Utah

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 08/03/2023 4.04.03 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year	2024
End Year	2025

State SAPT Unique Entity Identification

Unique Entity ID	1B08TI085836

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

First Name	Brent
Last Name	Kelsey
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	801-540-5242
Fax	385-465-6040
Email Address	bkelsey@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	Brent
Last Name	Kelsey
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	801-540-5242
Fax	385-465-6040
Email Address	bkelsey@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	801-995-2176
Fax	385-465-6040
Email Address	shlong@utah.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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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).
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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: 04/19/2021 Expires: 04/30/2024

Footnotes:

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Fiscal Year 2024

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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.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

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: 04/19/2021 Expires: 04/30/2024

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 M/SUD prevention (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 M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. 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."

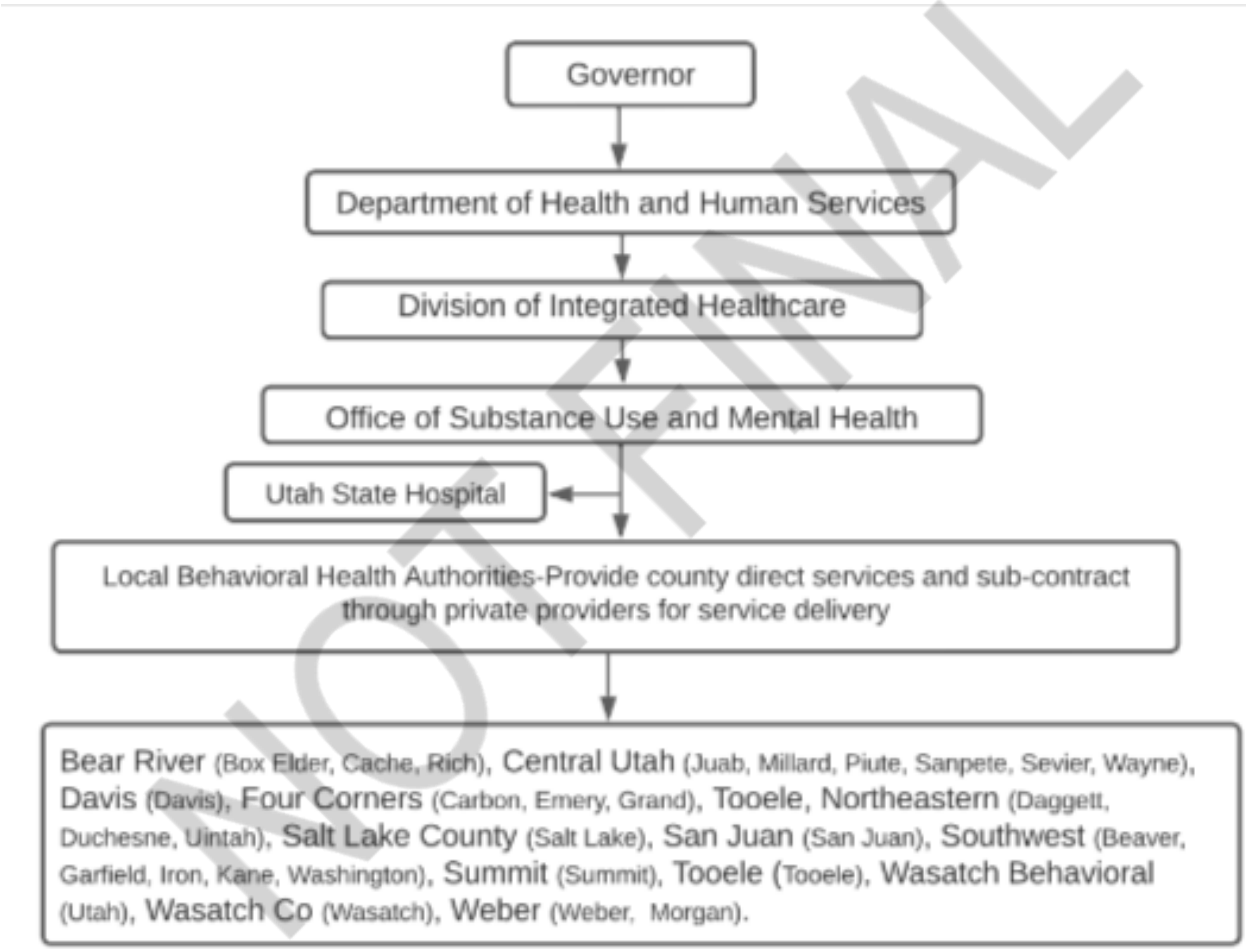
OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

PLANNING STEP 1: Assess the strengths and organizational capacity

I. Overview of State Behavioral Health System

In the 2021 Legislative Session, H.B. 365 State Agency Realignment, was passed that merges the Utah Department of Human Services and the Utah Department of Health. The new Department was established on July 1, 2022 and is called the Department of Health and Human Services. More information can be found at https://sites.google.com/utah.gov/hhsplan/home.

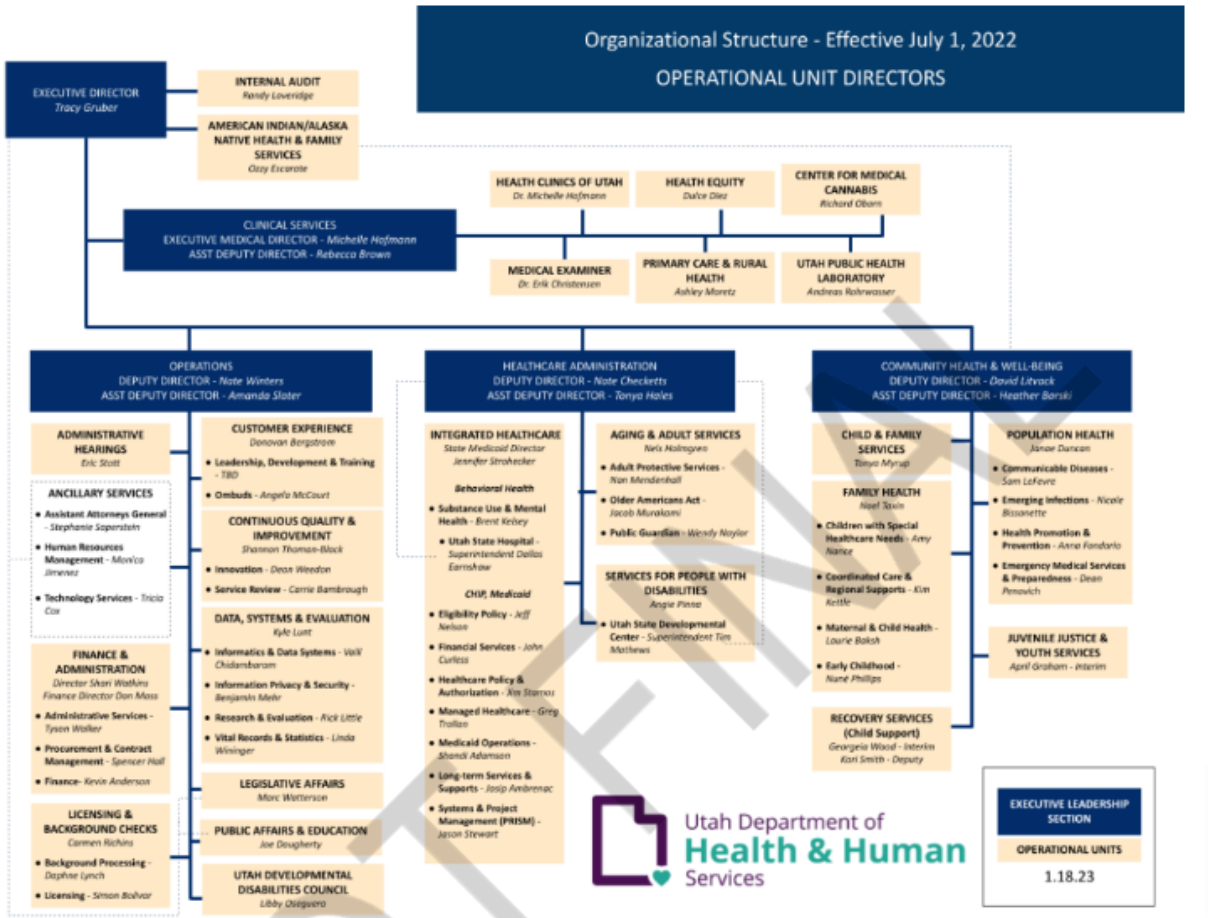


Organization of the Utah Public Behavioral Health System

a. State level organization—Health and Human Services

The Department Executive Director is a member of the Governor's Cabinet Council along with all other Department heads. The Department of Health and Human Services is one of the

largest departments in Utah State government and currently consists of the following service offices and divisions:



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

There are currently multiple groups meeting to address Prescription Drug Abuse, Opioid Overdose Prevention, Suicide Prevention, Recovery Supports (Employment, Housing, Peer Supports), Integration, Clients with Complex Needs, Longterm Services and Supports, and Children/Youth Mobile Crisis Outreach and Follow up Care, all to ensure collaboration

and to maximize the use of available resources.

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

An ongoing focus of the DHHS is a continuing effort to identify and enroll uninsured individuals either through the State's Avenue H private health insurance exchange, or Legacy Medicaid, Targeted Adult Medicaid, or Expansion Medicaid. In the 2019 Legislative session, Senate Bill 96 was passed that put Utah's Medicaid Expansion bill into Law. This new law expands Medicaid to parents and adults without dependent children earning up to 100% federal poverty level (approximately $20,120 annual income for an individual as of Spring 2023).

The State received CMS approval for a new 1115 Waiver to fully expand Medicaid in January 2020 with a work requirement. The work requirement was then suspended due to the pandemic. At this time, the waiver includes:

- A community engagement requirement and mandatory enrollment in employer sponsored insurance;
- Adults without dependent children enrolled in this eligibility group receive full state plan benefits;
- Adults with dependent children/caretakers receive a slightly modified benefit package that the mandatorily covered section 1931 parents/caretakers population receives, consistent with the currently approved PCN demonstration.
- Non-provision of non-emergency medical transportation (NEMT) for the adults with dependent children/caretakers in the Adult Expansion Population;
- The enhanced federal medical assistance percentage (FMAP) for newly eligible individuals who are part of the Adult Expansion Population.

CMS has also approved expanded eligibility criteria for the Targeted Adults, which has three subgroups. Targeted Adults are adults without dependent children, age 19-64,with effective incomes of up to 5 percent of the FPL (0 percent of the FPL, plus the five percent income disregard) who meet specified criteria in one of the three subgroups:

- Individuals experiencing chronic homelessness:
- Individuals involved in the justice system and needing substance use or mental health treatment; and
- Individuals needing substance abuse or mental health treatment.

This amendment expands the criteria to include such populations as individuals who are victims of domestic violence without a place to reside and individuals on probation or parole with a serious mental illness or serious substance use disorder.

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

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 abuse in Utah. Utah Statutes require that 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 OSUMH "*...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").

The Assistant Director of The Office of Substance Use and Mental Health serves as the SSA and SMHA, and as such oversees the provision of Behavioral Health Services in the State. The Assistant Director is supported by a Director and Assistant Director over Adult Mental Health services. OSUMH carries out its statutory obligations by contracting with Local Substance Abuse and Mental Health Authorities for the delivery of Behavioral Health services. The State Prevention team was moved under the direct supervision of the Office of Health Promotion and Prevention (OHPP) with the merger but some functions of prevention are still overseen by OSUMH. 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.

The OSUMH distributes federal and state funds through contracts (counties are required to provide matching funds), and monitors the Local Authorities to ensure compliance with statutory mandates and contracted services. Contracting requirements, monitoring and oversight, rule writing, interagency coordination, and technical assistance are used to influence and guide systems of care. The OSUMH also provides leadership and coordination with other state agencies, the state legislature and advocacy groups.

The Utah Department of Health and Human Services operates with the following Vision statement:

> *The Utah Department of Health and Human Services will advocate for, support, and serve all individuals and communities in Utah. We will ensure*

all Utahns have fair and equitable opportunities to live safe and healthy lives. We will achieve this through effective policy and a seamless system of services and programs.

The Utah Department of Health and Human Services Strategies:

1. Ensure quality care, services and programs are accessible where and when they're needed Strategy
2. Foster safe and supportive environments Strategy
3. Improve health outcomes, both physical and mental Strategy
4. Create a high-quality and efficient department Strategy
5. Build public trust in DHHS

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 sets policy for substance use and mental health programs funded with state and federal funds. OSUMH's vision is healthy individuals, families and communities and our mission is to promote health, hope, and healing.

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

OSUMH Experience of the Result: All Utahns have fair and equitable access to a broad array of prevention and mental health and substance use disorder services, where and when they are needed. Local substance use and mental health authorities use evidence-based practices, integrate mental and physical health care, and demonstrate improved outcomes. Fewer Utah youth use alcohol and drugs, and fewer Utahns of all ages are negatively affected by mental health symptoms and substance use disorders. Fewer Utahns experience suicidal ideation, attempts, or death.

OSUMH Strategies:

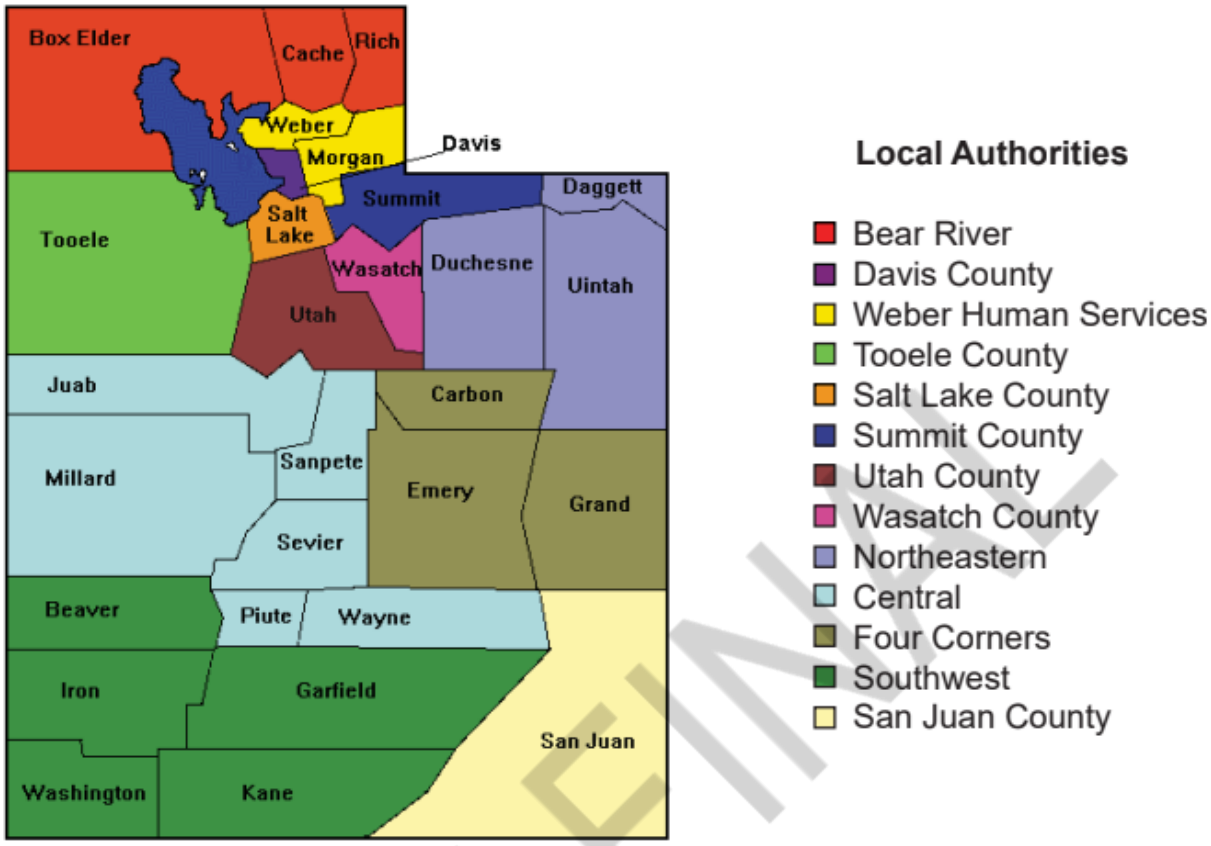
1. Advance prevention and early intervention to reduce the impact of substance use and mental health disorders, substance misuse, and to promote well-being.
2. Continue to develop a comprehensive and integrated mental health crisis response system.
3. Work to improve access to high quality treatment and recovery services.
4. Collaborate with and provide training to providers, systems, and community partners to improve quality of care and well-being.
5. Reduce the time spent on activities that do not contribute toward the OSUMH result.
6. Strengthen a work culture where everyone feels supported, valued, and safe.
7. Monitor services and systems to efficiently and continually improve outcomes and ensure fiscal responsibility.

Utah State Statute Utah Code 26B-5-102, specifically mandates the Local Substance Abuse Authorities (LSAA) provide a "continuum of services for Adolescents and Adults" aimed at substance use disorders, prevention and treatment; and requires Local Mental Health Authorities (LMHA) to provide ten mandatory services for individuals with serious mental illness or severe emotional disturbance. Thus, Utah's Local Mental Health Authorities 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 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.

A Local Mental Health or Substance Abuse Authority is generally the governing body of a county. The 29 counties in Utah have organized themselves into 13 Local Substance Abuse Authorities and 13 Local Mental Health Authorities. (See attached diagram). Twenty-three of the counties have joined together under inter-local agreements to create six Local Authorities, where one commissioner representing each county holds a seat on the governing board for that Local Authority. 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 OSUMH.

Local Authorities set the priorities to meet local needs, but at a minimum must provide ten statutorily mandated mental health services as well as peer support services mandated through Medicaid contract, and a continuum of substance use disorder services either directly or through contracts and agreements. Area plans describing what services will be provided with state, federal and county funds are developed and submitted to OSUMH annually. These plans become the foundation of contracts between OSUMH and each of the Local Authorities.

Utah's public Behavioral Health system for child, youth/adolescent and family services has the same organizational structure as the adult system. Local Authorities are required to outline in their area plan how they are planning to provide mental health and substance abuse treatment and prevention services to this population as well as the adult population. 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 at: https://sumh.utah.gov/ . Contracts with the Local Authorities and their funding allocations are approved only after the Area Plans have been approved by the OSUMH Director.



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

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

c. Addressing the needs of Utah's diverse racial, ethnic and sexual gender minorities, youth and the underserved The greatest challenges faced in providing

mental health, substance use disorder treatment and prevention services for residents of Utah are due to the distribution of the population and the decentralized nature of the system. Utah is 84,900 square miles with urban, rural and frontier communities. The 2022 US Census estimates Utah's population to be 3,380,800, Utah grew by about 41,700 people from 2021 to 2022, the ninth biggest net population growth and 10th highest growth rate of any state.

Since, as stated above, by Statute and rule, the Counties/Local Authorities are responsible for planning and providing services for their residents, this widely varied geography and population presents significant challenges in this area. An example of the diverse nature of the challenges facing authorities can be seen by comparing the following:
Salt Lake County 1 county 35.76% of the state's population 0.9% of state's area
Weber Human Services 2 counties, 8.51% of the state's population, 1.4% of the state's area,
Central Utah Counseling, 6 counties, 2.55% of the state's population 20.3% of the state's area.

