program helps individuals in an inpatient setting to step out of inpatient and follows them for two weeks post hospitalization, to provide the support necessary to connect with outpatient services and appointments, to prevent rehospitalization.

Assertive Community Treatment, Assertive Community Outreach Treatment and Assisted Outpatient Treatment teams are available in urban counties, providing a “hospital without walls” for individuals on civil commitment or AOT court orders, and for those who struggle to remain stable in the community. Rural counties provide a similar level of care through Intensive Case Management.

There are four Prevention and Recovery of Early Psychosis (PREP) teams in Utah that provide Coordinated Specialty Care (CSC) to young adults with Clinical High Risk for Psychosis (CHRP) or First Episode Psychosis (FEP). The CSC treatment model provides therapy, medication management, case management, peer support, and occupational therapy. The treatment team is focused on early identification and intervention of psychosis symptoms in order to support the young adult managing those symptoms and preventing relapse and hospitalization. These PREP teams are located in the most populated areas of the state and the SUMH is working to expand services to non-metro areas of the state.

For children, each regional area has multi-agency staffings to help support coordinated care for children with complex presentations and high utilization.

5. Please indicate areas of technical assistance needs related to this section.

Not at this time.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

1. In order to complete column B of the table, please use the most recent federal prevalence estimate from the National Survey on Drug Use and Health or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	173,082	23,290
2.Children with SED	170,023	12,916

2. 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.

Prevalence data is obtained using the Substance Abuse and Mental Health Services Administration (SAMHSA) numbers. Incidence data is obtained via prediction based on historical data.

3. Please indicate areas of technical assistance needs related to this section.

n/a

Criterion 3: Children's Services

Provides for a system of integrated services for children to receive care for their multiple needs.

Criterion 3

1. Does your state integrate the following services into a comprehensive system of care?[1]

a)	Social Services	◉ Yes	○ No
b)	Educational services, including services provided under IDEA	◉ Yes	○ No
c)	Juvenile justice services	◉ Yes	○ No
d)	Substance use 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 systems	◉ Yes	○ No

2. Please indicate areas of technical assistance needs related to this section.

n/a

[1] *A system of care is a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*

Criterion 4

a. Describe your state's tailored services to rural population with SMI/SED. See the federal **Rural Behavioral Health** page for program resources.

In Utah, 9 of 13 Local Authorities are classified with regions that are rural or frontier. In SFY24, 31.8% of individuals served by the public mental health system were in one of these rural or frontier regions. This includes 5% of rural clients receiving services while incarcerated and 260 individuals on civil commitment.

All rural Local Authorities provide the 11 mandated services to their consumers, including psychiatric inpatient care, residential care, outpatient programs, medication management, 24 hour crisis care, psychosocial/psychoeducational rehabilitation programs, case management, community supports, services for incarcerated individuals and services for unfunded individuals. In some cases, particularly inpatient and residential care, rural Local Authorities will subcontract services from urban centers where more resources are available. Two rural communities Four Corners/Southwestern part of the state have no refusal receiving centers, one receiving center in the Northern part of the state is planning to open in SFY2026, and another in the central part of the state has been approved and awaiting funding. All Local Authorities now have mobile crisis outreach teams, including the rural/frontier areas. Two of the rural/frontier Local Authorities will fly staff into more remote regions in order to provide in-person care.

In response to a workforce shortage and the inherent difficulties in providing services in a rural area (ie. transportation), training programs for peer support specialists have focused on practicums that include rural regions and minority populations. In addition, SUMH has encouraged rural and frontier Local Authorities to explore opportunities for telehealth. The pandemic resulted in all Local Authorities rapidly moving to telehealth services, a capacity that has been maintained as meetings are again available in person. In addition to telehealth across counties within the agency catchment area, programs such as the University of Utah ECHO program provide an opportunity for collaboration and consultation on more complex physical and mental health clients without requiring the consumer to travel outside their county.

b. Describe your state's tailored services to people with SMI/SED experiencing homelessness. See the federal **Homeless Programs and Resources** for program resources[1]

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 experiencing homelessness 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. OSUMH staff are active in all three CoCs. The CoCs have a variety of responsibilities such as “oversight of the Homeless Management Information System (HMIS), developing and implementing strategic plans, identification of housing and service capacity and gaps, ensuring broad and inclusive participation, and applying for CoC program funding. Working in line with their CoCs, and more locally, their Local Homelessness Councils, the LMHAs provide an array of services from outreach and engagement, case management, EBPS in mental health and substance use treatment, limited housing, peer support services, and other supports and recovery services based on individual needs to people experiencing homelessness. All Local Authorities are required to participate on their Local Homelessness Council.

SUMH oversees the Projects for the Assistance in Transition from Homelessness (PATH) grant funding for the state. PATH grant funds are used to fund outreach, case management, screening and assessment, behavioral health treatment, and housing prevention costs.

c. Describe your state's tailored services to the older adult population with SMI. See the federal **Resources for Older Adults** webpage for resources[2]

The Local Mental Health Authorities provide Specialized Rehabilitative Services for individuals 55 and older in the community and Nursing Facilities, dependent on capacity, with the array of services based on individual needs.

SUMH works with the Division of Aging and Adult Services, who administers a wide variety of home and community-based services for Utah residents who are 60 and older. Programs and services are primarily delivered by a network of 12 Area Agencies on Aging which reach all geographic areas of the state.
The Department of Human Services has a goal to provide services that allow people to remain independent. These services include:
Meals on Wheels – to homebound seniors
Senior Centers – community-based center where seniors gather for services and activities
Caregiver Support – short-term program that supports and assists caregivers
Healthcare benefits and fraud prevention information and assistance

Investigations of vulnerable adult abuse, neglect and exploitation
OSUMH partners with the DHHS- Division of Aging and Adult Services, who administers the Aging Waiver: This waiver is designed to provide services statewide to help older adults remain in their homes or other community based settings. Individuals are able to live as independently as possible with supportive services provided through this waiver program. Waiver services may include:
Adult Companion Services
Adult Day Health Services
Case Management
Chore Services
Community Transition Services
Emergency Response Systems
Environmental Accessibility Adaptations
Fiscal Management Services
Home Delivered Supplemental Meals
Homemaker Services
Medication Reminder Systems
Non-medical Transportation
Personal Attendant Program Training
Personal Attendant Services
Personal Budget Assistance
Respite Care Services (May Be Provided in Long Term Care Settings)
Specialized Medical Equipment
Supportive Maintenance Home Health Aide

d. Please indicate areas of technical assistance needs related to this section.

n/a

[1] **https://www.samhsa.gov/homelessness-programs-resources**

[2] **https://www.samhsa.gov/resources-serving-older-adults**

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

1. Describe your state's management systems.

SUMH has developed a Disaster Counseling Certification Program that supports short term interventions with individuals and groups experiencing psychological reactions to small and large scale disasters. These interventions involve using Psychological First Aid and Skills for Psychological Recovery, with the goal to assist disaster survivors in understanding their current situation and reactions, mitigating additional stress, promoting the use of coping strategies, providing emotional support, and encouraging linkages with other individuals and agencies that may help survivors recover to their pre-disaster level of functioning. The cadre of disaster counselors maintained by OSUMH was activated in response to the pandemic to address increased mental health and substance use disorder symptoms across the population. Utah was able to activate 52 trained individuals speaking multiple languages in urban, rural and tribal settings within a few weeks. This response continued as the pandemic ebbed and flowed, providing critical support to individuals requiring both response and recovery. This program has offered opportunities for post-disaster growth and resilience, but also highlighted opportunities for Utah to strengthen local disaster response and post-pandemic planning.
Mental Health Block Grant (MHBG) dollars have been targeted to provide the development of a Crisis Intervention Team program statewide for individuals with SMI and SED. This has included suicide prevention training for peer support specialists, in addition to prevention and intervention trainings to clinicians. Funds address the crisis continuum including the statewide Lifeline Crisis Line, a statewide warm line manned by peer support specialists, mobile crisis outreach teams, and receiving centers. Block Grant dollars are disbursed through the Local Authorities to provide individual crisis response services to those who are unfunded.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access the federal resource guide **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders.**

2. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Utah encourages the use of telehealth services when appropriate to expand access to treatment services for rural and underserved populations statewide. Utah DHHS provides access to Zoom for telehealth purposes to its employees and subcontractors. This allows for critical services to be provided statewide through the Mental Health/Substance Use, Juvenile Justice, and Services for People with Disabilities systems. Currently, there are over 376 registered users who are utilizing DHHS Zoom access to provide services.

