Utah

UNIFORM APPLICATION
FY 2022/2023 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 07/30/2021 4:20:38 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

Plan Year
Start Year 2022
End Year 2023

State SAPT DUNS Number
Number 878593383
Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant
Agency Name Utah Department of Human Services
Organizational Unit Division of Substance Abuse and Mental Health
Mailing Address 195 North 1950 West
City Salt Lake City
Zip Code 84116

II. Contact Person for the SAPT Grantee of the Block Grant
First Name Doug
Last Name Thomas
Agency Name Division of Substance Abuse and Mental Health
Mailing Address 195 North 1950 West
City Salt Lake City
Zip Code 84116
Telephone 801-538-4298
Fax 801-538-9892
Email Address dothomas@utah.gov

State CMHS DUNS Number
Number 878593383
Expiration Date 11/24/2021

I. State Agency to be the CMHS Grantee for the Block Grant
Agency Name Utah Department of Human Services
Organizational Unit Division of Substance Abuse and Mental Health
Mailing Address 195 North 1950 West
City Salt Lake City
Zip Code 84116

II. Contact Person for the CMHS Grantee of the Block Grant
First Name Doug
Last Name Thomas
Agency Name Division of Substance Abuse and Mental Health
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

do@utah.gov

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

Email Address   shlong@utah.gov

Footnotes:

In the 2021 Legislative Session H.B. 365 State Agency Realignment was passed that would merge the Utah Department of Human Services and the Utah Department of Health. More information can be found at https://sites.google.com/utah.gov/hhsplan/home. We anticipate this merger to affect many aspects of our Division over the next 2 years.
State Information

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

Fiscal Year 2022

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

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

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

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

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

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

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

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

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.


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

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions.
to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


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

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

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

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

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

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

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

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

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

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

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

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

3. Certifications Regarding Lobbying

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

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

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

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

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


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

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

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

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

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

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

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

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

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

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

State: ___________________________________________________________________________

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

Signature of CEO or Designee: __________________________________________________________________________

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

mm/dd/yyyy

Footnotes:

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

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022
September 1, 2021

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

To the Grants Management Officer,

Pursuant to Title V of the Public Health Act, I hereby certify that the state of Utah will assume responsibility for the implementation of the Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Program for Fiscal Year 2022-2023 and Fiscal Year 2023-2024.

Utah Department of Human Services' Division of Substance Abuse and Mental Health has been designated the state agency to carry out the policies and programs of the Block Grant. Accordingly, I delegate Tracy Gruber, Executive Director of the Utah Department of Human Services, the authority to sign the Assurances and Certifications and any documents to the FY2022-2023 and FY2023-2024 Substance Abuse Block Grant and the FY2022-2023 and FY2023-2024 Mental Health Block Grant.

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

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

Sincerely

Spencer Cox
Governor
August 1, 2021

Tracy Gruber, Executive Director
Department of Human Services
195 North 1950 West
Salt Lake City, UT 84116

RE: Letter Designating Signatory Authority for Mental Health Block Grant and Substance Abuse Prevention and Treatment Block Grant

Dear Tracy:

DSAMH is requesting your approval for the Letter Designating Signatory Authority for Mental Health Block Grant and Substance Abuse Prevention and Treatment Block Grant.

Please review and sign where indicated. You may contact Xochiatl Thomas, 385-341-0545, or Cindy Lopez, 801-516-8328, with any questions regarding this application.

Thank you,

Xochiatl Thomas
Budget Director

Enclosures

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### State Information

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

**Fiscal Year 2022**

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

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

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

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

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

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

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to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


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

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

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

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

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

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

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

3. Certifications Regarding Lobbying

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

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

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

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

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


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

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

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

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

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

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

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

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereof 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: ________________________________

Title: Executive Director of Utah Dept. of Human Services Date Signed: 07/23/2021

mm/dd/yyyy

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

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

Footnotes:
# State Information

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

### Fiscal Year 2022

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

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   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

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

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

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

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

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

3. Certifications Regarding Lobbying

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

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

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

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

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


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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

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

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

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

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

Signature of CEO or Designee:  

Title:  Executive Director of Utah Dept. of Human Services  Date Signed:  07/23/2021

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

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

(SAPT) September 1, 2021 through September 30, 2025 $13,428,346 ($3,357,086 per year)

B. SABG Guidance

States are required to plan for, expend, and report on the FY 21 SABG ARPA Supplemental Funding based on 42 U.S.C. Chapter 6A, Subchapter XVII, Part B, Subpart II: Block Grants for Prevention and Treatment of Substance Abuse, and 45 CFR, Part 96, Subpart L. Consistent with HHS Disaster Relief Flexibilities, SAMHSA may waive requirements with respect to allowable activities, timelines, or reporting requirements for the SABG as deemed necessary to facilitate a grantee’s response to coronavirus. Accordingly, all regular provisions of the statute and regulations pertaining to the SABG are fully applicable to the planning and expenditure of the SABG ARPA Supplemental Funding. Substance Abuse and Mental Health Services Administration
1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov
This includes, but is not limited to, the definitions, assurances, requirements, and restrictions of the SABG standard funding.

The SABG allocation requires states to expend not less than twenty percent (20%) of their total allocation for substance use disorder (SUD) primary prevention services for individuals who do not require treatment for substance abuse, in accordance with 42 USC 300x-22 and 45 CFR 96.124 and 96.125. The SABG allocation also requires “designated states” to expend five percent (5%) of their total allocation for EIS/HIV Services, in accordance with 42 USC 300x-24(b) and 45 CFR 96.128.

The SUD prevention, intervention, treatment, and recovery support services continuum includes various evidence-based services and supports for individuals, families, and communities. Integral to the SABG are its efforts to support health equity through its priority focus on the provision of SUD prevention, treatment, and recovery support services to identified underserved populations. These underserved and marginalized populations include, but are not limited to, pregnant women and women with dependent children; persons who inject drugs; persons using opioids and/or stimulant drugs associated with drug overdoses; persons at risk for HIV, TB, and Hepatitis; person d welfare system; Black, Indigenous, and People of Color (BIPOC); LGBTQIA+ individuals; rural populations; and other underserved groups.

SAMHSA recommends states develop, enhance or improve the following through the SABG ARPA funds:

• Develop and expand the use of FDA-approved medications and digital therapeutics as a part of addiction treatment that can provide interactive, evidence-based behavioral therapies for the treatment of opioid use disorders, alcohol use disorders, and tobacco use disorders, along with the implementation of other evidence-based treatments and practices.
• Provide increased access, including same-day or next-day appointments, and low barrier approaches, for those in need of SUD treatment services.
• Direct critical resources in expanding broad-based state and local community strategies and approaches in addressing the drug overdose epidemic, involving SUD prevention, intervention, treatment, and recovery support services.
• Improve information technology infrastructure, including the availability of broadband and “digital health” technology to support access to evidence-based services.

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GPS to expedite response times and to remotely meet with the individual in need of services.
• The adoption and use of health information technology to improve access to and coordination of SUD prevention, intervention, treatment, and recovery support services and care delivery, consistent with the provisions of HIPAA and 42 CFR, Part 2.
• Advance telehealth opportunities to expand services for hard-to-reach locations, especially rural and frontier areas. Expand technology options for callers, including the use of texting, telephone, and telehealth. Note: States may not use the funds to purchase any items for consumers/clients.
Substance Abuse and Mental Health Services Administration
1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov
• Enhance the primary prevention infrastructure within your state and communities using the Strategic Prevention Framework planning model and implementing evidence-based practices, the six CSAP prevention strategies with an emphasis on environmental approaches.
• Consider incorporating strategies around adverse childhood experiences to improve substance misuse outcomes among all populations, but especially young adults 18-25 and those over 26 years of age; preventing and reducing marijuana use by youth below the state’s legal age of use; and mitigating the impact of increased alcohol access by youth as identified during the COVID-19 pandemic. It is important to identify and address disparities and describe how you are incorporating equitable approaches.
• Support expansion of peer-based recovery support services (e.g. recovery community organizations, recovery community centers, recovery high schools, collegiate recovery programs, recovery residences, alternative peer group programs) to ensure a recovery orientation which expands support networks and recovery services. These programs are helping people sustain their recovery, engaging families and significant others, bridging the gap between treatment and long-term recovery, and supporting people reentering the community from incarceration.

**SAMHSA requests that the following information is included when submitting the proposals:**
1. Identify the needs and gaps of your state’s SUD services continuum, related to developing a comprehensive prevention, intervention, treatment, and recovery support services continuum.

Needs, gaps and recommendations were identified in the latest Utah mental health and substance use disorder reports which include the 2018 Crisis System Optimization report conducted by RI International Consulting, Kem Gardner and Utah Hospital Association (UHA) Reports, Student Health And Risk Prevention (SHARP) survey, National Survey on Drug Use among Households (NSDUH), Department of Health (DOH). Department of Human Services (DHS) Social and Behavioral Health During Covid-19 Report for Incident Command, Utah’s 2020 Intergenerational Poverty report, the Multicultural Advisory Committee’s COVID-19 Response reports, and other relevant health and health disparity reports. These reports highlight that more people were experiencing substance use disorders before the pandemic began and that rates of substance use disorders have increased and are expected to continue to increase after the pandemic.
Racial and ethnic minority communities and other communities have been disproportionately impacted by Covid-19. The patterns of increased anxiety, financial insecurity, and substance misuse was observed across all age groups and genders. These negative outcomes increased as the duration of stay at home orders or quarantine increased, and also increased as the length of the pandemic became increasingly unknown.

- The overall trend of opioid prescriptions filled has increased since the pandemic began and shows an increase in risk for misuse and addiction in the future. Utah has identified Opioid Use Disorder and the treatment for it as a priority across our state. We have continually worked to educate on the use of FDA approved medications but still struggle with acceptance for the use of medications to treat addiction and the stigma associated with it.

- Drug overdose deaths are the leading cause of injury death in Utah, outpacing deaths due to firearms, falls, and motor vehicle crashes. DSAMH staff participate in the fatality review committee and continue to work towards identifying the gaps and needs in our system where an overdose death occurred especially for individuals that were currently or had been part of our behavioral health system and understanding ways to reduce overdose deaths.

- Child abuse and neglect as well as domestic violence rates have increased during the pandemic and substance misuse is both a risk and causal factor of these problems. DSAMH collaborates with the Division of Children and Family Services in order to coordinate care and services for families, parents and children. Their are still needs in our system to identify and rapidly coordinate care.

- Prevention services include data driven priorities taken from the SHARP Statewide Survey, College/University surveys, and state/local data on risk and protective factors and target negative trend data over the last few survey administrations both statewide and in local areas of greatest concern. Identifying needs at an early state is one of our priorities in order to reduce the need for further treatment services.

- Tobacco and Marijuana use is increasing. As part of a full continuum of care DSAMH has worked to include Tobacco and Marijuana use in prevention services, as part of our normal screening, assessment and treatment planning processes and we continue to work to improve access to Nicotine Replacement Therapy and other appropriate uses of FDA approved medications.

- The following factors are also trending in the wrong direction and need to be addressed: Low Commitment to School - trending up 45.7%; Depressive Symptoms - Trending up 36.4%; Attitudes favorable to Antisocial Behavior (individual) - trending up 34.9%; Perceived Risk of Drug Use - trending down 34.6%. All of which significantly impact youth and youth adult substance use and misuse. We are focusing efforts in youth prevention services and early screening and assessment and placing individuals in appropriate levels of services. DSAMH continues to work on referring individuals to
other community and sister agencies in which cognitive and developmental disabilities can be addressed.

- Treatment services rely on incidence and prevalence data along with stakeholder feedback to address the areas with greatest need. Continuing to work on improving data collection from our behavioral system but also private providers and the Medicaid office in order to identify gaps and needs in our system and address those concerns.

- 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.

- Affordable Housing has been identified as a need across our state for many years. Utah's housing market has been strong and healthy, leaving affordable housing hard to come by. 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. This is the same for apartment rentals whose prices have also increased and created a housing shortage across the state.

These needs and gaps have great impact across our full continuum of care from prevention services, Mental health and Substance Use treatment services and recovery support services which are greatly needed right now as our state struggles to normalize during the pandemic.

2. Describe how your state’s spending plan proposal will address the state’s substance use disorder services continuum, including a budget that addresses the needs and gaps related to this continuum.

Proposed funds for evidence based prevention interventions are supported by the latest research (https://nam.edu/perspectives-2015-unleashing-the-power-of-prevention/) on changing individual and community norms and behaviors. Validated risk and protective factors will be targeted in local communities to decrease substance misuse. Data driven formulas will provide additional resources for rural areas and areas with higher needs. Competitive bids will provide an opportunity to assess community readiness to implement proposed interventions and ensure funds reach areas with the highest demonstrated need. The communities will also identify the gaps in equity and demonstrate how prevention services will address the needs and gaps of high need populations.

Youth and young adults needing access to substance use disorder services along with detoxification and withdrawal services will be addressed with these funds through evidence-based and SAMHSA approved strategies to decrease use and increase meaningful life activities like housing, school, employment and related activities.
Recovery support services focus on filling gaps in social determinants of health need areas which have been adversely impacted by Covid-19 and are often created when people begin misusing substances and eliminate their formal and informal support systems which are crucial to managing their illness and maintaining long term recovery. Priority populations are pregnant women and IV users as well as others identified as being affected by COVID.

The proposed interventions will increase healthcare integration, access to care in rural services and decrease health disparities for individuals disproportionately affected by Covid-19. The proposed interventions also align with Governor Cox’s One Utah Roadmap report. These funds will enhance services currently offered by contracted providers of Division of Substance Abuse and Mental Health (DSAMH) and Department of Human Services (DHS)/Department of Human Services (DHS) to address the ongoing and long-term impact of Covid-19 on the citizens of Utah. The proposed allocation of funds reflect priorities of: the required use of the SAPT Block Grant per SAMHSA, the reports identified and referenced above, Division of Substance Abuse and Mental Health (DSAMH)/Department of Human Services (DHS), the public mental health and substance use disorder and health systems and the Utah Behavioral Health Planning Council.

Funding for these service projects will be allocated out to our Local Substance Use Authorities, Local Health Departments or contracted out through a Request for proposal process.

A full continuum of services will be utilized which will include several different prevention measures such as campaign efforts and Drug Free Community mini grant projects that will be awarded to areas of most need. After School programs for middle schools that will address reducing alcohol and other drug misuse and Higher Education Prevention System efforts that will promote misuse efforts on campus.

Funding will be provided to expand access to Mobile Crisis Outreach Teams (MCOT) in an effort to respond to Substance Use Disorder calls. This also includes efforts to provide training to MCOT teams in regards to specific substance use disorder needs and services.

Volunteers of America have developed a very robust withdrawal and intoxication management program that provides great wrap-around services to individuals in need of a safe place to be while they detox and withdrawal from substances. DSAMH will be using this model to increase detoxification and withdrawal management services across the state, utilizing medication management and providing wrap-around services to support individuals in this state in their recovery. We also will focus on providing integrated physical and behavioral health services and a smooth transition from detox services to other levels of care or services as indicated. IV drug users and Pregnant women are identified as priority populations.

Utah is working on starting a Mobile Medication Assisted Therapy Clinic. We have several providers that are interested in starting a Mobile Clinic that would provide Medication Assisted Therapy and counseling services to individuals that are not able to travel or are outside of the typical service areas. The Mobile Clinic will be utilized in Rural/Frontier areas of the state and
possibly in Salt Lake City where there are large amounts of transient populations that are not able to make it to a clinic for services.

Services for youth with a Substance Use Disorder will include efforts to increase screening and assessment and increase access to appropriate ASAM level of treatment services which will be supported by a contract for Technical Assistance to improve statewide access and treatment retention across the state.

Increased Recovery Support services to individuals in Recovery. This will include clients at any point in recovery: pre-treatment, treatment, post-treatment, etc. We understand that everyone has their own path to recovery and support that each path is individually unique. DSAMH supports the SAMHSA Recovery model: Health, Home, Purpose and Community. Utah will provide funding to the Local Authorities as directed through our federally funded allocation but will also provide an RFP for mini-grants to local community organizations that provide and promote recovery and will prioritize efforts from agencies providing recovery support and peer services to specialty populations such as LGBTQIA+ and minority populations.

Insert Budget

3. Describe your state’s progress in addressing the rising drug overdose rate in many parts of the country, and what steps the state will be taking to improve access to SUD treatment, by improving identification of persons in need, reducing barriers to admission to treatment, and strengthening mechanisms to promote client engagement and retention in SUD treatment and recovery support services.

In 2016, Utah was fourth in the nation for opioid overdose deaths. Between 2016 to 2020 in Utah, we have seen the following:

- Overdose deaths involving opioids have decreased from 78% in 2016 to 74.2% in 2020.
- Fentanyl deaths increased from 8.2% in 2016 to 23.2% in 2020.
- Stimulants involved in overdose deaths increased from 32.6% in 2016 to 50.7% in 2020.

The majority of these involved methamphetamines.

When using 2019 as a comparison year, crude overdose rates involving any drug and crude overdose rates involving an opioid were lower in 2019 than any of the previous eight years. According to Utah Office of the Medical Examiner data:

- There were 632 overdose deaths involving any drug in 2018 including 440 overdose deaths involving an opioid. This represents a 2.7% decrease in overdose deaths involving any drug and a very slight (less than one percent) increase in deaths involving an opioid compared with 2020.
- There were 615 overdose deaths involving any drug in 2020 including 442 overdose deaths involving an opioid. This represents a 7.7% increase in overdose deaths involving any drug and a 10.8% increase in deaths involving an opioid compared with
In Utah we have a state wide overdose fatality review committee that meets monthly to discuss the trends in overdoses in Utah. It is a multidisciplinary group of professionals, both state and community level partners, to provide information and discuss resources and interventions to help prevent similar overdoses in the future. Some of the recommendations out of these reviews have included; increased access to syringe service programs, continued and expanded peer support services in hospitals when people present for an overdose, increase in diversion centers to streamline individuals being able to be assessed and transitioned into treatment settings more quickly, which includes induction into MAT.

Utah has provided provider trainings for ASAM to ensure individuals are placed in appropriate levels of care. We have purchased the use of the LSI-RNR and the LSI-R:SV to improve criminogenic risk screenings for justice-involved individuals. We are currently working on a contract with King’s College of London to implement the Substance Use Recovery Evaluator (SURE) tool as a psychometrically valid recovery outcome measure to help clients stay engaged and to help clinicians monitor client progress in recovery and intervene when determined. Using evidence based screening tools throughout a client’s treatment episode will help determine appropriate levels of care and when a client should increase or decrease levels of care. Recognizing that each client’s treatment and recovery path is different and designing individualized treatment and recovery plans is an important part to retention.

4. Describe your state’s progress in implementing the increased and widespread use of FDA approved medications for the treatment of opioid use disorder, alcohol use disorder, and tobacco use disorder, in combination with other substance use disorder evidence-based treatments and practices.

A combined report was completed in April 2020 from the Kem C. Gardner Policy Institute and the Pew Charitable Trusts to identify ways to Move Toward Evidence-Based Programs: Medication-Assisted Treatment for Opioid Use Disorder in Utah. Based on this report we have been able to more clearly see the areas throughout Utah that have discrepancies in rates of opioid overdose deaths and rates of providers for MAT. We are able to target pilot projects and fund programs that have fewer resources, in order to expand opportunities to access MAT.

Medication Assisted Treatment (MAT) induction in Urgent Care Settings. This project will be put out to bid through a request for proposal process (RFP) to providers that can provide the appropriate services within the counties of highest rates of need to receive priority for funding. We look at creating an additional, easy access point for people to start on MAT and piloting MAT induction sites that could work with existing healthcare system in the state (MountainStar HealthCare (HCA), Intermountain Health Care (IHC), University of Utah, or Federally Qualified Health Centers (FQHCs)). This is supported by SAMSHA’s Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings focusing found at https://effectivehealthcare.ahrq.gov/products/opioid-use-disorder/technical-brief. By providing services to individuals in Urgent Care and other related medical settings.

Mobile MAT Clinic/ Unit. This project will be put out to bid to providers through a request for proposal process (RFP) that can provide the appropriate services within the counties of highest rates of need to receive priority for funding. (Mobile MAT, linked with Local Authority Mobile Crisis Outreach Team (MCOT) and crisis services. Purchase of a mobile medical clinic vehicle that provides physical health space along with counseling services for those seeking medication for opioid use disorders. In rural areas waived providers are not easily accessible and public transportation is often limited, excluding people from accessing these services.) There are two forms of Medication Assisted Treatment (MAT) that can currently be provided or prescribed from a mobile MAT clinic.

Once the new regulations from the Drug Enforcement Administration (DEA) are approved and in place (21 CFR Parts 1300, 1301, and 1304) any current Opioid Treatment Program, Opioid Treatment Program (OTP), could add a mobile clinic to their current program to provide methadone and any of the other Food and Drug Administration (FDA) approved medications for the treatment of opioid use disorder from the mobile clinic. As per the proposed federal rule change from the DEA “DEA’s comparative analysis shows that the cost of operating a mobile unit is less than the cost of operating a physical location”. Should this rule be approved and implemented Utah would work with an existing OTP or an agency who would like to open an OTP with a mobile component to implement this increase to access of methadone treatment in Utah.

SAMHSA MAT Technical Brief (Mobile MAT addresses barriers)-
https://effectivehealthcare.ahrq.gov/products/opioid-use-disorder/technical-brief

SAMHSA TIP 63 Treatment Improvement Protocol re: Medications for Opioid Use Disorder

DSAMH encourages the use of all FDA approved Medication Assisted Therapy for the treatment of substance use disorders. Providers are required to screen and assess for opioid use and tobacco use in which medication, counseling and/or treatment services can be recommended and provided.