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

2021 Utah Population and Land Mass Totals

Local Authority	% of Population	% of Land
Bear River	5.83	9.7
Weber	8.51	1.4
Salt Lake	35.76	0.9
Davis	11	0.4
Tooele	2.32	8.4
Wasatch	1.09	1.4
Utah	20.11	2.4
Summit	1.29	2.3

Central	2.55	20.3
SouthWest	8.13	21.3
Northeastern	1.73	10.2
Four Corners	1.23	11.7
San Juan	0.46	9.5

Additionally, the Native American Tribal organizations are located throughout the state (see Map below on page 7). Since planning for and providing services is a County responsibility, each County and or local authority is tasked with the requirement to include Native Americans as well as other minority and underserved groups in their planning process.

Demographics

According to the most recent United States Census Bureau (2022), the racial composition of Utah is:

- White: 90.0%
- Two or more races: 2.9%
- Asian: 2.8%

- Black or African American: 1.6%
- Native American: 1.5%
- Native Hawaiian or Pacific Islander: 1.2%
- Hispanic or Latino: 15.1%
- White alone, not Hispanic or Latino: 76.7%

Given the diverse nature of the various Local Authorities, geographically, culturally, economically and organizationally, the specifics of planning for services is left to the Counties and their Local Authorities, and monitored closely by the OSUMH during its annual audits, area plan reviews and technical assistance visits.

Women and women with dependent children: Utah has focused on women with dependent children for several years including providing appropriate levels of services to include a full continuum of care. Local Authorities have been working with community partners to provide a network of providers that can provide gender responsive, trauma-informed services, medical care, behavioral health, family support and recovery support services for not only the women but for the entire family.

See Table below - The Table outlines all Pregnant and Parenting Women's service providers providing services throughout the state. Services are located in all 13 Local Authorities. The Local Authorities also provide education and referral services to any woman that identifies as pregnant in which they provide intermittent services such as education, counseling and referrals to medical/prenatal care or community resources.

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 - Brock Alder	Bear River Health Department - 655 East 1300 North, Logan, Utah 84321; (435) 792-6500	PPW Outpatient - Accepts Children
Cabon 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
San Juan	Director - Tammy Squires	San Juan Counseling - 365 South Main, Blanding, Utah 84511; (435)	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
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 - Gary K. Dalton	Tooele County Department of Human Services - 47 South Main St. RM 114, Tooele, Utah 84074; (435)	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 - Juergen Korbanka	Wasatch Behavioral Health (WBH) - 750 N. Freedom Blvd, Provo, Utah 84601; (801) 373-4760	PPW - Outpatient - Accepts Children.
Utah County	Director - Randy Huntington	Utah County Substance Use Disorder (SUD) Treatment - 151 S. University Ave, Ste 1400, Provo, Utah 84601	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	Director - Brian Butler Associate 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

The use of Family Peer Support Specialists and Certified Peer Support Specialists to promote behavioral health services and recovery for all priority populations.

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

Local Authorities report there are no waiting list for treatment services and services are provided to priority populations as required. Wait lists and priority standards are reviewed during the annual monitoring site visits with each Local Authority.

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

The Office has also encouraged the use of Medication-Assisted Treatment (MAT) services for Opioid user disorder including individuals identified as IV users in which the Office has included language to support the use of MAT in the Office Directives that state:

> *Funds allocated by OSUMH shall not be expended by any agency which would deny any eligible client, patient or individual access to their program because of their use of FDA-approved medications for the treatment of substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine mono product mono product formulations, naltrexone products including extended-release and oral formulations or implantable buprenorphine).*

See Table below: Table outlines a list of OTP providers throughout the State that have agreements with Local Authorities to provide MAT services.

		Contracts or MOU's with Local Authorities and Opioid Treatment Providers	
Salt Lake County	Director - Tim Whalen; 2001 South State, Suite S2300, Salt Lake City, Utah 84190; (385) 468-4727	Metamorphosis Salt Lake - 169 East 5900 South #101, Salt Lake City, Utah 84123; Director - Debra Drabner - (801) 631-4835; CEO Shannon Terwedo - (530) 320-9220	Opioid Treatment Provider Program, which has an MOU with Valley Phoenix Women and Children's Residential to provide MAT. Outpatient and PPW services.
Salt Lake County	Director - Tim Whalen; 2001 South State, Suite S2300, Salt Lake City, Utah 84190; (385) 468-4727	Project Reality - Salt Lake; 150 East 700 South, Salt Lake City, Utah 84111; (801) 364-8080; Director Linda Moore (801) 558-8496	Opioid Treatment Provider Program, which has a contract with Salt Lake County Behavioral Health to provide MAT. Outpatient and PPW services.
Salt Lake County	Director - Tim Whalen; 2001 South State, Suite S2300, Salt Lake City, Utah 84190; (385) 468-4727	Project Reality - Murray; 5280 South Comerce Drive, Suite D110, Murray, Utah 84107; (385) 881-0170; Director Linda Moore (801) 558-8496	Opioid Treatment Provider Program, which has a contract with Salt Lake County Behavioral Health to provide MAT. Outpatient and PPW services.
Utah County	Director - Richard Nance	Project Reality - Provo; 151 South University Avenue, Suite 1400, Provo, Utah 84606; Director - Linda Moore (801) 558-8496	Opioid Treatment Provider Program, which has a contract with Utah County Division of Substance Abuse to provide MAT. General Outpatient including PPW services.
Weber County	Director - Richard Nance	Discovery House - Orem; 714 South State Street, Orem, Utah 84058. (801) 426-6565. Director - Daniel Hymas (208) 313-7333.	Opioid Treatment Provider Program, which has a contract with Utah County Division of Substance Abuse to provide MAT. General Outpatient including PPW services.
Weber County	Director - Kevin Eastman	Metamorphosis - Ogden; 2557 Lincoln Avenue, Ogden, Utah 84401, (801) 622-5272. Director - Raquel Dee (801) 510-4758. CEO - Shannon Terwedo - (530) 320-9220	Opioid Treatment Provider Program, which has a contract with Weber Human Serivces. Outpatient and PPW services.
Weber County	Director - Kevin Eastman	Discovery House - Layton	Opioid Treatment Provider Program, which has a contract with Weber Human Services. Outpatient and PPW services.
Carbon County	Director - Karen	Operation Recovery - Price - 77 South 600 East, Suite C, Price, Utah 84501; (435) 613-6289; Director - Linda Moore - (801) 558-8496	Opioid Treatment Provider Program, which has a contract with Weber Human Services. Outpatient and PPW services.

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), 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 and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

PLANNING STEP 2: Identifying the Unmet Service Needs and Critical Gaps within the Current Service System.

In 2023, the University of Utah Kem C. Gardner Policy Institute completed a Utah Behavioral Health Assessment & Master Plan. At this time a draft of the report has been released for public review. OSUMH will be reviewing the report in order to address areas that OSUMH can address with Utah's Behavioral Health system.

Challenges Related to Utah Demographics:

- The US Census in 2022 estimates Utah's population to be 3,380,800, the population percent change – April 1, 2020 (estimates base) to July 1, 2022, is 3.3%. According to the Erin Alberty report Utah grew by about 41,700 people from July 2021 to 2022, the ninth biggest net population growth and 10th highest growth rate of any state.
- US Census 2022 the overall persons in poverty rate in the State of Utah is 8.6%.
- Compared to national averages, the Utah population is younger and lives longer, and has a higher birth rate. Currently Utah averages the highest number of persons per household (3.62 for Utah versus 2.64 nationally) and comparatively has a higher population under the age of 18 at 29% compared to 22.3% nationally.
- Salt Lake City is estimated to contain 35.76% of the State's population, making it densely populated and leaving other areas of the state rural or uninhabited. Service participation in the frontier areas of the state can be very difficult. In some counties, the drive is approximately 1.5 hours to attend a parenting class or an indicated program. Three hours of driving for 1 hour of service is disheartening and discourages people from attending. LSAAs are looking at unique ways to serve the frontier areas, but other barriers are coming to light. One suggestion was to provide an online course. With some areas, the service must be available on a mobile device because few people have computers in the home (in frontier areas). Internet service is often poor or non-existent. These communities often have some of the highest rates of suicide and substance use disorder.
- The US Census in 2022 estimates Utah's population to be 3,380,800, Utah grew by about 41,700 people from July 2021 to 2022, the ninth biggest net population growth and 10th highest growth rate of any state and increasingly diverse in culture. According to the Kem Gardner report those identifying as two or more races are the fastest growing population group, with an average annual percentage growth rate of 8.1 percent. Utah's Hispanic population continues to be the fastest growing community in the state. Specific barriers and gaps are discussed below in the "Culture and Disparities" section.
- Utah is home to 8 federally recognized American Indian Tribes including the Northern Ute, Navajo, Paiute, Goshute, Northwestern Band of Shoshone, San Juan Southern Paiute, Skull Valley Band of Goshute, and White Mesa Band of the Ute Mountain. Native American populations reside in various reservations across the state, with the bulk living in the Northeastern and Southeastern regions of the state; Federal, State, County and Native American jurisdictions are all involved in providing services.
    - The Native population accounts for 29.71% of those living below the poverty level.
    - The Northeastern and Southeastern regions are relatively remote with poor transportation and sparse populations, which further stretch the state's resources.

- The direct planning and provision of services is the responsibility of the Local Authorities in those areas, and the provision of services to Native American populations is a part of the annual contract review and audit.
- Success in negotiating service agreements and coordinating services is often an issue of local politics and personalities.
- Utah's Department of Health and Human Services has developed an inter-tribal council and signed a coordination/collaboration agreement with the various Native American tribal representatives supporting the need for planning and coordination at a state level.

Medication Assisted Treatment (MAT)/Intravenous (IV) Drug Use:

Access to MAT services has shown to be limited in some regions. Utah is an expansive state with only 5 out of its 29 counties being Urban with the majority 13 counties being frontier. We know that some of our Rural and Frontier locations do not have prescribers available to provide MAT. Some areas have begun services through Telehealth but still have limited availability due to a lack of internet infrastructure and limited cell phone service coverage.

OSUMH has collected a list of Buprenorphine waivered prescribers across the State and although the list indicates there are reasonable amounts of prescribers in the State, we have come to understand that many of these providers choose not to prescribe or limit the number of individuals they will treat with this medication. OSUMH has identified this as an access issue and has been working with Local Authorities and other community partners to identify the reasons for the providers' decisions. Our goal is to educate prescribers and offer support in order for them to be open to providing services and coordinating care when appropriate so that they feel supported to give the best care possible to those in need.

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

As indicated above there are some service gaps in relation to MAT access in some parts of the state. Not all forms of MAT are offered throughout the state, however at this time there is access to at least one type of MAT in all areas. We recognize that not all clients are screened for communicable diseases or screened for high risk behaviors that can lead to TB or other communicable diseases. One of the gaps is that not all behavioral health providers know what to ask during a screening to address these issues We have found that not all clients are forthcoming in their full use history or in regards to high risk behaviors but hope with continual conversations and education that we can address these issues and provide referrals, treatments and care to those that need it.

Residential Services:

OSUMH has worked to maintain funding for residential services for women with dependent children. With research supporting the practice of keeping children with their mothers, OSUMH provides support for these services. In FY19, OSUMH and Women's Treatment

Providers secured 1 Million dollars in ongoing State General Funds to help sustain the two of the larger Women and Children's Residential Treatment Programs in Salt Lake County which were at risk for closure at that time which is still in effect as of FY2023. In addition, OSUMH and the Utah Division of Child and Family Services (DCFS) have worked together to provide ongoing IV-E entitlement funding through the Family First Prevention Services Act (FFPSA) to the six Women and Children's Residential Treatment Programs in Utah to pay for the children's room and board, which Medicaid does not cover. Due to lack of funding and staffing, Utah only has six residential treatment programs across the state specifically designed for women with children. This creates limited space and access issues. Because of the limited availability of these specialty programs, OSUMH requires that all six Women and Children's Residential Programs be open to accepting clients from across the state. The Women and Children's Residential Programs work with the Local Authorities through MOU's and agreements to fund these treatment services. OSUMH also encourages Local Authorities to contract with private treatment agencies to provide better access to services in their local area.

Services for Youth:

The numbers of youth referred into mental health treatment, substance use disorder (SUD) treatment, and SUD early intervention programs have decreased steadily over the past 7 years. The decreases in youth served are inconsistent with the epidemiological data showing the need for treatment among Utah youth. SHARP data from 2021 collected from 71,001 students identified 3.3%, or 2,343 youth, were in need of alcohol and drug treatment, with 1,517 receiving SUD and co-occurring treatment services through local authority providers. Adolescent and transitional-aged youth substance misuse and related behaviors should be identified as early as possible. Screening should occur in health care (medical visits, emergency room, etc.), educational, and other youth-serving settings. Existing systems should allow mentors, teachers, family members, and youth themselves to make referrals (or self-refer). Early Intervention is critical in reaching adolescents. Adolescents should be invited to participate in community events, provided information about substance use risks, normal or safe levels of use, and strategies to quit or cut down on use and use-related risk behaviors, have increased screening access, be provided community resources, and referred to other programs through community partnerships based on individual need. Focusing on collaboration and aligning training opportunities between mental health and SUD providers can allow for better early identification of SUD risk factors and early substance misuse as often youth and their families are accessing services for mental health without recognizing the need for SUD services. This can allow for additional opportunities to provide upstream prevention services to youth and families surrounding SUD. Due to the prevalence rates of childhood trauma and the implications it has on early brain development, the earlier the system can intervene to support families, adolescents and their families can build resiliency and intervene in substance misuse before a dependency develops.

There are four Prevention and Recovery of Early Psychosis (PREP) teams in Utah that provide Coordinated Speciality Care (CSC) to young adults through age 25 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. These PREP

teams are located in the most populated areas of the state and the Office of Substance Use and Mental Health is working to expand services to non-metro areas of the state.

Recovery Support Services:

Recovery Support Services (RSS) have been widely provided across our state for several years but with limited funding available. Starting in FY20 OSUMH made an effort to open up other federal and state funding options to help support and fund recovery support services which are still being supported to this day. Utah has not had a recovery support program for individuals that are considered Severe and Persistent Mentally Ill (SPMI) or youth with Serious Emotional Disturbance (SED). Treating SPMI and SED populations has been a need and gap in our behavioral health system. There is currently a housing crisis in Utah with lack of affordable housing and limited appropriate housing across the State for those with an SUD. The housing crisis was exacerbated by the COVID pandemic and strong demand for affordable housing which have continued to be a problem. During the pandemic Utah saw an even further increase in housing costs leaving prices 30% higher than they were one year ago and hitting all-time record highs. The housing market has seen a reduction over the past several months but not enough to alleviate the oval housing crisis in Utah. This is the same for apartment rentals whose prices have also increased and created a housing shortage across the state. Utah has made eligible funding available to support clients with housing needs especially those seeking Licensed Recovery Residences across the state and have focused efforts on gaining affordable housing options for this population. Licensed Recovery Residence, however, is a huge need in our State and an important factor to one's Recovery. According to the Utah Office of Licensing there are 127 licensed Recovery Residences in 2023 that span across the state, which is not enough to meet the need for individuals seeking a safe sober living environment.

Culture and Disparities:

In 2021 OSUMH's Health Disparities Research Team conducted the Health Disparities in Utah's Public Mental Health System survey. Report found here: https://sumh.utah.gov/data-reports/health-disparities-report It looked at four different populations: Black, Indigenous, and People of Color (BIPOC), People with Developmental Disabilities, Members of LGBTQIA+ community and Transition-Age Youth.. The results indicated recommendations for the following actions: increased representation of the four populations and providing education, increased input on all policy and practice decisions from voices within the workforce and community and recommended inclusion of diverse voices in the development delivery, and evaluation of all future trainings, guidelines and educational materials within the mental health and substance use systems. They also recognized the value of addressing changes at each structural level.

- Organizational Level- Agencies need voices and representation of the target population to inform policies, practices and decisions.
- Structural Level-Public spaces, public-facing documents, programs and services in Utah behavioral health systems need to reflect and address the diverse needs and values of the target populations.
- Service Level- Service Providers need more knowledge about the target populations and need specific skills in order to provide culturally sensitive and responsive services. OSUMH will be working within our own Local Authorities and with our community system to make these changes and to better service our community.

In 2021 and 2022, each of the Local Authorities set and worked toward goals based on data for their specific site. We continue to use the results to help structure services as identified as needs and gaps in our system. After conducting the needs assessment, OSUMH targeted funding towards the recommended needs of the assessment, and initiated an opportunity for each of the Local Authorities (LAs) to hire an equity and inclusion officer to oversee services. LAs are required to set health disparity goals specific to their community needs, and to review progress and additional goals within the LA annual area plans. Additional follow up reviews are being conducted and steps are being made to improve access and service delivery.

Integrated Care:

- Approximately 21.0% of adults in the U.S. experienced some kind of mental illness during 2020. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.https://ibis.health.utah.gov/ibisph-view/indicator/view/Dep.SA.html
- The Utah Department of Health Human Services reports 22% of Utah's adult population suffers from chronic health conditions, and has continuously found statistical information concurrent with national research indicating a high rate of co-occurring chronic physical illness and mental illness in Utah's adult population (Source: Utah Department of Health, CDC Behavioral Risk Factor Surveillance System Report).
- Utah's adults with mental illness are at greater risk of chronic health conditions, just as those with chronic health conditions are at increased risk of mental illness. (Source: Utah Department of Health, CDC Behavioral Risk Factor Surveillance System Report).
- Through a growing partnership with the Utah Department of Health, OSUMH is working to analyze the need and capacity for programming and create integrated solutions to support this population.
- Another access issue comes in the form of lack of referrals from physical health professionals. The State has identified that physicians, seen as one of the first to identify or make contact with individuals with mental health and substance use disorders, are uneducated regarding MH and SUD treatment services which leads to a lack of addressing the issue while the patient is being seen. OSUMH has placed emphasis on providing Screening, Brief Intervention, Referral and Treatment (SBIRT) training to physical health providers and has also taken steps to contract with a platform provider that will allow physical health providers to search available treatment slots. OSUMH is currently working with Juvare, an emergency management software company, and the Utah Medical Hospitals to pilot the project that will allow monitoring and tracking of State hospital beds for individuals with SPMI. The efforts of the bed registry were delayed when the pandemic. Over the past year we have worked to get MOU's in place with the state hospital organizations. We are currently in the process of going live for a pilot period with the hospital's organizations that have signed MOU's and will be looking to add more as others come on board. We hope to expand this project and are able to track all available treatment services across the public and those willing to participate in the private sector as well. This effort is to empower physical health and other community

providers in knowing what services are available when they come across someone that identifies as needing services. We would like to target prenatal care providers as an effort to reach pregnant women with SUD.

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

- Adults with serious and persistent mental illness in Utah have excessively high rates of poor nutrition, smoking, obesity, and over 66% of this population does not engage in regular physical activity. These individuals have rates of arthritis, asthma, and hypertension significantly higher than the general population.
- In 2005, Utah published its Wellness Directive which requires public behavioral health care providers to monitor weight and screen for primary health conditions such as diabetes and hepatitis. Day programs and Clubhouse programs must include a wellness component. Treatment plans include goals related to wellness when appropriate.
- Utah Health Improvement Plan 2017-2020 published by the Utah Department of Health highlights three main health initiatives: Reducing obesity and related chronic conditions, reducing prescription drug misuse, abuse and overdose and improving mental health and reducing suicide.
- Utah is committed to making SAMHSA-HRSA's Whole Health Wellness and Resiliency model readily available to our local authorities throughout the state to support the development of integrated primary and behavioral health services.
- According to the Utah State Health Department, Utah's base line, set in SFY 1991 and 1992, expenditures for tuberculosis services for individuals in substance use disorder treatment is $12,760 and in SFY 2014 the State expended $35,726 annually. Utah's local substance abuse authorities are required to conduct tuberculosis testing within their agencies and refer positively screened clients to appropriate health care services for further testing and treatment.