3. Please indicate areas of technical assistance needs related to this section.

n/a

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Footnotes:

Environmental Factors and Plan

7. Substance Use Disorder Treatment – Required for SUPTRS BG

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 (with medications for addiction treatment included in v-x):

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Withdrawal Management (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive outpatient	◉ Yes	○ No
viii)	Inpatient/residential	◉ Yes	○ No
ix)	Aftercare/Continuing Care	◉ Yes	○ No
x)	Recovery support	◉ Yes	○ No

b) Services for special populations:

i)	Prioritized services for veterans?	◉ Yes	○ No
ii)	Adolescents?	◉ Yes	○ No
iii)	Older Adults?	◉ Yes	○ No

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? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Does your state have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling? (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots? (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare? (●) Yes ( ) No

d) Inclusion of recovery support services? (●) Yes ( ) No

e) Health navigators to assist clients with community linkages? (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance? (●) Yes ( ) No

h) Providing transportation to and from services? (●) Yes ( ) No

i) Educational assistance? (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The Office of Substance Use and Mental Health (OSUMH) conducts annual site visits for the Local Authority Substance Use and Mental Health Treatment Providers, which either provide direct or contracted services for Women, Pregnant Women and Women with Dependent Children's Programs (PWWDC). 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. The Annual monitoring visits consist of agency reviews that look at clinical services, policy and procedures, licensures, finances and billings, contracts, and contract oversight and monitoring. Monitoring reports are developed and any findings are reported and agency review and responses are required in order to rectify any findings. The findings are then followed up on and also made part of the next annual review process.

OSUMH's Monitoring Protocol has different levels of findings for the Local Authorities that require a Correction Action Plan which needs to be submitted to OSUMH for approval. OSUMH also provides ongoing training and technical assistance for the Local Authority Providers regarding best practice for PWWDC and ensures that their needs are being met. Each year, OSUMH hosts an annual training regarding gender specific and trauma-informed approaches, which has included the following training since 2009: (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. A copy of OSUMH monitoring can be found at Contracts and Monitoring | SUMH (utah.gov). OSUMH staff provide training and technical assistance to providers based on request or when need is indicated.

The Utah office of licensing and Background checks also provide agency licensure annual monitoring reviews to ensure agencies are compliant with the Utah licensing requirements. OSUMH works in close partnership with the Office of Licensing to ensure agencies are licensed and providing appropriate services under their licensure and that services are provided in a safe and healthy environment.

Criterion 4,5&6

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)** Monitoring requirements as outlined in the authorizing **statute** and implementing **regulation**? (●) Yes ( ) No

2. Has your state identified a need for 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 (e.g., military families, veterans, adolescents, older adults)? (●) Yes ( ) No

3. States are required to monitor program compliance related to activites 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 by our monitoring team. 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. Program staff also provide support, education and technical assistance on going and when requested or identified as a need.

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. Has your state identified a need for 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 have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery?

○ Yes ○ No

2. Has your state identified a need for any of the following:

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

○ Yes ○ No

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

○ Yes ○ No

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

○ Yes ○ No

Hypodermic Needle Prohibition

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes for the purpose of injecting illicit substances **(42 U.S.C.§ 300x-31(a)(1)(F))**?

● Yes ○ No

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention, and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Workforce development efforts to expand service access? (●) Yes ( ) No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services? (●) Yes ( ) No

c) Establish a peer recovery support network to assist in filling the gaps? (●) Yes ( ) No

d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, persons experiencing homelessness)? (●) Yes ( ) No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, such as primary healthcare, public health, VA, and community organizations? (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered care? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services (●) Yes ( ) No

b) Establish a program to provide trauma-informed care (●) Yes ( ) No

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice system, adult criminal justice system, and education. (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (**42 U.S.C.§ 300x-65**, 42 CF Part 54 (**§54.8(b) and §54.8(c)(4)**) and **68 FR 56430-56449**)? (●) Yes ( ) No

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries? ( ) Yes (●) No

b) An organized referral system to identify alternative providers? (●) Yes ( ) No

c) A system to maintain a list of referrals made by religious organizations? ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Review and update of screening and assessment instruments? ( ) Yes (●) No

b) Review of current levels of care to determine changes or additions? ( ) Yes (●) No

c) Identify workforce needs to expand service capabilities? (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements? ○ Yes ● No

b) Training on responding to requests asking for acknowledgement of the presence of clients? ○ Yes ● No

c) Updating written procedures which regulate and control access to records? ● Yes ○ No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure? ○ Yes ● No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? ● Yes ○ No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (**42 U.S.C.§300x-52(a)**) and **45 §CFR 96.136** require states to conduct independent peer review of not fewer than 5 percent of the Block Grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of Block Grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

More than 5% of the Local Authorities are selected annually to be part of the peer review process. They 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. The peer review committee made up of the Local Authorities can make exceptions for local authorities that are unable to meet the deadline for the annual review based on requests made for these exceptions annually. The exceptions will be based on meeting SAMHSA requirements of 5% of providers annually for peer review in accordance with the Public Health Service Act requirements.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan? ● Yes ○ No

b) Establishment of policies and procedures related to independent peer review? ○ Yes ● No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations? ● Yes ○ No

4. Does your state require a Block Grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for Block Grant funds? ○ Yes ● No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service? ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing? ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state? ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services? ◉ Yes ○ No

c) Performance-based accountability? ◉ Yes ○ No

d) Data collection and reporting requirements? ◉ Yes ○ No

If the answer is No to any of the above, please explain the reason.

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs? ○ Yes ◉ No

b) Addition of training sessions designed to increase employee understanding of recovery support services? ○ Yes ◉ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services? ◉ Yes ○ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort? ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers[1] (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) SMI Adviser ○ Yes ◉ No

c) Addiction TTC? ◉ Yes ○ No

d) State Opioid Response Network? ◉ Yes ○ No

e) Strategic Prevention Technical Assistance Center (SPTAC) ◉ Yes ○ No

Waivers

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections **42 U.S.C.§ 300x-22(b)**,**300x-23**,**300x-24**, and **300x-28** (**42 U.S.C.§ 300x-32(e)**).*

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women (300x-22(b)) ○ Yes ◉ No

2. Is your state considering requesting a waiver of any requirements related to:

a) Intravenous substance use (300x-23) ○ Yes ◉ No

3. Is Your State Considering Requesting a Waiver of any Requirements Related to Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus (300x-24)

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

4. Is Your State Considering Requesting a Waiver of any Requirements Related to Additional Agreements (**42 U.S.C. § 300x-28**)

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 that govern the Mental Health and Substance Use Disorder Programs.

https://le.utah.gov/xcode/Title26B/Chapter5/26B-5-P1.html?v=C26B-5-P1_2023050320230503
https://le.utah.gov/xcode/Title17/Chapter43/17-43.html?v=C17-43_1800010118000101

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[1] **https://www.samhsa.gov/technology-transfer-centers-ttc-program**

Footnotes:

Utah is a non-designated state.

When reported it is a waivered state the intent is to clarify the non-designation for funding obligations required by the SUPTR.

We recommend agencies to become accredited but it is not currently a requirement.

Environmental Factors and Plan

8. Uniform Reporting System and Mental Health Client-Level Data (MH-CLD)/Mental Health Treatment Episode Data Set (MH-TEDS) – Required for MHBG

Narrative Question

Health surveillance is critical to the federal government's ability to develop new models of care to address substance use and mental illness. Health surveillance data provides decision makers, researchers, and the public with enhanced information about the extent of substance use 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. Title XIX, Part B, Subpart III of the Public Health Services Act **(42 U.S.C. §300x-52(a))**, mandates the Secretary of the Department of Health and Human Services to assess the extent to which states and jurisdictions have implemented the state plan for the preceding fiscal year. The annual report aims to provide information aiding the Secretary in this determination.

42 U.S.C. §300x-53(a) requires states and jurisdictions to provide any data required by the Secretary and cooperate with the Secretary in the development of uniform criteria for data collection. Data collected annually from the 59 MHBG grantees is done through the Uniform Reporting System (URS), Mental Health Client-Level Data (MH-CLD), and Mental Health Treatment Episode Data Set (MH-TEDS) as part of the MHBG Implementation Report. The URS is an initiative to utilize data in decision support and planning in public mental health systems, fostering program accountability. It encompasses 23 data tables collected from states and territories, comprising sociodemographic client characteristics, outcomes of care, utilization of evidence-based practices, client assessment of care, Medicaid funding status, living situation, employment status, crisis response services, readmission to psychiatric hospitals, as well as expenditures data. Currently, data are collected through a standardized Excel data reporting template. The MHBG program uses the URS, which includes the National Outcome Measures (NOMS), offering data on service utilization and outcomes. These data are aggregated by individual states and jurisdictions.

In addition to the aggregate URS data, Mental Health Client-Level Data (MH-CLD) are currently collected. SMHAs are state entities with the primary responsibility for reporting data in accordance with the reporting terms and conditions of the Behavioral Health Services Information System (BHSIS) Agreements funded by the federal government. The BHSIS Agreement stipulates that SMHAs submit data in compliance with the Community Mental Health Services Block Grant (MHBG) reporting requirements. The MH-CLD is a compilation of demographic, clinical attributes, and outcomes that are routinely collected by the SMHAs in monitoring individuals receiving mental health services at the client-level from programs funded or provided by the SMHA.

MH-TEDS is focused on treatment events, such as admissions and discharges from service centers. Admission and discharge records can be linked to track treatment episodes and the treatment services received by individuals. Thus, with MH-TEDS, both the individual client and the treatment episode can serve as a unit of analysis. In contrast, with MH-CLD, the client is the sole unit of analysis. The same set of mental health disorders for National Outcome Measures (NOMs) enumerated under MH-CLD is also supported by MH-TEDS. Thus, while both MH-TEDS and MH-CLD collect similar client-level data, the collection method differs.