5. Explain how your state plans to collaborate with other departments or agencies to address the SUD services continuum.

Collaboration will take place at many different levels, Governmental, Local Counties with our Local Authorities and with community providers.
DSAMH will be coordinating with the Utah Department of Health (DOH) regarding crisis response services and services involving MAT to coordinate partnerships with primary care providers and other health care providers. Collaborate with the Division of Child and Family Services (DCFS), Department of Juvenile Justice Services (DJJS), Courts and community partners regarding youth treatment services to ensure there is no duplication of services and improve quality of care and treatment placement. We will coordinate with Local law enforcement agencies, Department of Corrections (DOC)- Adult Probation and Parole, where services will not be provided to individuals that are incarcerated but to those individuals that have been released from incarceration and are acclimating back into society, target populations are pregnant women, IV users, adult women and men. Hospitals and healthcare providers as well as Local Substance Abuse Authorities and contractors to coordinate efforts around withdrawal and intoxication management services across the state, populations to be serviced are priority populations such as pregnant women, IV users, and all other populations of need. We will collaborate with the Department of Workforce Services and the Utah State Board of Education to ensure quality and evidence based after school services are offered around the state. We will be coordinating and working with many community agencies in the delivery of services that address the needs for prevention and treatment services through competitive bid processes. These agencies will include clinical treatment service providers, community recovery support agencies, campaign agencies, prevention service agencies, educational and school service providers, etc. We will also be coordinating many efforts through our Local Authority’s (Local Substance Abuse and Mental Health Authorities).

Funding for these services will be allocated out to our Local Substance Use Authorities, Local Health Departments or contracted out through a Request for proposal process.

DSAMH is focused on providing a full continuum of services and our community partners play a large role in those efforts. From prevention efforts to treatment services and aftercare our community partners play a role. We have great relationships with our community behavioral health providers which provide a full continuum of services, our local medical hospitals and clinics that help identify clients in need of treatment services and can provide a warm handoff to providers and also help in our integrated care services through a continuum. We work closely with local legal and justice agencies through our new Diversion Units, Drug Court services, Mobile Crisis Outreach Teams and with our Department of Probation that providers referrals into treatment services and collaborate at every point to ensure individuals are receiving the best services possible and to reduce recidivism rates. Our community providers that do community outreach, crisis intervention, recovery support services, and provide an abundance of peer support services in which they provide an abundance of community resources and support in order to ensure we have a full continuum of care for individuals and families in recovery.

In 2021 our Legislature passed a bill to merge the Department of Human Services with the Department of Health. The merger will be completed in 2022, this effort of merging Departments is to streamline the process for individuals that are in need of and receiving services. There are many changes our system is undergoing currently but eventually the process of requesting services and receiving access will be fluent, quick, responsive and
6. Describe how the state plans to use SABG ARPA funding to promote health equity among identified underserved populations, and how it plans to address health disparities in the planning, delivery, and evaluation of SUD prevention, intervention, treatment, and recovery support services.

DSAMH has developed a Health Disparities Research Team made up of DSAMH program staff, data and research professionals, other state and community agencies, community members and peers. In 2021, the team conducted the Health Disparities in Utah’s Public Mental Health System. It looked at four different populations: People of Color, People with Developmental Disabilities, Members of LGBTQIA+ community and Transition-Age Youth and Young. 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.

DSAMH will be working within our state behavioral health system, other state agencies, community providers and organizations, community members, peers and other parties of interest to identify additional gaps and needs in our state across our full continuum of services.

7. Describe the state’s efforts and plans to promote an increased emphasis on the development, delivery, and support of widespread SUD recovery support services, systems, and mechanisms across the state.

Substance Abuse and Mental Health Services Administration
1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov

Utah has dedicated part of the ARPA funding to provide Recovery Support Services to individuals in Recovery through two different projects. The first will provide dedicated funding for Recovery Support Services to our Local Substance use Authorities on our federally approved allocation formula. This will provide funding to each Local Authority in which they can provide an array of approved recovery support services. Recovery support service data is required and is uploaded into our state SAMHIS system monthly. This will allow us to review the services being provided by each Local Authority continually. DSAMH along with the Recovery Support Steering Committee and the Local Authority Clinical Directors and Public Data Committee have developed a Recovery Support Service manual that defines services, funding, service delivery, and establishes reimbursement rates for all approved recovery support services. Services provided that are not included in the Recovery Support manual are not reimbursed.

The second Recovery Support Service project will be an RFP which will allow for 8-10 contracts...
services. We recognize that recovery is different for everyone and each path is different, contracts will be awarded in an effort to recognize unique paths in recovery and support efforts to support individual and community needs while also recognizing the service needs of specialty populations such as LGBTQIA+ and minority populations.

8. Describe other state priorities or activities that the state plans to fund during the performance period of September 1, 2021 through September 30, 2025 using ARPA Funds.

Drinking While Pregnant Campaign which is a prevention campaign using existing coalitions to raise awareness about harms of drinking if pregnant. The project will address risks of consuming alcohol while pregnant, promoting healthy behaviors during pregnancy. To make this project successful, the prevention workgroup is collaborating with multiple stakeholders (Mother to Baby, Intermountain Hospitals, Poison Control, Community Coalitions statewide).

The largest project under these funds will be the Prevention Prepared Communities. This will focus on supporting community coalitions to become prepared for Drug Free Community Grants or for other funding sources. Applicants may have previously applied for the DFC grant but may not have received the grant. The project has grantees work through the Strategic Prevention Framework, with the outcome of developing a strategic prevention plan for that community. Priority funding to communities / entities that have submitted applications for DFC grants. The applications include community and program measures, sustainability plans, and the grant requires an established community coalition (CTC & CADCA Academy include sustainability planning). The project focus is on local factors with the strongest trend changes.

After School Prevention Programming: This is a competitive grant project that promotes evidence based prevention programming that focuses on the after school timeframe or strategies that support youth. The applicants will provide selective or indicated prevention services to reduce alcohol and other substance use among youth.

Prevention in Higher Education: This is a competitive grant project that promotes and builds prevention coalition efforts on public institutions of higher education. The population of 18-25 years old has been neglected. This project aims to support evidence based strategies that can be sustained after grant funding has ended. The outcome would be a decrease in the number of underage drinkers and binge drinking young adults on higher education campuses in Utah.

Medication Assisted Treatment in Urgent Care settings. This will be conducted through an RFP bid process. This is an effort to create additional, easy access points for individuals to have access to Medication Assisted Therapy. We also plan for this to be another point of integrated care and look for settings such as Intermountain HealthCare, one of our largest healthcare organizations, Federally Qualified Health Care Centers, the University of Utah or other health care clinics and organizations.

9. Describe your state plans for enhancing your state’s prevention infrastructure which may include incorporating work around ACEs and improving substance misuse outcomes among young adults and older adults. (Primary Prevention set-aside)

Utah has proposed projects that will strengthen communities statewide. The proposal has allowed for local level planning and identification of needs and gaps to be filled. The aim of the
impact the consumption rates among youth and adults. These factors impact the ACEs of a community.

The projects work with coalitions to increase the capacity of communities with higher need populations - after school youth, 18-25 year olds, and pregnant persons. By addressing risk and protective factors, Utah should see a decrease in substance misuse outcomes.

a. The impact of increased access to marijuana and the state’s strategies to prevent misuse by the underage population.

The Prevention Prepared Communities (PPC) project and the After School Program (ASP) project both address risk factors related to cannabis use in Utah. Currently, Utah has legalized medical cannabis with limits on access among youth. Preliminary data and reports tell us that youth are obtaining access to cannabis (vape or edibles) from family and friends, or social media. PPC will allow communities to target specific risk and protective factors related to cannabis use in their areas. The ASP will minimize the risk among youth during the after school hours that generally has less adult monitoring (hours of 3 pm - 6 pm). By increasing adult monitoring and preparing communities to use evidence based strategies, Utah will see a change in access to cannabis and the misuse among youth.

b. Strategies to reduce the COVID-19 impact of increased alcohol accessibility and Misuse.

During the pandemic, Utah has seen a temporary change in alcohol policy. These policy changes impact the access of alcohol within communities as well as the community perception of access and availability. The PPC project as well as the Drinking While Pregnant (DWP) campaign will mitigate the increased access. As communities identify the issues and factors in their own communities, they will be able to address the risk factors, environmental factors/strategies and protective factors that will assist in decreasing the impact of alcohol availability.

c. How the state is using equitable strategies to reduce disparities in the state’s prevention planning and approaches.

By using data, local level involvement, state level oversight. Utah will increase the number of equitable and appropriate strategies in prevention planning. Because of the unique communities throughout the state, having local involvement and engagement will guide more of the prevention planning and approaches. The state prevention staff will guide and coach communities that may have difficulties in reaching populations that haven’t been involved in the prevention planning process previously. Utah will also utilize the regional Prevention Technology and Transfer Center for assistance in strategies to reduce disparities.

Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, upload the document (Microsoft Word or pdf) using the tab into the State Information Section, Chief Executive Officer’s Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority [SA]. Please title this document “ARPA Funding Plan 2021 (SA).”

10. Describe how the state will use, or considered, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, implementation from Office of the National Coordinator for Health Information Technology.
health IT products used or that will be used to support SUD clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (https://www.healthit.gov/isa/), including but not limited to those standards described in the “Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data” section and the “Social Determinants of Health” section.

Not Applicable to our application.
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- Program evaluations use standardized methods and data collection.
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**Recovery Support Services**

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<th>Award Expenditure (Fiscal 2019)</th>
<th>Description</th>
<th>Source</th>
<th>Sub-activities</th>
<th>Grants and GP</th>
<th>One-Goal Indicators and Practices</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Services: Outreach</td>
<td>$873,875</td>
<td>$686,472</td>
<td>Crisis Services provides a continuous service to individuals in emotional distress or a psychiatric crisis, overdose prevention services, follow-up services, education on how to support wellness with mental health services, community coordination and support services to individuals in the community as scored on the Crisis Act (CA) rating.</td>
<td>Contract: providing crisis services</td>
<td>Priority population: (mental health)</td>
<td>10% of client visits results</td>
<td>40% of calls</td>
<td>Crisis services to empower individuals as they work toward recovery and access to the care they need.</td>
</tr>
<tr>
<td>Recovery Peer Support: Interventions</td>
<td>$1,505,300</td>
<td>$550</td>
<td>Service delivery improvement (Mental Health Services)</td>
<td>Interventions to help individuals who have had mental health problems.</td>
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<td>Crisis Services: Cutting, Linking and Supporting Services</td>
<td>$217,919</td>
<td>$250,200</td>
<td>Reducing serious violence (SVC)</td>
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<td>Service delivery intervention: (SVC)</td>
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<td>Recovery Housing Support and Others</td>
<td>$205,100</td>
<td>$216,000</td>
<td>Behavioral health recovery support and linkage to services for individuals in the SUDs work to support housing programs.</td>
<td>Supportive housing for homeless and low-income SUDs clients.</td>
<td>Service delivery intervention: (SUDs)</td>
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</tr>
<tr>
<td>Employment and Economic Opportunity: Supported Employment and Workers with Intellectual Disabilities</td>
<td>$263,975</td>
<td>$21,500</td>
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<td>Service delivery intervention: (SUDs)</td>
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<td>Total</td>
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<tr>
<td><strong>Children, Youth &amp; Family</strong></td>
<td>Early Childhood Education</td>
<td>U.S.</td>
<td>$1,132,000</td>
<td>-</td>
<td>5</td>
<td>1</td>
<td>These funds are for evidence-based treatments (1) for particular autism spectrum; mental health and pediatrics services for low-income and their families. Clinician networks will be included in the cohort.</td>
<td>Contraindicated to VA agency</td>
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State Information

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

Fiscal Year 2022

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

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<tr>
<td>Section 1911</td>
<td>Formula Grants to States</td>
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| 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      |
Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the
awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is
the case, you will be notified.

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

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

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

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

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

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

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

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real
Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or
whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real
property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of
employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C.
§276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards
for federally assisted construction subagreements.

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

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental
quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b)
notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood
hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management
program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §1451 et seq.); (f) conformity of Federal actions to
State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).


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

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

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

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

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

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

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

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

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

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

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

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

3. Certifications Regarding Lobbying

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

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

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

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

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


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

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

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

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

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

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

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

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

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

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

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

Signature of CEO or Designee 1:  

Title: Executive Director of Utah Dept. of Human Services  

Date Signed:  

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

Footnotes:
September 1, 2021

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

To the Grants Management Officer,

Pursuant to Title V of the Public Health Act, I hereby certify that the state of Utah will assume responsibility for the implementation of the Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Program for Fiscal Year 2022-2023 and Fiscal Year 2023-2024.

Utah Department of Human Services’ Division of Substance Abuse and Mental Health has been designated the state agency to carry out the policies and programs of the Block Grant. Accordingly, I delegate Tracy Gruber, Executive Director of the Utah Department of Human Services, the authority to sign the Assurances and Certifications and any documents to the FY2022-2023 and FY2023-2024 Substance Abuse Block Grant and the FY2022-2023 and FY2023-2024 Mental Health Block Grant.

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

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

Sincerely

Spencer Cox
Governor
August 1, 2021

Tracy Gruber, Executive Director
Department of Human Services
195 North 1950 West
Salt Lake City, UT 84116

RE: Letter Designating Signatory Authority for Mental Health Block Grant and Substance Abuse Prevention and Treatment Block Grant

Dear Tracy:

DSAMH is requesting your approval for the Letter Designating Signatory Authority for Mental Health Block Grant and Substance Abuse Prevention and Treatment Block Grant.

Please review and sign where indicated. You may contact Xochiatl Thomas, 385-341-0545, or Cindy Lopez, 801-516-8328, with any questions regarding this application.

Thank you,

Xochiatl Thomas
Budget Director

Enclosures
sw
# State Information

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

**Fiscal Year 2022**

U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administrations  
Funding Agreements  
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## Title XIX, Part B, Subpart II of the Public Health Service Act

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

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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 nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

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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
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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.

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

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LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 2 CFR Part 182 by:
   a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
   b. Establishing an ongoing drug-free awareness program to inform employees about--
      1. The dangers of drug abuse in the workplace;
      2. The grantee's policy of maintaining a drug-free workplace;
      3. Any available drug counseling, rehabilitation, and employee assistance programs; and
      4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
   c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
   d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
      1. Abide by the terms of the statement; and
      2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
   e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
   f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
      1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
      2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
   g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

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

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

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

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)


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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

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

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

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

State: ________________________________

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

Signature of CEO or Designee: [Signature]

Title: Executive Director of Utah Dept. of Human Services

Date Signed: 07/23/2021

mm/dd/yyyy

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

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

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

Fiscal Year 2022

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

| Title XIX, Part B, Subpart II of the Public Health Service Act |
|------------------|------------------|
| **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 |

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employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no
later than five calendar days after such conviction;

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

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

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

3. Certifications Regarding Lobbying

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

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

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

2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.
The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

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


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

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

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

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

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

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

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

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

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

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

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

Signature of CEO or Designee: [Signature]

Title: Executive Director of Utah Dept. of Human Services

Date Signed: 07/23/2021

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

Please upload the states American Rescue Plan funding proposal here in addition to the other documents.

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

Footnotes:

(SAPT) September 1, 2021 through September 30, 2025 $13,428,346 ($3,357,086 per year)

B. SABG Guidance
States are required to plan for, expend, and report on the FY 21 SABG ARPA Supplemental Funding based on 42 U.S.C. Chapter 6A, Subchapter XVII, Part B, Subpart II: Block Grants for Prevention and Treatment of Substance Abuse, and 45 CFR, Part 96, Subpart L. Consistent with HHS Disaster Relief Flexibilities, SAMHSA may waive requirements with respect to allowable activities, timelines, or reporting requirements for the SABG as deemed necessary to facilitate a grantee’s response to coronavirus. Accordingly, all regular provisions of the statute and regulations pertaining to the SABG are fully applicable to the planning and expenditure of the SABG ARPA Supplemental Funding. Substance Abuse and Mental Health Services Administration 1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov
This includes, but is not limited to, the definitions, assurances, requirements, and restrictions of the SABG standard funding.

The SABG allocation requires states to expend not less than twenty percent (20%) of their total allocation for substance use disorder (SUD) primary prevention services for individuals who do not require treatment for substance abuse, in accordance with 42 USC 300x-22 and 45 CFR 96.124 and 96.125. The SABG allocation also requires “designated states” to expend five percent (5%) of their total allocation for EIS/HIV Services, in accordance with 42 USC 300x-24(b) and 45 CFR 96.128.

The SUD prevention, intervention, treatment, and recovery support services continuum includes various evidence-based services and supports for individuals, families, and communities. Integral to the SABG are its efforts to support health equity through its priority focus on the provision of SUD prevention, treatment, and recovery support services to identified underserved populations. These underserved and marginalized populations include, but are not limited to, pregnant women and women with dependent children; persons who inject drugs; persons using opioids and/or stimulant drugs associated with drug overdoses; persons at risk for HIV, TB, and Hepatitis; person d welfare system; Black, Indigenous, and People of Color (BIPOC); LGBTQIA+ individuals; rural populations; and other underserved groups.

SAMHSA recommends states develop, enhance or improve the following through the SABG ARPA funds:
• Develop and expand the use of FDA-approved medications and digital therapeutics as a part of addiction treatment that can provide interactive, evidence-based behavioral therapies for the treatment of opioid use disorders, alcohol use disorders, and tobacco use disorders, along with the implementation of other evidence-based treatments and practices.
• Provide increased access, including same-day or next-day appointments, and low barrier approaches, for those in need of SUD treatment services.
• Direct critical resources in expanding broad-based state and local community strategies and approaches in addressing the drug overdose epidemic, involving SUD prevention, intervention, treatment, and recovery support services.
• Improve information technology infrastructure, including the availability of broadband and digital health technologies, support for training and education of
GPS to expedite response times and to remotely meet with the individual in need of services.
• The adoption and use of health information technology to improve access to and coordination of SUD prevention, intervention, treatment, and recovery support services and care delivery, consistent with the provisions of HIPAA and 42 CFR, Part 2.
• Advance telehealth opportunities to expand services for hard-to-reach locations, especially rural and frontier areas. Expand technology options for callers, including the use of texting, telephone, and telehealth. Note: States may not use the funds to purchase any items for consumers/clients.

Substance Abuse and Mental Health Services Administration
1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov
• Enhance the primary prevention infrastructure within your state and communities using the Strategic Prevention Framework planning model and implementing evidence-based practices, the six CSAP prevention strategies with an emphasis on environmental approaches.
• Consider incorporating strategies around adverse childhood experiences to improve substance misuse outcomes among all populations, but especially young adults 18-25 and those over 26 years of age; preventing and reducing marijuana use by youth below the state’s legal age of use; and mitigating the impact of increased alcohol access by youth as identified during the COVID-19 pandemic. It is important to identify and address disparities and describe how you are incorporating equitable approaches.
• Support expansion of peer-based recovery support services (e.g. recovery community organizations, recovery community centers, recovery high schools, collegiate recovery programs, recovery residences, alternative peer group programs) to ensure a recovery orientation which expands support networks and recovery services. These programs are helping people sustain their recovery, engaging families and significant others, bridging the gap between treatment and long-term recovery, and supporting people reentering the community from incarceration.

**SAMHSA requests that the following information is included when submitting the proposals:**

1. Identify the needs and gaps of your state’s SUD services continuum, related to developing a comprehensive prevention, intervention, treatment, and recovery support services continuum.

Needs, gaps and recommendations were identified in the latest Utah mental health and substance use disorder reports which include the 2018 Crisis System Optimization report conducted by RI International Consulting, Kem Gardner and Utah Hospital Association (UHA) Reports, Student Health And Risk Prevention (SHARP) survey, National Survey on Drug Use among Households (NSDUH), Department of Health (DOH). Department of Human Services (DHS) Social and Behavioral Health During Covid-19 Report for Incident Command, Utah’s 2020 Intergenerational Poverty report, the Multicultural Advisory Committee’s COVID-19 Response reports, and other relevant health and health disparity reports. These reports highlight that more people were experiencing substance use disorders before the pandemic began and that rates of substance use disorders have increased and are expected to continue to increase after the pandemic.
Racial and ethnic minority communities and other communities have been disproportionately impacted by Covid-19. The patterns of increased anxiety, financial insecurity, and substance misuse was observed across all age groups and genders. These negative outcomes increased as the duration of stay at home orders or quarantine increased, and also increased as the length of the pandemic became increasingly unknown.

- The overall trend of opioid prescriptions filled has increased since the pandemic began and shows an increase in risk for misuse and addiction in the future. Utah has identified Opioid Use Disorder and the treatment for it as a priority across our state. We have continually worked to educate on the use of FDA approved medications but still struggle with acceptance for the use of medications to treat addiction and the stigma associated with it.

- Drug overdose deaths are the leading cause of injury death in Utah, outpacing deaths due to firearms, falls, and motor vehicle crashes. DSAMH staff participate in the fatality review committee and continue to work towards identifying the gaps and needs in our system where an overdose death occurred especially for individuals that were currently or had been part of our behavioral health system and understanding ways to reduce overdose deaths.