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

<u>Tobacco Use:</u>

- Forty-four percent of all cigarettes in America are consumed by individuals who live with mental illness and/or substance abuse disorders (Source <u>The Journal of the American</u>

Medical Association). Nationally, people with mental illness die 25-28 years earlier on average than the general population, largely due to conditions caused or worsened by smoking. (Source: National Association of State Mental Health Program Directors).

- Although a relatively low number of adults use tobacco in Utah (8.0% compared to the national average of 16.0% 2019, IBIS), smoking claims the lives of more than 1,300 Utahns adults each year and a total of 16.6% of cancer deaths attributed to smoking. Smoking exacerbates or causes nearly every chronic condition and contributes to Utah's primary causes of death including heart disease, respiratory disease, and cancer, especially in the disparate population of adults with serious mental illness.
- American Indian/Native Alaskan have the highest percentage of tobacco use of 20.9%.
- 71.65% of individuals admitted for SUD Services use tobacco (TEDS Data, 2020).
- Annual health care costs in Utah directly caused by smoking is $542 million , Medicaid costs caused by smoking is $125.9 million (2021, tobacco free kids).
- While youth tobacco use rates are among the lowest in the nation (0.8% combustible cigarettes, past 30 day use; Student Health and Risk Prevention survey), Utah has seen higher rates in the use of vaping products (e-cigarettes). Past 30 day vaping among all youth is 6.3%. Youth in Utah are more likely to use a vaping device than misuse any substance. (SHARP 2021).

Access to Mental Health Care:

The 2021 Mental Health America report card ranked Utah as 51st on combined adult and youth measures, ranking 32nd on youth measures and 51st on adult measures.

For individual measures:

- Youths ranked 48th with a high rate of at least one major depressive episode, 47th for students identified with emotional disturbance in an individualized education program, and 40th for youth with a severe major depressive episode in 2021.
- Adults ranked 51st with the highest rates of mental illness and serious thoughts of suicide, also ranking 49th for adults with any mental illness and unmet need.

A comprehensive report released by the Kem Gardner Policy Institute and the Utah Hospital Association in 2019 described the following:

- Close to one in five adults experience poor mental health. Over half of Utah adults with mental illness did not receive mental health illness treatment or counseling. Almost 40% of Utah’s depressed youth ages 12-17 did not receive treatment for depression.
- Utah has a mental health provider shortage in all counties, and has fewer mental health providers per 100,000 people than the National average. The shortage is particularly evident in rural areas, resulting in long wait lists and limited access to care.
- Most public mental health services are carved out of Medicaid which can lead to difficulties to deliver coordinated integrated care to clients in the public health system. Approximately 30% of commercial health insurances are high-deductible health plans. Parity continues to be a barrier as many commercial insurances provide limited coverage for mental health care.
- A shortage of long-term and intermediate beds, in addition to housing concerns mentioned previously, results in very few options for step-up care from emergency rooms and inpatient floors or for step-down care from the State Hospital.

By legislative intent, with the exception of the Utah State Hospital, no substance use disorder or community mental health center is operated by the State; the state does not provide clinical care. The Utah State Hospital provides mental health services, in addition to forensic services to individuals found incompetent to stand trial or not guilty by reason of insanity. An increased referral for forensic beds has decreased available civil beds. The 2021 Legislative session resulted in funding for 32 more beds at the State Hospital which will be primarily targeted to individuals meeting both forensic and civil criteria.

Economic Factors:

- Due to large household sizes in Utah, per capita income is slightly lower than the national average. The median household income in Utah is slightly higher than the national average.
- Individuals and families living in rural Utah are more likely to experience more dire risk factors due to economic limitations and the geographic challenges that cause limited access to resources, services and opportunities.
- According to the US Census- Utah, the average per-capita income for Utahns in 2021 (past 12 months) was $33,378 with 8.6% of the population living in poverty. Source: https://www.census.gov/quickfacts/UT
- Median household income is $79,449 (2021)
- The 2020 Rural Health Info Hub indicates a poverty rate of 10.3% exists in rural Utah, compared to a 7.0% level in urban areas of the state.
- USDA-ERS, 2017-2021 reports that 7.8% of the rural population has not completed high school, while 6.8% of the urban population lacks a high school diploma.
- In Utah-2022, 2.4% of the labor force was unemployed, significantly lower than the national rate of 3.6% (Bureau of Labor Statistics). The unemployment rate in rural Utah is 3.5%, while in urban Utah it is 2.6% (USDA-ERS, 2021).

Suicide:

Utah has a high prevelance of suicide which continues to be a need accross our state. We have increased outreach and training efforts which have been increased due to the Mental Health crisis we currently are facing with the pandemic but the need for services continues to increase.

- The Utah suicide rate in 2021 was 19.4 per 100,000 population..
- Utahs suicide rate increased annually for over a decade through 2016. However, beginning in 2017, the rate plateaued through 2021.
- There were 645 suicide deaths in 2021 (Crude Rate: 19.4*)
- Male: 79% (Crude Rate: 30.2)
- Female: 21% (Crude Rate 8.2
- Whites comprised 91% of the deaths. Percentages of NativeAmericans are highest among all race groups, followed by Black or African Americans
- Use of a firearm was the most common method of suicide death (57%) for Utahns followed by asphyxiation (24%) and then poisoning (14%).
- Suicide rates are higher among males in every age group, particularly in middle aged males, aged 25 - 54
- Based on CDC NCHS Degree of Rurality, the single county identified as Large Fringe Metro has a crude rate of 31.5. The second highest crude rates are found in the Non-Core counties (14 of 29 Utah counties) at 26.8.

A statewide media campaign "Live On Utah" is in it's third year to promote suicide prevention in Utah. The campaign is funded with both public and private funds, and includes a variety of media from traditional posters and stickers through an enhanced website) (https://liveonutah.org/, social media, billboards and advertising. It also includes the first ever suicide prevention training delivered entirely over social media (Instagram @liveonutah).

Data;

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

There is a lack of information and surveillance in regards to the number of individuals who use substances intravenously. While we have service numbers for individuals who receive treatment that have reported using intravenously, but no identified ways to see how this compares to the general population and the needs of those who are not currently being served in the public systems. Medicaid expansion in the State we do not capture data on individuals that receive services through private agencies or other organizations which limits our overall data. Some ways to gather this data is though data comparing with other agencies who serve individuals with a history of intravenous drug use, such as the Department of Health Bureau of Epidemiology Violence and Injury Prevention Program in part with their Syringe Service Programs and other community partners, the HIV and Hep C treatment programs and infectious disease outreach teams.

Prevention:

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

The prevention system in Utah is one of the most effective. With that said, there are still challenges and barriers. During the Partnership for Success 2013 grant, Utah began moving towards Community Centered Evidence Based Prevention. Community Centered Evidence Based Prevention (CCEBP) incorporates three main components: a) prevention efforts should be driven through community coalitions that represent the diversity of stakeholders within a community, b) the use of a data driven prevention process through which communities conduct a needs and resources assessment to identify prevention priorities in the community that will yield

the greatest benefit, and c) the implementation of strategies that have been tested and proven to be effective. While the LSAAs have all completed an assessment, some areas struggle with adopting a full comprehensive strategic plan (outlining the full Strategic Prevention Framework process used in their communities) with CCEBPs. We continue to provide ongoing technical assistance on strategic planning and increasing CCEBPs. In rural areas there are barriers due to travel to services. There are some rural offices, but with a portion of Utah's landscape considered "frontier", some areas are more remote. This issue impacts some of the most at need communities. OSUMH will assist in resolving these gaps and needs by utilizing Regional Directors that provide additional technical assistance to LSAAs. The RDs are responsible for specific LSAAs and have developed action plans to support the unique needs of that LSAA.

Workforce:
Workforce development is another need and gap throughout our state. This is true for our whole network from urban, rural, and frontier. Newly hired staff tend to stay for a shorter period of time before they move on. With medicaid expansion being an all willing provider we are aware that private providers may be looking to expand their agencies and be looking to hire more trained clinical staff which may lead to more demands for additional qualified behavioral health professionals. OSUMH is working with a Quality Care Workgroup that is looking at ways to collaborate with the local Universities to provide better EBPs and additional exposure to Substance Use and Mental Health practices to encourage and grow the workforce. Recently Medical Directors have been leaving their positions within the behavioral health sector and opting for jobs within larger medical organizations that are offering higher pay and more benefits. As our behavioral health system has focused for many years to provide integrated services, this shift in medical staff is creating a dilemma for the behavioral health system in order to provide the much needed medical oversight to individuals within the behavioral health system. The pandemic has changed the way many of our providers conducted normal business which allowed telehealth and telework. Some have continued to allow such practices while others have gone back to in person services. Some of the workforce have left employment for jobs that would allow them to continue teleworking which has impacted in-person jobs.

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

The SEOW has been integral in identifying statewide priorities for SUD and Mental Health related issues which help us identify needs and gaps in our system. The SEOW has access to vital statistics, injury and death data related to substance use and mental health, treatment needs, consumption data for youth and adults, risk factor data and archival data sets (ex. Juvenile Justice, Child and Family Services).The SEOW reviews the following available datasets: Student Health and Risk Prevention survey, death related to substance use, suicide rates, injury data from

hospital reports related to suicide, injury data from hospital reports related to substance use (Drug Abuse Warning Network, DAWN), overdose and unintentional death data (Medical examiner's office, IBIS), treatment needs and admission data collected through the public system, and measures related to substance use and mental health collected through the Behavioral Risk Factor Surveillance System, such as prescription drug use and mental health needs.

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

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Prevention and Early Intervention

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

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

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) Prevention of overdose deaths directly aligns to the key result of reducing the number of Utahns dying of drug-related causes.
2) Reduce suicide deaths and attempt in Utah with the goal of achieving no suicides.
3) Reduce harms related to mental disorders and promote mental wellbeing by increasing early access to mental health providers.
4) Reduce the misuse of alcohol and other drugs.
5) Increase Community Centered Evidence Based Prevention (CCEBP) Communities by 20%
6) Increase early intervention services
7) Increase outreach services through collaborative efforts with Department of Health

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase access to Naloxone kits

Baseline Measurement: Baseline: FY23 11,392 nasal distributed and 33,950 intramuscular. Total of 45,342.

First-year target/outcome measurement: FY24-Increase Nalonxone kits distrubted by 5% from baseline year.

Second-year target/outcome measurement: FY25- Increase Naloxone kits distributed by 7% from baseline year.

Data Source:

Number of Naloxone kits distributed through contracted quarterly submitted reports. SOR grant

Description of Data:

Data is collected from data submissions provided by the contractor quarterly. This is a data requirement for the SOR grant.

Data issues/caveats that affect outcome measures:

No issues with data collection at this time. However there has been delays in receiving orders of Naloxone which has slowed down the ability to distribute certain medications due to shortages nationwide.

Indicator #: 2

Indicator: Decrease 30 Day alcohol use--all grades

Baseline Measurement: 2021: 4.3%; CCEBP Communities 14.8%

First-year target/outcome measurement: 2024: Increase Community Centered Evidence Based Prevention (CCEBP) Communities by 20%.

Second-year target/outcome measurement: 2025: 3.87%

Data Source:

Student Health and Risk Prevention (SHARP) survey
Annual Area Plans submitted by Local Authorities

Substance Abuse Mental Health Information System

Description of Data:

6, 8, 10, 12 grade students throughout the state. Asked if they had any alcohol more than a sip in the past 30 days.
Report of identified prevention communities, by readiness status. Local Authorities report these annually. Baseline data for CCEBP: Local Authorities identified 108 prioritized communities. Of those, 16 were at a readiness of "Established, healthy strong coalition".

Data issues/caveats that affect outcome measures:

Survey is collected biennially. Also note that confidence interval is +/-5%.
Any policy that may impact services at the direct service level.
Additional communities may be identified each year that may change the number of prioritized communities.

Indicator #: 3

Indicator: Decrease 30 day E-cigarette use among Youth - all grades

Baseline Measurement: 2021: 6.3%; CCEBP Communities 14.8%

First-year target/outcome measurement: 2024: Increase Community Centered Evidence Based Prevention (CCEBP) Communities by 20%.

Second-year target/outcome measurement: 2025: 5.67 Past 30 Day E-cigarette Use Among All Youth

Data Source:

Student Health and Risk Prevention (SHARP) survey
Annual Area Plan submitted by Local Authorities

Description of Data:

The statewide survey administered to 6, 8, 10, 12 grade students collects substance abuse, mental health, risk, and protective factor data.
question: Have you used e-cigarettes in the past 30 days?
Report of identified prevention communities, by readiness status. Local Authorities report these annually. Baseline data for CCEBP: Local Authorities identified 108 prioritized communities. Of those, 16 were at a readiness of "Established, healthy strong coalition".

Data issues/caveats that affect outcome measures:

Survey is collected biennially. Also note that confidence interval is +/-5%.
Any policy that may impact services at the direct service level.
Additional communities may be identified each year that may change the number of prioritized communities.

Indicator #: 4

Indicator: Maintain Prescription Drug Use Among Youth - All Grades

Baseline Measurement: 2021: 1.7%; CCEBP Communities 14.8%

First-year target/outcome measurement: 2024: Increase Community Centered Evidence Based Prevention (CCEBP) Communities by 20%.

Second-year target/outcome measurement: 2025: 1.7%

Data Source:

Student Health and Risk Prevention (SHARP) Survey,
Annual Area Plans submitted by Local Authorities

Description of Data:

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

Tuinal, Seconal, Ambien, Lunesta, or Sonata) without a doctor telling you to take them, during the past 30 days?
On how many occasions (if any) have you used prescription stimulants or amphetamines (such as Adderall, Ritalin, or Dexedrine) without a doctor telling you to take them, during the past 30 days?
Report of identified prevention communities, by readiness status. Local Authorities report these annually. Baseline data for CCEBP: Local Authorities identified 108 prioritized communities. Of those, 16 were at a readiness of "Established, healthy strong coalition".

Data issues/caveats that affect outcome measures:

Survey is collected biennially. Also note that confidence interval is +/-5%.
Any policy that may impact services at the direct service level.
Additional communities may be identified each year that may change the number of prioritized communities.

Indicator #: 5

Indicator: Maintain Youth 30 Day Cannabis Use - all grades

Baseline Measurement: 2021: 4.5%; CCEBP Communities 14.8%

First-year target/outcome measurement: 2024: Increase Community Centered Evidence Based Prevention (CCEBP) Communities by 20%.

Second-year target/outcome measurement: 2025: 4.5%

Data Source:

Student Health and Risk Prevention (SHARP) survey
Annual Area Plan submitted by Local Authorities

Description of Data:

The statewide survey administered to 6, 8, 10, 12 grade students collects substance abuse, mental health, risk, and protective factor data. Question: Have you used marijuana (THC, pot, Hash hish) in the past 30 days?
Report of identified prevention communities, by readiness status. Local Authorities report these annually. Baseline data for CCEBP: Local Authorities identified 108 prioritized communities. Of those, 16 were at a readiness of "Established, healthy strong coalition".

Data issues/caveats that affect outcome measures:

Survey is collected biennially. Also note that confidence interval is +/-5%.
Any policy that may impact services at the direct service level.
Additional communities may be identified each year that may change the number of prioritized communities.

Indicator #: 6

Indicator: Decrease Opioid Death Rate

Baseline Measurement: 2021: 13.57 per 100,000

First-year target/outcome measurement: 2024: Decrease by 5%

Second-year target/outcome measurement: 2025: Decrease by 10%

Data Source:

Utah Medical Examiner

Description of Data:

Estimates are based on occurrent deaths (deaths occurring in Utah, regardless of residence status) 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.

Indicator #: 7

Indicator: Increase outreach and engagement with high-risk populations through HCV screenings and referrals to SUD treatment

Baseline Measurement: FY23 HCV Screenings 1286 with 191 referrals to SUD treatment

First-year target/outcome measurement: Fy24: increase HCV screenings by 2% from baseline and 2% referrals to treatment.

Second-year target/outcome measurement: FY24: Increase HCV screenings by4% from baseline and 4% referrals to treatment.

Data Source:

Data from the Health Department VIPP Program (SOR Grant)

Description of Data:

Clients provided screenings for HCV and referred to SUD treatment

Data issues/caveats that affect outcome measures:

Unduplicated counts or based on clients that received screenings which could be multiple events.

Priority #: 2

Priority Area: Behavioral Health Crisis Response System

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

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

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.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase the number of people accessing the 988 and the Statewide Crisis Line

Baseline Measurement: Lack of information about 988 and the crisis line is impacting whether people are accessing the services.

First-year target/outcome measurement: Develop and begin implementation of a marketing and communication strategic plan.

Second-year target/outcome measurement: Offer 10 educational presentations on 988 and Crisis services

Data Source:

Communications and marketing will be used to create a strategic plan for increasing awareness using educational presentations

Description of Data:

Educational presentations will increase surveys to assess quality of training, in addition to the number of presentations provided.

Data issues/caveats that affect outcome measures:

Time to contract with the communications and marketing agency may impact the time to complete the plan and provide the trainings.

Indicator #: 2

Indicator: Increase Mobile Crisis Outreach services across the state.

Baseline Measurement: FY22: 6,516 mobile crisis response services provided

First-year target/outcome measurement: Increase number of mobile crisis response services by 5%

Second-year target/outcome measurement: 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:

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: Establish and expand receiving center services

Baseline Measurement: Currently there are 3 active no-refusal receiving centers (RC)

First-year target/outcome measurement: Increase number of receiving centers to meet minimum availability standards by 1 RC

Second-year target/outcome measurement: Increase number of receiving centers to meet minimum availability standards by 1 more RC

Data Source:

Number of receiving center services (admissions) provided
Number of in-home stabilization services provided

Description of Data:

Minimum availability standards = one receiving center within 2 hours driving distance statewide

Data issues/caveats that affect outcome measures:

Difficulty obtaining construction materials has impacted building/remodeling for the centers. Workforce shortages affect whether the receiving centers can open when planned.

Priority #: 3

Priority Area: Substance Use and Mental Health Treatment

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

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

Goal of the priority area:

Improve outcomes among people receiving substance use and mental health treatment.

Strategies to attain the goal:

1) Increase early access to services and supports.
2) Focus on improving quality of care
3) Partner with criminal justice agencies to ensure individuals receive necessary services.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: FY22: 15,487 unduplicated

First-year target/outcome measurement: FY24: Increase number of individuals served by 2% from baseline

Second-year target/outcome measurement: FY25: 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: Increase access to mental health services

Baseline Measurement: 60,559 individuals were served by the Local Authorities in FY22

First-year target/outcome measurement: 1% increase in the number of individuals served by the Local Authorities

Second-year target/outcome measurement: 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:

With the post-pandemic Medicaid "unwinding", there may be an initial decrease in individuals served in the public mental health system. Efforts are being made to ensure that individuals with SMI are not impacted by the change.