Please note: *Efforts are underway to standardize the client level data collection by requiring states to submit client-level data through the MH-CLD system. Currently, over three-quarters of states participate in MH-CLD reporting. Starting in Fiscal Year 2028, MH-CLD reporting will be mandatory for all states. States that currently submit data through MH-TEDS are encouraged to begin transitioning their systems now and may request technical assistance to support this transition process*

This effort reflects the federal commitment to improving data quality and accessibility within the mental health field, facilitating more comprehensive and accurate analyses of mental health service provision, outcomes, and trends. This unified reporting system would promote efficiency in data collection and reporting, enhancing the reliability and usefulness of mental health data for policymakers, researchers, and service providers.

Please respond to the following items:

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

Utah's behavioral health data collection system (SAMHIS-Substance Abuse and Mental Health Information System) is extremely similar in documentation, process, and interface as the Behavioral Health Services Information system. SAMHIS is a Utah stand-alone collection system. SAMHIS is used by behavioral health providers to submit their client level detail per the provider. Data is sent at the provider level, but clients are assigned a unique master identifier within the system to track the client through time and services at multiple providers.

2. Is the SMHA 's current data collection and reporting system specific to mental health services or it is 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.).

Utah's behavioral health data collection system (SAMHIS-Substance Abuse and Mental Health Information System) is a state stand-alone collection system that includes both mental health and substance use disorder data. To protect client privacy and prevent stigma, the Utah behavioral health data collection system is not linked to other sources.

While efforts have been made to define the importance of linkages, few projects have been approved as providing meaningful information for linkages when compared against our belief in client confidentiality. Utah regulates these project ideas through a robust system of Institutional Review Board approval and expert SMHA data steward and privacy protections.

3. What is the current capacity of the SMHA in linking data with other state agencies/entities (e.g., Medicaid, criminal/juvenile justice, public health, hospitals, employment, school boards, education, etc.)?

Data sharing to link when benefit has been found is a routine job duty of the system and administrators. Due to these routine functions and policies, the linking processes itself has not been difficult and Utah has found no issue with matching processes when projects are found to be valuable. However, the value of these linkage projects has often been overstated and few projects have moved forward. By example, Utah has purchased a client outcome software that providers are given access to. Through contracts and agreements, Utah routinely (multiple times a year) links clients in this system to its own system.

4. Briefly describe the SMHA 's ability to report evidence-based practices (EBPs) including Early Serious Mental Illness (ESMI and Behavioral Health Crisis Services (BHCS) outcome data at the client-level.

Collecting EPBs at the client level has proven functionally difficult. While demographic, procedural, and duration are scalable for collection, providers have noted it rather difficult to identify a single, specific procedure/treatment for documentation. As providers are required to administer the OQ (outcome questionnaire), this became the default EBP and other evidence-based practices have not been routinely documented.
The Coordinated Specialty Care (CSC) teams, serving clients who have experienced a first episode of psychosis, participate in fidelity reviews at least every other year based on the practice guidelines set by the Early Assessment and Support Alliance (EASA). The CSC team also collects client-level data at intake, 6 months, and discharge.
Behavioral health crisis outcome data is collected and reported on the SUMH public-facing dashboard (sumh.utah.gov/data-portal-home). This data, available for receiving centers, mobile crisis outreach teams, and stabilization mobile response services, includes number served, demographic information, insurance, referral source, primary presenting concern, law enforcement involvement, and discharge information.

5. Briefly describe the limitations of the SMHA 's existing data system.

Utah's data system functions similar to any other client data system stored at a secondary location. While the system is not without user, maintenance, or enhancement issues, these are not events beyond the routine expectations of a similar system.

6. What strategies are being employed by the SMHA to enhance data quality?

Foremost, Utah has a provider led monthly meeting to evaluation and data. At this provider controlled monthly meeting, all providers are welcome to attend and discuss issues or enhancements with each other and the State. Good communication with providers enhances Utah's data quality at the start.

Similar to BHSIS, Utah makes public yearly updated file specification instructions for providers when submitting data. Providers must adhere to these specification files when submitting data. At monthly provider meetings, these file specifications can be the subject of enhancement or coordination for better processes for data quality.

Utah employs a robust automated file validation processes similar to BHISIS and an automated client level validation process. Providers are responsible for the data specifications and data validation which they control on a provider specific log in website similar to BHSIS.

7. Please describe any barriers (staffing, IT infrastructure, legislative, or regulatory policies, funding, etc.) that would limit your state from collecting and reporting data to the federal government.

At this time, Utah experiences a good relationship with providers and has no barriers that indefinitely stop reporting to the federal government.

8. Please indicate areas of technical assistance needs related to this section.

None. At this time, Utah's system appears to be well aligned with the BHSIS system and Utah is proud of the level and the degree information is gathered, refactored for federal submission, and made publicly available on the SMHA website

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Footnotes:

Environmental Factors and Plan

9. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

There is a mandatory 5 percent set-aside within MHBG allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *…….to support evidence-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to fund some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expending 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence-based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system has 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.The expectation is that states will build on the emerging and growing body of evidence, including guidance developed by the federal government, for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization services to support reducing distress, and the promotion of skill development and outcomes, all towards managing costs and better investment of resources.

Several resources exist to help states. These include **Crisis Services: Meeting Needs, Saving Lives**, which consists of the **National Guidelines for Behavioral Health Coordinated System of Crisis Care** as well as an **Advisory: Peer Support Services in Crisis Care** There is also the **National Guidelines for Child and Youth Behavioral Health Crisis Care** which offers best practices, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth, and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by the 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

When individuals experience a crisis related to mental health, substance use, and/or homelessness (due to mental illness or a co-occurring disorder), a no-wrong door comprehensive crisis system should be put in place. Based on the National Guidelines, there are three major components to a comprehensive crisis system, and each must be in place in order for the system to be optimally effective. These three-core structural or programmatic elements are: Crisis Call Center, Mobile Crisis Response Team, and Crisis Receiving and Stabilization Facilities.

Crisis Contact Center. In times of mental health or substance use crisis, 911 is typically called, which results in police or emergency medical services (EMS) dispatch. A crisis call center (which may provide text and chat services as well) provides an alternative. Crisis call centers should be made available statewide, provide real-time access to a live crisis counselor on a 24/7 basis, meet National Suicide Prevention Lifeline operational guidelines, and serve as "Air Traffic Control" to assess, coordinate, and determine the appropriate response to a crisis. In doing so, these centers should integrate and collaborate with existing 911 and 211 centers, as well as other applicable call centers, to ensure access to the appropriate level of crisis response. 211 centers serve as an entry point to crisis services in many states and provide information and referral to callers on where to obtain assistance from local and national social

services, government agencies, and non-profit organizations.

The public has become accustomed to calling 911 for any emergency because it is an easy number to remember, and they receive a quick response. Many of the crisis systems in the United States continue to use 911 for several reasons such as they are still building their crisis systems or because they have no mechanism to fund a call center separate from 911. However, they recognize that the sure way to minimize the involvement of law enforcement in a behavioral health crisis response is to divert calls from 911. There are basically three diversion models in operation at this time: (1) the 911-based system with dispatchers who forward calls to either law enforcement's responder team (law enforcement officer with a behavioral health professional) or to their Crisis Intervention Team (CIT) with law enforcement officers who have received Crisis Intervention Training, including awareness of mental health and substance use disorders, and related symptoms, de-escalation methods, and how to engage and connect people to supportive services; (2) the 911-based system with well-trained 911 dispatchers who triage calls to state or local crisis call centers for individuals who are not a threat to themselves or others; the call centers may then refer appropriate calls to local mobile response teams (MRTs), also called mobile crisis teams (MCTs); and (3) State or local Crisis Contact Centers with well-trained counselors who receive calls directly (without utilizing 911 at all) on their own toll-free numbers.

Mobile Crisis Response Team. Once a behavioral health crisis has been identified and a crisis line has been called, a mobile response may be required if the crisis cannot be resolved by phone alone. Historically, law enforcement has been dispatched to the location of the individual in crisis. But in an effective crisis system, mobile crisis teams, including a licensed clinician, should be dispatched to the location of the individual in crisis, accompanied by Emergency Medical Services (EMS) or police only as warranted. Ideally, peer support professionals would be integrated into this response. Assessment should take place on site, and the individual should be connected to the appropriate level of care, if needed, as deemed by the clinician and response team.

Crisis Receiving and Stabilization Facilities. In a typical response system, EMS or police would transport the individual in crisis either to an ED or to a jail. Crisis Receiving and Stabilization Facilities provide a cost-effective alternative. These facilities should be available to accept individuals by walk-in or drop-off 24/7 and should have a "no wrong door" policy that supports all individuals, including those who need involuntary services. When anyone arrives, including law enforcement or EMS who are dropping off an individual, the hand-off should be "warm" (welcoming), timely and efficient. These facilities provide assessment for, and treatment of mental health and substance use crisis issues, including initiating medications for opioid use disorder (MOUD), and also provide wrap-around services. The multi-disciplinary team, including peers, at the facility can work with the individual to coordinate next steps in care, to help prevent future mental health crises and repeat contacts with the system, including follow-up care.