- Child abuse and neglect as well as domestic violence rates have increased during the pandemic and substance misuse is both a risk and causal factor of these problems. DSAMH collaborates with the Division of Children and Family Services in order to coordinate care and services for families, parents and children. Their are still needs in our system to identify and rapidly coordinate care.

- Prevention services include data driven priorities taken from the SHARP Statewide Survey, College/University surveys, and state/local data on risk and protective factors and target negative trend data over the last few survey administrations both statewide and in local areas of greatest concern. Identifying needs at an early state is one of our priorities in order to reduce the need for further treatment services.

- Tobacco and Marijuana use is increasing. As part of a full continuum of care DSAMH has worked to include Tobacco and Marijuana use in prevention services, as part of our normal screening, assessment and treatment planning processes and we continue to work to improve access to Nicotine Replacement Therapy and other appropriate uses of FDA approved medications.

- The following factors are also trending in the wrong direction and need to be addressed: Low Commitment to School - trending up 45.7%; Depressive Symptoms - Trending up 36.4%; Attitudes favorable to Antisocial Behavior (individual) - trending up 34.9%; Perceived Risk of Drug Use - trending down 34.6%. All of which significantly impact youth and youth adult substance use and misuse. We are focusing efforts in youth prevention services and early screening and assessment and placing individuals in appropriate levels of services. DSAMH continues to work on referring individuals to
other community and sister agencies in which cognitive and developmental disabilities can be addressed.

- Treatment services rely on incidence and prevalence data along with stakeholder feedback to address the areas with greatest need. Continuing to work on improving data collection from our behavioral system but also private providers and the Medicaid office in order to identify gaps and needs in our system and address those concerns.

- 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.

- Affordable Housing has been identified as a need across our state for many years. Utah's housing market has been strong and healthy, leaving affordable housing hard to come by. 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. This is the same for apartment rentals whose prices have also increased and created a housing shortage across the state.

These needs and gaps have great impact across our full continuum of care from prevention services, Mental health and Substance Use treatment services and recovery support services which are greatly needed right now as our state struggles to normalize during the pandemic.

2. Describe how your state's spending plan proposal will address the state's substance use disorder services continuum, including a budget that addresses the needs and gaps related to this continuum.

Proposed funds for evidence based prevention interventions are supported by the latest research (https://nam.edu/perspectives-2015-unleashing-the-power-of-prevention/) on changing individual and community norms and behaviors. Validated risk and protective factors will be targeted in local communities to decrease substance misuse. Data driven formulas will provide additional resources for rural areas and areas with higher needs. Competitive bids will provide an opportunity to assess community readiness to implement proposed interventions and ensure funds reach areas with the highest demonstrated need. The communities will also identify the gaps in equity and demonstrate how prevention services will address the needs and gaps of high need populations.

Youth and young adults needing access to substance use disorder services along with detoxification and withdrawal services will be addressed with these funds through evidence-based and SAMHSA approved strategies to decrease use and increase meaningful life activities like housing, school, employment and related activities.
Recovery support services focus on filling gaps in social determinants of health need areas which have been adversely impacted by Covid-19 and are often created when people begin misusing substances and eliminate their formal and informal support systems which are crucial to managing their illness and maintaining long term recovery. Priority populations are pregnant women and IV users as well as others identified as being affected by COVID.

The proposed interventions will increase healthcare integration, access to care in rural services and decrease health disparities for individuals disproportionately affected by Covid-19. The proposed interventions also align with Governor Cox’s One Utah Roadmap report. These funds will enhance services currently offered by contracted providers of Division of Substance Abuse and Mental Health (DSAMH) and Department of Human Services (DHS)/Department of Human Services (DHS) to address the ongoing and long-term impact of Covid-19 on the citizens of Utah. The proposed allocation of funds reflect priorities of: the required use of the SAPT Block Grant per SAMHSA, the reports identified and referenced above, Division of Substance Abuse and Mental Health (DSAMH)/Department of Human Services (DHS), the public mental health and substance use disorder and health systems and the Utah Behavioral Health Planning Council.

Funding for these service projects will be allocated out to our Local Substance Use Authorities, Local Health Departments or contracted out through a Request for proposal process.

A full continuum of services will be utilized which will include several different prevention measures such as campaign efforts and Drug Free Community mini grant projects that will be awarded to areas of most need. After School programs for middle schools that will address reducing alcohol and other drug misuse and Higher Education Prevention System efforts that will promote misuse efforts on campus.

Funding will be provided to expand access to Mobile Crisis Outreach Teams (MCOT) in an effort to respond to Substance Use Disorder calls. This also includes efforts to provide training to MCOT teams in regards to specific substance use disorder needs and services.

Volunteers of America have developed a very robust withdrawal and intoxication management program that provides great wrap-around services to individuals in need of a safe place to be while they detox and withdrawal from substances. DSAMH will be using this model to increase detoxification and withdrawal management services across the state, utilizing medication management and providing wrap-around services to support individuals in this state in their recovery. We also will focus on providing integrated physical and behavioral health services and a smooth transition from detox services to other levels of care or services as indicated. IV drug users and Pregnant women are identified as priority populations.

Utah is working on starting a Mobile Medication Assisted Therapy Clinic. We have several providers that are interested in starting a Mobile Clinic that would provide Medication Assisted Therapy and counseling services to individuals that are not able to travel or are outside of the typical service areas. The Mobile Clinic will be utilized in Rural/Frontier areas of the state and...
possibly in Salt Lake City where there are large amounts of transient populations that are not able to make it to a clinic for services.

Services for youth with a Substance Use Disorder will include efforts to increase screening and assessment and increase access to appropriate ASAM level of treatment services which will be supported by a contract for Technical Assistance to improve statewide access and treatment retention across the state.

Increased Recovery Support services to individuals in Recovery. This will include clients at any point in recovery; pre-treatment, treatment, post-treatment, etc. We understand that everyone has their own path to recovery and support that each path is individually unique. DSAMH supports the SAMHSA Recovery model: Health, Home, Purpose and Community. Utah will provide funding to the Local Authorities as directed through our federally funded allocation but will also provide an RFP for mini-grants to local community organizations that provide and promote recovery and will prioritize efforts from agencies providing recovery support and peer services to specialty populations such as LGBTQIA+ and minority populations.

Insert Budget

3. Describe your state’s progress in addressing the rising drug overdose rate in many parts of the country, and what steps the state will be taking to improve access to SUD treatment, by improving identification of persons in need, reducing barriers to admission to treatment, and strengthening mechanisms to promote client engagement and retention in SUD treatment and recovery support services.

In 2016, Utah was fourth in the nation for opioid overdose deaths. Between 2016 to 2020 in Utah, we have seen the following:

- Overdose deaths involving opioids have decreased from 78% in 2016 to 74.2% in 2020.
- Fentanyl deaths increased from 8.2% in 2016 to 23.2% in 2020.
- Stimulants involved in overdose deaths increased from 32.6% in 2016 to 50.7% in 2020.

The majority of these involved methamphetamines.

When using 2019 as a comparison year, crude overdose rates involving any drug and crude overdose rates involving an opioid were lower in 2019 than any of the previous eight years. According to Utah Office of the Medical Examiner data:

- There were 632 overdose deaths involving any drug in 2018 including 440 overdose deaths involving an opioid. This represents a 2.7% decrease in overdose deaths involving any drug and a very slight (less than one percent) increase in deaths involving an opioid compared with 2020.
- There were 615 overdose deaths involving any drug in 2020 including 442 overdose deaths involving an opioid. This represents a 7.7% increase in overdose deaths involving any drug and a 10.8% increase in deaths involving an opioid compared with
In Utah we have a state wide overdose fatality review committee that meets monthly to discuss the trends in overdoses in Utah. It is a multidisciplinary group of professionals, both state and community level partners, to provide information and discuss resources and interventions to help prevent similar overdoses in the future. Some of the recommendations out of these reviews have included; increased access to syringe service programs, continued and expanded peer support services in hospitals when people present for an overdose, increase in diversion centers to streamline individuals being able to be assessed and transitioned into treatment settings more quickly, which includes induction into MAT.

Utah has provided provider trainings for ASAM to ensure individuals are placed in appropriate levels of care. We have purchased the use of the LSI-RNR and the LSI-R:SV to improve criminogenic risk screenings for justice-involved individuals. We are currently working on a contract with King’s College of London to implement the Substance Use Recovery Evaluator (SURE) tool as a psychometrically valid recovery outcome measure to help clients stay engaged and to help clinicians monitor client progress in recovery and intervene when determined. Using evidence-based screening tools throughout a client’s treatment episode will help determine appropriate levels of care and when a client should increase or decrease levels of care. Recognizing that each client’s treatment and recovery path is different and designing individualized treatment and recovery plans is an important part to retention.

4. Describe your state’s progress in implementing the increased and widespread use of FDA approved medications for the treatment of opioid use disorder, alcohol use disorder, and tobacco use disorder, in combination with other substance use disorder evidence-based treatments and practices.

A combined report was completed in April 2020 from the Kem C. Gardner Policy Institute and the Pew Charitable Trusts to identify ways to Move Toward Evidence-Based Programs: Medication-Assisted Treatment for Opioid Use Disorder in Utah. Based on this report we have been able to more clearly see the areas throughout Utah that have discrepancies in rates of opioid overdose deaths and rates of providers for MAT. We are able to target pilot projects and fund programs that have fewer resources, in order to expand opportunities to access MAT.

**Medication Assisted Treatment (MAT) induction in Urgent Care Settings.** This project will be put out to bid through a request for proposal process (RFP) to providers that can provide the appropriate services within the counties of highest rates of need to receive priority for funding. We look at creating an additional, easy access point for people to start on MAT and piloting MAT induction sites that could work with existing healthcare system in the state (MountainStar HealthCare (HCA), Intermountain Health Care (IHC), University of Utah, or Federally Qualified Health Centers (FQHCs)). This is supported by SAMSHA’s Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings focusing found at [https://effectivehealthcare.ahrq.gov/products/opioid-use-disorder/technical-brief](https://effectivehealthcare.ahrq.gov/products/opioid-use-disorder/technical-brief). By providing services to individuals in Urgent Care and other related medical settings.

Mobile MAT Clinic/ Unit. This project will be put out to bid to providers through a request for proposal process (RFP) that can provide the appropriate services within the counties of highest rates of need to receive priority for funding. (Mobile MAT, linked with Local Authority Mobile Crisis Outreach Team (MCOT) and crisis services. Purchase of a mobile medical clinic vehicle that provides physical health space along with counseling services for those seeking medication for opioid use disorders. In rural areas waived providers are not easily accessible and public transportation is often limited, excluding people from accessing these services.) There are two forms of Medication Assisted Treatment (MAT) that can currently be provided or prescribed from a mobile MAT clinic.

Once the new regulations from the Drug Enforcement Administration (DEA) are approved and in place (21 CFR Parts 1300, 1301, and 1304) any current Opioid Treatment Program, Opioid Treatment Program (OTP), could add a mobile clinic to their current program to provide methadone and any of the other Food and Drug Administration (FDA) approved medications for the treatment of opioid use disorder from the mobile clinic. As per the proposed federal rule change from the DEA “DEA’s comparative analysis shows that the cost of operating a mobile unit is less than the cost of operating a physical location”. Should this rule be approved and implemented Utah would work with an existing OTP or an agency who would like to open an OTP with a mobile component to implement this increase to access of methadone treatment in Utah.

SAMHSA MAT Technical Brief (Mobile MAT addresses barriers)-
https://effectivehealthcare.ahrq.gov/products/opioid-use-disorder/technical-brief

SAMHSA TIP 63 Treatment Improvement Protocol re: Medications for Opioid Use Disorder

DSAMH encourages the use of all FDA approved Medication Assisted Therapy for the treatment of substance use disorders. Providers are required to screen and assess for opioid use and tobacco use in which medication, counseling and/or treatment services can be recommended and provided.

5. Explain how your state plans to collaborate with other departments or agencies to address the SUD services continuum.

Collaboration will take place at many different levels, Governmental, Local Counties with our Local Authorities and with community providers.
DSAMH will be coordinating with the Utah Department of Health (DOH) regarding crisis response services and services involving MAT to coordinate partnerships with primary care providers and other health care providers. Collaborate with the Division of Child and Family Services (DCFS), Department of Juvenile Justice Services (DJJS), Courts and community partners regarding youth treatment services to ensure there is no duplication of services and improve quality of care and treatment placement. We will coordinate with Local law enforcement agencies, Department of Corrections (DOC)- Adult Probation and Parole, where services will not be provided to individuals that are incarcerated but to those individuals that have been released from incarceration and are acclimating back into society, target populations are pregnant women, IV users, adult women and men. Hospitals and healthcare providers as well as Local Substance Abuse Authorities and contractors to coordinate efforts around withdrawal and intoxication management services across the state, populations to be serviced are priority populations such as pregnant women, IV users, and all other populations of need. We will collaborate with the Department of Workforce Services and the Utah State Board of Education to ensure quality and evidence based after school services are offered around the state. We will be coordinating and working with many community agencies in the delivery of services that address the needs for prevention and treatment services through competitive bid processes. These agencies will include clinical treatment service providers, community recovery support agencies, campaign agencies, prevention service agencies, educational and school service providers, etc. We will also be coordinating many efforts through our Local Authority’s (Local Substance Abuse and Mental Health Authorities).

Funding for these services will be allocated out to our Local Substance Use Authorities, Local Health Departments or contracted out through a Request for proposal process.

DSAMH is focused on providing a full continuum of services and our community partners play a large role in those efforts. From prevention efforts to treatment services and aftercare our community partners play a role. We have great relationships with our community behavioral health providers which provide a full continuum of services, our local medical hospitals and clinics that help identify clients in need of treatment services and can provide a warm handoff to providers and also help in our integrated care services through a continuum. We work closely with local legal and justice agencies through our new Diversion Units, Drug Court services, Mobile Crisis Outreach Teams and with our Department of Probation that providers referrals into treatment services and collaborate at every point to ensure individuals are receiving the best services possible and to reduce recidivism rates. Our community providers that do community outreach, crisis intervention, recovery support services, and provide an abundance of peer support services in which they provide an abundance of community resources and support in order to ensure we have a full continuum of care for individuals and families in recovery.

In 2021 our Legislature passed a bill to merge the Department of Human Services with the Department of Health. The merger will be completed in 2022, this effort of merging Departments is to streamline the process for individuals that are in need of and receiving services. There are many changes our system is undergoing currently but eventually the process of requesting services and receiving access will be fluent, quick, responsive and
6. Describe how the state plans to use SABG ARPA funding to promote health equity among identified underserved populations, and how it plans to address health disparities in the planning, delivery, and evaluation of SUD prevention, intervention, treatment, and recovery support services.

DSAMH has developed a Health Disparities Research Team made up of DSAMH program staff, data and research professionals, other state and community agencies, community members and peers. In 2021, the team conducted the Health Disparities in Utah's Public Mental Health System. It looked at four different populations: People of Color, People with Developmental Disabilities, Members of LGBTQIA+ community and Transition-Age Youth and Young. 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.

DSAMH will be working within our state behavioral health system, other state agencies, community providers and organizations, community members, peers and other parties of interest to identify additional gaps and needs in our state across our full continuum of services.

7. Describe the state’s efforts and plans to promote an increased emphasis on the development, delivery, and support of widespread SUD recovery support services, systems, and mechanisms across the state.
Substance Abuse and Mental Health Services Administration
1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov

Utah has dedicated part of the ARPA funding to provide Recovery Support Services to individuals in Recovery through two different projects. The first will provide dedicated funding for Recovery Support Services to our Local Substance use Authorities on our federally approved allocation formula. This will provide funding to each Local Authority in which they can provide an array of approved recovery support services. Recovery support service data is required and is uploaded into our state SAMHIS system monthly. This will allow us to review the services being provided by each Local Authority continually. DSAMH along with the Recovery Support Steering Committee and the Local Authority Clinical Directors and Public Data Committee have developed a Recovery Support Service manual that defines services, funding, service delivery, and establishes reimbursement rates for all approved recovery support services. Services provided that are not included in the Recovery Support manual are not reimbursed.

The second Recovery Support Service project will be an RFP which will allow for 8-10 contracts
services. We recognize that recovery is different for everyone and each path is different, contracts will be awarded in an effort to recognize unique paths in recovery and support efforts to support individual and community needs while also recognizing the service needs of specialty populations such as LGBTQIA+ and minority populations.

8. Describe other state priorities or activities that the state plans to fund during the performance period of September 1, 2021 through September 30, 2025 using ARPA Funds.

Drinking While Pregnant Campaign which is a prevention campaign using existing coalitions to raise awareness about harms of drinking if pregnant. The project will address risks of consuming alcohol while pregnant, promoting healthy behaviors during pregnancy. To make this project successful, the prevention workgroup is collaborating with multiple stakeholders (Mother to Baby, Intermountain Hospitals, Poison Control, Community Coalitions statewide).

The largest project under these funds will be the Prevention Prepared Communities. This will focus on supporting community coalitions to become prepared for Drug Free Community Grants or for other funding sources. Applicants may have previously applied for the DFC grant but may not have received the grant. The project has grantees work through the Strategic Prevention Framework, with the outcome of developing a strategic prevention plan for that community. Priority funding to communities/entities that have submitted applications for DFC grants. The applications include community and program measures, sustainability plans, and the grant requires an established community coalition (CTC & CADCA Academy include sustainability planning). The project focus is on local factors with the strongest trend changes.

After School Prevention Programming: This is a competitive grant project that promotes evidence based prevention programming that focuses on the after school timeframe or strategies that support youth. The applicants will provide selective or indicated prevention services to reduce alcohol and other substance use among youth.

Prevention in Higher Education: This is a competitive grant project that promotes and builds prevention coalition efforts on public institutions of higher education. The population of 18-25 years old has been neglected. This project aims to support evidence based strategies that can be sustained after grant funding has ended. The outcome would be a decrease in the number of underage drinkers and binge drinking young adults on higher education campuses in Utah.

Medication Assisted Treatment in Urgent Care settings. This will be conducted through an RFP bid process. This is an effort to create additional, easy access points for individuals to have access to Medication Assisted Therapy. We also plan for this to be another point of integrated care and look for settings such as Intermountain HealthCare, one of our largest healthcare organizations, Federally Qualified Health Care Centers, the University of Utah or other health care clinics and organizations.

9. Describe your state plans for enhancing your state’s prevention infrastructure which may include incorporating work around ACEs and improving substance misuse outcomes among young adults and older adults. (Primary Prevention set-aside)

Utah has proposed projects that will strengthen communities statewide. The proposal has allowed for local level planning and identification of needs and gaps to be filled. The aim of the
impact the consumption rates among youth and adults. These factors impact the ACEs of a community.

The projects work with coalitions to increase the capacity of communities with higher need populations - after school youth, 18-25 year olds, and pregnant persons. By addressing risk and protective factors, Utah should see a decrease in substance misuse outcomes.

a. The impact of increased access to marijuana and the state’s strategies to prevent misuse by the underage population.

The Prevention Prepared Communities (PPC) project and the After School Program (ASP) project both address risk factors related to cannabis use in Utah. Currently, Utah has legalized medical cannabis with limits on access among youth. Preliminary data and reports tell us that youth are obtaining access to cannabis (vape or edibles) from family and friends, or social media. PPC will allow communities to target specific risk and protective factors related to cannabis use in their areas. The ASP will minimize the risk among youth during the after school hours that generally has less adult monitoring (hours of 3 pm - 6 pm).

By increasing adult monitoring and preparing communities to use evidence-based strategies, Utah will see a change in access to cannabis and the misuse among youth.

b. Strategies to reduce the COVID-19 impact of increased alcohol accessibility and Misuse.

During the pandemic, Utah has seen a temporary change in alcohol policy. These policy changes impact the access of alcohol within communities as well as the community perception of access and availability. The PPC project as well as the Drinking While Pregnant (DWP) campaign will mitigate the increased access. As communities identify the issues and factors in their own communities, they will be able to address the risk factors, environmental factors/strategies and protective factors that will assist in decreasing the impact of alcohol availability.

c. How the state is using equitable strategies to reduce disparities in the state’s prevention planning and approaches.

By using data, local level involvement, state level oversight. Utah will increase the number of equitable and appropriate strategies in prevention planning. Because of the unique communities throughout the state, having local involvement and engagement will guide more of the prevention planning and approaches. The state prevention staff will guide and coach communities that may have difficulties in reaching populations that haven't been involved in the prevention planning process previously. Utah will also utilize the regional Prevention Technology and Transfer Center for assistance in strategies to reduce disparities.

Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, upload the document (Microsoft Word or pdf) using the tab into the State Information Section, Chief Executive Officer’s Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority [SA]. Please title this document “ARPA Funding Plan 2021 (SA).”

10. Describe how the state will use, or considered, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, how the state is partnering with Office of the National Coordinator for Health Information Technology.
health IT products used or that will be used to support SUD clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (https://www.healthit.gov/isa/), including but not limited to those standards described in the “Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data” section and the “Social Determinants of Health” section.