Indicator #: 3

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

Baseline Measurement: Fy22: 7354 forms returned of which 82% reported positive "General Satisfaction"

First-year target/outcome measurement: FY24: Increase of 2% from baseline

Second-year target/outcome measurement: FY25: Increase of 5% from baseline.

Data Source:

Adult Consumer Satisfaction Survey 2022 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 #: 4

Indicator: Increase use of Mental Health evidence-based practices (EBPs)

Baseline Measurement: Twenty-six EBPs are offered across the Local Authorities

First-year target/outcome measurement: Increase number of EBPs offered at Local Authorities by 1 EBP.

Second-year target/outcome measurement: Increase number of EBPs offered at Local Authorities by a second EBP.

Data Source:

Number of evidence based practices implemented to fidelity
Hours of training provided on evidence-based practice
Implementation of fidelity monitoring
Clinical supervision

Description of Data:

Data is provided by the Local Authorities in the annual Area Plans.
Statewide trainings are planned for EBPs for those agencies that do not provide including Motivational Interviewing and DIMENSIONS nicotine cessation. Other trainings will be added as they are identified.

Data issues/caveats that affect outcome measures:

Data is impacted when clinicians do not mark all EBPs provided during a session, if multiple EBPs are used.

Indicator #: 5

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

Baseline Measurement: FY22: Individuals served invovled with the Justice System 7,189

First-year target/outcome measurement: Fy24: increase baseline by 2%

Second-year target/outcome measurement: Fy25: Increase baseline by 5%

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 #: 6

Indicator: Opportunities for integrated physical and behavioral health care in the public system

Baseline Measurement: Data related to integrated care is not currently being collected by the Local Authorities

First-year target/outcome measurement: Develop baseline of expected data collection for integrated care by Local Authorities

Second-year target/outcome measurement: Using baseline data, identify and begin implementation of two strategies to increase integrated care within the Local Authority system

Data Source:

SAMHIS and TEDS data

Description of Data:

Development of an indicator for integrated care for improved data tracking

Data issues/caveats that affect outcome measures:

Local Authorities use a variety of electronic databases and have recently modified data submission due to a major change at the state level.

Indicator #: 7

Indicator: Increase the number of pregnant women served (priority population goal)

Baseline Measurement: established in FY2020 331 pregnant women served

First-year target/outcome measurement: Increase pregnant women served in treatment services by 2% from baseline. 2024

Second-year target/outcome measurement: Increase pregnant women served in treatment services by 4% from baseline. 2025

Data Source:

State SAMHIS data, TEDs.

Description of Data:

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

Data issues/caveats that affect outcome measures:

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

Indicator #: 8

Indicator: Increase use of FDA approved medications for individuals that identify as IV users (Priority population) SUD

Baseline Measurement: established baseline in FY23 4,303 IV users received FDA approved medications - served

First-year target/outcome measurement: FY24: Increase baseline by 2%

Second-year target/outcome measurement: FY25: Increase baseline by 4%

Data Source:

SAMHIS and TEDs Data. Report from new Mobile Clinic contract for rural Utah (FY24 New service contract)

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. In FY20 SAMHIS data reported 4725 clients had IV or Intramuscular Injection (pri, sec, tert) of which 1,236 had MAT (methadone or MAT EBP) as an EBP indicator.

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 #: 9

Indicator: Address behavioral health inequities, disparities, and stigma to advance health equity, diversity, inclusion, and access.

Baseline Measurement: There is no continuity across Local Authorities related to the provision of screening tools and treatment for diverse communities.

First-year target/outcome measurement: Data will be gathered to establish the demographics of client need versus provision of services across the public system.

Second-year target/outcome measurement: Services to marginalized populations will increase by 10%

Data Source:

SAMHIS
TEDS
IBIS
UBHPAC

Description of Data:

Demographics of SMI and SUD population
Demographics of SMI/SUD treatment providers

Data issues/caveats that affect outcome measures:

Individuals being served by community providers may be missed by the current method of gathering data so a full data set will require assistance from CBOs.

Priority #: 4

Priority Area: Recovery and Resiliency

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

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

Goal of the priority area:

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

Strategies to attain the goal:

1) Implement non-clinical recovery support strategies.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 1800 adults and 341 youth received MH PSS in FY22; 2,971 SUD clients received PSS services

First-year target/outcome measurement: Increase % of individuals served by PSS by 5%

Second-year target/outcome measurement: Increase % of individuals served by PSS by 5% more in second year.

Data Source:

SAMHIS data
TEDs data
OSUMH data portal - https://sumh.utah.gov/data-reports/data-portal-home
OSUMH 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: Individuals with MH or SUD disorders participate in meaningful daily activities in which they find purpose.

Baseline Measurement: Five Individual Placement and Support (IPS) teams are operating to fidelity in Utah

First-year target/outcome measurement: Two IPS teams will have fidelity reviews to establish a baseline

Second-year target/outcome measurement: Two IPS teams will improve to good or very good fidelity.

Data Source:

IPS Learning Community data portal
OSUMH IPS trainer

Description of Data:

Number of fidelity reviews completed
Score for fidelity reviews
Ongoing training to assess sites that are ready for fidelity reviews

Data issues/caveats that affect outcome measures:

Workforce shortage issues have impacted IPS teams, leading to staff turnover and a need for ongoing training.

Indicator #: 3

Indicator: Implement and increase the use of the Substance Use Recovery Evaluator Tool (SURE) SUD

Baseline Measurement: FY23: None - new tool

First-year target/outcome measurement: FY24: Set baseline. Train on the use of the SURE tool

Second-year target/outcome measurement: FY25: Increase number of administrations of the SURE annually by 20%

Data Source:

OQ Analyst system (implemented). MHMS (contract and work with programming to get tool set up in system)

Description of Data:

Substance Use Recovery Tool: Number of SURE administrations.

Data issues/caveats that affect outcome measures:

This is a brand new tool that was just implemented in the OQ analyst platform. The state is still in the stage of training our public behavioral health system to administer the tool. Next phase is to look at the data and address implementation issues. Address appropriate Clinical use of the tool as Clinicians start to review the summary data and address results with clients. Adjustments will need to be made on the state target and outcomes as the tool gets implemented in the pilot phase.

Indicator #: 4

Indicator: Increase the Family Peer Support workforce

Baseline Measurement: Utah has 85 FPSS that have been certified.

First-year target/outcome measurement: The # of FPSS trained will increase by 20%

Second-year target/outcome measurement: The # of FPSS trained will increase by 20% more (total 40% increase).

Data Source:

UCLAPPS
USU (provides FPSS training)

Description of Data:

UCLAPPS is the Utah peer certification software for tracking all forms of OSUMH certifications.
A new dual certification provides expedited training to CPSS

Data issues/caveats that affect outcome measures:

Loss of the primary training agency and records in FY22.

Priority #: 5

Priority Area: Substance Use and Mental Health Training Opportunities

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

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

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase training opportunities to individuals in the public behavioral health system through the Core Principle training contracts

Baseline Measurement: Baseline: 0 Contracts are just being put into place for the Core Principle trainings

First-year target/outcome measurement: FY24: target of 1000 Behavioral Health workers receive training from the 5 Core Principle training contracts

Second-year target/outcome measurement: FY25: target of 1500 Behavioral Health workers receive training from the 5 Core Principle training contracts

Data Source:

Quarterly reports submitted from the 5 agencies awarded a Core Principle contact

Description of Data:

The 5 agencies that are awarded one of the Core Principle training contracts are required to submit monthly data reports on how many individuals working with individuals with SUD or MH. Quarterly reports must include Number of trainings provided in that quarter and number of individuals trained. Trainings are all EBP models; Integrated Care, MI, EBP Annual Conferences, ECHO Behavioral Health series, Trauma Informed Care

Data issues/caveats that affect outcome measures:

This RFP was a new training RFP for OSUMH. The 5 awardees are all at different stages of contracting. 2 contracts are in the process of signing, 2 contracts are still in writing and the other last on is still in discussion regarding details of the trainings, etc. Contracts have not been finalized for signature yet, but this will be done shortly. If there are any delays in contracting this could delay the delivery of trainings or reporting. Will required training for the contracts to submit the correct data.

Indicator #: 2

Indicator: Train Local Authorities on Structured Interview for Psychosis-Risk Syndromes (SIPS)

Baseline Measurement: 4 teams are currently trained to administer SIPS

First-year target/outcome measurement: 2 additional Local Authorities will be trained to administer SIPS

Second-year target/outcome measurement: 2 additional Local Authorities will be trained to administer SIPS (total of 4 LAs trained over 2

years)

Data Source:

OSUMH Youth-in-Transition team provide opportunities for training to Local Authorities.

Description of Data:

Only Local Authorities providing First Episode Psychosis care are trained to administer SIPS. SIPS training will not be included in the FEP MHBG set-aside as it is a prodromal tool.

Data issues/caveats that affect outcome measures:

Rural areas do not have the population base or workforce to provide a Coordinated Specialty Care team for First Episode Psychosis. These areas have also not been trained to recognize or screen for prodromal symptoms to improve early identification.

Indicator #: 3

Indicator: Development of a Forensic Peer Support (PSS) Training Program

Baseline Measurement: A curriculum has been purchased from Arizona and is being modified for Utah. Utah does not currently have a formal forensic peer support system.

First-year target/outcome measurement: A forensic peer curriculum will be established and an initial pilot training will be completed.

Second-year target/outcome measurement: 40 PSS will be trained with the Forensic PSS curriculum

Data Source:

UCLAPPS
The Forensic Peer Support Workgroup

Description of Data:

UCLAPPS is the Utah peer certification software for tracking all forms of OSUMH certifications.
The Forensic Peer Support Workgroup meets to modify a forensic curriculum purchased from Arizona.

Data issues/caveats that affect outcome measures:

This is a new program with a new curriculum. The peers to be trained must have lived experience with both behavioral health and criminal justice. Peers that are trained may struggle to obtain employment due to background issues.

Indicator #: 4

Indicator: Increase teams trained on Coordinated Specialty Care (CSC) for First Episode Psychosis (FEP)

Baseline Measurement: 4 teams are currently trained for CSC

First-year target/outcome measurement: Increase number of teams trained with CSC by 1 team.

Second-year target/outcome measurement: Increase number of teams trained with CSC by a second team.

Data Source:

OSUMH Youth-in-Transition team

Description of Data:

OSUMH 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.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	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) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$17,781,039.40		$20,898,564.00	$6,217,699.00	$19,302,403.00	$3,826,289.00	$1,595,972.00		$9,141,180.45	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$3,094,231.30		$7,209,526.00	$1,489,182.00	$5,317,373.00	$790,441.00	$290,557.00		$1,337,563.43	
b. Recovery Support Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$1,454,855.21	
c. All Other	$14,686,808.10		$13,689,038.00	$4,728,517.00	$13,985,030.00	$3,035,848.00	$1,305,415.00		$6,348,761.81	
2. Primary Prevention[d]	$6,457,728.00		$0.00	$1,012,328.00	$401,487.00	$152,868.00	$823,337.00		$5,630,000.00	$0.00
a. Substance Use Primary Prevention	$6,457,728.00		$0.00	$1,012,328.00	$401,487.00	$152,868.00	$823,337.00		$5,630,000.00	
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
6. Early Intervention Services for HIV	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$1,275,724.60		$0.00	$0.00	$0.00	$0.00	$0.00		$777,430.55	
12. Total	**$25,514,492.00**	**$0.00**	**$20,898,564.00**	**$7,230,027.00**	**$19,703,890.00**	**$3,979,157.00**	**$2,419,309.00**	**$0.00**	**$15,548,611.00**	**$13,428,346.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	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) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]		$231,000.00						$200,000.00		$0.00	
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$1,084,863.00						$347,812.00		$610,722.00	
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital											
8. Other 24-Hour Care								$0.00			
9. Ambulatory/Community Non-24 Hour Care		$8,447,901.00						$2,582,495.00		$7,963,851.00	
10. Crisis Services (5 percent set-aside)[f]		$542,431.00						$173,906.00		$1,217,390.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$542,431.00						$173,906.00		$210,856.00	
12. Total	**$0.00**	**$10,848,626.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$3,478,119.00**	**$0.00**	**$10,002,819.00**	**$1,033,760.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:
Our office has drawn $ for the COVID-19 relief funds as of 6/30/23 (BMHBGTX1)
Our office has drawn $ for the ARP funds as of 6/30/23 (BMHBARP1)

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's 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, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	1,000	250
2. Women with Dependent Children	20,000	2,855
3. Individuals with a co-occurring M/SUD	30,000	7,450
4. Persons who inject drugs	6,000	3,956
5. Persons experiencing homelessness	947	3,625

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

We do not have a good method of collecting the number for those that are in need and are homeless. The Department of Workforce Service, 2023 Utah State Homelessness Report found at https://jobs.utah.gov/homelessness/homelessnessreport.pdf (page 27) indicates data collected at point in time that there were a total of 947 SUD clients identified as homeless. We will continue to look for other methods to report In Need data for those with SUD and that are homeless. State TEDS data reports a total of 3,414 clients identified at admission as being homelessness.

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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$17,781,039.40	$7,686,325.24	$7,888,329.70
2 . Substance Use Primary Prevention	$6,457,728.00	$5,630,000.00	$4,868,599.00
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$0.00
5 . Recovery Support Services[5]	$0.00	$1,454,855.21	$0.00
6 . Administration (SSA Level Only)	$1,275,724.60	$777,430.55	$671,417.30
7. Total	**$25,514,492.00**	**$15,548,611.00**	**$13,428,346.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). 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 services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
2. Education	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
3. Alternatives	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
4. Problem Identification and Referral	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			

5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
6. Environmental	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
7. Section 1926 (Synar)-Tobacco	Universal	$0	$0	$0
	Selected	$0	$0	$0
	Indicated	$0	$0	$0
	Unspecified	$0	$0	$0
	Total	**$0**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$0**	**$0**	**$0**
Total SUPTRS BG Award[3]		**$25,514,492**	**$15,548,611**	**$13,428,346**
Planned Primary Prevention Percentage		**0.00 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$2,151,946	$1,504,566	$1,120,000
Universal Indirect	$1,704,042	$2,527,049	$1,888,000
Selected	$1,673,072	$78,709	$64,000
Indicated	$366,573	$11,129	$32,000
Column Total	**$5,895,633**	**$4,121,453**	**$3,104,000**
Total SUPTRS BG Award[3]	**$25,514,492**	**$15,548,611**	**$13,428,346**
Planned Primary Prevention Percentage	**23.11 %**	**26.51 %**	**23.12 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☑	☐	☐
Heroin	☑	☐	☐
Inhalants	☑	☐	☐
Methamphetamine	☑	☐	☐
Fentanyl	☑	☐	☐
Prioritized Populations			
Students in College	☑	☑	☑
Military Families	☑	☑	☑
LGBTQI+	☑	☑	☑
American Indians/Alaska Natives	☑	☑	☑
African American	☑	☑	☑
Hispanic	☑	☑	☑
Persons Experiencing Homelessness	☑	☑	☑
Native Hawaiian/Other Pacific Islanders	☑	☑	☑
Asian	☑	☑	☑
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [SUPTRS]

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$0.00	$0.00	$0.00	$1,838,912.00	$2,300,000.00
2. Infrastructure Support	$0.00	$0.00	$0.00	$0.00	$0.00
3. Partnerships, community outreach, and needs assessment	$205,000.00	$449,467.00	$0.00	$1,250,000.00	$1,668,599.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$0.00	$0.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$50,000.00	$27,500.00	$0.00	$0.00	$0.00
6. Research and Evaluation	$0.00	$0.00	$0.00	$80,000.00	$0.00
7. Training and Education	$280,000.00	$85,128.00	$0.00	$844,328.00	$1,500,000.00
8. Total	**$535,000.00**	**$562,095.00**	**$0.00**	**$4,013,240.00**	**$5,468,599.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Footnotes:

Planning Tables

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

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total			**$**	**$**

Please wait while data loads...

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. 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 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: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. 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 seriousness 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 detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

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

f) Persons with substance use disorders in the justice system

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

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

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

a) Adults with serious mental illness
There are four Prevention and Recovery of Early Psychosis (PREP) teams in Utah that provide Coordinated Speciality 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. These PREP teams are located in the most populated areas of the state and the Office of Substance Use and Mental Health is working to expand services to non-metro areas of the state.
b) Pregnant women with substance use disorders
The 13 Local Authority Substance Use and Mental Health Providers ensures 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 or 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 from other counties in their program.

OSUMH 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.
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 or minimal waiting lists for residential treatment services. Individuals on waiting lists for residential treatment services receive interim services until a bed is available.

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c) Women with substance use disorders who have dependent children
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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 from other counties in their program.

d) Persons who inject drugs
OSUMH identifies individuals who inject drugs as a priority population. Upon intake clients are asked if they have a history of IV use, in which 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. We also are utilizing early identification sites such as receiving centers, local hospitals and clinics to try and idenfiy 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 accross 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.

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.

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 OSUMH staff and biweekly meetings with Medicaid, OSUMH, and community stakeholders. OSUMH 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 integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. 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

a) Access to behavioral health care facilitated through primary care providers
The state supports the integration of care and provides TA to behavioral health providers upon request. A bill was passed in the 2022 legislative session that funded Collaborative Care start up costs for primary care practices in rural areas. OSUMH was tasked with awarding and overseeing the implementation of the programs.
b) Efforts to improve behavioral health care provided by primary care providers
The funding from the 2022 legislative session allows OSUMH to work more closely with primary care providers than in the past. OSUMH staff has collaborated with local content leaders to provide Collaborative Care Model TA, question and answer sessions, and other support as requested. OSUMH has a strong working relationship with the Office of Primary Care and Rural Health and support. OSUMH staff participate in a funding review committee to provide a behavioral health perspective. OSUMH staff participate in bimonthly Behavioral Health Integration Collaborative calls with local providers to discuss and address barriers to implementing behavioral health integration in primary care settings.
c) Efforts to integrate primary care into behavioral health settings

The State provides oversight for the Local Authority Substance Use Disorder (LSAA) and Mental Health (LMHA) providers, who integrate substance use disorder (SUD) and mental health (MH) services through direct service delivery or contracted services. They provide a continuum of services including prevention, treatment, outpatient treatment, and residential services. The LSAAs and LMHAs coordinate closely with physical health care providers, including Federally Qualified Health Care Centers (FQHCs) and Community Health Centers (CHCs), to provide integrated behavioral health and physical health care services.

The LSAA/LMHAs have behavioral and physical health care clinics integrated at levels from one through 6 of SAMHSA-HRSA's Center for Integrated Care Levels of Collaboration/Integration. Some examples of integration at higher levels are: (1) Fourth Street Clinic (physical health, mental health, substance use disorder treatment in Salt Lake City); (2) Odyssey House of Utah - Martindale Clinic; (3) Weber Human Services with an integrated health home (Level 6); (4) Bear River Health Department - SUD Treatment; (5) Summit Behavioral Health co-located with the Summit Health Department; (6) Wasatch Behavioral Health with Mountainlands Community Health Center in Provo; (7) Wasatch Behavioral Health, Workforce Services and Health Department co-located in Payson; (8) San Juan Counseling Center co-located with the San Juan Health Department ; and (9) St George Family Health Center provides a physical health and mental health provider at each clinic session. The LSAA/LMHAs also coordinate closely with Accountable Care Organizations, such as Intermountain Health Care (IHC) and Healthy U.