Currently, the 988 Suicide and Crisis Lifeline (Lifeline) connects with local call centers throughout the United States. Call center staff is comprised of individuals who are trained to utilize best practices in handling behavioral health calls. Local call centers automatically engage in a safety assessment for every call; if an imminent risk exists and cannot be deescalated, they forward the call to either 911 or to a local mobile crisis team for a response. If there is no imminent risk, the call center will work with the individual (or the person calling on their behalf) for as long as needed or, if necessary, dispatch a local MRT.

988 – 3-Digit behavioral health crisis number. The National Suicide Hotline Designation Act (**P.L. 116-172**) provides an opportunity to support the infrastructure, service and long-term funding for community and state 988 response, a national 3-digit behavioral health crisis number that was approved by the Federal Communications Commission in July 2020. In July 2022, the National Suicide Prevention Lifeline transitioned to 988 Suicide & Crisis Lifeline, but the 1-800-273-TALK is still operational and directs calls to the Lifeline network. The 988 transition has supported and expanded the Lifeline network and will continue utilizing the life-saving behavioral health crisis services that the Lifeline and Veterans Crisis Line centers currently provide.

Building Crisis Services Systems. Most communities across the United States have limited, but growing, crisis services, although some have an organized system of services that provide on-demand behavioral health assessment and stabilization services, coordinate and collaborate to divert from jails, minimize the use of EDs, reduce hospital visits, and reduce the involvement of law enforcement. Those that have such systems did not create them overnight, but it involved dedicated individuals, collaboration, considerable planning, and creative methods of blending sources of funding.

1. Briefly describe your state's crisis system. For all regions/areas of your state, include a description of access to crisis contact centers, availability of mobile crisis and behavioral health first responder services, utilization of crisis receiving and stabilization centers.

Utah has implemented SAMHSA Best Practice Guidelines of providing services to anyone, anytime, anywhere. With regard to establishing a system in which a person has "someone to talk to", The Utah Office of Substance Use and Mental Health (SUMH) has a contract with the Huntsmen Mental Health Institute (HMHI) to provide one statewide 988 suicide prevention and crisis lifeline. It operates 24/7 providing suicide prevention and crisis Lifeline support to all areas of the state. In March of 2023, this crisis center also began assumption of Utah based texts and chats.

Utah continues to establish services to ensure that consumers in crisis have access to "someone to respond". Utilizing our provider network of 13

Local Mental Health Authorities (LMHA) to provide mental health and crisis services to their communities, Mobile Crisis Outreach teams are available statewide. All counties have access to MCOT teams 24/7, with some limitations on rural access after business hours. These team services are located within all 13 LMHA and are dispatched by 988 suicide prevention and crisis lifeline as well as community referrals directed to their centers, maintaining and ensuring an approach of "no wrong door". In addition, 24/29 counties have access to youth specific mobile crisis outreach teams and stabilization services.

Building a comprehensive behavioral health crisis system remains a critical priority for Utah. A robust system must ensure individuals in crisis not only have access to someone to talk to and someone to respond, but also have access to a safe place to go. Currently, Utah operates crisis receiving centers in Salt Lake City, Davis County, Utah County, Weber County, Carbon County, and Wasatch County. An additional center is under construction in Cache County and is anticipated to open in Spring 2025.
Utah also partners with the Division of Juvenile Justice and Youth Services to support youth-specific receiving centers for individuals ages 11 to 18. For younger children, crisis nurseries—operated outside of the State's unified behavioral health system—provide essential crisis support and respite care for children ages 0 to 10.
Recognizing that the most effective response to family and youth often involves maintaining children safely in their homes, Utah has implemented the Stabilization and Mobile Response (SMR) program. This program provides immediate mobile crisis response across all 29 counties and offers intensive, in-home stabilization MM services in 24 counties. Expanding access to these services statewide remains a key goal to ensure equitable and effective crisis care for all Utah families.

In addition SUMH contracts with CIT Utah (Crisis Intervention Teams) to support CIT programs for law enforcement officers statewide.The state has identified a need for additional base mental health training for law enforcement officers and is exploring opportunities to generate revenue to offer such.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the published guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the published guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to contact	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to be	☐	☐	☐	☐	☑	☐

3. Briefly explain your stages of implementation selections here.

omeone to talk to: Full implementation/Program Sustainability: All programs are being implemented, funding is sustained and stable, but capacity and progress towards 90% instate answer rate for text and chat services is an ongoing initiative.

Someone to respond: Full Implementation: Coverage in 100%, 7 counties are without overnight services due to limited workforce.

Safeplace to go or to be: Adult coverage in this area is developing, with approximately 7/29 counties having reasonable access to a Receiving Center. However, statewide coverage for youth and children exists through partner programming and over 50% of the state has access to children, youth and family crisis stabilization services 22/29 counties.

1. Someone to talk to: Crisis Call Capacity : Full implementation: All programs are being implemented, funding is sustained and stable, but capacity and progress towards 90% instate answer rate for text and chat services is an ongoing initiative.
a. Number of locally based crisis call Centers in state: Program Sustainability, the state operates one statewide crisis line center

i. In the 988 Suicide and Crisis lifeline network: Program Sustainability, the state operates One Center
ii. Not in the suicide lifeline network: Program Sustainability, there are 0 crisis centers not in the lifeline network.
b. Number of Crisis Call Centers with follow up protocols in place: Program Sustainability One
c. Percent of 911 calls that are coded as BH related: Exploration and Installation. Limited data collection is available in this area, but Utah is examining partnerships with 911 PSAPs to gather this. Additional support from the FCC to encourage PSAPs to offer this would be helpful.
2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities). Initial Implementation MCOT are located within each 13 LMHA's and able to respond to approximately (90% ?) of all Counties within Utah
a. Independent of first responder structures (police, paramedic, fire). All of our state funded MCOT teams are housed within the LMHA's and are independent from police, fire, and paramedics.
b. Integrated with first responder structures (police, paramedic, fire) OSUMH does not fund any co response models.
c. Number that employs peers: All counties are encouraged to hire peers as best practice. Staffing limitations sometimes precludes this.
3. Safe place to go or to be:
Adult Zero Refusal Crisis Receiving Centers: Approximately 50% of the states' population is able to access a Receiving Center along the Wasatch front with existing 4 Receiving Centers operated by Intermountain Healthcare and Weber Human Services, Davis Behavioral Health, Wasatch Behavioral Health, and Huntsman Mental Health Institute (opening Aug 2023). These programs reasonably can accommodate persons in 7 counties with reasonable driving distances to their centers.
Youth Service Centers and Crisis Nurseries: Operated by our partner agencies Juvenile Justice and Youth Services and Children's Family Support Centers, these statewide programs offer crisis services to youth over 11 and children under 10 respectively. Though not operated by SUMH, the programs are a vital part of the continuum of crisis services available.
Stabilization and Mobile Response: Serving families recently experiencing crisis, or at risk for out of home placement, emergency services, or disruption of activities of daily living. This family driven crisis stabilization model is offered within 22 counties of the state and provides up to 6-8 weeks of in-home crisis stabilization services for children, youth and families that is family driven. The program relies heavily on models set by Mobile Response and Stabilization Services (MRSS) and offers individualized, wrap-around support that addresses systemic drivers of crisis services using system of care informed principles.
a. Number of Emergency Departments: Requested from Utah Hospital Association
b. Number of Emergency Departments that operate a specialized behavioral health component: Requested from Utah Hospital Association
c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis) 7 total as of July 2, 2026. In addition, one more Receiving Centers that is in process for petitioning legislative support to develop in a rural area.

Existing locations include: (1) Wasatch Behavioral Health in Utah County (serving Wasatch and Utah counties) (1) Davis Behavioral Health serving Davis County (1) McKay Dee Access Center Weber and Morgan Counties (1) Huntsman Mental Health Institute Receiving Center serving Salt Lake County, Washington County, Carbon County and one in development in Cache County.

The rural receiving center yet to be awarded, will be located in another county of the 3rd class.

Additionally, the state of Utah operates 11 youth service centers through the Division of Juvenile Justice and Youth Services, and these servicel centers serve as Youth Recviecing Centers for the entire state for youth aged 11-18. Locations include:
Cache Valley Youth Center (Cache County)
Weber Valley Youth Center (Weber County)
Farmington Bay Youth Center (Davis County)
Salt Lake County Youth Services (JJYS contracted, Salt Lake County)
Vantage Point (JJYS contracted, Utah County)
Iron County Youth Center (Iron County)
Washington County Youth Center (Washington County)
Split Mountain Youth Center (Vernal)
Castle Country Youth Center (Price)
Central Utah Youth Center (Richfield)
Canyonlands Youth Center (Blanding)

Utah also operates Crisis Nurseries throughout the state as operated by Family Support Centers, for ages 0-10.
Additionally, Utah recently invested Bipartisan Safer Communities Act monies to support a peer run crisis drop in center in Salt Lake City. This center serves individuals in crisis situations with a peer run living room approach. Limited hours (9-5) are available currently, but plans to expand to 24/7 in the coming months exist.