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<td>Medicaid 2021/22 Funding</td>
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<tr>
<td>Crisis Services</td>
<td>Utah</td>
<td>$1,675,878</td>
<td>$663,337</td>
<td>The site has provided therapeutic assistance to individuals in emotional distress or psychological crisis, providing peer support services, follow-up services, education and training, support to individuals with mental health needs, coordination and support to individuals in the community as needed at the Mental Health Crisis Hotline (M101) and first responders in coordination with local mental health authorities. Services are 24/7/365 at no cost. The goal of these services is to empower clients and individuals with the tools and resources to reduce the need that they need.</td>
<td>Core</td>
<td>Contracting: providing the service</td>
<td>Priority areas: (1) acute crisis - wide</td>
<td>Indicated negative, first contact element of Emergency and Practice crisis systems</td>
<td>percentage of callers satisfaction and empathy</td>
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<td>Recovery Treatment</td>
<td>Utah</td>
<td>$1,555,738</td>
<td>$5</td>
<td>Recover case management/CD case-related events (office visits, telephone, transportation, and other MD services, community support, employment, housing, etc.)</td>
<td>Level 1</td>
<td>Core</td>
<td>Reduced 24/7/365 adults (60)</td>
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<td>Number of identified needs and barriers to include: CMHC/BA accessing ODI/ODS funding</td>
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<td>Substance Use</td>
<td>Utah</td>
<td>$1,013,080</td>
<td>$5</td>
<td>Saint Joseph Health Services and SLLO Collaborate. Program Manager manages a statewide system of mental health care for adult consumers and performs a variety of functions in the mental health system. Planning such as research, program development, statistical analysis of populations, policy analysis, advocacy, and organizational development to assess the needs of children and adults who have been identified as having needs and who are treated for these needs.</td>
<td>Core</td>
<td>Core</td>
<td>MH/SSC adult clients</td>
<td>Core</td>
<td>Number of identified needs and barriers to include: CMHC/BA accessing ODI/ODS funding</td>
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<tr>
<td>Crisis Services</td>
<td>Utah</td>
<td>$573,910</td>
<td>$520,000</td>
<td>Recovery center provides 24 hour services for transmission, observation, medicalization, crisis management and support with a pre-referral framework (VMC).</td>
<td>Core</td>
<td>Core</td>
<td>MH/SSC clients with urgent needs</td>
<td>Core</td>
<td>Number of identified needs and barriers to include: CMHC/BA accessing ODI/ODS funding</td>
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<td>Recovery Housing</td>
<td>Utah</td>
<td>$201,000</td>
<td>$201,000</td>
<td>Behavioral health recovery services and support to link individuals in the SLLO network to housing programs.</td>
<td>Core</td>
<td>Core</td>
<td>MH/SSC clients with urgent needs</td>
<td>Core</td>
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<td>Supported Employment</td>
<td>Utah</td>
<td>$2,403,473</td>
<td>$2,184,022</td>
<td>Supported employment for individuals with disabilities</td>
<td>Core</td>
<td>Core</td>
<td>MH/SSC clients with urgent needs</td>
<td>Core</td>
<td>Number of identified needs and barriers to include: CMHC/BA accessing ODI/ODS funding</td>
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<td>Award Amount (FY 2022-2023)</td>
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<tr>
<td>Youth Violence Prevention</td>
<td>Early Intervention</td>
<td>Utah, USI, EOC</td>
<td>$151,000</td>
<td>To increase outcomes for evidence-based treatment (EBT) services for children and families, EOC clinical case managers will be included in the cohort</td>
<td>Contracted to EOC</td>
<td>EBT services for children and families</td>
<td>Remaining</td>
<td>Comprehensive approach to violence prevention and intervention for children and families, including evidence-based treatment services.</td>
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<td>Title of Work Area/Category</td>
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<tr>
<td>CRF</td>
<td>Free Support, Specialized, and Innovative Services</td>
<td>$14,400</td>
<td>$15,000</td>
<td>Improving the training, supervision, and structure of Youth Support Services using a results-driven, collaborative, and innovative approach.</td>
<td>Sustain and expand support services and programs for youth and adults, ensuring a high level of quality and accessibility.</td>
<td>KLDB, الا, RFA, and SRF</td>
<td>Ongoing and SFRP</td>
<td>Research and/or SBP</td>
<td>Economic advancement, enhanced workforce development, social mobility, and increased access to opportunities.</td>
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<tr>
<td>CRF</td>
<td>Free Support, Specialized, and Innovative Services</td>
<td>$19,340</td>
<td>$20,000</td>
<td>An innovative, results-based approach that leverages community partnerships and resources to provide comprehensive support services for youth and adults.</td>
<td>Sustain and expand support services and programs for youth and adults, ensuring a high level of quality and accessibility.</td>
<td>KLDB, الا, RFA, and SRF</td>
<td>Ongoing and SFRP</td>
<td>Research and/or SBP</td>
<td>Economic advancement, enhanced workforce development, social mobility, and increased access to opportunities.</td>
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<td>Demonstration</td>
<td>$5,000</td>
<td>$5,000</td>
<td>Demonstrating the effectiveness of innovative approaches to support services for youth and adults.</td>
<td>Sustain and expand support services and programs for youth and adults, ensuring a high level of quality and accessibility.</td>
<td>KLDB, الا, RFA, and SRF</td>
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<td>Ongoing and SFRP</td>
<td>Research and/or SBP</td>
<td>Economic advancement, enhanced workforce development, social mobility, and increased access to opportunities.</td>
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**Notes:**
- The table above represents a summary of projects and their associated costs and objectives, focusing on support services for youth and adults.
- The focus areas include Free Support, Specialized, and Innovative Services, and Demonstration.
- The table details the award amounts, project descriptions, and anticipated rate elements for each project.
- The one-click roadmap emphasizes economic advancement, enhanced workforce development, social mobility, and increased access to opportunities.

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[1] Combined with Row 21
## State Information

### Disclosure of Lobbying Activities

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

**Standard Form LLL (click here)**

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<thead>
<tr>
<th>Name</th>
<th>Tracy Gruber</th>
</tr>
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<tbody>
<tr>
<td>Title</td>
<td>Executive Director of Utah Dept. of Human Services</td>
</tr>
<tr>
<td>Organization</td>
<td>Utah State Department of Human Services</td>
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OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

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Planning Steps

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

Narrative Question:

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

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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 will be called the Department of Health and Human Services. More information can be found at https://sites.google.com/utah.gov/hhsplan/home.

![Organizational Chart]

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 Human Services (soon to be the Department of Health and Human Services) has been one of the largest departments in Utah State government and currently consists of the following service offices and divisions:
• Division of Substance Abuse and Mental Health (substance use disorders, prevention, and mental health)
• Division of Aging & Adult Services (programs supported under the Older Americans Act and Adult Protective Services)
• Division of Services for People with Disabilities (persons with developmental delays, intellectual disabilities and traumatic brain injuries)
• Division of Child & Family Services (child welfare)
• Division of Juvenile Justice Services (youth corrections)
• Office of Recovery Services (child support enforcement)
• Office of Public Guardian (guardian/conservator services for vulnerable adults)
• Office of Licensing (for all public and private human service provider agencies within Utah)
• Office of Quality and Design

Coordination will continue to be a major emphasis in the Department of Health and Human Services/Division of Substance Abuse and Mental Health (DHHS/DSAMH). 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, DHS has comprised a new interagency workgroup to address and advise on integrated service approaches addressing consistency and efficiency in key operations. The workgroup will address key issues and give input on barriers and opportunities that are collectively shared between all agencies.

There are currently multiple groups meeting to address Prescription Drug Abuse, Opioid Overdose Prevention, Suicide Prevention, Recovery Supports (Employment, Housing, Peer Supports), 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. DSAMH provides oversight, technical assistance and support to the Local Substance Abuse Authority (LSAA) prevention staff. DSAMH also collaborates with other state agencies on statewide prevention strategies, including underage drinking prevention, opioid overdose prevention and suicide prevention.

An ongoing focus of the Department of Health and Human Services, is a continuing effort to identify and enroll uninsured individuals either through the State’s Avenue H, private health insurance exchange, or Legacy 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 $12,490 annual income for an individual). Approximately 70,000 – 90,000 Utah residents will become newly eligible for Medicaid. Approximately 40,000 individuals from 101-138% FPL will continue to receive services through the federal Marketplace. Enrollment eligibility started April 1, 2019. The State submitted a new 1115 Waiver to CMS called the Per Capita Cap Plan. This plan will replace the plan implemented on April 1, 2019 and will be effective upon CMS approval. The Per Capita Plan covers adults up to 100% FPL and requests the following provisions: self-sufficiency requirement, enrollment cap, up to 12-month continuous eligibility, employer-sponsored insurance enrollment, lockout for program violation provision, and a per capita cap. This plan will also request 90% federal/10% state funding.

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

The Utah Division of Substance Abuse and Mental Health is authorized under Utah State Code Annotated §62A-15-103 as the single state authority for mental health and substance abuse in Utah. Utah Statutes require that the State Division of Substance Abuse and Mental Health to: “...set policy for its operation and for programs funded with state and federal money...establish, by rule, minimum standards for local substance abuse authorities and local mental health authorities...develop program policies, standards, rules, and fee schedules for the division...” (Utah Code Title 62A, Chapter 15, Section 105 “Authority and Responsibilities”) and that DSAMH “...contract with local substance abuse authorities and local mental health authorities to provide a comprehensive continuum of services...in accordance with division policy, contract provisions, and the local plan...” (Utah Code 62A-15-103. “Division -- Creation – Responsibilities”).

The Director of The Division of Substance Abuse and Mental Health serves as the SSA and SMHA, and as such oversees the provision of Behavioral Health Services in the State. The Director is supported by an Assistant Directors of Adult Mental Health, Children, Youth, and Family Mental Health, and an Assistant Director of Substance Abuse. DSAMH carries out its statutory obligations by contracting with Local Substance Abuse and Mental Health Authorities for the delivery of Behavioral Health services. 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 DSAMH 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 DSAMH also provides leadership and coordination with other state agencies, the state legislature and advocacy groups.

Utah’s public behavioral health system operates with the following Vision, Mission, Function and Principles statements:

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

DSAMH has 5 primary strategic initiatives that focus on Prevention and Early Intervention, Zero Suicides, Promote Recovery, Improve Care for Children and Youth, and Health System Integration. DSAMH uses these strategic initiatives to plan, develop and implement programs, and track goals and outcomes.

Utah State Statute Utah Code 62A-15-103, 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 DSAMH.
Local Authorities set the priorities to meet local needs, but at a minimum must provide ten statutorily mandated mental health services as well as peer support services mandated through Medicaid contract, and a continuum of substance use disorder services either directly or through contracts and agreements. Area plans describing what services will be provided with state, federal and county funds are developed and submitted to DSAMH annually. These plans become the foundation of contracts between DSAMH and each of the Local Authorities.

Utah’s public Behavioral Health system for child, youth/adolescent and family services has the same organizational structure as the adult system. Local Authorities are required to outline in their area plan how they are planning to provide mental health and substance abuse treatment and prevention services to this population as well as the adult population. This plan is based on statutory requirements and a Division Directive that is provided each year to the local authorities shortly after the Legislative Session ends in March. The current Division Directives are located at: http://www.dsamh.utah.gov. Contracts with the Local Authorities and their funding allocations are approved only after the Area Plans have been approved by the DSAMH 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 DSAMH. The
State Hospital currently provides active psychiatric treatment for 252 adult patients and has the capacity to provide active psychiatric treatment for 72 children. Patients must be actively experiencing symptoms of severe and persistent mental illness to qualify for services, and are placed through a civil commitment or forensic commitment. The State Hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and certified for Medicare/Medicaid reimbursement by the Center for Medicare & Medicaid Services.

State statute allocates all pediatric and youth beds to the Local Mental Health Authorities, but the DSAMH is responsible for establishing a bed allocation formula, which is based on the percentage of state population within each Local Authority's catchment area and a rural differential. The 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 US Census in 2021 estimates Utah's population to be 3,310,774, a 19.79% increase from 2010 (2,763,885). Utah is currently the nation’s fourth fastest growing state over the past year, growing by 1.614% in 2020.

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

<table>
<thead>
<tr>
<th></th>
<th>Count</th>
<th>Population Percentage</th>
<th>Area Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salt Lake County</td>
<td>1</td>
<td>35.76%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Weber Human Services</td>
<td>2</td>
<td>8.51%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Central Utah Counseling</td>
<td>6</td>
<td>2.55%</td>
<td>20.3%</td>
</tr>
</tbody>
</table>

As shown in the chart and map below, the Local Authorities have significant differences in the size of their areas of responsibility and in the density of their populations.
<table>
<thead>
<tr>
<th>Local Authority</th>
<th>% of Population</th>
<th>% of Land</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bear River</td>
<td>5.83</td>
<td>9.7</td>
</tr>
<tr>
<td>Weber</td>
<td>8.51</td>
<td>1.4</td>
</tr>
<tr>
<td>Salt Lake</td>
<td>35.76</td>
<td>0.9</td>
</tr>
<tr>
<td>Davis</td>
<td>11</td>
<td>0.4</td>
</tr>
<tr>
<td>Tooele</td>
<td>2.32</td>
<td>8.4</td>
</tr>
<tr>
<td>Wasatch</td>
<td>1.09</td>
<td>1.4</td>
</tr>
<tr>
<td>Utah</td>
<td>20.11</td>
<td>2.4</td>
</tr>
<tr>
<td>Summit</td>
<td>1.29</td>
<td>2.3</td>
</tr>
<tr>
<td>Central</td>
<td>2.55</td>
<td>20.3</td>
</tr>
<tr>
<td>SouthWest</td>
<td>8.13</td>
<td>21.3</td>
</tr>
<tr>
<td>Northeastern</td>
<td>1.73</td>
<td>10.2</td>
</tr>
<tr>
<td>Four Corners</td>
<td>1.23</td>
<td>11.7</td>
</tr>
<tr>
<td>San Juan</td>
<td>0.46</td>
<td>9.5</td>
</tr>
</tbody>
</table>

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 (2019), the racial composition of Utah is:

- White: 90.63%
- Two or more races: 2.6%
- Asian: 2.7%
- Black or African American: 1.5%
- Native American: 19%
- Native Hawaiian or Pacific Islander: 1.1%
- Hispanic or Latino: 14.4%
- White alone, not Hispanic or Latino: 77.8%

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

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.
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

<table>
<thead>
<tr>
<th>Local Authorities - Pregnant and Parenting Women’s Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>County</td>
</tr>
<tr>
<td>--------</td>
</tr>
<tr>
<td>Cache County</td>
</tr>
<tr>
<td>Cabon County</td>
</tr>
<tr>
<td>Central Utah</td>
</tr>
<tr>
<td>Davis County</td>
</tr>
<tr>
<td>Salt Lake County</td>
</tr>
<tr>
<td>San Juan</td>
</tr>
<tr>
<td>Washington County</td>
</tr>
<tr>
<td>Summit County</td>
</tr>
<tr>
<td>Uintah Basin - Tri County</td>
</tr>
<tr>
<td>Utah County</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Wasatch County</td>
</tr>
</tbody>
</table>
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 Division has also encouraged the use of Medication-Assisted Treatment (MAT) services for Opioid user disorder including individuals identified as IV users in which the Division has included language to support the use of MAT in the Division Directives that state:

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

See Table below: Table outlines a list of OTP providers throughout the State that have agreements with Local Authorities to provide MAT services.
<table>
<thead>
<tr>
<th>County</th>
<th>Director Name</th>
<th>Address</th>
<th>Phone Numbers</th>
<th>Opioid Treatment Provider Program Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salt Lake County</td>
<td>Director - Tim Whalen</td>
<td>2001 South State, Suite 5200, Salt Lake City, Utah 84190; (385) 468-4727</td>
<td>Metamorphosis Salt Lake - 169 East 5900 South #101, Salt Lake City, Utah 84123; Director - Debra Drabner - (801) 631-4835; CEO Shannon Terwedo - (530) 320-9220</td>
<td>Opioid Treatment Provider Program, which has an MOU with Valley Phoenix Women and Children’s Residential to provide MAT. Outpatient and PWW services.</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>Director - Tim Whalen</td>
<td>2001 South State, Suite 5200, Salt Lake City, Utah 84190; (385) 468-4727</td>
<td>Project Reality - Salt Lake; 150 East 700 South, Salt Lake City, Utah 84111; (801) 364-8080; Director Linda Moore (801) 558-8496</td>
<td>Opioid Treatment Provider Program, which has a contract with Salt Lake County Behavioral Health to provide MAT. Outpatient and PWW services.</td>
</tr>
<tr>
<td>Salt Lake County</td>
<td>Director - Tim Whalen</td>
<td>2001 South State, Suite 5200, Salt Lake City, Utah 84190; (385) 468-4727</td>
<td>Project Reality - Murray; 5280 South Comer Drive, Suite D110, Murray, Utah 84107; (385) 881-0170; Director Linda Moore (801) 558-8496</td>
<td>Opioid Treatment Provider Program, which has a contract with Salt Lake County Behavioral Health to provide MAT. Outpatient and PWW services.</td>
</tr>
<tr>
<td>Utah County</td>
<td>Director - Richard Nance</td>
<td>Project Reality - Provo; 151 South University Avenue, Suite 1400, Provo, Utah 84606; Director - Linda Moore (801) 558-8496</td>
<td>Discovery House - Orem; 714 South State Street, Orem, Utah 84058. (801) 426-6565. Director - Daniel Hymas (208) 313-7333.</td>
<td>Opioid Treatment Provider Program, which has a contract with Utah County Division of Substance Abuse to provide MAT. General Outpatient including PWW services.</td>
</tr>
<tr>
<td>Weber County</td>
<td>Director - Richard Nance</td>
<td>Project Reality - Provo; 151 South University Avenue, Suite 1400, Provo, Utah 84606; Director - Linda Moore (801) 558-8496</td>
<td>Discovery House - Orem; 714 South State Street, Orem, Utah 84058. (801) 426-6565. Director - Daniel Hymas (208) 313-7333.</td>
<td>Opioid Treatment Provider Program, which has a contract with Utah County Division of Substance Abuse to provide MAT. General Outpatient including PWW services.</td>
</tr>
<tr>
<td>Weber County</td>
<td>Director - Kevin Eastman</td>
<td>Metamorphosis - Ogden; 2557 Lincoln Avenue, Ogden, Utah 84401, (801) 622-5272. Director - Raquel Dee (801) 510-4758. CEO - Shannon Terwedo - (530) 320-9220</td>
<td>Operation Recovery - Price - 77 South 600 East, Suite C, Price, Utah 84501; (435) 613-6289; Director - Linda Moore - (801) 558-8496</td>
<td>Opioid Treatment Provider Program, which has a contract with Weber Human Services. Outpatient and PWW services.</td>
</tr>
<tr>
<td>Weber County</td>
<td>Director - Kevin Eastman</td>
<td>Discovery House - Layton</td>
<td>Operation Recovery - Price - 77 South 600 East, Suite C, Price, Utah 84501; (435) 613-6289; Director - Linda Moore - (801) 558-8496</td>
<td>Opioid Treatment Provider Program, which has a contract with Weber Human Services. Outpatient and PWW services.</td>
</tr>
<tr>
<td>Carbon County</td>
<td>Director - Karen</td>
<td>Metamorphosis - Ogden; 2557 Lincoln Avenue, Ogden, Utah 84401, (801) 622-5272. Director - Raquel Dee (801) 510-4758. CEO - Shannon Terwedo - (530) 320-9220</td>
<td>Operation Recovery - Price - 77 South 600 East, Suite C, Price, Utah 84501; (435) 613-6289; Director - Linda Moore - (801) 558-8496</td>
<td>Opioid Treatment Provider Program, which has a contract with Weber Human Services. Outpatient and PWW services.</td>
</tr>
</tbody>
</table>
Planning Steps

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

Narrative Question:
This step should identify the unmet service needs and critical gaps in the state’s current M/SUD system of care as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state’s M/SUD system of care. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, SUD prevention, and SUD treatment goals at the state level.
PLANNING STEP 2: Identifying the Unmet Service Needs and Critical Gaps within the Current Service System.

Challenges Related to Utah Demographics:

- The US Census in 2021 estimates Utah's population to be 3,310,774, a 19.79% increase from 2010 (2,763,885). Utah is currently the nation’s fastest growing state over the past year, growing by 1.614% in 2020.
- US Census 2019 the overall persons in poverty rate in the State of Utah is 8.9%.
- 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.
- According to the 2020 U.S. Census, Utah is the fastest growing state with a population growth of 18.4% in the past decade 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.
DSAMH 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. DSAMH 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.

DSAMH has been working with Local Authorities and their community partners in providing educational opportunities and efforts towards use of MAT and FDA guidelines, and will continue to offer efforts to support the use of MAT by reaching out to 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:
DSAMH has worked to maintain funding for residential services for women with dependent children. With research supporting the practice of keeping children with their mothers, DSAMH provides support for these services. In FY18 and FY19, DSAMH 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. In addition, DSAMH and the Utah Division of Child and Family Services (DCFS) have worked together to provide ongoing IV-E entitlement funding through the Family First Prevention Services Act (FFPSA) to the six Women and Children’s Residential Treatment Programs in Utah to pay for the children’s room and board, which Medicaid does not cover. 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,
DSAMH 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. DSAMH 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 2019 identify 4%, or 12,419 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.

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 DSAMH made an effort to open up other federal and state funding options to help support and fund recovery support services. 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 has been exacerbated by the COVID pandemic and strong demand for affordable housing. 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. 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 118 licensed Recovery Residences in 2021 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 DSAMH’s Health Disparities Research Team conducted the Health Disparities in Utah's Public Mental Health System survey. It looked at four different populations: People of Color, People with Developmental Disabilities, Members of LGBTQIA+ community, and Transition-Age Youth and Young. 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.

DSAMH will be working within our own Local Authorities and with our community system to make these changes and to better service our community.