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

4. 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

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

a) Adults with serious mental illness. All Local Authorities are required to provide a continuum of care for individuals with serious mental illness. For those rural and frontier regions that do not have the capacity to provide higher levels of care, agreements are created between Local Authorities to ensure that all levels of care are available. Methods for care coordination are dependent on level of acuity with assertive community treatment teams in the most populated centers and intensive case management in less populated areas for those with high acuity needs. Care coordination provided through case management and peer support are funded with Medicaid dollars. Utah also has three urban receiving centers, two rural receiving centers in process, MCOT teams across the state, and a statewide warm line, in addition to the 988 statewide crisis line. It is expected that most individuals seen along the crisis continuum will receive a warm handoff to a lower level of care whenever possible. Peer support agencies are available for follow up after a crisis call, to provide support and ensure that the handoff was successful. Those agencies are funded by Medicaid and Block Grant dollars.
b) Adults with substance use disorders. 12 out of 13 of our Local Authorities are combined behavioral health providers in which SUD and MH services can be provided. In the one local authority that is not co-located they have SUD and MH available; it is just provided by two separate departments. Individuals are screened for MH and SUD needs and referred to recommended services such as physical health or behavioral health as indicated. These needs are continually screened throughout the episodes of care. Each Local Authority has access to the Local Health Department in which an individual can be provided to those identified as needing medical or physical care. There are also collaborative efforts with local medical clinics and FQHCs to provide physical care. Releases of information are collected to help with the coordination of care regarding physical care such as medical diagnosis, medications, etc. Coordination of care is funded from braided funding. Medicaid, Insurance, Block Grant, State funds and local funding are all used to support services with identified needs.
c) Children and youth with serious emotional disturbances or substance use disorders
Care coordination is required service provision of the LMHA for Medicaid members. The LMHA engages in regional care coordination with other child servicing agencies to support regionally driven care coordination. If a youth needs more intensive care coordination, a regional area may engage with High Fidelity wraparound support, if the youth meets the criteria. LMHA may partner with LEAs to support mental health screening, onsite behavioral health services or consultation services to support care coordination. DHHS approaches care coordination for DHHS served youth through a collaborative solution focused manner to address gaps and barriers to service access.

5. 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.

The State requires that the LSAA/LMHAs provide services on a sliding scale fee basis for individuals with SUD, MH and co-occurring SUD and MH disorders. They also offer services through insurance, Medicaid, SAPT and MH Block Grant funds, private grants and other funding sources. In addition, the State works closely with the Utah Medicaid Office, Accountable Care Organizations and the Association for Utah Community Health to ensure that various funding options are available for the public. The Utah Department of Human Services (DHS) also operates on a Systems of Care Approach, where individuals and their families are able to access services through various options and funding sources.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race ● Yes ○ No

b) Ethnicity ● Yes ○ No

c) Gender ● Yes ○ No

d) Sexual orientation ○ Yes ● No

e) Gender identity ○ Yes ● No

f) Age ● Yes ○ No

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

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

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

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

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

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

In 2021,OSUMH conducted a Health Disparities Needs Assessment which reviewed services being delivered across the public behavioral health system. It looked at four different populations: Black, Indigenous, and People of Color (BIPOC), People with Developmental Disabilities, Members of LGBTQIA+ community and Transition-Age Youth. In 2021 and 2022, each of the Local Authorities set and worked toward goals based on data for their specific site. We continue to use the results to help structure services as identified as needs and gaps in our system. Report found here: https://sumh.utah.gov/data-reports/health-disparities-report After conducting the needs assessment, OSUMH targeted funding towards the recommended needs of the assessment, and initiated an opportunity for each of the Local Authorities (LAs) to hire an equity and inclusion officer to oversee services. LAs are required to set health disparity goals specific to their community needs, and to review progress and additional goals within the LA annual area plans. Additional follow up reviews are being conducted and steps are being made to improve access and service delivery.

OSUMH has two staff positions targeting marginalized populations. A needs assessment has been conducted by a Deaf and Hard of Hearing specialist, and a statewide plan to address gaps and needs is being developed. An additional staff member has been hired to focus on individuals with behavioral health disorders and co-occurring intellectual disabilities/developmental disabilities (I/DD). This staff member is working with LAs to develop mental health liaisons for those individuals who have treatment needs across both the I/DD and MH/SUD systems, particularly children and youth.

As the certifying body for Peer Support certification, OSUMH has active contracts with two agencies to provide peer support specialist training for the Spanish-speaking population. One agency has trained 32 Spanish speaking Peer Support specialists within the last year. The second agency is ready to start training. In addition to the peer support efforts, covid-related block grant funds were used to target treatment and recovery support services to marginalized populations including Hispanic, Pacific Islander/Native Hawaiian, and refugee populations. A majority of the contracts developed during this time will be continued for ongoing services.

OSUMH is working to have all web based applications and documents conform to ADD standards including the block grant which has been difficult because of all the different formats and cell configurations.

Please indicate areas of technical assistance needed related to this section

OSUMH has been working to make all web-based applications ADD compliant. One of those documents is the SUPTRA application which has proven to be difficult because of the all the different fields and cell configurations. We have reached out to the SUD GPO to see if any other states have done this or if SAMHSA has looked at modifying the application to meet ADA standards which resulted in a negative. We would like to encourage or have assistance in restructuring the WebBGAS application so that we can have it we ADA compliant for review and publication. Thank you

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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

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

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

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

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

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

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

2. Which value based purchasing strategies do you use in your state (check all that apply):

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

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

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

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

Medicaid will pay an enhanced rate for services provided by an Assertive Community Treatment (ACT) team. ACT is an evidence-based practice designed to maintain SMI individuals at the lowest level of care possible within the community. Use of wrap-around services, including ACT, FAST, and SMR are a critical component of the Utah continuum of care.

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

OSUMH uses the feedback and guidance that it receives from the Utah Behavioral Health Planning Advisory Counsel to assist with identifying projects, programs, gaps and needs across our state and in our communities that need to be addressed. This helps us guide funding and ensure the best use of funds to serve our community.

With the merger of the Department of Health and Human Services, the Division of Integrated HealthCare which OSUMH is part of, we work in close collaboration with the Office of Medicaid under the same Division which allows us to coordinate and share data and hold discussions regarding Medicaid billing and payment to ensure we are working together. Staff from OSUMH and Medicaid meeting weekly to review billing issues or concerns and how to coordinate our efforts.

Utah has submitted a prior to release waiver in order to provide services to individuals within incarcerated settings 90 days prior to release. Much like the services currently being provided in CA. OSUMH will be working with the Department of Corrections and the medical staff within the Prison to identify and support those individuals that are in needs of services during this time period.

In 2023 the Department of Corrections Clinical Services Division (Mental Health) was moved from the Department of Corrections to DHHS. These services are now being overseen by DHHS to help increase access, care and service delivery as well as foster improved referrals and access to care as individuals transitions into society.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Coordinated Specialty Care	4

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
1084863	1084863

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

The four sites facilitating Coordinated Specialty Care (CSC) bill Medicaid for allowable services such as therapy and case management. There is not currently a bundled rate for CSC in Utah and services that are not Medicaid reimbursable are still facilitated by the CSC team to ensure fidelity to the model.

Components of CSC include: therapy, medication management, case management, peer support, and occupational therapy, psychoeducation (individual and family), supported employment (IPS).

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

The Utah Office of Substance Use and Mental Health (OSUMH) uses the 10% set aside funds to contract with three 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 was the pilot site for the 5% set aside, with expansion to Davis Behavioral Health and Wasatch Behavioral Health with the 10% set aside. Within the last year, Volunteers of America, Utah, a community service organization, has also introduced a CSC program.
Each of the LMHAs providing CSC services include the following components: Medication Management, Individual and Group Psychotherapy, Dialectical Behavioral Therapy, 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 provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

(●) Yes ( ) No

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

The four Coordinated Specialty Care (CSC) teams provide essential services to those clients identified as Clinical High-Risk of Psychosis (CHRP) and First-episode Psychosis (FEP). The essential services provided include therapy, case management, medication management, supported education and employment, peer support, and occupational therapy. Clients engaged with the CSC 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) as well as individualized relapse prevention plans.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

Programs at the primary pilot site (Weber Human Services) and the expansion sites (Davis Behavioral Health, Wasatch Behavioral Health, and Volunteers of America, Utah) will continue to be developed and refined. Ongoing training, coaching, technical assistance, and monitoring are provided 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.

Strategic Plan for FY 2024 and FFY 2025
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 and refer transition-age youth for services.
Objective 2: Racial/ethnic minority communities understand early psychosis and are able to identify and refer transition-age youth for services.
Objective 3: First responders (mobile crisis, law enforcement) and medical personnel understand early psychosis and are able to identify and refer transition-age youth for services.
Objective 4: Criminal/juvenile justice system personnel understand early psychosis and are able to identify and refer transition-age youth for services.
Objective 5: Child welfare system personnel understand early psychosis and are able to identify and refer transition-age youth for services.
Objective 6: Intellectual and Physical disability system personnel understand early psychosis and are able to identify and refer transition-age youth for services.
Objective 7: Families, young people, and natural supports understand early psychosis and are able to identify and refer transition-age youth for services.
Objective 8: General public understands early psychosis and the stigma associated with it is reduced and/or eliminated.
Objective 9: A program logo will be developed in the next 12 to 24 months to be used for social marketing and community education

purposes.

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: Engage in conversations with LMHAs on integrating early psychosis services into the Mental Health Centers Area Plan by 2025
Objective 2: Expand fully structured early psychosis program to at least one additional LMHA by 2025

Specific planned activities for FY 2024 and 2025 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)
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 with the 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 your state's ESMI/FEP programs.

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

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

OnTrack NY created a 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, and percentage agreeing to services, number of clients served per team, and average months in treatment. For Utah, with a population of 3,338,000 the incidence rate per year ranges from 501 (low estimate) to 1001 (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 with a first episode psychosis who need support from the public mental health system?

Technical assistance focused on transition-age youth will be coordinated with the local mental health authorities. Training will address 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. The 10% set aside funds will not be used for SIPS training.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

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

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. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

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 consumers and their caregivers in making health care decisions, and enhance communication.

OSUMH does not provide direct services to consumers. Office Directives created by OSUMH 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. OSUMH 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, and for 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 OSUMH 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, OSUMH 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 SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

OSUMH 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 on the monitoring in the past. OSUMH is including this question specifically in the monitoring process beginning in the SFY24-25 season.

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

None at this time.

Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and 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. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, 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 M/SUD 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 M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

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?

OSUMH will track requirements and provide technical assistance through the following mechanisms:
The OSUMH leadership meets with the 14 Local Authority Directors each month. There are also monthly meetings of the OSUMH with the Local Authority Prevention Managers, Finance Managers, Data Manager, Directors and Clinical Directors.
Annual on-site monitoring visits for each Local Authority, along with compliance checks.
https://sumh.utah.gov/providers/contracts-and-monitoring
Annual Office Directives training
Review of annual Area Plans and end-of-year Area Plan reports which include which EBP are being utilized.
Budget reviews are accomplished as part of the Area Plan Approval Process.
Claims/payment adjudication - Cost Reimbursement billings are reviewed by program administrators and finance managers prior to disbursement.
Expenditure report analysis - These are done periodically during the year with a wrap up at year end.
Client level encounter/use/performance analysis data - OSUMH uses Outcome Score Cards as well as information submitted to SAMHIS for ongoing analysis. https://sumh.utah.gov/data-reports/scorecards
Annual educational conferences funded by OSUMH (Generations Conference, Fall Substance Abuse Conference, UofU Addiction Update Conference, Critical Issues, Utah Valley Addictions Conference) Utah Peer Conference, include program presentations that

outline requirements for participation.
Data is being tracked on EBPs usage and EBPs are reviewed during the monitoring process and outlined annually in the LA Area Plans.

Please indicate areas of technical assistance needed related to this section

None at this time

Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

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

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

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

Please respond to the following items:

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

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

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

Issues include getting mental health services and substance abuse services in the frontier areas of Utah, including the Navajo and the Goshute Tribes. Transportation in these areas is a significant barrier, with two Local Authorities flying into remote regions weekly in order to provide services. Telehealth services can also be impacted as cell service can be unpredictable. There is also great concern about lack of healthcare and medical resources on reservations which have been greatly impacted by the pandemic.

The reservations have seen high infection and death rates due to COVID and still trying to mend from the pandemic. We also see high numbers of deaths related to substance misuse and mental health issues in tribal areas. OSUMH is working with the Local Authorities to address the needs of the tribal organizations within their catchment areas. Some of the Local Authorities have built good relationships with the tribes. We are also working with the State Department of Health that have been working with the tribes on medical, vaccinations and health care. We will be working with the Health Department to ensure services can be provided and to create stronger partnerships and address needs and gaps within the tribal communities.

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

On July 1, 2022, the Department of Human Services and Department of Health merged, resulting in the Utah Department of Health and Human Services. As part of the restructuring, a new Office of American Indian/Alaska Native (AI/AN) Health & Family Services has been created. This office reports directly to the DHHS Executive Director, emphasizing the importance of recognizing and being responsive to tribal issues.

OSUMH is working hard to ensure our state partners are working to increase access and care and to have additional internal discussions to address Medicaid and services provided by other state departments.

The State of Utah's State Opioid Response Dollars currently support two Tribal-focused opioid projects. One of the projects is in collaboration with Utah State University (USU), and the second is with the Utah Department of Health and Human Services (DHHS) AI/AN Office. The project with USU is community focused and aims to benefit the Ute Indian Tribe of the Uintah and Ouray Reservation, Navajo Nation, Paiute Indian Tribe of Utah, Northwestern Band of Shoshone Nation, Skull Valley Band of Goshute, and the Confederated Tribes of Goshute by providing training and educational opportunities. The DHHS project is a higher-level, state-wide project to create culturally appropriate educational materials and gather demographic, SUD, and overdose data.

In September 2023 OSUMH will host the SUD Fall Conference after a 3 year hiatus during the pandemic, during this time we have reached out to the tribal council to provide free scholarships and have also reached out in order to have presenters come present at the conference regarding services to tribal communities.

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

None at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use 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 target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

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) (●) Yes ( ) No

- **a)** [x] Data on consequences of substance-using behaviors
- **b)** [x] Substance-using behaviors
- **c)** [x] 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)** [x] Children (under age 12)
- **b)** [x] Youth (ages 12-17)
- **c)** [x] Young adults/college age (ages 18-26)
- **d)** [x] Adults (ages 27-54)
- **e)** [x] Older adults (age 55 and above)
- **f)** [x] Cultural/ethnic minorities
- **g)** [x] Sexual/gender minorities
- **h)** [x] Rural communities
- **i)** [ ] Others (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

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) ☐ Others (please list)

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?

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

Definition 1: It is included on Office of Substance Use and Mental Health approved Federal Lists or Registries of evidence based interventions
Definition 2: It is reported (with positive effects) in peer-reviewed journals
Definition 3: Documented effectiveness supported by other sources of information and the consensus judgment of informed experts, as described in the following set of guidelines, all of which must be met: (Please note that all four criteria must be met):
a. The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
b. The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
c. The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern or credible and positive effects; and
d. The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.
The Evidence-Based Workgroup will serve as the informed experts for Utah. The EBW developed a tier tool for providers and developers to identify which tier of effectiveness the program, policy or strategy might fit. In addition, there is a checklist for submission and a guidance document on how to submit for approval.
https://sumh.utah.gov/services/prevention/implement-an-evidence-based-program

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

6. Does your state integrate the National CLAS standards into the assessment step? ○ Yes ◉ No

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

b) If no, please explain in the box below.

During the assessment step we focus on ensuring that our student survey is easily read. It is written at a 6th grade reading level. Students have access to interpretation when needed. Through the trainings that we conduct, our providers are educated on how to be culturally competent while conducting an assessment, and are encouraged to include diverse populations in their assessment.

Utah is currently working on a plan to incorporate CLAS standards into assessment steps. We are working to ensure that each Local Authority has the ability to provide screening, assessment and treatment that meet culturally and linguistically appropriate services (CLAS) that will help improve the quality of services provided to all individuals. OSUMH has provided support and funding to the Local Authorities in order for them to higher equity and inclusion officers within their organizations. We will be working with these new positions to review and implement CLAS standards within each organization.

OSUMH strives to include provisions of health and equity into our current Results Based Accountability (RBA) plan which

is under revision. We do require each Local Authority to provide individualized services and service plans (Client Centered Planning) in which CLAS standards should be identified and that health services.

7. Does your state integrate sustainability into the assessment step? (●) Yes ( ) No

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

To ensure the sustainability of the assessment process within our prevention system we focus on collaboration with partners, ensuring buy-in from partners, and ensuring funding is sustainable. A key piece to our assessment is our student survey which we have ensured is funded through sustainable funding sources. Collaboration is another key aspect of sustaining our student survey. We have created an advisory board over the survey, are working with our communication team on developing clear messaging around the survey to enhance partner and community support, and we provide customized trainings around the data to build stakeholder support in the use of the data. To enhance data collection we have worked to build relationships with diverse populations including with our tribal communities. Our system is also built upon our Regional Director system which helps sustain all of the SPF process including assessment by being a resource for training and technical assistance to communities on the SPF.

b) If no, please explain in the box below.

None at this time.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use 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 target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

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.

Utah has a certification program of Substance Use Prevention Specialist Training. (SAPST). All contracted prevention professionals are required to have SAPST certification.
Through the Association of Utah Substance Abuse Professionals, prevention specialists can become a licensed prevention specialist with the International Certification and Reciprocity Consortium.

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 technical assistance through Regional Directors (RD). RDs meet with local providers and does a review with them to identify needs. RDs communicate needs with the Office to provide necessary TA. OSUMH coordinates the delivery of several SAPST throughout the year, and sponsors an annual conference.

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.

The State supports and local providers use the Tri Ethnic Center model to assess community readiness to implement prevention strategies.

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

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

The trainings that we provide educate on cultural competence and how to engage all sectors and members of the community in the prevention process. As our system works to build resources and readiness, we take into account the diverse population within our state and how we can engage with them in prevention work.

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

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

Part of our capacity is around supporting and implementing Community Centered Evidence-Based Prevention (CCEBP),

which centers around our Regional Director (RD) system. We have built the capacity of this system by ensuring the funding used for those positions is long term sustainable funding. This allows us to have the capacity to implement CCEBP. The trainings that we provide to educate the prevention system are also provided with sustainable funding, these trainings include the Universal Prevention Curriculum training, and trainings offered through our PTTC. We also have several trained SAPST instructors to ensure that we can provide that training to all prevention staff across the state.

b) If no, please explain in the box below.

None at this time.

Narratve Question

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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 BGAS by going to the **Attachments Page** and upload the plan.

Plan created in 2023.

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

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

- **a)** [ ] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [x] Timelines
- **c)** [x] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [ ] Cultural competence component (i.e., National CLAS Standards)
- **g)** [ ] Sustainability component
- **h)** [ ] Other (please list):
- **i)** [ ] Not applicable/no prevention strategic plan

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

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with 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

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

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The Evidence-Based Workgroup will serve as the informed experts for Utah. The EBW developed a tier tool for providers and developers to identify which tier of effectiveness the program, policy or strategy might fit. In addition, there is a checklist for submission and a guidance document on how to submit for approval.
https://sumh.utah.gov/services/prevention/implement-an-evidence-based-program

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

7. 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?