4. Based on the National Guidelines for Behavioral Health Crisis Care and the **National Guidelines for Child and Youth Behavioral Health Crisis Care**, explain how the state will develop the crisis system.

Utah has a 5 year plan, and has included crisis services in their Behavioral Health Master Plan. Utah's 5 year plan mirrors SAMHSA's, with a goal of 80% of people having access to someone to respond by 2025 and 80% of people having a safe place to be by 2027.

5. Other program implementation data that characterizes crisis services system development.

Someone to contact: Crisis Contact Capacity

a. Number of locally based crisis call Centers in state
i. In the 988 Suicide and Crisis lifeline network: 1
ii. Not in the suicide lifeline network: 0

b. Number of Crisis Call Centers with follow up protocols in place

i. In the 988 Suicide and Crisis lifeline network: 1

ii. Not in the suicide lifeline network: 0

c. Estimated percent of 911 calls that are coded out as BH related: 17

Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of public safety first responder structures (police, paramedic, fire): 13

b. Integrated with public safety first responder structures (police, paramedic, fire):

c. Number that utilizes peer recovery services as a core component of the model:

Safe place to be

a. Number of Emergency Departments: 34

b. Number of Emergency Departments that operate a specialized behavioral health component: 0

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis): 6

6. Briefly describe the proposed/planned activities utilizing the 5% set aside. If applicable, please describe how the state is leveraging the CCBHC model as a part of crisis response systems, including any role in mobile crisis response and crisis follow-up. As a part of this response, please also describe any state-led coordination between the 988 system and CCBHCs.

The majority of Utah's 5% set aside goes to support the Utah Crisis Line. However, all 13 MCOT teams also receive some of this money. Utah has four SAMHSA funded CCBHC clinics. Each CCBHC relies on the Huntsman Mental Health Institute for crisis service delivery in their catchment areas (Salt Lake and Tooele counties). Utah has a CCBHC planning grant and will be utilizing the same practice of leveraging the robust crisis system across the state to provide crisis care for CCBHCs through nonfinancial DCO agreements. As Utah is still in the planning phase of CCBHC implementation, there is no state led coordination between the 988 and CCBHC systems at this time. We do not currently have the CCBHC model in place. Utah does, however, have a robust crisis care continuum that is funded by the 5% set aside as well as a generous state fund.

7. Please indicate areas of technical assistance needs related to this section.

n/a

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Footnotes:

Environmental Factors and Plan

10. Recovery – Required for MHBG & SUPTRS BG

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality behavioral health care. The expansion in access to; and coverage for, health care drives the promotion of 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 health and substance use disorders.

Recovery is supported through the key components of health (access to quality physical health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of a recovery- guided approach to person-centered care is inclusive of shared decision-making, culturally welcoming and sensitive to social needs of the individual, their family, and communities. Because mental and substance use disorders can be chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management of recovery and personal success over the lifespan.

The following working definition of recovery from mental and/or substance use disorders has stood the test of time:

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, there are 10 identified 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 **Working Definition of Recovery.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the several federally supported national technical assistance and training centers. States are strongly encouraged to take proactive steps to implement and expand recovery support services and collaborate with existing RCOs and RCCs. Block Grant guidance is also available at the **Recovery Support Services Table**.

Because recovery is based on the involvement of peers/people in recovery, their family members and caregivers, SMHAs and SSAs should engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing organizations and direct resources for enhancing peer, family, and youth networks such as RCOs and RCCs 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 behavioral health treatment system.

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) Use Block Grant funds for recovery support services? (●) Yes ( ) No

d) Involvement of people with lived experience /peers/family members in planning, implementation, or evaluation of the impact of the state's behavioral health system? (●) Yes ( ) No

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 SUMH for many years. SUMH has put together a Recovery Oriented System of Care (ROSC) committee that meets monthly and addresses system changes toward a ROSC model. OSUMH has also focused efforts on individualized care and meeting the individuals where they are at in their recovery. All Local Authorities have included Certified Peer Support Specialists (CPSS)/Family Peer Support Specialists (FPSS) 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. SUMH also contracts with National Alliance for Mental Illness (NAMI), Jack's Recovery Support Serivces formally known as Latino Behavioral Health Services (LBHS), Multicultural Counseling Center, Asian Association of Utah, Child and Family Empowerment Services, American Foundation for Suicide Prevention (AFSP), Utah Support Advocates for Recovery Awareness (USARA) and Utah Association of Peer Support Specialists UAPSS), Utah Peer Network (UPN), Mental Health America-Utah (MHA-Utah) Recovery Community Organizations (RCOs) 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. i.e., RCOs, RCCs, peer-run organizations.

SUMH has programs to assist with support and payment of recovery support services for those individuals who do not receive Medicaid funding. This may include: Individuals enrolled into a Drug Court program, parolees re-entering into the community, individuals compelled to treatment through the Justice Reinvestment Initiative, and individuals in treatment or working their recovery that are identified as needing additional support through our Recovery Support Service program. The Recovery Support Service Program is directed by a manual that outlines approved services. Services are provided through vouchers and data is collected in the SAMHIS system which allows us to collect and review data on the services that are utilized and funding spent. A portion of Local Authorities have chosen to use local County funds to assist with Recovery Support Services.

SUMH has contracts with community based peer organizations such as Utah Supports Advocacy for Recovery Awareness (USARA) and Recovery Community Organizations (RCOs) to provide Recovery Support Services to those individuals with Behavioral Health disorders in need of assistance throughout the community. In 2023 SUMH sent out an RFP and contracted with 12 other Community based organizations to provide health and well being and community based recovery outreach to individuals within their own community. These efforts were to increase access and opportunities for individuals and to address community needs and engagement. SUMH also works and collaborates with the Utah Association of Peer Support Specialists UAPSS), Utah Peer Network (UPN), Mental Health America-Utah (MHA-Utah).
Substance Use Disorder Recovery Supports include: transportation assistance, childcare, identification cards and birth certificates, employment support, housing assistance, Drivers Licenses, community referrals, medication assistance, MAT, budgeting, educational services, etc.

Certified Peer Support Specialists work with the Assertive Community Treatment (ACT), Assertive Community Outreach Teams (ACOT), Assisted Outpatient Treatment (AOT), and Mobile Crisis Outreach Teams (MCOT), provide support through a statewide warm line, and respond to calls from local Emergency Rooms when substance use is identified.

5. Does the state have any activities that it would like to highlight?

SUMH contracted with King's College of London to utilize the Substance Use Recovery Evaluator (SURE) screening tool. The SURE is a patient-reported outcome measure used to assess recovery. It is designed to guage an individuals progress in recovery across several domains including; alcohol and other drug use, self-care, relationships, material resources and outlook on life. The domains are reviewed and can be evaluated based on domain score changes over time and changes can be addressed with the individual. The SURE tool is currently being utilized within our Local Authority provider system and also by out Recovery Community Organizations and Peer Community Providers.

SUMH has initiated a Peer Support Steering Committee that meets monthly. The committee is composed of individuals representing peer services across the state, and includes substance use and mental health, peer trainers, marginalized populations, and advocates. The committee serves to provide peer voice to SUMH peer-related decisions. The committee is not limited to Block Grant funding (the focus of the Utah Behavioral Health Planning and Advisory Council), but provides an opportunity for peer involvement in decisions related to training peers, supervision, program expansion, peer-related Rule, and ongoing efforts to develop services for marginalized populations.

6. Please indicate areas of technical assistance needs related to this section.

NA

Footnotes:

Environmental Factors and Plan

11. Children and Adolescents M/SUD Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG 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 disorder 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.[1] 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.[2] For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3]

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 using substances the age of 18. Of people who started using substances before the age of 18, one in four will develop a substance use disorder compared to one in 25 who started using substances after age 21.[4]

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 use, 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, states are encouraged to designate a point person for children to assist schools in assuring identified children relate to available prevention services and interventions, mental health and/or substance use screening, treatment, and recovery support services.

Since 1993, the federally funded Children's Mental Health Initiative (CMHI) has been used as an approach to build the system of care model 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, states have also received planning and implementation grants for adolescent and transition age youth SUD and MH treatment and infrastructure development. This work has included a focus on formal partnership development across child serving systems and policy change related to 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 functioning of children, youth and young adults in home, school, and community settings. 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.[5]

According to data from the 2017 Report to Congress on systems of care, services reach many children and youth typically underserved by the mental health system.

1. improve emotional and behavioral outcomes for children and youth.
2. enhance family outcomes, such as decreased caregiver stress.
3. decrease suicidal ideation and gestures.
4. expand the availability of effective supports and services; and
5. save money by reducing costs in high-cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

The expectation is that states will build on the well-documented, effective system of care approach. 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:

1. 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);
2. supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education

and employment); and

3. residential services (e.g., therapeutic foster care, crisis stabilization services, and inpatient medical withdrawal management).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance use disorder at Columbia University. (June, 2011). Adolescent Substance use disorder: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? (●) Yes ( ) No

b) The resilience of children and youth with SED? (●) Yes ( ) No

c) The recovery of children and youth with SUD? (●) Yes ( ) No

d) The resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Health care? (●) Yes ( ) No

c) Juvenile justice? (●) Yes ( ) No

d) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance use prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

c) Is the child serving system connected with the Early Serious Mental Illness (ESMI) services? (●) Yes ( ) No

d) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provides 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 Health and Human Services (DHHS) provides integrated services with a systems of care approach through

close collaboration with the Office of Substance Use and Mental Health (SUMH), Division of Child and Family Services, Division of Juvenile Justice and Youth Services, Utah State Board of Education, Law Enforcement, and other community partners. SUMH provides integrated services for mental health (MH) and substance use disorder (SUD) needs for children and youth through the Local Authority (LA) system and contracted providers. Integrated approaches are being evaluated to better serve individuals with physical health and intellectual/developmental disabilities and needs.