Integrated Care:
- **The Utah Department of Health reports 22% of Utah’s adult population suffers from chronic health conditions, and has continuously found statistical information concurrent with national research indicating a high rate of co-occurring chronic physical illness and mental illness in Utah’s adult population (Source: Utah Department of Health, CDC Behavioral Risk Factor Surveillance System Report).**
- **Utah’s adults with mental illness are at greater risk of chronic health conditions, just as those with chronic health conditions are at increased risk of mental illness. (Source: Utah Department of Health, CDC Behavioral Risk Factor Surveillance System Report).**
- **Through a growing partnership with the Utah Department of Health, DSAMH 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. DSAMH 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. DSAMH 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. We have a new target date of September 1, 2021 to have the bed registry go live. 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 inatives: Reducting 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. DSAMH has placed emphasis on providing SBIRT training to physical health providers and has also taken steps to contract with a platform provider that will allow Physical Health providers to search available treatment slots. DSAMH is currently working with Juvare and the State Health Department to pilot the project that will allow monitoring and tracking of State hospital beds for individuals with 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.
Tobacco Use:

- Forty-four percent of all cigarettes in America are consumed by individuals who live with mental illness and/or substance abuse disorders (Source: *The Journal of the American Medical Association*). 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 (1.2% combustible cigarettes, past 30 day use; Student Health and Risk Prevention survey), Utah is seeing an increase in vaping (e-cigarettes). Past 30 day vaping among all youth is 9.7%. Vaping is now the number one substance used among youth. (SHARP 2019).

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:**
- As mentioned previously, Utah has a higher median household income but a significantly lower per capita income when compared to National data, a function of the high birthrate and lower median age.
- Individuals and families living in rural Utah are more likely to experience more dire risk factors due to economic limitations and the geographic challenges that cause limited access to resources, services and opportunities.
- According to the US Census- Utah, the average per-capita income for Utahns in 2019 (past 12 months) was $34,103 with 10.5% of the population living in poverty. Source: https://www.census.gov/quickfacts/UT
- Median household income is $62,843 (2015-2019)
- The 2019 Rural Health Info Hub indicates a poverty rate of 11.2% exists in rural Utah, compared to a 8.6% level in urban areas of the state.
- USDA reports that 10.7% of the rural population did not complete high school, compared to 12.5% of urban populations.
- As of June 2021, Utah has the lowest unemployment rate of 2.7% compared to the nation at 5.9% (Utah Department of Workforce Services). The unemployment rate in rural Utah is at 3.3%, while in urban Utah it is at 2.5% (USDA-ERS, 2019).

**Suicide:**
Utah has a high prevalence of suicide which continues to be a need across our state. We have increased outreach 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 2019 was 20.4 per 100,000 population.
- Utah's suicide rate increased annually for over a decade through 2016. However, preliminary data indicates a leveling off or slight decrease for 2017 through 2019
- There were 654 suicide deaths in 2019 (Crude Rate: 20.4*)
- Male: 78% (Crude Rate: 31.8/ F: 8.9)
- 87% White
- Rates for Native Americans are highest among all race groups, followed by White and Black or African Americans, who had similar rates of suicide.
Use of a firearm was the most common method of suicide death (50%) for Utahns followed by asphyxiation (29%) and then poisoning (15%).

Suicide rates are higher among males in every age group.

**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. DSAMH can match client data with the Division of Child and Family Services (DCFS) and Juvenile Justice Services (JJS). However, standards and definitions and data collection among the three agencies varies considerably. Efforts to standardize data collection and documentation by all providers, at least regarding admittance and discharge data would help 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. DSAMH will assist in resolving these gaps and needs by utilizing Regional Directors that provide additional technical assistance to LSAAs. The RDs are responsible for specific LSAAs and have developed action plans to support the unique needs of that LSAA.

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. DSAMH 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 Services, University of Utah Family Medicine, Utah Department of Public Safety, National Alliance for Mental Illness, Local Substance Abuse Authorities (Rural and Urban representatives), Bach Harrison, and DSAMH - 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.
### Priority #:
1

### Priority Area:
Prevention

### Priority Type:
SAP

### Population(s):
PP

### Goal of the priority area:
Decrease or eliminate the substance use disorders and related fatalities across the State.

### Strategies to attain the goal:
- All Goals: Increase Community Centered Evidence Based Prevention (CCEBP) Communities by 20%.
- Goal E: Multiple strategies

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Goal A: Decrease 30 Day alcohol use - all grades</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>2019: 5.5%; CCEBP Communities 11.7%</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>2022: Increase Community Centered Evidence Based Prevention (CCEBP) Communities by 20%.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>2023: 4.5%</td>
</tr>
</tbody>
</table>

### 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 111 prioritized communities. Of those, only 13 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.

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Goal B: Maintain Prescription Drug use among youth - all grades</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>2019: 1.9%; CCEBP Communities 11.7%</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>2022: Increase Community Centered Evidence Based Prevention (CCEBP) Communities by 20%.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>2023: 1.9%</td>
</tr>
</tbody>
</table>

### 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 111 prioritized communities. Of those, only 13 were at a readiness of "Established, healthy strong coalition".

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**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.

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**Indicator #:** 3  
**Indicator:** Goal C: Maintain Youth 30 day Cannabis Use - all grades  
**Baseline Measurement:** 2019: 6.2%; CCEBP Communities 11.7%  
**First-year target/outcome measurement:** 2022: Increase Community Centered Evidence Based Prevention (CCEBP) Communities by 20%.  
**Second-year target/outcome measurement:** 2023: 6.2%  
**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 111 prioritized communities. Of those, only 13 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.

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**Indicator #:** 4  
**Indicator:** Goal D: Decrease 30 Day E-cigarette use among youth - all grades  
**Baseline Measurement:** 2019: 9.7%; CCEBP Communities 11.7%  
**First-year target/outcome measurement:** 2022: Increase Community Centered Evidence Based Prevention (CCEBP) Communities by 20%.  
**Second-year target/outcome measurement:** 2023: 8.7% past 30 days 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 111 prioritized communities. Of those, only 13 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: Goal E: Decrease Opioid Deaths
Baseline Measurement: 2020: 390 Deaths
First-year target/outcome measurement: 2022: decrease by 5%
Second-year target/outcome measurement: 2023: 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.

Priority #: 2
Priority Area: Zero Suicide Initiative
Priority Type: SAP, SAT, MHS
Population(s): SMI, SED
Goal of the priority area:
Decrease or eliminate the number of suicides across the state.

Strategies to attain the goal:
A: 1-Educate and promote the Zero Suicide Framework to health systems and other organizations.
B: 1- Provide training to individuals and providers regarding evidence based gatekeeper tools.
C: 1- Locate and engage community partners on establishing and engaging in means reduction activities.

Annual Performance Indicators to measure goal success:

Indicator #: 1
Indicator: Goal A: Number of health systems/organizations training in the Zero Suicide Framework
Baseline Measurement: 21 agencies received training in 2018-2020
First-year target/outcome measurement: 4 agencies will receive training
### Indicator #2: Goal B: Number of people trained in an evidence-based gatekeeper training

<table>
<thead>
<tr>
<th>Baseline Measurement:</th>
<th>15,573 individuals (state average, aggregate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First-year target/outcome measurement:</td>
<td>17,000 Utahns are trained in an evidence-based gatekeeper training</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>20,000 Utahns are trained in an evidence-based gatekeeper training</td>
</tr>
</tbody>
</table>

#### Data Source:
DSAMH training records and reporting tools

#### Description of Data:
Number of trainings, number of attendees, sign-in sheets

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

### Indicator #3: Goal C: Number of partnerships established/engaging in evidence informed means reduction activities.

<table>
<thead>
<tr>
<th>Baseline Measurement:</th>
<th>Zero partnerships established</th>
</tr>
</thead>
<tbody>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Five firearm retailers, instructors, organizations, associations in Utah will be involved in suicide education, prevention and awareness efforts</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Ten firearm retailers, instructors, organizations, associations in Utah will be involved in suicide education, prevention and awareness efforts</td>
</tr>
</tbody>
</table>

#### Data Source:
Data collected and recorded by agencies.

#### Description of Data:
Means reduction committees, community events, response to requests, trainings offered, etc.

#### Data issues/caveats that affect outcome measures:
Partnerships may be informal and more difficult to track.
Population(s): SMI, SED, PWDC, PP, ESMI, PWID, EIS/HIV, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/ Juvenile Justice, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:
The goal is to expand access to vital services and support systems that facilitate recovery for individuals.

Strategies to attain the goal:
Goal A: Increase opportunities and range of specialized training for CPSS and FPSS
Goal B: Review of Local Authority data and provision of technical assistance if numbers do not increase.
Goal C and D: Provide education, funding and service providers that can provide MAT services in order to increase the number of clients that have access to MAT through the public behavioral health system.
Goal E: Provide support, training and education around approved Recover Support Services to the Local Authorities.
Goal F: Provide support and training around working with pregnant women with SUDs. Local Authorities will have at least one specialty trained clinician in the maternalmentalhealth.utah.gov directory.
Goal G: Provision of supported employment training to Local Authorities and stakeholder agencies from the DSAMH Supported Employment Program Administrator and Individual Placement and Support state-wide trainer.
Goal H: Development and provision of a geriatric SMI enhancement training.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Goal A: Increase number of Peer Support Specialists with specialized training
Baseline Measurement: 137 CPSS have specialized training that includes youth-in-transition and integration training.
First-year target/outcome measurement: Completion of a Forensic peer support curriculum and pilot training.
Second-year target/outcome measurement: 50 additional CPSS are trained with enhancement curricula.
Data Source: CPSS database, training invoices, HRSA grant information
Description of Data: CPSS database is used to track all CPSS certified by DSAMH, invoices are used to identify CPSS receiving specialized training, grant information is collected for HRSA paraprofessional training grant
Data issues/caveats that affect outcome measures:
All data sources collect both unique and duplicative data. All data is being downloaded into a new electronic online database.

Indicator #: 2
Indicator: Goal B: Increase percent of clients retained in SUD treatment 90 or more days
Baseline Measurement: 2020: 57.0%
First-year target/outcome measurement: 2022: 60 (5% increase from baseline)
Second-year target/outcome measurement: 2023: 62.7 (10% increase from baseline)
Data Source: SAMHIS and TEDs data. Annual Scorecard
Description of Data: Percent of clients retained in treatment 90 or more days. Taken from date of intake to date of discharge.
Data issues/caveats that affect outcome measures:
Discharge data not reflecting accurate dates, i.e., occurs when a client is a now show to treatment services for 30 days however the date of last contact may not be accurately reported.
Indicator #: 3
Indicator: Goal C: Increase use of FDA approved medication for individuals that identify as IV users (Priority population)
Baseline Measurement: established baseline FY2020 4725 clients served indicated IV or Intramuscular Injection (pri, sec, tert) of which 1,236 received MAT.
First-year target/outcome measurement: Increase MAT services to individuals identified as IV or Intramuscular injection users by 2% from baseline
Second-year target/outcome measurement: Increase MAT services to individuals identified as IV or Intramuscular injection users by 4% from baseline (2% increase from first year target)
Data Source: SAMHIS and TEDs data
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 #: 4
Indicator: Goal: D Increase use of FDA approved Medication Assisted Treatment for clients with OUD
Baseline Measurement: established baseline FY2020 2227 clients using MAT
First-year target/outcome measurement: increase number of clients using MAT by 2% from baseline in FY2022
Second-year target/outcome measurement: increase number of clients using MAT by 5% from baseline in FY2023
Data Source: These numbers are pulled from our state fiscal year SAMHIS submissions of clients served with OUD identified as primary, secondary or tertiary that have the MAT or Methadone indicators
Description of Data: State data collection submitted, data is pulled using clients identified as primary, secondary or tertiary OUD that have a MAT or Methadone indicator.
Data issues/caveats that affect outcome measures: Utah became a Medicaid expansion state in April 2019, clients have the option to go to outside MAT providers that are outside of our public behavioral health network and in doing so the data for these clients accessing MAT services elsewhere will not be accounted for.

Indicator #: 5
Indicator: Goal E: Increase number of Local Authorities reporting MH and SUD Recovery Support Services (RSS) data.
Baseline Measurement: established 2020: 13/13 LA are submitted RSS data. 0/13 reporting MH RSS data.
First-year target/outcome measurement: Increase baseline 5/13 reporting MH RSS data.
Second-year target/outcome measurement: Increase baseline 10/13 reporting MH RSS data.
Data Source: monthly SAMHIS data submissions from Local Authorities, Tableau Recovery Support Service Reports.
**Description of Data:**

Local Authorities upload monthly SAMHIS data in which data can be filtered to determine services being utilized and reported. Tableau report will be used to determine which LA are reporting data and what services are being utilized.

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

SAMHIS data is submitted 30 days past the end of a month so data has a short lag. data may indicate errors and need to be cleaned up and resubmitted. With Medicaid expansion some qualifying RSS services could be done outside of the public behavioral health system in which we would not be able to collect that data. Need to ensure we can capture MH Recovery Support Service data separately than SUD Recovery Support data to ensure clients are receiving services and LA are submitting data.

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**Indicator #:** 6  
**Indicator:** Goal F: 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. 2022  
**Second-year target/outcome measurement:** Increase pregnant women served in treatment services by 4% from baseline. 2023  
**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.

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**Indicator #:** 7  
**Indicator:** Goal G: Increase employment rates for clients enrolled in Substance Use services  
**Baseline Measurement:** 31.3% increase from admit to discharge in FY2020  
**First-year target/outcome measurement:** Increase % of those employed full time and part time by 2%  
**Second-year target/outcome measurement:** Increase % of those employed full time and part time by 5%  
**Data Source:** Substance Use SAMHIS and TEDs data

**Description of Data:**

Increased Employment - Percent increase in those employed full/part time or student from admit to discharge

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

NA. Some programs such as Drug Court, etc do not allow clients to seek employment for the first few stages of Drug Court. The Pandemic has affected Utah’s workforce and has affect on overall employment rates.

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**Indicator #:** 8  
**Indicator:** Goal H: Increase number of Peer Support Specialists trained to work with older adults with SMI  
**Baseline Measurement:** No CPSS have training targeted to work with older adults with SMI
First-year target/outcome measurement: Creation of an 8 hour geriatric enhancement training for PSS.

Second-year target/outcome measurement: 25 CPSS will be trained with the geriatric curriculum as a pilot training.

Data Source:
DSAMH Certified Peer Support Database

Description of Data:
8 hour Geriatric Enhancement curriculum, sign-in sheets from geriatric enhancement trainings.

Data issues/caveats that affect outcome measures:
Development of the curriculum may run into issues related to availability of those with expertise, CPSS who have already received specialized training to work in integrated settings will be targeted for the pilot training.

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

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

Strategies to attain the goal:
Goal A: Increase outreach efforts to improve services to families and youth
Goal B: Provide outreach and education to schools and other community organizations to increase service delivery.
Goal C: Increase access for youth services through collaborative efforts with community referral sources.

Annual Performance Indicators to measure goal success

Indicator #:
1

Indicator: Goal A: Provide upstream services for youth and their families by improving access to early childhood mental health resources.

Baseline Measurement: Baseline Measurement: 1,038 youth 0-5 served in FY20. No current baseline captured for 0-8yo.

First-year target/outcome measurement: Capture baseline of the number of children 0-8 receiving services.

Second-year target/outcome measurement: Increase number of children 0-8 receiving services by 10%.

Data Source:
SAMHIS data

Description of Data:
SAMHIS

Data issues/caveats that affect outcome measures:
Unknown
First-year target/outcome measurement: To create baseline data of youth receiving these services.
Second-year target/outcome measurement: Increase the number of children and youth receiving school-based mental health and wellness services by 5%.

Data Source:
SAMHIS, MOU reporting requirements, USBE

Description of Data:
SAMHIS, local school data, state school data

Data issues/caveats that affect outcome measures:
FERPA/HIPAA concerns, general data sharing needs.

Priority #: 5
Priority Area: Health Systems Integration
Priority Type: SAT, MHS
Population(s): SMI, SED, PWWDC, ESMI, PWID, EIS/HIV, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disabilities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:
Improved coordination of care and integration of physical and behavioral health

Indicators:

**Indicator #: 1**

Data issues/caveats that affect outcome measures:
Medicaid expansion in Utah may effect the number of youth served in the Public system as clients will have a choice to go to public Medicaid providers. We don’t expect this to effect the numbers of youth much. The pandemic has affected access to services for youth, most were transitioned to telehealth services which has impacted delivery methods and we do not fully understand if this will increase or decrease youth that access services.

A: Educate Local Authorities regarding alternative models for provision of integrated services. Provide technical assistance as models are implemented. Provide technical assistance as models are implemented.
B: Educate and train CPSS as community health workers (CHW). Identify appropriate CHWs and offer cross-training as CPSS or FPSS.
C: Work with the LA to educate staff and clients regarding the health benefits of quit tobacco use. Identify Smoking Cessation trainers and hold annual Cessation training’s. Encourage LA to build Smoking Cessation efforts into client treatment plans.
Baseline Measurement: Local authority providers statewide fall in a variety of positions on the Standard Framework scale.

First-year target/outcome measurement: 2 providers increase their level by 1.

Second-year target/outcome measurement: 2 additional providers increase their level by 1.

Data Source:
DSAMH annual monitoring of all Local Authority providers, including clinics with a range of integration.

Description of Data:
Programmatic and service delivery structure is collected and discussed at yearly monitoring visits. Along with year-round support as requested, this information is used to place each provider on the Standard Framework scale.

Data issues/caveats that affect outcome measures:
Due to the unique treatment settings and barriers faced in rural, urban, and frontier areas of the state there is a level of subjectivity to each provider’s placement on the scale.

Indicator #2
Indicator: Goal B: Increase CPSS cross-training with Community Health Worker (CHW) certification
Baseline Measurement: Two CPSS are cross-trained as CHWs
First-year target/outcome measurement: 10 CPSS cross-trained as CHW
Second-year target/outcome measurement: 20 CPSS cross-trained as CHW
Data Source:
Utah Department of Health CHW training program, CPSS training agencies (Utah State University, Optum)

Description of Data:
Certification records are kept by DSAMH and DOH that will inform DSAMH which CPSS are dual certified.

Data issues/caveats that affect outcome measures:
Cross-referencing the certification records may miss a few individuals that are cross-trained due to name changes or data entry errors.

Indicator #3
Indicator: Goal C: Decrease tobacco use for clients that are diagnosed with SUD disorder from Intake to discharge
Baseline Measurement: Established in 2020: 4.0% decrease on tobacco use from intake to discharge (state average)
First-year target/outcome measurement: decrease tobacco use by 1% in year 1 from baseline in FY2022
Second-year target/outcome measurement: decrease tobacco use by 2% in year 2 from baseline in FY2023
Data Source:
DSAMH annual scorecard

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

Data issues/caveats that affect outcome measures:
Tobacco use data is valid only if the data for admission and discharge is collected by the local authorities.
Student Health and Risk Prevention (SHARP) Data is collected on the odd years; baseline is 2019, first year is 2021 data, second year is 2023 data. NSDUH data is only available for 2018 as the baseline at this time. Prevention outcome measures will continue to use the SHARP data as it is the most reliable and most current data available for substance use related outcomes. Utah’s State Epidemiological Outcomes Workgroup (SEOW) will continue to seek out additional measures for the even year reporting.

During the 2021 Legislation session a bill passed to merge the Utah Department of Human Services and the Utah Department of Health. We anticipate changes to the following that may ultimately affect the services DSAMH provides: Organizational chart and flow, administration process such as contracting, monitoring and finance, service delivery, data and collection, etc.
### Planning Tables

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

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2022/2023. ONLY include funds expended by the executive branch agency administering the SABG.

Planning Period Start Date: 7/1/2021 Planning Period End Date: 6/30/2023

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
<th>H. COVID-19 Relief Funds (MHBG)*</th>
<th>I. COVID-19 Relief Funds (SABG)*</th>
<th>J. ARP Funds (SABG)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention(^4) and Treatment</td>
<td>$11,167,411.00</td>
<td>$20,650,330.00</td>
<td>$3,123,847.00</td>
<td>$19,106,626.00</td>
<td>$6,542,083.00</td>
<td>$3,397,707.00</td>
<td>$9,141,180.00</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children(^4)</td>
<td>$2,158,527.00</td>
<td>$8,943,883.00</td>
<td>$874,083.00</td>
<td>$6,758,781.00</td>
<td>$1,505,762.00</td>
<td>$735,761.00</td>
<td>$1,766,880.00</td>
<td>$0.00</td>
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<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td>$9,008,884.00</td>
<td>$11,706,447.00</td>
<td>$2,249,764.00</td>
<td>$12,347,845.00</td>
<td>$5,036,321.00</td>
<td>$2,661,946.00</td>
<td>$7,374,299.10</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention(^4)</td>
<td>$4,995,486.00</td>
<td>$12,276.00</td>
<td>$202,249.00</td>
<td>$214,517.00</td>
<td>$251,340.00</td>
<td>$1,175,783.00</td>
<td>$5,630,000.00</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td>$4,995,486.00</td>
<td>$12,276.00</td>
<td>$202,249.00</td>
<td>$214,517.00</td>
<td>$251,340.00</td>
<td>$1,175,783.00</td>
<td>$5,630,000.00</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
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</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Other 24-Hour Care</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Administration (excluding program/provider level) MHBG and SABG must be reported separately</td>
<td>$603,617.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$777,431.00</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Crisis Services (5 percent set-aside)</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Total</td>
<td>$16,766,514.00</td>
<td>$0.00</td>
<td>$20,662,606.00</td>
<td>$3,326,096.00</td>
<td>$19,421,143.00</td>
<td>$6,793,423.00</td>
<td>$4,573,490.00</td>
<td>$0.00</td>
<td>$15,548,611.00</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

\(^4\) The 24-month expenditure period for the COVID-19 Relief Supplemental funding is March 15, 2021 – March 14, 2023, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between July 1, 2021 – March 14, 2023 should be entered in Column I.