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8. Does your state integrate the National CLAS Standards into the planning step? (●) Yes ( ) No

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

Trainings we provide educate on being culturally competent as communities plan the strategies they will be implementing. We educate our providers on the importance of working with tribal and other diverse communities.

b) If no, please explain in the box below.

n/a

9. Does your state integrate sustainability into the planning step? (●) Yes ( ) No

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

As part of the SAPST training that our providers are required to take, prevention specialists are educated on how to sustain the planning process in their communities. Our RD system is provides communities with the training and technical

assistance need to sustain a planning process at the community level. Our prevention system relies upon CCEBP (community coalitions), and other funding, including the opioid settlement dollars have been acquired to sustain that process.

b) If no, please explain in the box below.

n/a

Narratve Question

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

Implementation

1. States distribute 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:

Know Your Script, Parents Empowered, Grey Matters, Community Awareness Events, Conferences, EveryDay Strog, School and Community Presentations

b) Education:

All Stars, Botvin's LifeSkills Training, Prime for Life, Strengthening Families Program, Catch My Breath, Parenting Wisely, Guiding Good Choices, Good Behavior Game, Why Try, Learning to Breathe, Circle of Security Parenting, Love and Logic, Active Parenting, Kids with Incredible Potential, Keepin? It REAL, Positive Action, Nuevo Dia–Strengthening Families Program, Protecting You, Protecting Me, Too Good for Drugs and Violence, Project Towards No Drug Abuse, Systematic Training for Effective Parenting (STEP), Second Step, Overcoming Obstacles, Retailer Education, 3rd Millenium Classroom, Voices, Sacred Paths, Youthworks.

c) Alternatives:

Big Brother, Big Sisters Mentoring, SPORT Prevention + Wellness, Afterschool Programs, Girls on the Run, Spy Hop

d) Problem Identification and Referral:

Personal Empowerment Program

e) Community-Based Processes:

Community Coalitions, Communities that Care, Youth Coalitions, Governing Youth Council, Statewide Prevention Networking

f) Environmental:

Alcohol Compliance Checks, Rx Drug Drop Boxes/Take Back Events, Synar, Shoulder Tap

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) If yes, please describe.

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

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

The SAPS Training that we provide educates providers on the need to be culturally competent as chosen prevention strategies are implemented. Other training opportunities have focused on the importance of advertising and delivering programs in a culturally acceptable way, including taking into account how materials are translated and disseminated. Our communication team has helped ensure the media campaigns we implement effectively reach the Spanish population.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

At a state level our role in sustaining implementation has focused on the training that we provide. Over the last several years the state has sustained the implementation of the CTC/coalition process through contracting with SDRG to ensure our communities have access to CTC materials and coaching. We also have state trainers of trainers for the SAPST curriculum and Guiding Good Choices Program. As a state we build partnerships for the implementation of prevention programs and strategies, and are continually looking for additional funding sources to sustain efforts. Our prevention system worked to obtain Opioid Settlement Dollars which will sustain the implementation of CCEBP moving forward.

b) If no, please explain in the box below

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use 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 target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

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

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 BGAS by going to the **Attachments Page** and upload the plan.

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

- **a)** ☐ Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** ☐ Includes evaluation information from sub-recipients
- **c)** ☐ Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** ☐ Establishes a process for providing timely evaluation information to stakeholders
- **e)** ☐ Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** ☐ Other (please list:)
- **g)** ☑ Not applicable/no prevention evaluation plan

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

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

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

- **a)** ☑ 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** ☑ Heavy use

c) ☑ Binge use

d) ☐ Perception of harm

e) ☑ Disapproval of use

f) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

g) ☑ Other (please describe):

Vaping

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

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

As part of the evaluation that we do, we collect demographic data and evaluate whether or not we are providing services to diverse populations across the state. We also provide trainings that educate on being culturally competent through all of the SPF steps including the evaluation step.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

The RD system that we have in place, through sustainable dollars, helps our providers with training and technical assistance around evaluation. Because our RD system is stable and sustainable, our providers evaluation efforts remain sustainable even as they experience staff turnover.

b) If no, please explain in the box below.

Footnotes:

Strategic RBA Plan

EXECUTIVE OFFICE: Office of Substance Use and Mental Health (OSUMH)
Substance Use Disorder Prevention

PLAN PERIOD: FY24

Objective 4: Reduce the misuse of alcohol and other drugs	**Associated Indicators/Performance Measures:** • Decrease 30 Day Alcohol Use - all grades by 10%, 4.3% to 3.87 by 2025 • Decrease 30 Day E-cigarette use among youth - all grades by 10%, 6.3% to 5.67% by 2025 • Maintain Prescription Drug Use among youth - all grades at 1.7% through 2025 • Maintain Youth 30 Day Cannabis Use - all grades at 4.5% through 2025
	Secondary Measure: • Increase CCEBP by 20% from 14.8% of communities at "established, health strong coalition level" to 17.76 communities by 2024. (Defined from Area Plan and coalition rating tool)

Alignment:		Responsible Unit: Substance Use Disorder (SUD) Prevention Team Leader(s):
Tactic 1:	Support, manage, and update the SHARP survey. This includes managing the contract and quality control, working with stakeholders, and providing trainings in using SHARP data (roadshow, offered to all LSAAs, and coalitions and general public).	In Process
Tactic 2:	Facilitate local prevention planning and implementation of best practices based on local data through training, technical assistance, and coaching on the Strategic Prevention Framework ● Communities that Care (CTC) ● Substance Abuse Prevention Specialist Training (SAPST, at least quarterly) ● Universal Prevention Curriculum (at least quarterly) ● Motivational Interviewing	In Process
Tactic 3:	Increase number of community coalitions by providing training and technical assistance to local authorities to determine where additional coalitions are needed (assessment and gap analysis)	In Process
Tactic 4:	Increase number of coalitions functioning at high quality (increase by 20%) by providing trainings, technical assistance, and coaching to Utah's prevention system using coalition assessment tools.	In Process

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

OSUMH operates under four guiding principles:
Systems, services, programs, activities, strategies, and policies should be trauma-informed, evidence-based, sustainable and culturally and linguistically competent.
Trauma-Informed: Most individuals with mental health and substance use disorders are also dealing with trauma issues. OSUMH recognizes the prevalence of trauma and takes a universal precautions position. Trauma affects all individuals involved, including staff and the local workforce. OSUMH is working to ensure that all aspects of its system recognize the impact of trauma and make every effort to avoid re-traumatization. OSUMH will continue in its efforts to promote the use of trauma-informed care and trauma specific services through training and technical assistance for the local authorities and community partners.
Evidence-based Practices: Utah's publicly funded behavioral health system is committed to provide the best possible services to individuals, families and communities. OSUMH provides training and consultation designed to promote evidence based practices. "Evidence-based" stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.
Sustainable: Utah's Publicly funded system must be sustainable over time and be organized to provide a stable level of services.
Culturally and Linguistically Competent: OSUMH believes all aspects of behavioral health services should recognize and adapt to reflect the diversity of Utah's individuals, families and communities. Individuals possess diverse cultural, economic, social backgrounds, values, beliefs, sexual orientations, ethnicity, religion, and languages. To be effective, behavioral health services need to be culturally and linguistically competent.

OSUMH has set the following priorities to emphasize specific goals and strategies in the coming years:
• Focus on prevention and early intervention
• Zero suicides in Utah
• Promote a recovery-oriented system of care led by people in recovery that is trauma informed and evidence-based
• Improve the system of care for children and youth
• Promote integrated healthcare

Sub State Organization: Utah State Statute specifically mandates the Local Substance Abuse Authorities (LSAA) provide a "continuum of services for Adolescents and Adults" aimed at substance abuse prevention and substance use disorder treatment. Utah's Local Mental Health Authorities (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 new 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 OSUMH. 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 misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	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.)

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

3. Describe your state's case management services

Case managers (CM) are certified by OSUMH and provide a Medicaid billable service to adults with SMI and children with SED. Case management provides coordination, advocacy, linking and management for individuals in treatment. It is a service that assists clients to gain access to needed medical (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 Mental Health Authorities throughout the State of Utah.

OSUMH is in the process of revising 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 10 mandated services, such as inpatient care, residential care, outpatient care, 24 hour crisis care, psychotropic medication management, case management, community supports, services to unfunded individuals, consultation and education services, and services to people incarcerated in county jails or other county correctional facilities. These all provide the support necessary to

help individuals with SMI remain stable in the community and to return to the community after a psychiatric crisis. In addition, many of the Local Mental Health Authorities (LMHA) 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 LMHAs provide day programs with psychosocial rehabilitation programs for individuals with SMI.

Utah's largest county provides a robust crisis response system including crisis lines, warm lines, mobile crisis outreach teams, and a receiving center to provide immediate support and stabilization with the goal of keeping people stable in the community. This system works closely with law enforcement (CIT officers), Fire, and EMS to provide crisis response and to connect with outpatient services. All the crisis services utilize Peer Support Specialists (with Peers in recovery) to promote connectedness, social interaction, and encourage individuals to take responsibility for their treatment and recovery. If hospitalized, the Peer Bridger program helps individuals in an inpatient setting to step out of inpatient and follows them for two weeks post hospitalization, to provide the support necessary to connect with outpatient services 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 Speciality 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 Office of Substance Use and Mental Health is working to expand services to non-metro areas of the state.

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

none 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

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	144,903	20300
2.Children with SED	131,892	10,500

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.

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

none at this time

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDEA	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion 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

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

none at this time.

**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.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

In Utah, 9 of 13 Local Authorities are classified with regions that are rural or frontier. In SFY21, 31% 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 10 mandated services to their consumers, including psychiatric inpatient care, residential care, outpatient programs, medication management, 24 hour crisis care, psychosocial/psychoeducational rehabilitation programs, case management, community supports, services for incarcerated individuals and services for unfunded individuals. In some cases, particularly inpatient and residential care, rural Local Authorities will subcontract services from urban centers where more resources are available. One of the rural Local Authorities in the Northern part of the state has received funding for a no-refusal receiving center. A second rural Local Authority in central Utah has just received approval to receive funding for a no-refusal receiving center. 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, OSUMH 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 targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

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, including one staff member who sits on the board of the Balance of State. 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,the LMHAs provide an array of services from outreach and engagement, case management, EBPS in mental health and substance use treatment, 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 Homeless Coordinating Committee.

OSUMH 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 targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

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.

OSUMH 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 Department of Health who administers the Aging Waiver: This waiver is designed to provide services statewide to help older adults remain in their homes or other community based settings. Individuals are able to live as independently as possible with supportive services provided through this waiver program. Waiver services may include:

Adult Companion Services
Adult Day Health Services

Case Management
Chore Services
Community Transition Services
Emergency Response Systems
Environmental Accessibility Adaptations
Fiscal Management Services
Home Delivered Supplemental Meals
Homemaker Services
Medication Reminder Systems
Non-medical Transportation
Personal Attendant Program Training
Personal Attendant Services
Personal Budget Assistance
Respite Care Services (May Be Provided in Long Term Care Settings)
Specialized Medical Equipment
Supportive Maintenance Home Health Aide

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

none at this time.

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.

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 for SAMHSA 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 or underserved 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 SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

OSUMH 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 Mental Health Authorities to provide individual crisis response services to those who are unfunded.

b. 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 270 registered users who are utilizing DHHS Zoom access to provide services.

Additionally, Utah used ARPA funding to supply schools with telehealth kits. The Utah Education and Telehealth Network (UETN) provides school nurses with telehealth technology, in order to perform virtual visits and assess the health of students remotely. UETN has delivered approximately 175 telehealth kits to 21 rural school districts. The goal of this project is to reduce the amount of time school nurses spend traveling to visit each school and improving access to care and the overall health of students in Utah.

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

none at this time.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required 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

i)	Screening	Yes / No
ii)	Education	Yes / No
iii)	Brief Intervention	Yes / No
iv)	Assessment	Yes / No
v)	Detox (inpatient/residential)	Yes / No
vi)	Outpatient	Yes / No
vii)	Intensive Outpatient	Yes / No
viii)	Inpatient/Residential	Yes / No
ix)	Aftercare; 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. 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). During the COVID-19 Pandemic, monitoring was conducted through telehealth. Now OSUMH is providing monitoring through a hybrid approach using telehealth and visits in person as needed.

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)** Syringe services programs, if applicable — (•) Yes ( ) No
- **e)** 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, LGBTQI+, 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. The Local Authorities also conduct interagency monitoring and are encouraged to conduct NIATx reviews of their own agency and procedures. The state also reviewed data submissions, conducts monthly meetings with Directors and Clinical Directors and provides TA if requested or required. Based on the findings from the annual monitoring visits a report is written and provided that outlines any areas of concern to be addressed and a written response is required on how the issue will be resolved. Areas identified as problems can result in a finding, the findings range from recommendations, Minor/Significant/Major Non-compliance issues that require action plans.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — (•) Yes ( ) No

2. 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

Syringe Service Programs

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(42 U.S.CÂ§ 300x-31(a)(1)F)? ◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ◉ Yes ○ No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

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

Criterion 8,9&10

Service System Needs

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

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

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ( ) Yes (●) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — ( ) Yes (●) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — ( ) Yes (●) No
- **f)** Explore expansion of services for:
  - **i)** MOUD — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — ( ) Yes (●) No

Service Coordination

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

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

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — ( ) Yes (●) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — ( ) Yes (●) No

Charitable Choice

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

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — ( ) Yes (●) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

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

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

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — ( ) Yes (●) No

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

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) 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.

13 Local Substance Abuse Authorities (14 Local Authorities all together including MH authorities) and the Department of Corrections all participate in an annual peer review process. They each conduct Peer to Peer Reviews on one another annually, giving feedback verbally and written. These Peer reviews are used to make changes to improve quality, service delivery, efficiency and overall system improvement. We also include the Department of Corrections in our Peer Review. The peer review committee 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 % of providers annually for peer review.

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

a) Development of a quality improvement plan — ( ) Yes (●) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

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

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

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

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

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

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

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

Professional Development

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

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

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

c) Performance-based accountability: ◉ Yes ○ No

d) Data collection and reporting requirements ◉ Yes ○ No

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

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

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

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

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

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

a) Prevention TTC? ◉ Yes ○ No

b) Mental Health TTC? ◉ Yes ○ No

c) Addiction TTC? ◉ Yes ○ No

d) State Targeted Response TTC? ◉ Yes ○ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

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

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ 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

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

At this time the state has not established a need to request a waiver for the above. The state can meet the requirements at this time.

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

11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ○ Yes ◉ No

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

None at this time.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

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

[2] *Ibid*

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

1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	(•) Yes ( ) No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	(•) Yes ( ) No
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	(•) Yes ( ) No
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	(•) Yes ( ) No
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	(•) Yes ( ) No
6.	Does the state use an evidence-based intervention to treat trauma?	(•) Yes ( ) No

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

(1) Policy / Plan for how the Office of Substance use and Mental Health (OSUMH) addresses individuals with trauma-related issues for M/SUD Providers.
OSUMH addresses individuals with trauma-related issues for M/SUD providers through their Strategic Initiatives, which are detailed in division policies, systems and programs, and activities to achieve legislative mandates, which include:

Focusing on prevention and early intervention
Developing a recovery-oriented System of Care, led by people in recovery, that is trauma-informed and evidence-based
Strengthening the system of care for children and youth that is family-driven, youth guided, and community based to make sure that it is culturally/linguistically competent
Encouraging integrated programs that address an individual's substance use disorder, mental health, and physical healthcare needs
Promoting Zero suicides in Utah

OSUMH's Scope of Responsibility ensures that trauma-related issues and other services are provided for M/SUD providers, which are outlined in Utah State Code Annotated (§62A-15-103):

Ensuring that prevention / treatment services for substance use and mental health are available throughout the state
Contracting with local county governments statutorily designated as local substance use and mental health authorities, to provide prevention or treatment services
Providing oversight and policy direction to local authorities.
Monitoring and evaluating mental health and substance use services through an annual site review process, reviewing local area plans, and program outcome data
Providing technical assistance and training to local authorities, including the evaluation of the effectiveness of prevention and treatment programs to share information with stakeholders
Supervising the administration of the Utah State Hospital

(2) How OSUMH provides information on trauma-specific assessment tools and interventions for M/SUD Providers.
OSUMH has been providing ongoing training and consultation for public and private providers across the state of Utah since 2009 regarding the following trauma specific assessment tools: (1) Creating Cultures that Care: An Assessment and Planning Protocol (2) Developing Trauma-Informed Organizations: A ToolKit (3) Screening and Assessment | The National Child Traumatic Stress Network (4) Adverse Childhood Experiences (ACES) Female and Male Version of Questionnaire
Trauma-Informed Utah (TIU) is contracted with OSUMH to provide training and technical assistance on the following trauma-specific assessment tools and resources, which are available to the public on their website:
Using Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision (nctsn.org)
Secondary Traumatic Stress Core Competencies in Trauma-Informed Supervision Self-Rating Tool
Professional Quality Life Scale
Taking Care of Yourself Assessment (nctsn.org)

(3) How OSUMH provides information on trauma-specific treatment and interventions for M/SUD providers.
OSUMH has been providing ongoing training and consultation for public and private providers across the state of Utah since 2009 regarding evidence-based trauma specific interventions, through the following training events and conferences:
Trauma Recovery and Empowerment Model for Women and Girls
Trauma Recovery and Empowerment Profile
Trauma-Recovery and Empowerment Model for Men
Seeking Safety
Beyond Trauma: A Healing Journey for Women
Helping Women Recover: A Program for Treating Addiction
Healing Trauma: A Brief Intervention for Women
Voices: A Program for Self-Discovery and Empowerment for Girls
Helping Men Recover: A Program for Treating Addiction
Exploring Trauma: Brief Intervention for Men
Utah Trauma Academy
Utah Fall Substance Abuse Conference
Critical Issues Facing Children and Adolescents
Generations Conference
Troubled Youth Conference
Trauma-Informed Care Training by OSUMH staff to various organizations
Addictions Update Conference

(4) OSUMH's plan for building the capacity of M/SUD Providers and organizations to implement a Trauma-Informed Approach.
OSUMH has worked with Dr. Stephanie Covington, Gabriella Grant, MA, Director of the Center of Excellence for Trauma-Informed Care and Treatment Innovations to receive ongoing training and consultation on trauma, Trauma-Informed Approach and Seeking Safety. OSUMH is also working with the Utah Department of Health and Human Services (DHHS) and community partners to further efforts on the Trauma-Informed Approach through the implementation of policies, procedures and statewide training and consultation on Trauma-Informed Supervision and program evaluation.
Utah is working on becoming a Trauma-Informed State through various efforts, the initiation of the committee - Resilient Utah, which ran for 5 years until Trauma-Informed Utah (TIU) became established. The TIU is a 5013C tax-exempt not-for-profit organization. The TIU provides training, technical assistance and resources to providers on trauma and the Trauma-Informed

Approach. More information can be found at Trauma Informed Utah
OSUMH is contracting with Trauma-Informed Utah to provide training and technical assistance for the Utah Department of Health and Human Services on the implementation of the Trauma-Informed Approach in their organizations.
OSUMH also provides training and resources on the Trauma-Informed Approach and trauma which are available to the public on their website: Trauma Informed Approach Training | SUMH (utah.gov).