There are thirteen LA's in Utah, which provide integrated SUD/MH services. One additional geographic area is divided into separate MH and SUD LA with a bidirectional referral relationship: Bear River - Bear River Health Department - SUD Treatment / Bear River Mental Health. The LA providers provide a continuum of services ranging from prevention, outpatient treatment, intensive outpatient treatment, residential treatment and recovery support services. Each of the Local Authorities have collaborative relationships with the Local Health Department and furthermore the Local FQHC and medical clinics to provide physical health services as well. We continue to strive towards a fully integrated behavioral health and physical health model, driven by the needs of the community receiving services.

Utah continues to be in a good position to expand and evolve the system of care statewide for children and youth from birth to age 21 and their families, regardless of their insurance coverage. This level of readiness is based on previous and current efforts in service delivery and infrastructure development.

SUMH actively partners across the DHHS system and LA system to increase collaboration and partnership to support youth access to services and recovery supports. SUMH partners with public and private stakeholders to address and increase collaboration in care and services. The intended goal is working towards decreased siloing of access points for youth and families seeking services including in schools, primary care, and private behavioral health systems.

SUMH mental health team helps shape and contribute to the system of care through policy development, technical assistance, monitoring and oversight. In FY 26-27, plans to enhance the support of early identification, treatment, recovery and resilience of children and youth with mental health and substance use disorders, including those with dual diagnosis of intellectual/developmental disabilities and co-occurring mental health as infant and early childhood mental health. Through continued work with DHHS divisions, LA's the Utah State Board of Education (USBE), and other private and public providers throughout the state, SUMH will continue to work collaboratively to ensure children, youth, and their families have their needs supported.

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

SUMH contributes and provides integrated services through following action steps and activities:

a. Collaborate with the DHHS child serving agencies to develop an integrated family and youth development plan across the Department to include youth with behaviorally complex presentations. In 2024 DHHS begin a DHHS system project to address youth with behaviorally complex presentations. The results of this project will address issues of system capacity development, internal collaboration, staff and agency training, collaboration across private and public child services agencies.

b. Increase the number of Certified Family Peer Support Specialists (FPSS): FPSS are individuals with lived experience raising or caring for a child or family member who experiences emotional, behavioral, mental health or substance use challenges who are certified and trained to provide resource facilitation and family to family peer support services to children, youth, and families regardless of insurance coverage. OSUMH oversees the certification process and works with contracted training partners to ensure statewide access to the FPSS training. The certification process includes an initial 40-hour training, certification exam, continuing education training, and 100 hours supervised practicum. In June 2019, there were 58 FPSS statewide. Utah experienced a dip in numbers due to the closure of a family based organization in 2021, however has rebounded as of 2025, with 104 FPSS statewide. Utah is exploring opportunities to strengthen alignment across the peer support workforce and to better engage those actively certified CPSS who also have lived experience as a caregiver. Utah has developed a dual certification endorsement to increase the workforce who meet the FPSS certification criteria without extending additional administrative burden to the individuals or agencies through time away for lengthy training.

c. Support a Certified Peer Support Specialist - transition age youth (CPSS-TAY) focused program: The Office is collaborating with the CPSS program to develop a training and supervision curriculum to support: i) young adults to become a CPSS-TAY, and ii) CPSS to develop the knowledge and skills to work with transition age youth-age (15 to 26-years-old). The office is currently reviewing the CPSS-TAY curriculum for approval and is hopeful to have the first training scheduled for November 2025. Furthermore, CPSSs can take an 8-hour Transition Age Youth specialty training for continuing education to develop applicable knowledge and skills to work with this population.

In 2021, three transition-age youth participated in the Youth MOVE National Youth Peer Support Training pilot program. This is a 40-hour training dedicated to peer support services for transition-age youth, with an emphasis on near-age youth peer support. The Division of Family Health within DHHS completed a contract with Youth MOVE National to facilitate transition-age youth focused peer support training in Utah. The contract was cancelled by the DHHS Division of Family Health after one year due to inability to provide administrative oversight. SUMH will be working to develop a CPSS-TAY curriculum to fill in the gap left by the terminated contract.

d. Expand knowledge of First-Episode Psychosis (FEP) and Clinical High-Risk for Psychosis (CHRP), and the Coordinated Specialty Care (CSC) model of treatment: There are currently five CSC teams in Utah which cover the most populated areas of the state, as well as one rural area that covers five counties. OSUMH has identified additional opportunities and needs to enhance education regarding FEP, CHRP, and CSC across the DHHS system, USBE, public and private stakeholders, and the community at large. The OSUMH will be working toward appropriate community education which includes cross-system collaboration to most appropriately meet the needs of youth and families experiencing CHRP or FEP. This effort will include education and outreach tools that are consistent across sites and the state.

e. Support School Based Behavioral Health (SBBH) through partnerships with the LAs, the Utah State Board of Education (USBE), and the local schools throughout Utah: USBE continues to be a key partner and helps provide technical assistance on collaborating with Local Education Authorities and on gathering outcome data. Targeted technical assistance has helped the mental health system understand schools' governing requirements and policies while strengthening referral practices and options to gather outcomes for the LAs. Parent consent and involvement is integral for all school-based services. Services vary by school and may include mental health screenings, individual, family, and group therapy; parent education; social skills and other skills development groups; Family Peer Support; case management; and consultation services.
SBBH service models across the state have decreased barriers for youth and families seeking behavioral health services in schools, including barriers associated with transportation, limited access in outpatient behavioral health settings, limited knowledge of treatment options in the community, and parental and youth time away from school and work to access services. Behavioral health services in schools continue to help reduce these barriers and promote healthy children and youth, and in turn increase academic success. State legislation passed in 2020 set guidelines to support school-based mental health screening and allocated funding to help students with identified needs access mental health services. This has allowed OSUMH and LMHA to evaluate partnerships within the LEAs to support access to care in conjunction with mental health screenings. In June 2021, School-Based Programs were accessible in 323 schools. As of June 2024, the number of schools in which SBBH programs were available from the LA system were 424 including access to services via telehealth in 84 schools.

f. Collaborate with DHHS child serving agencies, LAs, and community partners to increase the access to quality services for children, youth, and their families who are experiencing co-occurring mental health and intellectual/developmental/autism-related disabilities. SUMH, through partnering with the LAs and community partners, identified a greater need to provide knowledge and skills related to working with individuals with IDD/MH to clinical teams. OSUMH continues with a multi-year plan to support training to enhance knowledge across the behavioral health workforce (therapists, case managers, skills workers, peers, crisis workers, etc). In addition, DHHS has begun work on an internal strategic plan to support youth with behaviorally complex presentations which include those with dual diagnosis IDD/MH.

g. SUMH has focused work on infant and early childhood mental health initiatives to support developing a statewide focus on this age group. SUMH has supported workforce development strategies including evidence based training, teleconsultation, and service delivery. SUMH has taken a dyadic approach to addressing infant and early childhood mental health to include maternal mental health screening and connection to treatment. SUMH partners within DHHS, The Children's Center Utah, Intermountain Primary Children's Hospital to advance efforts.

H. SUMH supported development of a project in which an LA has established integrated mental health service provision in multiple pediatric offices in their catchment area. This model in which the LA is co-located in a pediatric primary care space has been well received and SUMH is looking to advance this approach in other catchment areas.

8. Please indicate areas of technical assistance needs related to this section.

n/a

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

12. Suicide Prevention – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death nationally, with over 49,000 people dying by suicide in 2022 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance use, painful losses, exposure to violence, economic and financial insecurity, and social isolation. Mental illness and substance use are possible factors in 90 percent of deaths by suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, M/SUD agencies are urged to lead in ways that are suitable to this growing area of concern. M/SUD agencies are encouraged to 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 since the FY2024-2025 Plan was submitted? ○ Yes ◉ No

2. Describe activities intended to reduce incidents of suicide in your state.

There are many activities in place targeting suicide prevention in Utah. Led by the Utah State Board of Education, all secondary schools are required to have a suicide prevention program/strategy and all licensed school staff are required to have ongoing training at the time of licensure and license renewal.

SUMH has youth/school based initiatives (described in detail in the youth section) that contribute to prevention efforts including school-based mental health and youth mobile crisis outreach teams. SUMH partners with our local crisis centers to provide 24/7 support including with the local National Suicide Prevention Lifeline (NSPL) affiliate who also provides application-based chat/text crisis support to youth needing support. The Trevor Project lifeline is also promoted within SUMH efforts.