\(^5\) 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” SABG. Per the instructions, the planning period for standard SABG expenditures is July 1, 2021 – June 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between September 1, 2021 and June 30, 2023 should be entered in Column J.

\(^6\) Prevention other than primary prevention

\(^7\) The 20 percent set aside funds in the SABG must be used for activities designed to prevent substance misuse.

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Footnotes:
- 07/28/2021: ARP funding is not budgeted to be spent until FFY24.
Table 2 State Agency Planned Expenditures (MH)

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2022/2023. Include public mental health services provided by mental health providers or funded by the state mental health agency by source of funding.

Planning Period Start Date: 7/1/2021
Planning Period End Date: 6/30/2023

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
<th>H. COVID-19 Relief Funds (MHBG)(^a)</th>
<th>I. COVID-19 Relief Funds (SABG)</th>
<th>J. ARP Funds (MHBG)(^b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary Prevention(^d)</td>
<td>$10,385,156.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)(^d)</td>
<td>$1,298,144.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$644,222.00</td>
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<tr>
<td>4. Tuberculosis Services</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$649,072.00</td>
<td>$472,971.00</td>
<td>$522,111.00</td>
</tr>
<tr>
<td>7. Other 24-Hour Care</td>
<td>$200,000.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td></td>
<td>$5,497,527.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$4,034,109.00</td>
<td></td>
</tr>
<tr>
<td>9. Administration (excluding program/provider level)(^f)</td>
<td>$49,072.00</td>
<td></td>
<td></td>
<td></td>
<td>$472,971.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$522,111.00</td>
</tr>
<tr>
<td>10. Crisis Services (5 percent set-aside)(^g)</td>
<td>$49,072.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$372,971.00</td>
<td>$322,111.00</td>
<td></td>
</tr>
<tr>
<td>11. Total</td>
<td>$0.00</td>
<td>$12,981,444.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$7,459,411.00</td>
<td>$0.00</td>
<td>$5,522,553.00</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) 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" SABG and MHBG. Per the instructions, the standard SABG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2022, for most states.

\(^b\) 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 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, 2021 - June 30, 2022, for most states.

\(^d\) Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside.

\(^e\) While a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

\(^f\) Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

\(^g\) Row 10 should include Crisis Services programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

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Footnotes:
Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

<table>
<thead>
<tr>
<th></th>
<th>Aggregate Number Estimated In Need</th>
<th>Aggregate Number In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pregnant Women</td>
<td>1,000</td>
<td>331</td>
</tr>
<tr>
<td>2. Women with Dependent Children</td>
<td>20,000</td>
<td>3,360</td>
</tr>
<tr>
<td>3. Individuals with a co-occurring M/SUD</td>
<td>30,000</td>
<td>7,969</td>
</tr>
<tr>
<td>4. Persons who inject drugs</td>
<td>6,000</td>
<td>4,725</td>
</tr>
<tr>
<td>5. Persons experiencing homelessness</td>
<td>622</td>
<td>3,414</td>
</tr>
</tbody>
</table>

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, 2020 Utah State Homelessness Report found at https://jobs.utah.gov/housing/scso/documents/homelessness2020.pdf (page 17) indicates data collected at point in time that there were a total of 622 SUD clients identified as homeless (508 that were sheltered and 114 that were non-sheltered). 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 SABG Planned Expenditures

Planning Period Start Date: 10/1/2021  Planning Period End Date: 9/30/2023

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY Grant Award</th>
<th>2022 SA Block</th>
<th>COVID-19 Award</th>
<th>ARP Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Use Disorder Prevention and Treatment$^3$</td>
<td></td>
<td>$10,446,994.00</td>
<td>$9,141,180.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>2. Primary Substance Use Disorder Prevention</td>
<td></td>
<td>$5,539,547.00</td>
<td>$5,630,000.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>3. Early Intervention Services for HIV$^4$</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$603,617.00</td>
<td>$777,431.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td><strong>6. Total</strong></td>
<td><strong>$16,590,158.00</strong></td>
<td><strong>$15,548,611.00</strong></td>
<td><strong>$0.00</strong></td>
<td></td>
</tr>
</tbody>
</table>

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 “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in this column.

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” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in this column.

3. Prevention other than Primary Prevention
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 Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

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

| Footnotes: |
| 07/28/2021: ARP funding is not budgeted to be spent until FFY24. |
### Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2021  Planning Period End Date: 9/30/2023

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>A</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SA Block Grant Award</td>
<td>FFY 2022</td>
</tr>
<tr>
<td>1. Information Dissemination</td>
<td>Universal</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>2. Education</td>
<td>Universal</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Alternatives</td>
<td>Universal</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>4. Problem Identification and Referral</td>
<td>Universal</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Indicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>5. Community-Based Process</td>
<td>Selective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>7. Section 1926 Tobacco</th>
<th>Universal</th>
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<th></th>
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</thead>
<tbody>
<tr>
<td>Selective</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

**Total Prevention Expenditures**

|  | $0 | $0 | $0 |

**Total SABG Award**

|  | $16,590,158 | $15,548,611 | $0 |

**Planned Primary Prevention Percentage**

|  | 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" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

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" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

3. Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2021    Planning Period End Date: 9/30/2023

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2022 SA Block Grant Award</th>
<th>COVID-19 Award $1</th>
<th>ARP Award $2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$1,767,903</td>
<td>$2,550,000</td>
<td>$0</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$1,516,834</td>
<td>$3,080,000</td>
<td>$0</td>
</tr>
<tr>
<td>Selective</td>
<td>$1,371,759</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Indicated</td>
<td>$338,990</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$4,995,486</strong></td>
<td><strong>$5,630,000</strong></td>
<td><strong>$0</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award $3</strong></td>
<td><strong>$16,590,158</strong></td>
<td><strong>$15,548,611</strong></td>
<td><strong>$0</strong></td>
</tr>
</tbody>
</table>
| **Planned Primary Prevention Percentage** | **30.11 %** | **36.21 %** | |}

1The 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" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023, for most states.

2The 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" SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 - September 30, 2023.

3Total SABG Award is populated from Table 4 - SABG Planned Expenditures

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

Footnotes:
07/28/2021: ARP is not budgeted to be spent until FFY24.
**Planning Tables**

**Table 5c SABG Planned Primary Prevention Targeted Priorities**
States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2022 and FFY 2023 SABG awards.

Planning Period Start Date: 10/1/2021       Planning Period End Date: 9/30/2023

<table>
<thead>
<tr>
<th>Targeted Substances</th>
<th>SABG Award</th>
<th>COVID-19 Award</th>
<th>ARP Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Tobacco</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Marijuana</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inhalants</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bath salts, Spice, K2)</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Populations</th>
<th>SABG Award</th>
<th>COVID-19 Award</th>
<th>ARP Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Military Families</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>African American</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Hispanic</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Homeless</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Asian</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Rural</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>
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” SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023, for most states.

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” SABG. Per the instructions, the standard SABG expenditures are for the planned expenditure period of October 1, 2021 – September 30, 2023.
# Planning Tables

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

Planning Period Start Date: 10/1/2021  
Planning Period End Date: 9/30/2023

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. SABG Treatment</th>
<th>B. SABG Prevention</th>
<th>C. SABG Integrated&lt;sup&gt;1&lt;/sup&gt;</th>
<th>D. COVID-19&lt;sup&gt;2&lt;/sup&gt;</th>
<th>E. ARP&lt;sup&gt;3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$2,100,000.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$205,000.00</td>
<td>$431,433.00</td>
<td>$0.00</td>
<td>$1,080,000.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$50,000.00</td>
<td>$27,500.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$280,000.00</td>
<td>$85,128.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$535,000.00</strong></td>
<td><strong>$544,061.00</strong></td>
<td><strong>$0.00</strong></td>
<td><strong>$3,180,000.00</strong></td>
<td><strong>$0.00</strong></td>
</tr>
</tbody>
</table>

<sup>1</sup>Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.
2The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the “standard” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned COVID-19 Relief Supplemental expenditures between October 1, 2021 – March 14, 2023 should be entered in Column D.

3The 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” SABG. Per the instructions, the planning period for standard SABG expenditures is October 1, 2021 – September 30, 2023. For purposes of this table, all planned ARP supplemental expenditures between October 1, 2021 and September 30, 2023 should be entered in Column E.

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

**Footnotes:**

07/28/2021: ARP funding is not budgeted to be spent until FFY24.
### Planning Tables

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

MHBG Planning Period Start Date: 07/01/2021   MHBG Planning Period End Date: 06/30/2023

<table>
<thead>
<tr>
<th>Activity</th>
<th>FFY 2022 Block Grant</th>
<th>FFY 2022 COVID Funds</th>
<th>FFY 2022 ARP Funds</th>
<th>FFY 2023 Block Grant</th>
<th>FFY 2023 COVID Funds</th>
<th>FFY 2023 ARP Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$16,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$16,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td>$5,789,640.00</td>
<td>$4,239,607.00</td>
<td>$3,221,110.00</td>
<td>$5,789,640.00</td>
<td>$2,119,804.00</td>
<td>$3,221,109.00</td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td>$164,482.00</td>
<td>$100,000.00</td>
<td>$0.00</td>
<td>$164,482.00</td>
<td>$50,000.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$50,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$50,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td>$100,000.00</td>
<td>$553,333.00</td>
<td>$0.00</td>
<td>$100,000.00</td>
<td>$276,667.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td>$77,600.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$77,600.00</td>
<td>$0.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>7. Training and Education</td>
<td>$293,000.00</td>
<td>$80,000.00</td>
<td>$0.00</td>
<td>$293,000.00</td>
<td>$40,000.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>8. Total</td>
<td>$6,490,722.00</td>
<td>$4,972,940.00</td>
<td>$3,221,110.00</td>
<td>$6,490,722.00</td>
<td>$2,486,471.00</td>
<td>$3,221,109.00</td>
</tr>
</tbody>
</table>

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” SABG and MHBG. Per the instructions, the standard MHBG expenditures are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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 are for the state planned expenditure period of July 1, 2021 - June 30, 2023, for most states.

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

**Footnotes:**
Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

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

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

One key population of concern is persons who are dually eligible for Medicare and Medicaid. Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible. SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment. Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider. SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with
partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment. Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

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

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA’s National Behavioral Health Quality Framework includes core measures that may be used by providers and payers. SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.


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

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

   The state provides oversight for the Local Authority Substance Use Disorder (LSAA) and Mental Health (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 LSAA 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) 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 Midtown Clinic 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.

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

   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 Block Grant fund, 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.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered

   ☐ Yes ☐ No
through Qualified Health Plans?

b) and Medicaid?  

Yes  No

4. Who is responsible for monitoring access to M/SUD services provided by the QHP?

The Division of Substance Abuse and Mental Health (DSAMH) is responsible for monitoring access to MH and SUD services through the QHP’s. DSAMH provides an Annual Site Visit where they monitor the LSAA/LMHA’s compliance with SAPT/MHBG Block Grant Requirements, service delivery and access to services. Part of this Site Visit includes access to integrated behavioral and physical health care services through the FQHCs, CHCs, and integrated clinics. At the Site Visit, DSAMH meets with the LSAA/LMHA Teams to review policies and procedures related to health and wellness and recovery goals. At times, the Site Visit includes an on-site visit to clinics such as the Odyssey House Martindale Clinic, Bear River integrated care unit located in Tremonton, San Juan Counseling Center and co-located Health Department, and Weber Human Services integrated clinic, to review how SUD and MH services are delivered in a variety of Integrated Clinics.

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

Yes  No

6. Do the M/SUD providers screen and refer for:

   a) Prevention and wellness education  

   Yes  No

   b) Health risks such as

   i) heart disease  

   Yes  No

   ii) hypertension  

   Yes  No

   iii) high cholesterol  

   Yes  No

   iv) diabetes  

   Yes  No

   c) Recovery supports

   Yes  No

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

Yes  No

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

Yes  No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

Utah has made progress toward parity for mental health and substance abuse. While the Mental Health and Parity Final Rule does not require Medicaid or CHIP to provide certain mental health or substance abuse benefits, it does require parity if those benefits are provided. In 2016, Utah requested a five-year extension of the Primary Care Network Demonstration waiver (1115). An amendment added to the waiver includes the implementation of Mental Health parity for the Non-Traditional Medicaid group. However, there is an exemption in the regulation for small employer plans for CHIP. In addition, Utah passed a Medication Expansion bill on April 1, 2019. In urban areas, the expansion coverage is managed by managed care organizations that may not offer the vast array of services provided to Legacy Medicaid recipients.

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

1. 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 will be called the Department of Health and Human Services.

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

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

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

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

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

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 - Requested

Narrative Question

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

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

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits." Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA’s and HHS’s attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

44 http://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf
45 http://www.ThinkCulturalHealth.hhs.gov
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?
   We are currently conducting a Needs assessment regarding linguistics for people in need of Mental Health and Substance Use services that are deaf or hard of hearing and DSAMH recently developed a Health Disparities Research Team made up of DSAMH program staff, data and research professionals, other state and community agencies, community members and peers. In 2021, the team conducted the Health Disparities in Utah's Public Mental Health System. It looked at four different populations: People of Color, People with Developmental Disabilities, Members of LGBTQIA+ community and Transition-Age Youth and Young. We will be using the results to help structure services as identified as needs and gaps in our system.

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

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

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

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

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

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,\textsuperscript{49} The New Freedom Commission on Mental Health,\textsuperscript{50} the IOM,\textsuperscript{51} NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).\textsuperscript{52} The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in “Psychiatry Online.”\textsuperscript{53} SAMHSA and other federal partners, the HHS’ Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

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

SAMHSA’s Treatment Improvement Protocol Series (TIPS)\textsuperscript{54} 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)\textsuperscript{55} was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.
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, accountable care organization, all payer/global payments, pay for performance (P4P)).
   h) The state has an evaluation plan to assess the impact of its purchasing decisions.

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

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

The Quality Care Workgroup is comprised of staff from DSAMH, Department of Human Services, Bach Harrison LLC, employees from local Universities, employees from the Utah Center for Evidence Based Treatment, Local Authorities, Utah’s National Association of Social Workers, ESI management. This work group is working towards implementing more EBP within the behavioral health undergard 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.

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

DSAMH 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.

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

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

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

   The Utah State Division of Substance Abuse and Mental Health (DSAMH) uses the 10% set aside funds to contract with four Local Mental Health Authorities in the State of Utah to provide Coordinated Specialty Care (CSC) programs for individuals experiencing early serious mental illness. Weber Human Services was the pilot site for the 5% set aside, with expansion to Davis Behavioral Health and Wasatch Mental Health with the 10% set aside. Within the last year, Four Corners Community Behavioral Health has also introduced a CSC program.

   Each of the LMHAs providing CSC services include the following components: Medication Management, Individual and Group Psychotherapy, Dialectical Behavioral Therapy, Supported Employment/Individual Placement and Support, Supported Education, Case Management, Peer Support, Multi or Single-Family Psychoeducation, and Recovery Oriented Cognitive Behavioral Therapy.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?
Specific planned activities for FY 2020 and 2021 are:

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

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

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

7. Please provide an updated description of the state’s chosen EBPs for the 10 percent set-aside for ESMI.

Several EBPs are used as part of the Prevention and Recovery in Early Psychosis (PREP) program in Utah. All the centers are using the Coordinated Specialty Care model and have had training from Ontrack NY, EASA program from Oregon and the PIER model from Maine. EBPs within the CSC include Dialectical Behavioral Therapy, Supported Employment/Individual Placement and Support, Supported Education, Multi and Single-Family Psychoeducation, Structured Interview for Prodromal Syndromes (SIPS), Occupational Therapy, Structured Clinical Interview for DSM 5 Disorders (SCID), Session rating Scale, and Recovery Oriented Cognitive Behavioral Therapy.

8. Please describe the planned activities for FY22 and FY23 for your state's ESMI programs including psychosis?

Programs at the primary pilot site (Weber Human Services) and the expansion sites (Davis Behavioral Health, Wasatch Mental Health, and Four Corners Community Behavioral Health) will continue to be developed and refined. Ongoing training, coaching, and technical assistance will be 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 FY22-23

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 young people of transition age for services.

Objective 2: Racial/ethnic minority communities understand early psychosis and are able to identify and refer young people of transition for services.

Objective 3: First responders (mobile crisis, law enforcement) and medical personnel understand early psychosis and are able to identify and refer young people of transition for services.

Objective 4: Criminal/juvenile justice system personnel understand early psychosis and are able to identify and refer young people of transition for services.

Objective 5: Child welfare system personnel understand early psychosis and are able to identify and refer young people of transition for services.

Objective 6: Intellectual and Physical disability system personnel understand early psychosis and are able to identify and refer young people of transition for services.

Objective 7: Families, young people, and natural supports understand early psychosis and are able to identify and refer young people of transition for services.

Objective 8: General public understands early psychosis and the stigma associated with it is reduced and/or eliminated.

Objective 9: A program logo is developed 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 LMHAs

Objective 1: Engage in conversations with LMHAs on integrating early psychosis services into the Mental Health Centers Area Plan by 2022

Objective 2: Expand fully structured early psychosis program to at least one additional LMHA by 2023
Expand Occupational Therapy into CSC.
Incorporate cognitive remediation/health into CSC.
Collaborate with the Office of Medicaid and Health Financing, Utah Department of Health to enhance service arrays for ESMI.
Conduct annual fidelity review to the PREP Practice Guidelines.
Develop and implement LMHA-specific Continuous Quality Improvement plan based on the fidelity review results.
Incorporate early psychosis focus into the integrated health/behavioral health model.
Continue with the technical assistance with EASA.
Expand youth empowerment activities e.g., youth advocacy and youth to youth peer support services.

9. Please explain the state’s provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

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

A fidelity tool has been developed to assess the fidelity implementation of CSC by LMHAs. Fidelity reviews started in early 2020 and will be conducted annually. An evaluation tool specific to the early psychosis program has been developed and is used by all LMHAs participating in the early psychosis program.

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

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

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

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Footnotes:
5. Person Centered Planning (PCP) - Required MHBG

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

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

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

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

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 DSAMH includes chart reviews, which focus on person-centered planning and evidence of client voice in the treatment choices. When client voice is not evident in goals and objectives, DSAMH offers technical assistance to treatment providers, requiring that treatment and recovery efforts are modified to ensure services are person-centered.

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

No technical assistance needed at this time.

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Footnotes:
Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

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

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

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

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

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?  Yes  No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?  Yes  No
3. Does the state have any activities related to this section that you would like to highlight? 

The Division will track requirements and provide technical assistance through the following mechanisms:

- The Division leadership meets with the 14 Local Authority Directors each month. There are also monthly meetings of the Division with the Local Authority Prevention Managers, Finance Managers, Data Managers and Clinical Directors.
- Annual on-site monitoring visits for each Local Authority, along with compliance checks. https://dsamh.utah.gov/contracts-and-monitoring
- Annual Division Directives training
- Review of annual Area Plans and end-of-year Area Plan reports
- 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 - The Division uses Outcome Score Cards as well as information submitted to SAMHIS for ongoing analysis. https://dsamh.utah.gov/scorecards
- Annual educational conferences funded by DSAMH (Generations Conference, Fall Substance Abuse Conference, Utah Valley Addictions Conference) include program presentations that outline requirements for participation.
Please indicate areas of technical assistance needed related to this section

None at this time.

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

Footnotes:
Environmental Factors and Plan

7. Tribes - Requested

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

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

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

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

Please respond to the following items:

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

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

   DSAMH has taken an active role in working with the Native American tribal organizations. This has included attendance at the quarterly Tribal Indian Issues Committee and active discussions with the tribal authorities during the annual site visits to the local authorities. A representative from DSAMH attends the Annual Native American Governor’s Summit.

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

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

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

   https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%2082009%29.pdf
3. Does the state have any activities related to this section that you would like to highlight?

The DSAMH attends the quarterly Tribal Indian Issues Committee, hosted by the tribal nations. These meetings have been coordinated to happen in the same week as the Tribal Leadership meetings to facilitate tribal leadership representation. Having the meetings on the reservations has greatly improved the quality of these meetings and understanding of the unique challenges faced by Utah’s Native population.

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

None at this time.

Footnotes:
Environmental Factors and Plan

8. Primary Prevention - Required SABG

Narrative Question
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

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

Please respond to the following items

Assessment

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

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

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

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

- Juvenile arrest data, children in protective custody, adult arrest data
- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

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

5. Does your state use needs assessment data to make decisions about the allocation of SABG primary prevention funds?

   Yes ☐ No ☐

   If yes, (please explain)
   A formula using incidence and prevalence of substance use disorder and population is used to allocate funding to communities.

   If no, (please explain) how SABG funds are allocated:
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals, families, and communities;
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3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
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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 Building

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

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

3. **Does your state have a formal mechanism to assess community readiness to implement prevention strategies?**
   - **Yes** ☑ No
     - If yes, please describe mechanism used
     - The State supports and local providers use the Tri Ethnic Center model to assess community readiness to implement prevention strategies.
Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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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.

**Planning**

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

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

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

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

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

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

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

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

a. The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
b. The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and

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

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

The Evidence-Based Workgroup will serve as the informed experts for Utah. The EBW developed a tier tool for providers and developers to identify which tier of effectiveness the program, policy or strategy might fit. In addition, there is a checklist for submission and a guidance document on how to submit for approval. https://dsamh.utah.gov/implement-an-evidence-based-program
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

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### Implementation

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

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

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

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

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

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

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

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?  