(5) OSUMH's Encouragement Employment of Peers with Lived Experience of trauma in developing Trauma-Informed Organizations.
Utah has developed a Certified Peer Support Specialist program which includes course materials, code of Ethics, ongoing Continuing Education Credits (CEU's), Certification application, etc. For more details go to Peer Support | SUMH (utah.gov).
There are Peer Support Specialists located at all 13 Local Substance Use and Mental Health Authorities that have lived experience of trauma who have been assisting with the development of Trauma-Informed Organizations. For example, Four Corners Behavioral Health is one of the local authorities that has been working on the implementation of the Trauma-Informed Approach in their agency over the past several years, where they have incorporated Peer Support Specialists and various staff members to help with these efforts.

(6) OSUMH's use of evidence-based intervention to treat trauma.
All 13 Local Authorities are using the following evidence-based interventions to treat trauma:
Trauma Recovery and Empowerment Model for Women and Girls
Trauma Recovery and Empowerment Profile
Trauma-Recovery and Empowerment Model for Men
Seeking Safety
Beyond Trauma: A Healing Journey for Women
Helping Women Recover: A Program for Treating Addiction
Healing Trauma: A Brief Intervention for Women
Voices: A Program for Self-Discovery and Empowerment for Girls
Helping Men Recover: A Program for Treating Addiction
Exploring Trauma: Brief Intervention for Men

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

None at this time.

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. (●) Yes ( ) No

Implementing screening and assessment tools that are linguistically appropriate. Training staff on health disparities and trauma informed care. looking at data in regards to racial and ethnic populations being placed in incarcerated settings and then transitioning out into the behavioral healthy system vs other populations and retention, recidivism rates for those populations. Providing racial and cultural sensitive recover support services. Looking at populations being referred or seeking services vs other populations, why are they different, how can we address their concerns vs their needs and change stigma and beliefs. The state has provided funding to the Local Authorities to hire health disparities officers. This will help address health disparities within the public behavioral health system.

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

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

In FY15 Utah legislatures passed the Justice Reinvestment Initiative (JRI) for adults and in FY17 HB 239 Juvenile Justice Reform was passed. The State has been working with community partners to enhance diversion, re-entry and integration of care. The legislature also passed requirements for OSUMH to oversee program certification for all agencies treating individuals that have been compelled to seek behavioral health services; this also encourages the use of Evidence Based screening and assessments

tools and the use of EBP to fidelity. In 2020 a Justice Reinvestment audit was conducted, the results indicated a few key factors that need improvement such as better data collection across agencies for individuals involved in criminal justice, ongoing use of criminogenic screening tools across the system. OSUMH is committed to addressing these concerns and has already implemented 2 new screening tools including the LSI-R:SV and the SURE tool. The Substance Use Recovery Evaluator Tool from Kings College of London was implemented in early 2023 as a Recovery tool to address changes in an individual's recovery and establish communication regarding trends or changes in their behaviors. OSUMH and other agencies are working on MOU's for the purpose of data sharing. In the 2023 legislative session the certification requirement for JRI provider certification was rescinded. Although this required agencies to follow certain standards and has since been rescinded our office is still working with private and public providers to ensure EBP and Best Practice Standards are still being conducted. We also work in conjunction with the Department of Professional Licensing and the Office of Licensing and Background Checks to help conduct monitoring of these agencies and practices.

Utah has increased Mobile Crisis Outreach Teams (MCOT) for SUD and MH in Counties areas across the state. Existing locations include:) As of August 2023, planned five open receiving centers with two more in the process of opening, with opening dates sometime in 2023. Additionally, one more Receiving Center will be established through a RFP process that is currently under review. Furthermore, two more Receiving Centers that are in process for petitioning legislative support to develop receiving centers. All which are throughout the state.

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 (opening August 2023) serving Salt Lake County. Additionally, in 2023 we anticipate the opening of a Receiving Center as operated by Four Corners Behavioral Health which will serve Carbon, Emery and Grand Counties and Southwest Behavioral Health Receiving Center, which will serve Washington, Iron, Kane, Garfield and Beaver counties.

The rural receiving center yet to be awarded, will be located in another county of the 3rd class. Three rural providers have expressed interest to pursue receiving center development, two of whom have outstanding requests to the Behavioral Health Crisis Response Commission to support requests for state general funding for such. All programs, existing, developed and to be awarded, are expected to serve both community and law enforcement referrals and act as zero refusal crisis stabilization units.

The state has also hired several forensic evaluators the perform forensic evaluations for Youth and Adults.

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

Technical assistance would be welcomed to address the intersection of criminal and juvenile justice to include with rural areas of our state, ID/D, and problematic sexual behavior.

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Footnotes:

Environmental Factors and Plan

14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** [x] Methadone
- **b)** [x] Buprenophine, Buprenorphine/naloxone
- **c)** [x] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [x] Naltrexone (oral, IM)
- **f)** [x] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? (●) Yes ( ) No

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

The state does not directly purchase medications as indicated in #3, however we do allow providers to utilize Block grant and other state funding to purchase these for individuals they are providing serviced to.

OSUMH coordinates with the following organizations to ensure that education and Quality Assurance (QA) is provided on MOUD and FDA-Approved medications for Utah State Opioid Treatment Providers and Office Based Opioid Treatment Providers:

Education on Evidenced-Based MOUD:
(1) Utah Department of Health and Human Services Licensing
(2) Commission on Accreditation of Rehabilitation Facilities (CARF)
(3) Joint Commission on the Accreditation of Healthcare Organizations (JACHO)
(4) Department of Professional Licensing, DOPL, Academic Detailing for prescribers, Pharmacy Board and the Controlled Substance Database (the Utah PDMP)
(5) Drug Enforcement Administration (DEA)

The State Opioid Treatment Authority (SOTA) hosts quarterly Opioid Treatment Provider Meeting (OTP) to address MOUD and OTP functions, collect quarterly and annual data and outcome reports to ensure ongoing quality of care. The State has also contract with a provider to conduct Naloxone Trainings and Train the Trainer (TOT) education. Through the Federal Opioid Grants, the State works to collaborate closely with the Opioid Treatment Providers, Accountable Care Organizations, Federally Quality Health Care Centers, Local Substance Use Authority and Mental Health Providers and the private sector to address the opioid epidemic through coordination of care, training, technical assistance.

1. Opioid Treatment Providers: There are 19 Opioid Treatment Providers (OTP's) throughout Utah that provide medication-assisted treatment (MAT) for individuals diagnosed with opioid-use disorders. They serve approximately 5000 individuals each year. At least eight clinics currently contracted with their local authority to provide services to the public system. All of the OTP's are enrolled as Medicaid providers. The Salt Lake County jail has implemented the first methadone program in an incarcerated setting within Utah. Utah also has 2 mobile methadone clinics that are operating in rural areas of the state.
2. Opioid Community Collaborative: IHC, Davis, Salt Lake and Weber County have an Interdisciplinary approach to providing MOUD for pregnant women, women between 20-35, individuals who are homeless and those with complex medical needs.
3. Salt Lake County Extended Release Naltrexone Pilot: Salt Lake County, Midtown health Clinic, Utah Department of Corrections One of the largest jail MOUD programs in Country (248 Participants). The first shot administered within County jail.
4. Certified Peer Support Specialists are offered an Integrated Care Enhancement, a 12 hour training focused on supported clients as they manage the combination of behavioral health and physical health challenges.
5. OSUMH received a Primary Care and Behavioral Health Integration grant from SAMHSA. The grant provides funding to three Local Authorities (urban and rural) and has multiple goals related to system change to improve integrated services.
6. One of the LSAAs, Summit County, has partnered with a local pediatrics office to provide the primary prevention parenting program, Systematic Training for Effective Parenting (STEP). They have reached over 2,000 people in a smaller county. The initiative has also decreased the stigma that those who attend parenting programs are "failing."

The State is working with the Department of Corrections and the Utah State Prison to provide vivitrol prior to release to Parolees at the Utah State Prison. This is a project that the State has been working since 2020.

OSUMH supports all FDA approved medications for the use of treating Substance Use Disorders.

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (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 evidenced-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 expend 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 expanding 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 will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-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 service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, 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 this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis 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 (OSUMH) 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 partial assumption of Utah based texts and chats.

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 SAMHSA 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 SAMHSA*

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.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. 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 first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:

- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. 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 talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☑	☐
Safe place to go or to be	☐	☐	☐	☑	☐	☐

b. Briefly explain your stages of implementation selections here.

Someone 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

3. Based on SAMHSA's National Guidelines for 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.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

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.

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

None at this time.

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

None at this time.

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

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 funding of recovery support services?	(•) Yes ( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(•) Yes ( ) No

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 OSUMH for many years. OSUMH 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. OSUMH also contracts with National Alliance for Mental Illness (NAMI), 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) andU tah 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

OSUMH 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.

OSUMH 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 OSUMH 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. OSUMH 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?

OSUMH has initiated a Peer Support Steering Committee that meets each month. 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 OSUMH 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. A second community-based committee, All Things Peers, has representation on the steering committee and serves as a working group. All Things Peer is not an OSUMH committee. The group meets monthly and is composed of peer leaders in Utah, with a focus on creating a statewide Peer plan.

The Utah Substance Abuse Advisory Council (USAAV) and Utah Behavioral Health Planning Advisory Council (UBHPAC) consist of members of the community including family/Peers and individuals in recovery. UBHPAC reviews the State's Office Directives,

Strategic Plan, and Block Grant application. They provide insightful feedback and advice on priority initiatives they would like to see addressed. PSS meetings and webinars are hosted, during which Peers give input on system implementation and changes.

OSUMH provides funding for Peer Support Specialist (PSS) training programs. OSUMH has also emphasized the use of Peer Support Specialists at each Local Authority. All Local Authorities have Peer Support Specialists and/or Family Peer Support Specialists on staff, and some use peer volunteers that assist with local MH/SUD system evaluations and input. OSUMH conducts Clubhouse and Day Program visits annually, including focus groups consisting of Peers who are encouraged to provide feedback regarding the MH/SUD system.

OSUMH works closely with the Peer organizations in Utah including the National Alliance on Mental Illness, Utah Substance Abuse Recovery Advocates (USARA), Latino Behavioral Health Services, Multicultural Counseling Center, Asian Association of Utah, Utah American Foundation for Suicide Prevention (AFSP), Utah Association of Peer Support Specialists UAPSS), Utah Peer Network (UPN), Mental Health America-Utah (MHA-Utah)and Peers working with the National Guard and Veteran Affairs Medical Center. Local Authorities also host alumni groups for individuals that have completed treatment in Drug Court programs for feedback and input. SAMHSA grants are also used to develop Peer-driven recovery supports in conjunction with other programs, including supports for those receiving higher levels of wrap-around care (Assertive Community Treatment, Assisted Outpatient Treatment), integrated care programs, and development of near-age peer support for youth-in-transition.

We expanded the funding of Recovery Support services with the use of Block Grant Supplemental funds and American Rescue Plan Act funds. One of our biggest needs is recovery housing which Utah continues to struggle with because of the current housing crisis and the pandemic that has greatly impacted our housing market even further. Affordable housing is a huge issue in Utah.

Expansion of Recovery support services through the Health, Exercise and Awareness Recovery Project and the Community Based Recovery Project with 12 additional community organizations that provide services to their own community members.

In 2021 Utah was awarded a HRSA grant, HRSA: Health Resources and Services Administration, It is the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable. This is a BHWET grant HRSA-21-090, Behavioral Health Workforce Education and Training grant meant to partner with The Utah Paraprofessional program, who is providing support, field training, and apprenticeships to the Utah Certified Peer Support Specialist (CPSS) and Family Peer Support Specialist (FPSS) Programs. YIPP is being implemented to increase the training capacity of provider organizations. This includes cross-training a more diverse group of paraprofessionals, a stronger practicum and a paid registered apprenticeship, and the opportunity for a formalized career ladder pathway for paraprofessionals.
YIPP-Youth-in-Transition Integration Paraprofessional Program

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

None at this time.

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Footnotes:

Public committee meetings are posted on the Offices website and public comment, feedback and input is received and reviewed.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	(•) Yes ( ) No
Home and community-based services	(•) Yes ( ) No
Peer support services	(•) Yes ( ) No
Employment services.	(•) Yes ( ) No

2. Does the state have a plan to transition individuals from hospital to community settings? (•) Yes ( ) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Utah incorporates the ADA community integration mandate into all of its practices. OSUMH PASRR Program (Preadmission Screening and Resident Review) helps to ensure that individuals are not inappropriately placed in nursing facilities, that individualized services are offered depending on their needs and to help determine the most appropriate setting. The PASRR program also works closely with the Office of Long-Term Services and Supports/Resident Assessment, who provides oversight to helps to ensure better care and monitoring for a safe and orderly discharge.

For several years, Utah has conducted homeless outreach initiatives. We conduct outreach efforts, community referrals, warm handoffs, and service support. Utah has been dealing with a housing crisis for several years, a situation worsened by the COVID pandemic. Wait lists for housing vouchers are 2-5 years long. In order to ensure individuals are able to discharge from higher levels of care and receive support within the community, OSUMH meets with the Utah State Hospital and Local Mental Health Authority liaisons to address housing and care supports for individuals with complex needs. High level staffings are held for individuals with unique challenges who may be able to transition from inpatient to the community, when supports and services are not readily available.

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

none at this time.

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Footnotes:

Utah's HCBS Final Rule (Settings Rule) and the Person-Centered Support Plan (PCSP) includes employment services within competitive and

integrated settings. Information can be found at the following DSPD link: https://dspd.utah.gov/settings-rule/
In addition, Utah has a State Plan (WIOA State Plan) that includes DWS' State Workforce Development Board and Vocational Rehabilitation, as well as Utah State Office of Education. Utah's State Plan includes employment for people with disabilities.
chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://jobs.utah.gov/wioa/wioastateplan.pdf

Environmental Factors and Plan

18. 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 condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[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 smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[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 abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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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 Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: 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**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

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 misuse 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 FEP and Clinical High Risk for Psychosis (CHRP) systems? (●) Yes ( ) No

d) Does the state have an established FEP program? (●) Yes ( ) No

Does the state have an established CHRP program? (●) Yes ( ) No

e) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Utah Department of Health and Human Services (DHHS) provides integrated services through a systems of care approach through close collaboration with the Office of Substance Use and Mental Health, Division of Child and Family Services, Division of Juvenile Justice and Youth Services, Utah State Board of Education, Law Enforcement, and other community partners. The Utah

State Office of Substance Use and Mental Health (OSUMH) provides integrated services for mental health (MH) and substance use disorder (SUD) needs for children and youth through the Local Authority Substance Use and Mental Health System and contracted providers. Integrated approaches are being evaluated to better serve individuals with physical health and intellectual/developmental disabilities and needs.

There are thirteen Local Authorities in Utah, which provide integrated SUD/MH services. One additional geographic area is divided into separate MH and SUD Local Authorities with a bidirectional referral relationship: Bear River - Bear River Health Department - SUD Treatment / Bear River Mental Health. The Local Authority Providers provide a continuum of services ranging from prevention, outpatient treatment, intensive outpatient treatment, residential treatment and recovery support services. 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 full 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.

OSUMH actively partners across the DHHS system and LMHA system to increase collaboration and partnership to support youth access to services and recovery supports. OSUMH 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.

The Office's Children, Youth and Families team (CYF) helps shape and contribute to the system of care through policy development, technical assistance, monitoring and oversight. In FY 24-25, CYF 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 and developmental disabilities and mental health , . Through continued work with DHHS divisions, Local Mental Health and Substance Abuse Authorities, , the Utah State Board of Education (USBE), and other private and public providers throughout the state, OSUMH 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?

OSUMH 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. The plan will address issues of system capacity development, staff and agency training, collaboration across private and public child services agencies and family and youth leadership training.

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 2023, with 85 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 is piloting dual certification endorsements 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 Youth-in-Transition focused Certified Peer Support Specialist (CPSS) program: The Division is collaborating with the CPSS program to develop a supplemental training and supervision curriculum to support: i) young adults to become a CPSS, and ii) CPSS to develop the knowledge and skills to work with youth in transition-age (15 to 26-years-old).
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 has initiated a contract with Youth MOVE National to facilitate transition-age youth focused peer support training in Utah.

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 four CSC teams in Utah which cover the most populated areas of the state. 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 education which includes cross-system collaboration to most appropriately meet the needs of youth and families experiencing CHRP or FEP.

e. Support School Based Behavioral Health (SBBH) through partnerships with the LMHAs, 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 LMHAs. 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 2023, the number of schools in which SBBH programs were available from the LMHA system were 367 including access to services via telehealth.
An area of focus has been schools with high rates of Intergenerational Poverty as identified by the Department of Education Title 1 program. OSUMH has supported LMHA school based work in 99 current Title 1 schools with identified high rates of Intergenerational Poverty. OSUMH plans to continue to increase the number partnerships of individual schools or school districts to support access to school based behavioral health

f. Collaborate with DHHS child serving agencies, LMHAs, 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. OSUMH, through partnering with the LMHAs and community partners, has identified a greater need to provide knowledge and skills related to working with individuals with IDD/MH to clinical teams. OSUMH has begun 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. Infant and Early Childhood Mental Health: OSUMH has focused work on infant and early childhood mental health initiatives to support developing a statewide focus on this age group. OSUMH has supported workforce development strategies including evidence based training, teleconsultation, and service delivery. OSUMH partners within DHHS and The Children's Center Utah to advance efforts.

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

For continued improvement in service delivery, policy development, monitoring and oversight, DSAMH would benefit from technical assistance regarding the following:

a. Family and youth peer support, with a focus on youth peer support and the national trends and data driven approaches for this type of work.

b. School based services. SAMHSA has identified schools as being a primary access point for providing mental and behavioral health services and has worked with the Mental Health Technology Transfer Centers to create trainings for schools and mental health systems. In addition to these resources, Local Authorities ask for more assistance to better prepare and train their workforce when they are working within school settings and with school based populations and to improve the continuum of care provided in conjunction with school systems. OSUMH has prioritized increasing collaboration between our LMHA's and LEA's and leverages opportunities through USBE's School Safety Center to further DHHS objectives. There are continued statewide efforts in addressing school behavioral health access, OSUMH would like to seek support from other states in approaching diversifying its approach to community access points for youth and families seeking behavioral health services beyond schools or traditional community mental health centers.

c. Continued assistance for intellectual and developmental disabilities and treating comorbid issues to include SUD and crisis support. Better training and workforce development are primary concerns for this type of technical assistance.

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

https://drive.google.com/file/d/1dEvRRJ8jvvJRpql3Sn9vsq_TcMrelmN2/view/

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.

OSUMH 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. OSUMH 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 OSUMH efforts.

OSUMH 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. OSUMH has also developed and implemented a required crisis worker certification training.

OSUMH contracts with National Alliance for Mental Illness (NAMI) Utah and local coalitions statewide to help them review data and choose local suicide prevention strategies for implementation through an RFP process. OSUMH currently provides funding and technical assistance to 18 local coalitions 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, OSUMH also contracts directly with local health and mental health authorities and community organizations to develop customized community-targeted upstream prevention awareness utilizing the statewide Live On Campaign. See https://liveonutah.org/.

OSUMH leads a robust firearm safety for suicide prevention effort including providing leadership to a committee of firearm related partners. Through this, OSUMH has developed education and training materials specific to firearm suicide prevention, distributed over 25,000 cable style gun locks annually, embedded a suicide prevention module into the Utah concealed carry permit training course, initiated a comprehensive study of firearm suicide, partnered with the local Children's Hospital on an Emergency Department (ED) means restriction initiative, and is beginning a training program for firearm retailers. Additionally, OSUMH intends to develop lethal means training (similar to CALM) for the public, in addition to a more clinical focus.