SUMH has been working on building out a continuum of crisis services and recently awarded a contract for a statewide crisis line and expansion of mobile crisis outreach teams into five new counties/regions of the state. MCOT response is now available statewide, including more rural locations. SUMH has also developed and implemented a required crisis worker certification training.

SUMH contracts with National Alliance for Mental Illness (NAMI) Utah and community focused providers statewide to help them review data and develop local suicide prevention strategies for implementation through an RFP process. SUMH currently provides funding and technical assistance to five community organizations who have implemented suicide prevention activities ranging from awareness and gatekeeper training, to school based programming, to reducing access to lethal means. Through an RFP process, SUMH also contracts directly with local health and mental health authorities and community organizations to develop comprehensive community suicide prevention programming, including prevention and postvention community plan development. SUMH implements the statewide suicide prevention media campaign, Live On Utah. See https://liveonutah.org/.

SUMH leads a robust firearm safety for suicide prevention effort including providing leadership to a committee of firearm related partners. Through this, SUMH has developed education and training materials specific to firearm suicide prevention, distributes over 8,000 cable style gun locks annually, and supports a training program for firearm retailers. SUMH partners with local health and mental health authorities, and the Utah Department of Veterans and Military affairs for the distribution of gun safes and medication lock boxes. Additionally, SUMH partnered to develop lethal means training (similar to Counseling on Access to Lethal Means) for the public, in addition to a more clinical focus.

SUMH works extensively to promote and implement the Zero Suicide (ZS) model in the public behavioral health care system with a focus on individuals with SMI/SED. We also work to implement Zero Suicide in partnership with health and behavioral health systems statewide. After working for many years on suicide prevention with the two largest health care system in Utah, they announced the formal adoption of the aspirational goal of zero through the Zero Suicide model in July 2017. SUMH has several ZS -focused training initiatives including providing training and case consultation in Brief Cognitive Behavioral Therapy for Suicide Risk, the Collaborative Assessment and Management of Suicidality, Counseling of Access to Lethal Means, and Crisis Response Planning. In 2021, SUMH began targeted Zero Suicide technical assistance to local behavioral health authorities and healthcare providers to further develop the framework within their organizations.

Following the award of the National Strategy for Suicide Prevention, SUMH is working with rural provider to promote suicide prevention with older adults living in Utah's nonmetropolitan counties (less than 50,000 people). Training includes both clinical and community audiences, and includes specific outreach to veteran-serving organizations and the Northern Ute tribe.

SUMH provides leadership and support to the Utah Suicide Prevention Committee and Coalition (USPCC). This includes workgroups focused on the implementation of the State Suicide Prevention Plan. The USPCC is composed of a diverse group of

stakeholders including organizations, businesses, healthcare providers, community members and leaders of behavioral health services in Utah. SUMH facilitates strategic planning, and implementation of strategies across the state at all levels of influence. The 2022-2026 plan can be founds at https://utahsuicideprevention.org/about/. The State Suicide Prevention Plan is up for review and revision in FY27.

3. Have you incorporated any strategies supportive of the Zero Suicide Initiative? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for patients with suicidal ideation being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

SUMH provides grants to three healthcare organizations to implement the Zero Suicide Framework in their organizations. All three Zero Suicide Grantees have identified care transitions as an essential focus area for their organizations. Common Spirit, Colorado Catholic Health Initiative, and House of Hope have conducted self-studies to identify gaps, and have identified goals and strategies to further develop the Zero Suicide Framework to fidelity within their organizations.

In addition, Southwest Behavioral Health has taken steps to ensure that they have a trainer on staff to teach Crisis Response Planning to staff. By providing regular training on how to conduct crisis response planning, patients develop appropriate safety plans to ensure they can manage suicidality while receiving treatment.

5. Have you begun any prioritized or statewide initiatives since the FFY 2024 - 2025 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

Utah continues to rank among the top ten in suicide rates nationally. However, since 2017, the rates have remained relatively stable. There are specific populations with higher rates and are being addressed in the state Suicide Prevention Plan, and through contracting practices with SUMH. Areas of higher rates include Native Americans, individuals living in Utah's most rural areas (nonmetropolitan, CDC CHDS), veterans and service members, and men of middle age.

6. Please indicate areas of technical assistance needs related to this section.

SUMH continues to receive technical assistance through SAMHSA project officers through three discretionary grants: National Strategy on Suicide Prevention, Project AWARE (Advancing Wellness and Resiliency in Education) and the Garrett Lee Smith. Additionally, SUMH receives technical assistance through the Governor's Challenge on Suicide Preveniton among Veterans, Service Members and Families. If additional assistance is needed, SUMH will reach out to national, local and organizations for support.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

13. Support of State Partners – Required for MHBG & SUPTRS BG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnerships that SMHAs and SSAs have or will develop with other health, social services, community-based organizations, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority 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 prioritize risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of M/SUD, 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 emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults with M/SUD.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and co-occurring M/SUD.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state, and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- Enhancing the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states is crucial to optimal outcomes. In many respects, successful implementation is dependent on leadership and

collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

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?

Utah is currently working to develop new partnerships with a newly developed state agency, Clinical Health Services (CHS), at the Department of Health and Human Services. CHS was formed based off of a need to improve clinical services inside the Utah State Prison. New partnerships are being developed to implement integrated physical and behavioral health services across the state, included those interagency relationships needed to build integrated services. Of note, Utah was awarded a CCBHC planning grant and also is part of the Physical Health Integration Learning Collaborative, vital components of these efforts.

SUMH is currently engaging with Intermountain Primary Children's Hospital on a community-based project to support the development of a statewide "Healthy Kids Scorecard" to measure children's wellness across multiple domains including behavioral health. SUMH has a seat on the mental health childhood leadership team to help develop this component of the scorecard. SUMH additionally has a seat on the Infant and Early Childhood Mental Health Working Group, focused on statewide quality improvement for infant and early childhood mental health.

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.

In the 2025 Legislative session, a newly formed Utah Behavioral Health Commission (UBHC) was appointed to help establish, improve, and guide behavioral health services in the state. UBHC is composed of four main Committees and several subcommittees and workgroups, The four main committees include the Utah State Substance Use and Mental Health Advisory Committee (USAAV); Education and Mental Health Committee; Statewide Suicide Prevention Committee; and the Behavioral Health Crisis Response Committee. These committees address behavioral health services, delivery, quality improvement and outcomes across the state for public and private providers.

SUMH conducts monthly meetings with the Utah Behavioral Health Committees which are made up with the Directors, Clinical Directors, Finance Directors and Data Directors from all Local Authorities. These groups meet to review, discuss, and coordinate efforts for substance misuse and mental health treatment across the state. These efforts are designed to improve access, treatment quality and coordination, financial efficiency, data, and client outcomes.

SUMH produces an annual scorecard that records service numbers and treatment-related outcomes. This information is used to monitor outcomes from each provider, with comparisons to statewide and national data. Utah has also developed a Tableau public-facing portal that provides live data and is utilized to review data and trends. Data is reviewed in the monitoring visits to assess whether the providers meet outcome expectations. Internally, SUMH develops an annual SUMH Result Based Accountability (RBA) plan that lists system goals. The RBA is reviewed quarterly, and is used to drive accountability and improve outcomes for behavioral health services, training, and supports.

4. Please indicate areas of technical assistance needs related to this section.

Not at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

14. State Planning/Advisory Council and Input on the Mental Health/Substance Use Block Grant Application – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in **42 U.S.C. §300x-3** for adults with SMI and children with SED. To assist with implementing and improving the Planning Council, states should consult the **State Behavioral Health Planning Councils: An Introductory Manual.**

Planning Councils are required by statute to review state plans and annual 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 advocates for individuals with M/SUD. States should include any recommendations for modifications to the application or comments to the annual report that were received from the Planning Council as part of their application, regardless of whether the state has accepted the recommendations. States should also submit documentation, preferably a letter signed by the Chair of the Planning Council, stating that the Planning Council reviewed the application and annual report. States should transmit these documents as application attachments.

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, letter from the Council Chair etc.)

The Office of Substance Use and Mental Health (SUMH) presents on and provides information regarding the State Plan to the Utah Behavioral Health Planning and Advisory Council (UBHPAC). UBHPAC is composed of mental health, substance use disorder, and prevention members from the community and state agencies. Community members of UBHPAC have formed work groups to address (1) expenditures; (2) Block Grant implementation; (3) populations and services; and (4) performance indicators and accomplishments. On August 1st, when the plan is submitted for public comment, SUMH posts a copy of the State Plan on the front page of their website for public comment and UBHPAC is made aware via email as well as announcements in meetings. A hard copy of the State Plan is provided at the front desk of SUMH, and a copy is posted on the SUMH Bulletin Board. The public is encouraged to provide feedback via email or calling OSUMH.
Minutes for UBHPAC and the UBHPAC executive meetings are posted on the OSUMH website, along with an audio recording of each meeting: https://dsamh.utah.gov/providers/behavioral-health-planning-council

2. Has the state received any recommendations on the State Plan or comments on the previous year's State Report?

a. State Plan — (●) Yes ( ) No

b. State Report — ( ) Yes (●) No

Attach the recommendations /comments that the state received from the Council (without regard to whether the State has made the recommended modifications).