   Yes ☐  No ☐

   If yes, please describe

   There are statutorily mandated site visits throughout the fiscal year. In addition, Utah is a reimbursement process state. This means that the provider must submit an invoice with supporting documentation for approval to be paid. Prior to the monitoring, each site submits a prevention plan that highlights services to be offered. The State reviews these plans to ensure services are primary prevention.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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

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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.

**Evaluation**

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? [ ] Yes [ ] No

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

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

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

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

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

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

   a) [x] 30-day use of alcohol, tobacco, prescription drugs, etc
   b) [x] Heavy use
   c) [x] Binge use
   d) [ ] Perception of harm
   e) [ ] Disapproval of use
d)  Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e)  Other (please describe):

Opioid and prescription drug use
Vaping
Footnotes:
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 will be called the Department of Health and Human Services. This may have an impact on prevention services.
DSAMH Vision -- Healthy Individuals, Families, and Communities
DSAMH Mission -- Promote Health, Hope, and Healing from Mental Illness and Substance Use Disorders
DSAMH Functions-- Partnerships, Quality, Education, Accountability and Leadership
DSAMH Principles-- Trauma-Informed, Evidence Based Practices, Sustainable, Culturally and Linguistically Competent

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

GOALS - OBJECTIVES - METRICS

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<tr>
<td>Goal 1.1 Prevent and reduce underage drinking</td>
<td>Objective 1.1.1 Reduce community norms favorable to underage drinking</td>
<td>Indicator: Decrease the percentage of underage drinking 30 Day Alcohol Use, youth</td>
</tr>
<tr>
<td></td>
<td>Objective 1.1.2 Reduce parental attitudes favorable towards underage drinking</td>
<td>Baseline: 7%, all grades, 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Target: 5%, all grades, 2023</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Timeframe: 2013-2023</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Responsible: Prevention Program Administrator (Craig)</td>
</tr>
<tr>
<td>Objective 1.1.3 Reduce youth access to alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective 1.1.4 Increase Communities That Care coalitions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective 1.1.5 Increase access to person-centered prevention services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Objective 1.1.6 Decrease risk factors and increase protective factors</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Goal 1.2 Prevent and reduce prescription drug misuse and abuse**

| Objective 1.2.1 Reduce community norms favorable to misuse and abuse |
| Objective 1.2.2 Reduce illicit access to prescription drugs |
| Objective 1.2.3 Increase Communities That Care efforts |
| Objective 1.2.4 Increase access to person-centered prevention services |
| Objective 1.2.5 Decrease risk factors and increase protective factors |

**Indicators:**
- **Indicator:** Decrease percentage of prescription drug misuse and abuse
  Prescription Drug Misuse in past 30 days among youth; adults
  - **Baseline:** Youth: 2.3, all grades, 2013
  - **Target:** Youth: 1.0, all grades, 2023
  - **Timeframe:** 2013-2023
  - **Responsible:** Prevention Program Administrator (Craig PoVey)

**Outcomes - Updates:**
- **2017:** 6.7% all grades (stable)
- **2019:** 5.5% all grades (decrease)
| Goal 1.3 Prevent and reduce cannabis use | Objective 1.3.1 Reduce community norms favorable to misuse and abuse  
Objective 1.3.2 Reduce access to cannabis  
Objective 1.3.3 Increase Communities That Care efforts  
Objective 1.3.4 Increase access to person-centered prevention services  
Objective 1.3.5 Decrease risk factors and increase protective factors | Indicator: Decrease the percentage of cannabis use  
Past 30 day use, youth  
Baseline: 6.2% all grades, 2019  
Target: maintain 6.2%  
Timeframe: 2019-2029  
Responsible: Prevention Program Administrator (Craig PoVey)  
OUTCOMES - UPDATES:  
2019: 6.2%, All Grades (slight increase) |
|---|---|---|
| Goal 1.4 Prevent and reduce depression and other mental illness | Objective 1.4.1 Identify opportunities to integrate Substance Use Disorder (SUD) and mental illness prevention systems, models, policies, and practices  
Objective 1.4.2 Increase access to evidence based programs proven to reduce mental illness  
Objective 1.4.3 Promote, educate, and provide leadership to increase the number of Communities That Care Coalitions addressing mental illness issues  
Objective 1.4.4 Decrease risk factors and increase protective factors. | Indicator: Reduce the percentage of mental illness needs for Mental Health Treatment(MH) - High mental health needs  
Baseline: 13.0 of all grades, 2013  
Target: 12.0 of all grades, 2019  
Timeframe: 2013-2019  
Responsible: Prevention Program Administrator (Craig PoVey)  
OUTCOMES - UPDATES:  
2017: 18%, all grades (Increase) |
| Goal 1.5 Prevent tobacco and nicotine use through E-cigarettes | Objective 1.5.1 Cooperate with the State Department of Health in the planning and administration of Synar Checks  
Objective 1.5.2 Reduce community norms favorable to use of tobacco and other nicotine products (e-cigarettes) | Indicator: Reduction of percentage of tobacco use  
Reduction of percentage of nicotine use, including e-cigs  
Past 30 day use, e-cigs youth  
Baseline: 9.7, all grades, 2019  
Target: 7.0, all grades, 2029 |
<table>
<thead>
<tr>
<th>Goal 1.6 Prevent and Reduce Opioid Misuse</th>
<th>Objective</th>
<th>Timeframe: 2018-2025</th>
</tr>
</thead>
</table>
| Objective 1.6.1 Reduce community norms favorable to opioid misuse | **Indicator:** Decrease the percentage of adults 18+ who report using opioids non-medically (BRFSS)* only asked when approved.  
**Baseline:** 2018, 2.4 %  
**Target:** 2025, 2.0 %  
**Responsible:** Prevention Program Administrator (Craig PoVey)  
**Outcomes:** 2.4% 2019 (trending down) |  |
| Objective 1.6.2 Reduce illicit access to opioids |  |
| Objective 1.6.3 Increase number of coalitions implementing Communities that Care model |  |
| Objective 1.6.4 Increase access to person-centered prevention services |  |
| Objective 1.6.5 Decrease risk factors and increase protective factors |  |
| **Baseline:** 6.4%, all grades, 2013  
**Target:** 3.2%, all grades, 2023  
**Timeframe:** 2013-2023 |  |

Outcomes:  
2017 - All grades, 6.4% (stable)  
2019 – All grades, 5.6% (decrease)  
Visits to Know Your Script Pounds drugs 2020: 16,971 (October 2020)  
Take back events: One (1) event, 44 locations each event  
# Communities that Care (CTC) Coalitions in Utah: 24  
# Selective, indicated Prevention: Number of programs provided - 1055; 84.5% considered evidence based |
### Goal 1.7 Reduce overdose deaths

<table>
<thead>
<tr>
<th>Objective: 1.7.1 Educate the general public on ways to reduce overdose deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective: 1.7.2 Educate the general public on Naloxone</td>
</tr>
<tr>
<td>Objective: 1.7.3 Incorporate education, and distribution of Naloxone kits among strategic plans of Local Substance Abuse Authorities (LSAAs), Local Mental Health Authorities (LMHAs), Communities That Care and other prevention coalitions</td>
</tr>
<tr>
<td>Objective: 1.7.4 Raise public awareness of opioid overdose using STO campaign and other resources</td>
</tr>
<tr>
<td>Objective: 1.7.5 Educate the general public on ways to reduce overdose deaths</td>
</tr>
<tr>
<td>Objective: 1.7.6 Increase availability and usage of Naloxone</td>
</tr>
</tbody>
</table>

**Indicator:** Opiate Overdose Deaths  
**Baseline:** 390, 2020  
**Target:** 350, 2025  
**Timeframe:** 2020-2025  
**Responsible:** Prevention Program Administrator (Craig PoVey)

**OUTCOMES - UPDATES:**

2020: 390 (increase)  
Visits to Opidemic.org  
# of people trained as Naloxone end users:  
# of Naloxone kits distributed: 36,115  
# of documented reversals: 1,036  
# of pounds from take back events/disposal: 16,971  
# of Take Back events scheduled: - 2020, 1 event scheduled with 44 locations each event  
# of permanent disposal locations added: as of Oct 2020, 183 permanent drop off locations.

### Strategic Initiative #2 – Zero Suicides

**GOALS**

Goal 2.1 Support UDOH and other stakeholders in implementation of the Utah Health Improvement Plan

**OBJECTIVES**

2.1.1 Increase availability and access to quality physical and behavioral health care- Goal: Promote the adoption of the ‘Zero Suicide’ framework by health and behavioral health care providers statewide.  
2.1.2 Increase social norms supportive of help-seeking and recovery- Goal: Train 10% of the Utah population in an evidence based gatekeeper training  
2.1.3 Reduce access to lethal means- Goal:: Partner with firearm retailers and gun owners to incorporate suicide awareness and prevention as a

**METRICS**

| Indicator: | Number of health systems/organizations formally adopting the Zero Suicide framework.  
| Baseline: | Zero organizations have adopted the Zero Suicide framework.  
| Target: | Ten health systems/organizations in Utah have formally adopted the Zero Suicide Framework.  
| Time frame: | 2017-2021  
| Responsible: | UHIP/Suicide Prevention Coordinator  
| Outcomes: | July 2018 - 13 health systems/orgs adopting
**Goal 2.2**
Engage community stakeholders and prevention coalitions in suicide prevention

<table>
<thead>
<tr>
<th>2.2.1 Train community members in Gatekeeper awareness and evidence-based trainings</th>
</tr>
</thead>
</table>

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

**Baseline:** # of prevention coalitions engaging in evidence based suicide prevention efforts

**Target:** Increase # of prevention coalitions engaged by

| Zero Suicide.  
July 2019- 28 health systems/org adopting ZS.  
**Indicator:** Number of people trained in an evidence-based gatekeeper training.  
**Baseline:** 25,000 (estimated)  
**Target:** A minimum of 299,592 Utahns are trained in an evidence-based gatekeeper training.  
**Time frame:** 2017-2021  
**Responsible:** UHIP/Suicide Prevention Coordinator  
**Outcomes:** July 2018- trained an additional 9000 individuals for total 34,000.  
July 2019- Trained an additional 35,953 individuals for a total 69,953  
**Indicator:** Number of formal partnerships established/engaging in research guided means reduction activities.  
**Baseline:** Zero partnerships established  
**Target:** Ten firearm retailers, instructors, enthusiasts in Utah have incorporated suicide education, prevention, and awareness efforts into their businesses.  
**Time frame:** 2017-2021  
**Responsible:** UHIP/Suicide Prevention Coordinator  
**Outcomes:** 2018 - 7 mini grants awarded to communities to carry out activities.  
July 2019- 14 organizations with formal partnerships. |
| and mental health promotion efforts statewide | 2.2.2 Engage workplaces in suicide prevention by using the Action Alliance Blueprint for Workplace Suicide Prevention and by training using Working Minds model  
2.2.3 Engage Institutes of Higher Education in suicide prevention using the Jed Foundation Campus Model | 10%  
**Time frame:** 2015-2021  
**Responsible:** Suicide Prevention Coordinator  
**Outcomes:**  
Baseline: 2015: 12 active coalitions  
July 2019 update: 25 active coalitions |
|---|---|---|
| Goal 2.3 | 2.3.1 Sustain and strengthen collaborations across agencies and public/private partners to advance suicide prevention  
2.3.2 Provide ongoing leadership to collaborate and coordinate the Utah Suicide Prevention Coalition, including the Executive Committee and relevant workgroups  
2.3.3 Update current state suicide prevention plan for 2017 | **Indicator:** Participation in Suicide Prevention Coalition meetings  
**Baseline:** 15 stakeholders represented at meetings  
**Target:** Maintain or increase the number of stakeholders engaged  
**Time frame:** 2015-2017  
**Responsible:** Suicide Prevention Coordinator (Kim Myers)  
**OUTCOMES - UPDATES (July 2018):**  
DSAMH continues to provide leadership to the coalition. Coalition meets every other month with approximately 40 participants at each meeting. Objective will continue. Utah Suicide Prevention Plan 2017-2021 revised and released May 2017  
July 2019: Coalition still meeting bi-monthly with approximately 40 to 50 participants per meeting. Eight sub-committees continue to meet regularly to implement strategies. Gov Herbert formed Suicide Prevention Taskforce to continue to advance public/private partnerships to advance efforts. |
| Goal 2.4 | 2.4.1 Promote suicide prevention as a core component of health care services. Promote the adoption of “zero suicides” as an aspirational goal by health care and community support systems that provide services and support to defined patient populations | **Indicator:** Universal Screening Rates in public mental health system  
**Baseline:** Dependent on Local Authority  
**Target:** Increase screening rates by 25% |
| Health) to better support individuals who are at risk of suicide through adoption of Zero Suicide framework | 2.4.2 Promote the adoption of universal screening for suicide risk within the public behavioral health care system  
2.4.3 Promote same day safety planning for individuals who screen positive for suicide risk  
2.4.4 Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means  
2.4.5 Provide training to community and clinical service providers on the prevention of suicide and related behaviors  
2.4.6 Develop collaborations between emergency departments and other healthcare providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow up after discharge  
2.4.7 Provide health care providers, first responders, and others with care and support when a patient under their care dies by suicide | Time frame: 2015-2018  
Responsible: Suicide Prevention Coordinator (Kim Myers)  
OUTCOMES - UPDATES: 2016 first implementation year for LA PIP, 2015 was baseline year.  
Indicator: Same-day safety planning for individuals screened as at risk for suicide  
Baseline: Dependent on Local Authority  
Target: Increase same day safety plans by 25%  
Time frame: 2015-2018  
Responsible: Suicide Prevention Coordinator (Kim Myers)  
OUTCOMES - UPDATES:  
2017 Dec. update - BASELINE Screening: 11%  Same Day Safety Plan: 45%  
2016 Screening: 55% Same Day Safety plan: 62%  
Zero Suicide Academy - 19 health/behavioral health care organizations represented  
July 2019:  
2015 Baseline Screening Rates: 6%  
2015 Baseline Safety Plan Rates: 40%  
2016 Year 1 Screening Remeasurement: 24%  
2016 Year 1 Safety Plan Remeasurement: 47%  
2017 Year 2 Screening Remeasurement: 50%  
2017 Year 2 Safety Plan Remeasurement: 54%  
2018 Year 3 Screening Remeasurement: 55%  
2018 Year 3 Safety Plan Remeasurement: 62% |
| Goal 2.5 Promote effective programs | 2.5.1 Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment | Indicator: Number of Media/Safe Messaging Trainings and number of attendees |

Printed: 7/30/2021 4:20 PM - Utah - OMB No. 0930-0168  Approved: 04/19/2019  Expires: 04/30/2022
and practices that increase protection from suicide risk.

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

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

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

3.1.4 Develop Additional Training for Peer Support in the State.
- Develop a Peer Supervision Curriculum and Implement Training.
- Develop an Integrated Health Training for CPSSs and FRFs, including online training modules.
- Develop a Suicide Prevention Training for FRFs and CPSSs and a T4T Training on Peer Suicide Prevention.

3.1.5 Increase Support for CPSS who are employed
- Hold monthly calls and quarterly webinars for Peer Support

Competence, Suicide Prevention, Integrated Care)

Timeframe: 2018-2020
Responsible: Heather Rydalch

OUTCOMES - UPDATES:
July 2018
3.1.1
- The Annual Peer Support Conference was held on June 8, 2018. Over 200 attended including CPSS’s FRF’s and other paraprofessionals.
- A total of 83 new CPSSs were trained between October 2017 and July 2018.
- USU has scheduled a Training for August 2018 and October 2018.
- An Integrated Health Curriculum for Peer Support is being finalized by DSAMH and will be available by August 2018 for an endorsement training for CPSSs and FRFs.
- A Cultural Competency Training for CPSSs and FRFs was held in March 2018.

3.1.2
- LAs have been educated throughout the year on annual monitoring visits regarding the Peer Role and Value of Peers, as well as the current wages across the state.
- 98 CPSSs and 44 FRFs are employed by the Local Authorities.
- A flyer promoting recovery and the Value of Peer work has been developed and will be handed out in 2018.
- A Supervision Curriculum for the State is being finalized and Supervision will be presented at the Fall Substance Abuse Conference in 2018.
### Goal 3.2  Promote and establish employment and education services statewide

<table>
<thead>
<tr>
<th>Objective 3.2.1</th>
<th>Identify current programs and barriers in both urban and rural counties. Develop a continuum across available services to describe funding gaps and create a strategic plan to address barriers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 3.2.2</td>
<td>Increase engagement of employment services for individuals in recovery.</td>
</tr>
<tr>
<td>Objective 3.2.3</td>
<td>Work with Medicaid and other sources to expand services through various funding mechanisms.</td>
</tr>
<tr>
<td>Objective 3.2.4</td>
<td>Increase the number of SUD participants employed/attending school.</td>
</tr>
<tr>
<td>Objective 3.2.5</td>
<td>Encourage IPS employment specialists to attend trauma-informed training and motivational interviewing.</td>
</tr>
</tbody>
</table>

**Indicator:** Increase integrated and competitive employment opportunities through Supported Employment (SE)/Individual Placement and Support (IPS)

**Baseline:** Two LMHAs engaged in SE/IPS providing services to approximately 100 individuals per year

**Target:** Engage two rural LMHAs and encourage hiring an employment specialist to provide SE/IPS services. Engage all accredited Clubhouses to provide SE/IPS services to approximately 25 additional individuals

**Timeframe:** 2014-2019

**Responsible:** Supported Employment Program Manager (Sharon Cook)

**Education Baseline:** Increase measured from admit to discharge

### OUTCOMES - UPDATES:

**May 2018**
- An IPS Trainer was hired at Alliance House to provide IPS training and services for accredited Clubhouses and Clubhouse-like programs. Rural LMHAs engaged in SE/IPS training and provided SE services.

**January 2018**
- Objective 3.2.1 - The Supported Employment Coordinating
Committee (SECC) continues to address SE/IPS barriers and provides strategies for sustainability and scalability. 3.2.2 - Total of eight sites are providing SE/IPS services.
- SE/IPS trainer provided statewide quarterly training for all employment specialists for FY18.
- The employment specialists have completed the Association of Community Rehabilitation Educators (ACRE) training. Expansion sites are implementing the IPS model to fidelity. All of the employment specialists received quarterly on-site IPS training with the IPS statewide trainer in FY18.
- 3.2.3 - Psychoeducational services and Targeted Case Management billing is being used as a funding method to sustain SE/IPS. Two IPS sites are receiving Vocational Rehabilitation Milestone Payments for providing SE services. An additional expansion site plans to collect Milestones in August 2018.