OSUMH works extensively on implementing the Zero Suicide (ZS) model in the public behavioral health care system with a focus on individuals with SMI/SED. We also work to implement Zero Suicide in partnership with health and behavioral health systems statewide. After working for many years on suicide prevention with the largest health care system in Utah, they announced the formal adoption of the aspirational goal of zero through the Zero Suicide model in July 2017. OSUMH 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, OSUMH began targeted Zero Suicide technical asistance to four local behavioral health authorities to further develop the framework within their organizations.

Following the award of the National Strategy for Suicide Prevention, OSUMH contracted with rural and urban providers to provide structured follow up/caring contacts to individuals discharing from emergency departments or inpatient units after being seen in those settings for suicide risk. Since then OSUMH has contracted with two local mental health authorities to continue caring contacts.

OSUMH provides leadership to the Utah Suicide Prevention Coalition and Executive Committee as well as a number of work groups. This diverse group of stakeholders has been involved with developing and implementing the Utah Suicide Prevention Plan, ongoing strategic planning, and implementation of strategies. The new 2021-26 State Suicide Prevention Plan will be released in September 2021 and will be found at https://liveonutah.org/about/.

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

OSUMH provides grants to three healthcare organizations to implment the Zero Suicide Framework in their organizations. All three Zero Suicide Grantees have identified care transitions as an essential focus area for their organizations.
Juvenile Justice and Youth Services (JJYS) provides care packages upon discharge to clients they serve. These packages include gun safes, weighted blankets, tappers, brochures and other essential items to help cope with stress and mental health issues while seeking private care. In addition to this, JJYS staff have been trained in providing safety plans to patients and updating policies to ensure safe transitions occur.
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 will receive safety plans to ensure they can manage suicidality while receiving treatment.
Utah State Hospital has focused on training clinicians and behavioral health staff in safety planning and addressing suicidality in patients to better support patients upon discharge. USH is currently working with staff and leadership to update policies to support and require staff to complete safety plans for patients at discharge.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

In 2021 Utah was no longer in the top ten states for rates of suicide deaths, a change from the previous decade. Suicide death ates have remained largely stable since 2017. However, there are specific populations which remain high in Utah and are being addressed in the state Suicide Prevention Plan, and within contracting practices within 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.

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

none at this time.

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Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The 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's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- 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.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. 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?

As integrated health has been emphasized and Medicaid Expansion has been implemented (began on April 1, 2019), OSUMH has recognized the need to strengthen relationships with primary care providers, Federally Qualified Health Centers, Accountable Care Organizations, and other network providers. In addition, Legislative changes emphasizing improved suicide prevention and crisis care have renewed the focus on emergency and crisis care at all levels. The focus on Mental Health Commissioners, Designated Examiners, Prosecutor/Defense Attorneys, State and County Corrections and Public Safety Agencies, Probation and Parole, Mobile Crisis Outreach, and justice reinvestment and forensic competency issues continues to increase. Many efforts have been made to forge stronger relationships with each agency, relationships with new staff in these agencies, and partnerships around mutually important issues related to behavioral health across sequential intercepts in continuum of care access by Utah citizens.

Listed below are just a few of the new and ongoing partnerships that the Office of Substance Use and Mental Health (OSUMH) is currently involved in.

a. Utah Behavioral Health Planning and Advisory Council (UBHPAC) is a council composed primarily of Peers who review Block Grant activities and provide feedback to OSUMH. UBHPAC is a subcommittee of the Utah Substance Abuse Advisory Council (USAAV). USAAV is a committee established by statute to advise the Governor on Substance Use Disorder issues. The Office sits on the council and provides membership to all four of the Council's Committees. UBHPAC has created work groups to address different components of the Block Grant, ensuring that peers both on and off the council are able to comment on programs and funding.
b. Division of Licensing and Background Checks: The Office has worked closely with the Division of Licensing to update rules and requirements for Opioid Treatment programs as well as a workgroup that created a Recovery Residence Licensing process to assist in providing safe sober housing for individuals in recovery. OSUMH staff sit on the Comprehensive Review Committee to review license appeals submitted to the Division of Licensing.
c. Criminal Justice: The Office has a long history of collaboration and cooperation with the Criminal Justice workers, to include the Administrative Office of the Courts, the Programming Office in the Department of Corrections which provides SUD services inside the prison system, with Adult Probation and Parole, with the judges and other Drug Court Team Members, and with the Clinical Health Services department of the prisons now located in DHHS. The collaboration with the Department of Corrections and the Commission on Criminal and Juvenile Justice (CCJJ) has already been discussed in section 13. In July 2023, the Utah Department of Corrections Clinical Services Bureau transferred health responsibilities, including behavioral health, to the Department of Health and Human Services as a new Division of "Correctional Health Services (CHS)". This change has opened multiple opportunities for closer collaboration, particularly across transitions out of incarceration. OSUMH and the Department of Corrections are currently working together to create a Forensic Peer Support specialty certification.
d. State Board of Education (USBE): OSUMH has a partnership with USBE related to School Safety Center (SSC) initiatives, mental health wellness and prevention, suicide prevention, youth in custody programming, and employment.
e. University of Utah. The Office meets monthly with multiple departments within the University of Utah system including their Integrated Health Team, Crisis Services Team, and the Inpatient hospital team in order to continually coordinate and improve service delivery between our systems. The Office is working with the Kem C. Gardner Institute at the University of Utah and the Utah Hospital Association (listed below) to create the Utah behavioral health master plan for ongoing development and improvement of the statewide system. OSUMH staff are also working with the University of Utah on a stigma reduction campaign and on school based work.
F. Utah Hospital Association: OSUMH meets monthly with the behavioral health committee of the Utah Hospital Association to develop and implement a strategic plan for behavioral health across the state and across systems, as mentioned above. The state Mental Health Preadmission Screening and Resident Review (PASRR) Office also meets with the Utah Hospital Association to review any issues that are impacting transition of individuals in and out of skilled nursing facilities.
f. Recovery Support: The Office contracts with and meets with the following recovery support organizations on numerous issues on a regular basis: National Alliance for Mental Illness (NAMI), Utah Support Advocates for Recovery Awareness (USARA), Latino Behavioral Health Services (LBHS), Multicultural Counseling Center (MCC), Asian Association of Utah (AAU), Fit2Recover, Warrior Strength, Addict II Athlete, Recovering Addict, School of Addiction Recovery (SOAR), Soap to Hope, Utah Peer Network, Utah Association of Peer Support Specialists, Mental Health America Utah, Journey of Hope, and Child and Family Empowerment Services (CFES). OSUMH has formal contracts with these agencies; several contracts are new and were initiated with covid-related funds as part of the outreach to marginalized and vulnerable populations.
g. Utah Department of Veterans Affairs (UDOVA) and the Utah National Guard: The Assistant Office Director sits on a statutory mandated Veteran's Affairs Committee, and monthly meetings are held with the VA and UDOVA to coordinate on issues such as Suicide Prevention, Mental Health Conferences, and improving service to Veterans and National Guard members. OSUMH also partners with the Department of Veteran Affairs and other organizations serving Service Members, Veterans and their Famliies (SMVF) on the Governor's and Mayor's Challenges to prevent suicide among Survice Members, Veterans and their Families.
h. A few of the committees and workgroups that the Office either attends, co-chairs, or has membership on committees across Divisions and Offices within the newly formed Utah DHHS are:
1) Medicaid - As OSUMH and Medicaid are now in the same Division. OSUMH has multiple organizational and collaborative meetings per month with Medicaid to expand, improve and advance funding options.
2) Nicotine Cessation
3) Prescription Drug Abuse Task Force
4) Narcan Distribution Work Group
5) Care Management Work Group
6) Prevention Coalitions statewide
7) Community Health Workers Workforce Development Workgroup
8) Utah Community Health Worker Coalition
i. OSUMH and other DHHS Offices meet regularly with Department leadership, these include the Division of Child and Family Services, Division of Aging and Adult Services, Division of Services for People with Disabilities, Division of Juvenile Justice and Youth Services
j. Department of Workforce Services, Vocational Rehabilitations
k. Insurance Commissioner
l. Opioid Treatment Programs
m. Private Health Care and Managed Care Organizations
n. Department of Professional Licensing (DOPL)
o. Utah Behavioral Health Care Council (UBHC)
p. Utah State University, Institute for Disability Research, Policy & Practice (IDRPP). The Institute for Disability Research, Policy &

Practice (IDRPP) is Utah's federally designated University Center for Excellence in Developmental Disabilities (UCEDD). OSUMH collaborates with IDRPP on several projects related to dual diagnosis of intellectual and developmental disability and mental health, with particular focus on workforce development and peer support.
q. Utah Developmental Disability Council (UDDC). The Utah Developmental Disabilities Council (UDDC) is a federally-funded organization that operates under the Developmental Disabilities Assistance and Bill of Rights Act (DD Act). OSUMH liaison regularly attends UDDC meetings and collaborates with self-advocates, care givers, community organizations, and other state entities to improve access of services for individuals with developmental disabilities across Utah.
r. Utah Disability Advisory Committee (UDAC). Utah Disability Advisory Committee (UDAC) membership includes people with disabilities and representatives from disability organizations, advocacy groups, and public health organizations.

Children's mental health and support of state partners:
OSUMH partners with child serving agencies throughout the state of Utah to ensure that children and youth are allowed to receive care in the least restrictive setting. According to the Foster Care Mental Health Treatment Restructuring Initiative Guiding Principles developed by the Division of Child and Family Services (DCFS) and the Division of Juvenile Justice and Youth Services (DJJYS), Principle 1.3 reads: "Each child is cared for in the least restrictive setting and for the shortest, appropriate duration to help the child achieve outcomes defined for that child, such as safety, connection to a permanent family or other caring adults, progress towards treatment plan goals, prevention of recidivism, or increasing skills and ability to function in society successfully as an adult. Children should grow up in family settings not institutions." With Utah's adoption and approach to the Family First Prevention Act beginning in October 2019, Utah has a more targeted approach to providing evidence based programming to families with the goal of preventing children from entering foster care and remaining in their communities. Although it is the goal to serve all children and youth within their own communities, there are situations when residential care, inpatient hospitalizations, and even the Utah State Hospital are necessary resources to provide the best care possible. When children and youth are in these settings, OSUMH, in partnership with LAs, DCFS, DJJYS, the Division for Services with People with Disabilities (DSPD), the Utah State Board of Education, Local Education Authorities, and other necessary providers and community partners collaborate to find effective transition services. Collaboration occurs throughout all levels of the state with individualized staffings at a local level to high level staffings at the state level. OSUMH and the LMHAs will ensure that services are in place for a child and youth's mental health. The collaboration that occurs also allows for a focus on family and peer needs (with the help of Certified Family Peer Support), education needs including Individualized Education Plans (IEPs) and Section 504 Plans for behavioral needs, and any other needs that will allow for the child and their family to succeed within their community.
OSUMH partners with The Children's Center Utah to support infant and early childhood statewide infrastructure and best practices development and Intermountain Primary Childrens to support upstream community health approaches and behavioral health alignment OSUMH supports the State Suicide Prevention Coalition (USPC). The USPC was established in 2012, and is a partnership of community members, suicide survivors, service providers, prevention professionals, researchers, and others dedicated to saving lives and advancing suicide prevention efforts in Utah. The Coalition USPC has eight additional subcommittees who are dedicated to implementation of the Utah Suicide Prevention Plan. The Utah Office of Substance Abuse and Mental Health (OSUMH) provides leadership and coordination to all of the committees. The USPC collaborates with and has representation on the Utah Substance Abuse and Mental Health Advisory Council (USAAV+) and the Governor's Suicide Prevention Task Force.

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.

OSUMH coordinates with other DHHS agencies to ensure appropriate and effective services for individuals served DHHS agencies. For youth LA engage on a regional level at multi agency staffing (MAS) to focus on care coordination for youth engaged in multiple child serving systems, or for youth that may need support from agencies they are yet to engage in. THese meetings may include DCFS, JJYS, LAs, Probation, school systems, advocate groups, etc.
LA's also coordinate with OSUMH for case or system engagement consultation to support care. For adults, LA's will engage with Multi Disciplinary (MDT) staffings to support care coordination across adult serving providers.
Additionally LA's utilize the "Outcome Questionnaire/Youth Outcome Questionnaire" tool to help determine symptom recovery outcomes and readiness for discharge from care.

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

none at this time

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Footnotes:

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21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

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

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The Office of Substance Use and Mental Health (OSUMH) 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, a printed version of the plan is distributed to members for continued discussion and feedback. OSUMH posts a copy of the State Plan on the front page of their website for public comment on August 1st, and UBHPAC is made aware via email as well as in meetings. A hard copy of the State Plan is provided at the front desk of the OSUMH, and a copy is posted on the OSUMH 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. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

OSUMH has created a Results Based Accountability (RBA) strategic plan. The plan is based on known barriers and gaps, and needs identified by both UBHPAC and the Utah Behavioral Health Master Plan. The RBA plan includes the following strategies:
1. Advance prevention and early intervention to reduce the impact of substance use and 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.

OSUMH 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.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ( ) Yes (●) No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

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 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.

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

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Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Javier Alegre	Providers		3269 S Main St Salt Lake City UT, 84115 PH: 801-935-4447	javier.alegre@latinobehavioral.org
Karla Arroyo	Providers		7625 3200 W Salt Lake City UT, 84084 PH: 801-915-0359	karlaa@mccounseling.com
Randee Barriga	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		934 S Main St Layton UT, 84041 PH: 801-773-7060	randeeg@dbhutah.org
Pam Bennett	State Employees		288 N 1460 W, Third Floor Salt Lake City UT, 84116 PH: 801-819-9450	pbennett1@utah.gov
Emily Bennett	Providers		860 E 4500 S, Ste 206 Salt Lake City UT, 84107 PH: 801-716-4617	emily@auch.org
Dan Braun	Providers		7138 S Highland Dr, Ste 103 Salt Lake City UT, 84121 PH: 801-453-9625	danb@wasatchpeds.net
Pete Caldwell	State Employees		288 N 1460 W, Third Floor Salt Lake City UT, 84116 PH: 385-226-4533	pgcaldwell@utah.gov
Cathy Davis	State Employees		250 E 500 S Salt Lake City UT, 84111 PH: 801-538-7861	cathy.davis@schools.utah.gov
Lisa Hancock	Providers		2526 Lake Park Blvd West Valley City UT, 84121 PH: 385-529-8014	lisa.hancock@optum.com
Terry Harrison	Providers		1724 S Main St Salt Lake City UT, 84115 PH: 801-486-5012	terryh@alliancehouse.org

Tyler Haven	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		288 N 1460 W, Third Floor Salt Lake City UT, 84116 PH: 208-340-5094	tylersoc@gmail.com
Peggy Hostetter	Others (Advocates who are not State employees or providers)		135 S 500 W, Apt 603 Salt Lake City UT, PH: 801-355-3570	phostetter@gmail.com
Ryan Hunsaker	Others (Advocates who are not State employees or providers)		PO Box 581287 Salt Lake City UT, 84158 PH: 801-634-9463	mrhunsaker@icloud.com
Jason Jacobs	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		8483 S 1275 E Sandy UT, 84094 PH: 801-577-6893	jasonsjacobs77@gmail.com
Jane Lepisto	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		277 E 350 N Alpine UT, 84004 PH: 801-368-0271	janelep1@gmail.com
Shanel Long	State Employees		288 N 1460 W, Third Floor Salt Lake City UT, 84116 PH: 801-995-2176	shlong@utah.gov
Jennifer Marchant	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1408 W Harris Ave Salt Lake City UT, 84104 PH: 901-971-6410	jmarchant@q.com
Jules Martinez	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3269 S Main St Salt Lake City UT, 84115 PH: 801-935-4447	jules.martinez@latinobehavioral.org
Amanda Martinez	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3269 S Main St, Suite 230 Salt Lake City UT, 84115 PH: 801-935-4447	amanda.martinez@latinobehavioral.org
Mary Jo McMillan	Providers		180 E 2100 S Salt Lake City UT, 84115 PH: 801-839-9950	maryjo@myusara.com
Rafael Montero	State Employees		926 W Baxter Dr South Jordan UT, 84095 PH: 801-446-2560	rmontero@utah.gov
Sigrid Nolte	Parents of children with SED		10238 Snow Iris Way Sandy UT, 84092 PH: 385-775-1012	siggy.nolte@gmail.com
James Park	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		296 E Utah Ave Tooele UT, 84074 PH: 801-841-1653	jjpark9958@gmail.com
Jeanine Park	Family Members of Individuals in Recovery (to include family members of adults with SMI)		296 E Utah Ave Tooele UT, 84074 PH: 801-841-1653	parkjeanie60@gmail.com

Andrew Riggle	Others (Advocates who are not State employees or providers)		205 N 400 W Salt Lake City UT, 84103 PH: 800-662-9080	ariggle@disabilitylawcenter.org
Brayden Robinson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3269 S Main St South Salt Lake UT, 84115 PH: 801-897-9072	brayden.robinson@utahpeernetwork.org
Jacob Russell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1030 W 1020 S Provo UT, 84061 PH: 775-412-7435	jacob_rssll@yahoo.com
Heather Rydalch	State Employees		288 N 1460 W, Third Floor Salt Lake City UT, 84116 PH: 801-386-1335	hrydalch@utah.gov
Jeannette Villata	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		7625 3200 W West Jordan UT, 84084 PH: 801-915-0359	jeannettev@mccounseling.com
Lisa Walker	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3269 S Main South Salt Lake UT, 84115 PH: 801-897-9072	lisa.walker@utahpeernetwork.org
Brendie Werrett	State Employees		14717 Minuteman Dr Draper UT, 84020 PH: 385-261-8799	bknorr@utah.gov
Rob Wesemann	Providers		1600 W 2200 S, Ste 202 West Valley City UT, 84115 PH: 801-323-9900	rob@namiut.org
Dave Wilde	State Employees		288 N 1460 W, Third Floor Salt Lake City UT, 84116 PH: 801-538-6155	djwilde@utah.gov

*Council members should be listed only once by type of membership and Agency/organization represented.

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Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	12	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	1	
Parents of children with SED	1	
Vacancies (individual & family members)	0	
Others (Advocates who are not State employees or providers)	3	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**17**	**51.52%**
State Employees	8	
Providers	8	
Vacancies	0	
Total State Employees & Providers	**16**	**48.48%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	6	
Individuals/Family Members from LGBTQI+ Populations	3	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**33**	

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22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ○ No

b) Posting of the plan on the web for public comment? ○ Yes ○ No

If yes, provide URL:

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

c) Other (e.g. public service announcements, print media) ○ Yes ○ No

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

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Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

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 SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG 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 SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to 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[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] 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 SABG 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.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] 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 SABG 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.

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 SABG 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 abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Utah is not a designated state and does not have plans to submit a request to use SUBG to fund syringes. We do have syringe exchange services available without our state but they are funded through other means and are provided by other Divisions of the state.

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
Utah Syringe Exchange Program	PO BOX 141010, Salt Lake City, UT -84114	$0.00	No	0	No

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Footnotes:

Utah is not a designated state and we do not have plans to submit a request for approval to use SUBG funds for the purpose of purchasing syringes in alignment with syringe exchange services.
Utah does have syringe exchange programs in the state however they are funded by other funding and are supported by other Divisions of the state and other community programs and partner.