3. What mechanism does the state use to plan and implement community mental health treatment, substance use prevention, SUD treatment, and recovery support services?

SUMH has created a Results Based Accountability (RBA) strategic plan. The plan is based on known barriers and gaps identified by UBHPAC, the Utah Behavioral Health Master Plan, and the Behavioral Health Commission. The RBA plan includes the following strategies:
1. Advance prevention and early intervention to reduce the impact of mental health disorders, substance misuse, and to promote well-being.
2. Continue to develop a comprehensive and integrated mental health crisis response system.
3. Work to improve access to high quality treatment and recovery services.
4. Collaborate with, and provide training to, providers, systems, and community partners to improve quality of care and well-being.
These subjects and the associated metrics are reflected in the Block Grant, with Strategy 3 separated into treatment and recovery.

SUMH provides guidance to all of the Local Substance Abuse Authorities and Local Mental Health Authorities during a combined Area Plan training in the spring of each year. The Local Authorities use that guidance to develop their Area Plans, in conjunction with their local partners. Each Local Authority also has consumers involved in the development of their plans and priorities. The Local Authorities are responsible for planning for and providing MH and SUD services to the residents of their counties.
Clinical directors for each of the Local Authorities, in conjunction with OSUMH, have a monthly Recovery-Oriented System of Care (ROSC) meeting to facilitate movement of the public behavioral health system to a recovery-oriented model. This includes review

and discussion of cost, quality, access, outcomes, integration, engagement and retention for mental health, substance use disorders and prevention, with an emphasis on identifying gaps.

4. Has the Council successfully integrated substance use prevention and SUD treatment recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

5. Is the membership representative of the service area population (e.g., rural, suburban, urban, older adults, families of young children?) (●) Yes ( ) No

6. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

   The Public Health Service Act (42 U.S.C.300x) mandates each state establish a State Mental Health Planning Council. The council is required to review and provide feedback on the states Mental Health Block Grant (MHBG) application and submit any recommendations. The Council monitors, reviews and evaluates the allocation and adequacy of mental health services in the state, serving as an advocate for adults with serious mental illness (SMI), children with serious emotional disturbances (SED) and other individuals with mental illness or emotional disturbances. UBHPAC is comprised of mental health and substance use disorder providers, peers in recovery, family members of individuals in recovery, advocates, state agencies, and other agencies that interact with the mental health system. From each member's perspective, issues and concerns are brought up during the monthly meeting and the council works together to better serve individuals with SMI and SED. An executive subcommittee meets monthly to determine the agenda for the larger full council meeting each month.

7. Please indicate areas of technical assistance needs related to this section.

   Not at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Mental Health Agency
State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Medicaid Agency

Start Year: 2026 End Year: 2027

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Javier Alegre	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Karla Arroyo	Parents of children with SED			
Eric Barker	State Employees			
Randee Barriga	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Emily Bennett	Advocates/representatives who are not state employees or providers			
Dan Braun	Providers			
Pete Caldwell	State Employees			
Amy Campbell	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Leah Colburn	State Employees			
Chandra Davis	Parents of children with SED			
Kim Davis	State Employees			
Cathy Davis	State Employees			
Melissa Edgeworth	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Kori Foote	Youth/adolescent representative (or member from an organization serving young people)			
Jennifer Gray	Persons in Recovery from or providing treatment for or advocating for SUD services			
	Individuals in recovery (including adults with			

Ruthena Hensley	SMI who are receiving or have received mental health services)			
Peggy Hostetter	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Ryan Hunsaker	Advocates/representatives who are not state employees or providers			
Jason Jacobs	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Jane Lepisto	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Martha Lilia Soto Caballos	Advocates/representatives who are not state employees or providers			
Jessica Makin	Youth/adolescent representative (or member from an organization serving young people)			
Jennifer Marchant	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Jules Martinez	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Bryan Martinez	Providers			
Mary Jo McMillan	Persons in Recovery from or providing treatment for or advocating for SUD services			
Aubrey Meyers	State Employees			
Rafael Montero	State Employees			
Sigrid Nolte	Parents of children with SED			
Jeanine Park	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
James Park	Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)			
Andrew Riggle	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Brayden Robinson	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Heather Rydalch	Individuals in recovery (including adults with SMI who are receiving or have received mental health services)			
Theo Schwartz	Youth/adolescent representative (or member from an organization serving young people)			
Jordan Sorenson	Advocates/representatives who are not state employees or providers			

Alica Wilcox	Parents of children with SED			

*Council members should be listed only once by type of membership and Agency/organization represented.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2026 End Year: 2027

Type of Membership	Number	Percentage of Total Membership
1. Individuals in recovery (including adults with SMI who are receiving or have received mental health services)	13	
2. Family members of individuals in recovery (family members of adults with SMI and family members who are not parents of children with SED)	2	
3. Parents of children with SED	4	
4. Vacancies (individuals and family members)	0	
5. Total individuals in recovery, family members, and parents of children with SED	**19**	**51.35%**
6. State Employees	7	
7. Providers	2	
8. Vacancies (state employees and providers)	0	
9. Total State Employees & Providers	**9**	**24.32%**
10. Persons in Recovery from or providing treatment for or advocating for SUD services	2	
11. Representatives from Federally Recognized Tribes	0	
12. Youth/adolescent representative (or member from an organization serving young people)	3	
13. Advocates/representatives who are not state employees or providers	4	
14. Other vacancies (who are not individuals in recovery/family members or state employees/providers)	0	
15. Total non-required but encouraged members	**9**	**24.32%**
16. Total membership (all members of the council)	**37**	

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

The prior representative for federally recognized tribes had to step back due to personal reasons. The planning council has been actively focused on recruiting a new memeber to fill this position.

Environmental Factors and Plan

15. Public Comment on the State Plan – Required for MHBG & SUPTRS BG

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, that 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 the federal government.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? (●) Yes ( ) No

b) Posting of the plan on the web for public comment? (●) Yes ( ) No

If yes, provide URL:

https://sumh.utah.gov/

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://sumh.utah.gov/

c) Other (e.g. public service announcements, print media) ( ) Yes (●) No

d) Please indicate areas of technical assistance needs related to this section.

Not at this time.

OMB No. 0930-0168 Approved: 05/28/2025 Expires: 01/31/2028

Footnotes:

Block Grant public comment announcement was made to the Utah Behavioral Health Committee and the Utah Behavioral Health Planning and Advisory Council. The application is formatted to be ADA accessible on the SUMH website.

Environmental Factors and Plan

16. Syringe Services Program (SSP) – Required for SUPTRS BG if Planning for Approval of SSP

Planning Period Start Date: 10/1/2025 Planning Period End Date: 9/30/2026

Narrative Question:
Use of SUPTRS BG funds to support syringe service programs (SSP) is authorized through appropriation acts which provide authority for federal programs or agencies to incur obligations and make payment, and therefore are subject to annual review. The following guidance for the application to budget SUPTRS BG funds for SSPs is therefore contingent upon authorizing language during the fiscal year for which the state is applying to the SUPTRS BG.

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SUPTRS BG to fund elements of an SSP other than to purchase sterile needles or syringes for the purpose of illicit drug use. States interested in directing SUPTRS BG funds to SSPs must provide the information requested below and receive approval from the State Project Officer.

States may consider making SUPTRS BG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SUPTRS BG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to persons who inject drugs (PWID), SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers. Federal funds cannot be supplanted, or in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

The federal government released three guidance documents regarding SSPs, These documents can be found on the **HIV.gov website.**

Please refer to guidance documents provided by the federal government on SSPs to inform the state's plan for use of SUPTRS BG funds for SSPs, if determined to be eligible. The state must follow the steps below when requesting to direct SUPTRS BG funds to SSPs during the award year for which the state is eligible and applying:

Step 1 - Request a **Determination of Need** from the CDC

Step 2 - Include request in the SUPTRS BG Application Plan to expend the funds for the award year which the state is planning support an existing SSP or establish a new SSP. Items to include in the request:

- Proposed protocols, timeline for implementation, and overall budget
- Submit planned expenditures and agency information on Table 16a listed below

Step 3 - Obtain SUPTRS BG State Project Officer Approval

Use of SUPTRS BG funds for SSPs future years are subject to authorizing language in appropriations bills, and must be re-applied for on an annual basis.

Additional Notes:

1. Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (**42 U.S.C.§ 300x-31(a)(1)(F)**) and **45 CFR § 96.135(a)(6)** explicitly prohibits the use of SUPTRS BG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

2. Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(a)**) and **45 CFR § 96.127** requires entities that receives SUPTRS BG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

3. Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (**42 U.S.C. § 300x-24(b)**) and **45 CFR 96.128** requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SUPTRS BG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (**42 U.S.C. 300x-28(c)**) and **45 CFR 96.132(c)** requires states to ensure that substance use prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to health services.

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Budget of SUPTRS BG for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone or other Opioid Overdose Reversal Medication Provider (Yes or No)
Utah Syringe Exchange Program	PO BOX 141010, Salt Lake City, UT -84114	$0.00	No	0	No
Totals:		$0.00		0	

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Footnotes:

Utah does not utilize SUPTRS funding for Syringe Service Programs. They are funded by other funds. Utah is not a designated state.