**Update June 2018**
- 3.2.1 - The Supported Employment Coordinating Committee (SECC) will continue to address SE/IPS sustainability and scalability. The data evaluator with U of U Criminal Justice Center will provide data outcomes to identify gaps and improve SE/IPS services.
- 3.2.2 - Total of eight sites are continuing to provide SE/IPS services and three accredited Clubhouses are in providing SE/IPS services.
  - Alliance House hired an FTE IPS Trainer and continues to provide IPS training for accredited Clubhouses and Clubhouse-like programs.
<table>
<thead>
<tr>
<th>Goal 3.3</th>
<th>Provide MH and SUD services in a trauma informed environment for clients and staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 3.3.1</strong></td>
<td>Review Division Directives and contracts to include the provision of services in a trauma informed environment</td>
</tr>
<tr>
<td><strong>Objective 3.3.2</strong></td>
<td>Create a Trauma Informed Workgroup that reports to the UBHC Clinical Directors to make recommendations about changes in policy, procedures, and funding strategy to move to a TIC system</td>
</tr>
<tr>
<td><strong>OBJECTIVE COMPLETE:</strong></td>
<td>Objective 3.3.2 Provide increased training and technical assistance for Local Authorities. Through the CABHI Grant, providing evidence based training on Trauma Informed Care (TIC)</td>
</tr>
<tr>
<td><strong>Indicator:</strong></td>
<td>Increase trauma informed services for clients</td>
</tr>
<tr>
<td><strong>Baseline:</strong></td>
<td>Four LAs are currently undergoing training</td>
</tr>
<tr>
<td><strong>Target:</strong></td>
<td>All LAs would be trained in trauma informed approach</td>
</tr>
<tr>
<td><strong>Timeframe:</strong></td>
<td>FY18</td>
</tr>
<tr>
<td><strong>Responsible:</strong></td>
<td>SUD and MH Program Administrators (Becky King, Robert Snarr)</td>
</tr>
</tbody>
</table>

**OUTCOMES - UPDATES - February and April 2018:**
The following statewide trauma-informed and gender responsive training events were provided for Local Authority and Private SUD and MH Providers:

- **Beyond Trauma: A Healing Journey for Women**
- **Healing Trauma: Brief Intervention for Women**
- **February 20 - 21, 2018**
- **Voices: A Program for Self-Discovery and Empowerment**
### Goal 3.4
Develop array of non-clinical services designed to provide necessary supports for individuals seeking recovery or in early recovery

<table>
<thead>
<tr>
<th>Objective 3.4.1</th>
<th>Expand contract language to encourage and incentivize expansion of services providing early intervention and post-acute treatment services to support recovery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 3.4.2</td>
<td>Work with appropriate committees and groups to ensure that essential health benefits in Utah include early intervention and recovery support services in insurance plans</td>
</tr>
<tr>
<td>Objective 3.4.3</td>
<td>Work with state and local community stakeholders to continue developing recovery oriented standards of care and work towards implementation planning and delivery</td>
</tr>
<tr>
<td>Objective 3.4.4</td>
<td>Recovery Support data specifications reported from each LA into TEDS</td>
</tr>
</tbody>
</table>

#### Indicator:
- Increase recovery oriented support services to clients
- **Baseline:** Scorecard history of recovery oriented services including: employment, housing, and peer support related services
- **Target:** Increase recovery oriented support services provided by 5%
- **Timeframe:** SFY20
- **Responsible:** (Pam Bennett, Shanel Long)

### OUTCOMES - UPDATES:
- **June 2018**
  - **3.4.1-** FY19 Division Directives modified RSS services (RSS manual and approved service list continually updated); Contract developed for

**for Girls**
April 24-25, 2018

**Trauma-Informed Approach Training - Salt Lake County Criminal Justice Services**
August 8-9, 2018

**OUTCOMES - UPDATES - 2019:**
The following statewide trauma-informed and gender responsive training events were provided for Local Authority and Private SUD and MH Providers:

- **Seeking Safety Youth Training - Utah State Youth Treatment Implementation Grant**
  - January 9 - 10, 2019
- **Trauma Recovery and Empowerment Model for Women and Men**
  - May 7-8, 2019
- **Seeking Safety Webinar**
  - June 25 - 26, 2019
- **Utah Trauma Academy**
  - October 21 - 25, 2019
<table>
<thead>
<tr>
<th><strong>Objective 3.4.5</strong> Expand funding sources and opportunities to support and expand Recovery Support Services to the Local Authorities and other community partners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provide funding for LBHS to work with LGBTQ Latinx youth.</strong></td>
</tr>
<tr>
<td><strong>3.4.3</strong> - ROSC and UBHC committee continue to address RSS and best practices. ROSC committee looking at Recovery Capital Scales: Possible selection: DLA-SUD. USARA developed Recovery Support Guidelines.</td>
</tr>
<tr>
<td><strong>3.4.4</strong> - 9 out of the 13 Local Authorities are now reporting in TEDS RSS services. RSS services to be expanded in FY20 to expand RSS services to additional clients and to use additional funding sources</td>
</tr>
<tr>
<td><strong>3.4.5</strong> - TANF Contracts to increase and support RSS services through CPSS: USARA Completed &amp; SouthWest completed contracted ends June 30, 2019. CPSS services will be expanded under the RSS program to all LAs. RSS Funding for FY20: JRI, Drug Court, Corrections, SOR, ORG-Recovery Residence (WFS), SABG MHBG.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Goal 3.5 Improve housing services across the state</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objective 3.5.1</strong> Identify current housing programs and barriers in both urban and rural counties</td>
</tr>
<tr>
<td><strong>Objective 3.5.2</strong> Develop a continuum across available services to describe funding gaps and create a strategic plan to address barriers</td>
</tr>
<tr>
<td><strong>Objective 3.5.3</strong> Explore Medicaid services to maximize funding mechanisms and ensure that those eligible for Medicaid are enrolled</td>
</tr>
</tbody>
</table>

**Indicator:** Explore the development of additional affordable supported housing and Medicaid resources

**Baseline:** Scorecard history for housing indicators

**Target:** Development of increase of 5% of additional affordable supported housing for individuals who are homeless/mental illness and/or substance use disorders.

**Timeframe:** SFY18

**Responsible:** Robert Snarr

**OUTCOMES - UPDATES:**

-
| Goal 3.6  
Promote JRI certification and implementation throughout public and private MH and SA systems. | Objective 3.6.1 Identify JRI providers and have them complete application for certification  
Objective 3.6.2 Promote JRI throughout the State also identify and address barriers  
Objective 3.6.3 Require each local authority to develop an annual plan that identifies their JRI committee and implementation plans  
Objective 3.6.4 Develop treatment standards for all public and private facilities and promote compliance of those standards to all providers  
Objective 3.6.5 Increase number of providers and individuals trained in EBP | **Indicator**: Increase the number of certified JRI providers that are trained in the use of evidence based practices  
**Baseline**: 99 sites, 24 private providers and all 13 Local Authority Providers certified  
**Target**: Maintain the certification process and continual certification of new and current providers  
**Timeframe**: SFY 2019  
**Responsible**: Thom Dunford  

**OUTCOMES - UPDATES:**  
**July 2018**  
3.6.1 DSAMH continues to reach out to public and private stakeholders to educate and inform them on the JRI certification process. New agencies continue to submit applications for Justice Certification on a monthly basis. The following update reflects the current certified provider count:  
- Received applications for 251 sites (up 32 over SFY 18) representing 110 (up 17 over SFY 18) private agencies and all 13 Local Authorities  
- Provisionally certified 208 sites (up 17 over SFY 18) with 168 (up 8 over SFY 18) private agency sites and 40 Local Authority sites  
- Provisionally certified 6 prison programs  
- Provisionally certified 15 jail programs  
- Provisionally certified 22 Adult Probation and Parole Programs  
- Revoked certification on 2 agencies 6 sites  
- Reinstated certification on 2 agencies 5 site  

3.6.2 The Justice Program Administrator is a member on the following committees:  
- CCJ JRI Implementation Committee  
- USAAV Justice Committee |
• DOC/ASCENT Community Reentry committee
• SB 205 Workgroup with Rep. Brad Daw
• Inmate Healthcare Study Work Group With CCJJ

3.6.3 The FY 2019 annual review of Local Authority programs was completed and all Local Authorities are holding regular implementation committee meetings. Some are very strong and collaborative in their function.

3.6.4 DSAMH continues to review program standards that are established in R523-4. A quarterly outreach meeting is held with a group of private providers and standards are regularly discussed. The Division is in a current rule revision process that makes sweeping changes to the certification process and simplifies screening and assessment expectations.

3.6.5 The following training has been offered to increase the use of EBPs:

• 3rd annual Utah Criminal Justice Conference at the University of Utah
• The Fall Substance Use Conference- September 2018
• ASAM
  ○ ASAM Skill-Building 2-day training opened to 40 participants Completed:
    ■ March 20-21, 2018
    ■ August 10-11, 2018
    ■ October 23-24, 2018
  ○ MI Enhanced ASAM/Tx Planning 2-day training opened to 42 participants Completed:
    ■ May 21-22, 2018
    ■ January 16-17, 2019
    ■ February 12-13, 2019
    ■ April 2-3, 2019
    ■ July 4 - 5, 2019
| Goal 3.7 Improve outcomes related to mental health treatment | Objective 3.7.1 - Demonstrate client’s self-report improved functioning after mental health services | Indicator: Positive outcomes (stable, improved and in recovery) during treatment (or discharged) as measured by OQ.  
Baseline FY2015: Reporting positive OQ outcomes - 84.1% Adults  
Target (DHS target): 69% of clients report positive outcomes  
Timeframe: 2016-2018  
Responsible: MH Administrator - Pam Bennett  
OUTCOMES - UPDATES:  
July 2019  
3.7.1 - FY18 Scorecard indicates that 84.96% in treatment and 84.83% are discharged with positive outcomes.  
3.7.1 - FY19 site monitoring demonstrated that several Local Authorities are not using the OQ as a clinical intervention as required. |
| --- | --- | --- |
| Goal 3.8 Expand access and participation in evidence-based treatment services for opioid use disorders | Objective 3.8.1 Increase the number of qualified prescribers who can prescribe medications approved to treat opioid use disorder  
Objective 3.8.2 Increase participation in Opioid Treatment Programs (OTP)  
Objective 3.8.3 Increase access and use of Naltrexone, Vivitrol, and Buprenorphine  
Objective 3.8.4 Increase use and training of SBIRT | Responsible: Shanel Long and VaRonica Little  
Indicator: 3.8.1 # of Providers waivered to prescribe MAT through SAMHSA  
Baseline FY2017: 288  
Target: Increase providers by 1% each year, focusing on Rural Areas  
TimeFrame: May 2017 - May 2018  
Update: July 2018 342 unduplicated waivered physicians |
| Objective 3.8.5 Improve treatment retention for individuals with opioid use disorders |
| Objective 3.8.6 Increase number and percent of clients with opioid use disorder who complete treatment successfully |
| Objective 3.8.7 Increase number of clients with public/private insurance |
| Objective 3.8.8 Increase the number of individuals voluntarily participating in Community Support Activities |

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

**Indicator:** 3.8.2 # of Participants in OTP’s based on Quarterly and Annual Reports.

**Baseline:** Calendar Year 2013, 1449 participants

**Target:** increase participants by 5% within 2 years

**TimeFrame:** Update Annually, per calendar year

**Update:** CY2017 Average census 2724 CY 2018 Average census 2847

**Indicator:** 3.8.3 Increase the use of all forms of FDA approved Medication Assisted Treatment including but not limited to Methadone, Naltrexone, Vivitrol and Buprenorphine within the public providers.

**Baseline:** FY17 1624

**Target:** increase baseline by 5%

**TimeFrame:** State Fiscal Year monitoring.

**Update:** FY2018 2166

These numbers are pulled from our state fiscal year TEDs submissions of clients served with OUD that have the MAT or Methadone indicators.

**Indicator:** 3.8.4 Providing SBIRT Trainings to partners

**Baseline:** None

**Target:** Complete at least 2 trainings in behavioral and physical health settings.

**TimeFrame:** May 1, 2017- May 1, 2019
**Update:** July 2018 8 in person trainings with 239 participants. Update: June 2019 10 in person trainings and 720 participants in the online SBIRT training throughout the year.

**Indicator:** 3.8.5 Treatment Retention

**Baseline:** FY2016 62.7% (retained in treatment for minimum of 60 days)

**Target:** Increase by 5% of baseline

**TimeFrame:** Annual Monitoring.

**Update:**
- FY2017 57.8%
- FY2018 55.4%

*The annual reporting data for this has changed and the retention rate went from retained in treatment for 60 days or more to retained in treatment for 90 or more. This continues to only indicate those with OUD as primary diagnoses which makes year to year accurate comparison but not the baseline.*

**Indicator:** 3.8.6 OUD clients who successfully complete treatment

**Baseline:** FY2016 36.1%

**Target:** Increase 5% of baseline

**TimeFrame:** Annual Monitoring

**Update:**
- FY2017 34.2%
- FY2018 40.2%

*limitation of data is that only those with primary OUD...*
can be identified with outcome data.

**Indicator:** 3.8.7 Percent of clients with insurance

**Baseline:** Service was not provided previously

**Target:** Enroll 200 Clients per year

**TimeFrame:** May 1, 2017 - May 1, 2019

**Update:** June 2018 438 new enrollments into insurance programs between May 1, 2017 - April 30, 2018

**Update:** June 2019 between April 2018 - May 1, 2019 there were 1,424 new enrollments into insurance programs

**Indicator:** 3.8.8 OUD clients engagement in Recovery Support Services within the public system.

**Baseline:** FY 16 18.1%

**Target:** Increase by 10% from baseline

**TimeFrame:** May 1, 2017 - May 1, 2019

**Update:** FY17 33.3%

**Update:** FY18 30.5%

---

### Strategic Initiative #4 – Improve Care for Children and Youth

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
<th>METRICS</th>
</tr>
</thead>
</table>
| Goal 4.1 Promote Community Based Services (Systems of Care Values) through increasing | Objective 4.1.1 Increase in state system knowledge of, and compliance with, the Interstate Compact on the Placement of Children (ICPC) process through a collaboration with Office of Licensing (OL), Division of Child and Family Services (DCFS), Division of Juvenile Justice, DSAMH and the LMHAs | **Indicator:** Compliance with ICPC process  
**Baseline:** Numbers of out of state clients accessing State or County services without reimbursement from the sending state through the ICPC process  
**First Year Target:** Establish baseline |
| Accountability of states placing youth in Residential Treatment Centers (RTCs) in Utah | Objective 4.1.2 Establish and utilize collaboratively developed procedures to ensure ICPC compliance  
Objective 4.1.3 Identify all states sending children and youth to RTCs in Utah and increase collaboration regarding compliance and oversight by sending state | Second Year Target: 20% reduction  
Data Source: Partner agencies, OL, DCFS, ICPC Local Authorities  
Description of Data: Research results, reports, Substance Abuse and Mental Health Information System (SAMHIS) and Outcome Data  
Responsible: Children, Youth, and Families Program Administrator (Eric Tadehara)  
OUTCOMES - UPDATES: July 2018  
Objective 4.1.1 - Office of Licensing (OL) has incorporate ICPC compliance in monitoring.  
Objective 4.1.1 - All LMHAs have been trained by DCFS regarding the ICPC system.  
Objective 4.1.2 -  
1. All LMHAs have been trained by DSAMH regarding procedures to follow when ICPC issues arise  
2. All DJJS staff supervising Detention, Receiving Centers and Multi-use Facilities have been trained to notify DJJS administration when a youth placed in Utah from out of state is ending up in one of their facilities.  
3. DSAMH, DJJS and DCFS are working to resolve ICPC situations when the arise and involve OL when violations occur.  
Goal 4.2 Increasing system knowledge for adolescent co-occurring substance use and mental | Objective 4.2.1 Develop and publish dashboard with data regarding the provision of services and outcomes for adolescents with co-occurring substance use and mental health disorders.  
Objective 4.2.2 Increase utilization of LMHA/LSAA supplied data regarding the provision of services and outcomes for adolescents with | Indicator: Adolescent Dashboard for Co-Occurring MH and Substance Use Disorders developed and used  
Baseline: None, this would be a newly developed Scorecard  
June 2018: Dashboard developed and published  
Data Source: SAMHIS, Local Authority Reports,
<table>
<thead>
<tr>
<th>health disorders</th>
<th>treatment</th>
<th>co-occurring substance use and mental health disorders</th>
<th>Responsible: Children, Youth and Family Program Administrator and Business Analysts (Leah Colburn, Ryan Carrier)</th>
</tr>
</thead>
</table>

**OUTCOMES - UPDATES: July 2018**: The dashboard is completed and is being updated as needed.

<table>
<thead>
<tr>
<th>Goal 4.3</th>
<th>Improve the quality of adolescent SUD treatment services through evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 4.3.1</td>
<td>Evaluate and measure treatment quality and effectiveness. Create a continuous quality improvement system through the Utah Quality Youth Treatment Project.</td>
</tr>
<tr>
<td>Objective 4.3.2</td>
<td>SRI will create The Utah Directory of Quality Youth Treatment dashboard and website.</td>
</tr>
<tr>
<td>Objective 4.3.</td>
<td>Evaluation strives to meet improvement benchmarks. Bi-Annual and Annual Reports generated for agencies and DSAMH Program Administrators.</td>
</tr>
</tbody>
</table>

**Indicator**: Annually review 24+ private and public adolescent SUD treatment providers during the project period (January 1, 2016 - June 30, 2021).

**Baseline**: 24 Providers/Agencies reviewed and assessed for quality adolescent SUD treatment

**Target**: Increase the number of new participating agencies by 5 by FY20

**Timeframe**: January 1, 2016 - June 30, 2021 Bi-annual and annual reports will be provided regarding the progress and effectiveness of this project.

**Responsible**: (Shanel Long, Shanin Rapp)

**OUTCOMES - UPDATES: 4.3.1** -

- 24 public, private, and one tribal treatment provider commit to participate in the Quality Youth Treatment Project.

- Project name changed to Utah Quality Youth Treatment Project, updated May 2018

**UPDATE: May 2019** 5 locations visited and many prepared after early pre-emptive visits from SRI. Many
| Goal 4.4 | Objective 4.4.1 - Assure youth and their families/caregivers have access to improved screening, evidence-based assessments, early and brief intervention services, treatment models, and recovery support services by strengthening the existing infrastructure system.  
Objective 4.4.2 - Provide training, consultation, and technical assistance to five treatment agencies in Screening, Assessment, and Brief Intervention using Gain Q3 MI, evidence-based treatment modality A-CRA, and training in the implementation of the Trauma-Informed Approach, Seeking Safety training, and Adolescent Development training.  
Objective 4.4.3 - Increase access to services along the continuum for youth and families by further support and collaboration of prevention, treatment, and recovery support services for adolescents and transitional aged youth ages 12-25 with SUD and/or co-occurring mental health disorders. | Indicator:  
Baseline: Establish a quality baseline of treatment among participating adolescent SUD treatment providers  
Target: Improve the integration and efficiency of the treatment and recovery support systems through the study and application of specific evidence-based treatment practices (EBPs).  
Responsible: Shanel Long and Shanin Rapp  
OUTCOMES - UPDATES:  
4.4.1 - sites have no youth currently being treated or any outside referrals coming in. Recruiting private programs to come aboard has some challenges.  
4.3.2  
UPDATE: MAY 2019 Project tools include the evaluation form, pre and post surveys for each agency, and youth input surveys. Website is under construction. Dashboard Directory is under construction.  
4.3.3  
UPDATE: May 2019 Evaluation reports for agencies are being redesigned to include a creative recruitment piece per each agency. Tools reconsidered to address recruitment and retention plans for agencies, where many sites aren’t receiving youth. |
intervention, treatment and recovery support efforts. Expansion of existing resources, and creation of new resources., RECOVERY SUPPORT SERVICES

Objective 4.4.4 - Continual participation in the Utah Quality Youth Treatment Project to insure the advancement of EBPs in treatment programming, improving treatment quality, providing transparency in service delivery, and reinforcing goals and providing support to providers.

UPDATE 2019: Continued efforts to strengthen the system through grant goals. Many partnerships are being forged.

4.4.2

UPDATE 2019: Certification for agencies has continued in A-CRA, with 4 of the 5 agencies having a Supervisor Clinician certified to train other clinicians in A-CRA. A-CRA and Gain Q3 MI have regular fidelity call opportunities. Seeking Safety training and fidelity calls, Trauma-Informed Care training and fidelity calls, and Adolescent Development Training all within FY19. GPRA data being collected.

4.4.3

Mar 2018

A special SUD Workgroup met July 2018 to consider tactics to address improved youth SUD treatment access and referral. Met with KOPPIR Founder August 2018 to discuss replicating, organizing, and disseminating the community family support model for use across the state.

UPDATE 2019: Several smaller work groups have combined to address the all-time low numbers of referrals for youth to the continuum of treatment services. The group is called the Youth Treatment and Early Intervention Referral Development Work Group.

UPDATE 2019: Discussions to create a handbook on how to hold a KOPPIR meeting in any community has commenced. The model was created by kids for kids and requires adults that are supportive of the meetings and active participators in the model. A board is being organized, with 50% youth members, to discuss the
<table>
<thead>
<tr>
<th>Goal 4.5</th>
<th>Improve outcomes related to mental health early intervention services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 4.5.1</td>
<td>Improve School-Based Behavioral Health (SBBH) partnerships and increase the number of Schools and Local Education Agency (LEA) partnerships.</td>
</tr>
<tr>
<td>Objective 4.5.2</td>
<td>Demonstrate client's improved functioning after mental health early intervention services (School-based behavioral Health (SBBH), Family Resource Facilitator (FRF) and Mobile Crisis)</td>
</tr>
<tr>
<td>Objective 4.5.3</td>
<td>Build and grow the mental health early intervention programs (School-based behavioral Health (SBBH), Family Resource Facilitator (FRF) and Mobile Crisis)</td>
</tr>
</tbody>
</table>

**Indicator:** Positive outcomes (stable, improved and in recovery) during treatment or post discharge as measured by Y/OQ. Other Proxy outcomes:

- **SBBH:** Improve GPA or DIBELS literacy score and reduce office disciplinary referrals
- **FRF:** (Data outcomes collected by the Utah Family Coalition FRF database) to include staying at home with proper supports, being enrolled at school, and staying out of legal trouble
- **Mobile Crisis:** Avoiding police involvement and out-of-home placement;

**Baseline FY2015:**

- Reporting positive OQ outcomes - 86.7% Children/Youth
- Avoiding police involvement: 74%
- Avoiding out-of-home placement: 67.4%
- Improved GPA: 14% or DIBELS: 42%
- Reduced office of disciplinary referrals: 45.6%
- At home with proper supports: 68.7%
Enrolled at school: 25%
Staying out of legal trouble: 59%

**Target (DHS Targets):**
- Reporting positive OQ outcomes 69% (DHS target) of clients report positive outcomes
- Avoiding police involvement: 73%
- Avoiding out-of-home placement: 68%
- Improved GPA: 14% or DIBELS: 42%
- Reduced office of disciplinary referrals: 46%
- At home with proper supports: 70%
- Enrolled at school: 30%
- Staying out of legal trouble: 70%

**Timeframe:** 2016-2018

**Responsible:** Children, Youth, and Families Program Administrator (Eric Tadehara)

**4.5.2 Baseline FY2017**

**(FRFs): July, 2017:** There are 2 FRFs working directly with Mobile Crisis Teams, 10 working solely as school-based FRFs, 2 working directly with DCFS, 2 working directly in the juvenile mental health courts, 2 working with The Children’s Center, 1 with USARA, 1 with the Early Psychosis team, and 1 working at USH.

2,410 children were served by FRFs

**SBBH: July 2017:** 313 total schools served; 89 specific to areas with high rates of Intergenerational Poverty; 3,335
youth served via SBBH

**Mobile Crisis Teams: July 2017:** Provided in 5 counties (Washington, Iron, Utah, Davis, and Salt Lake); 4,193 served by mobile crisis teams

**Target (DHS Targets):**

- **FRF:** Continue to maintain and grow the number of certified FRFs, Family Peer Support, and Wraparound Specialists.
  - FRF - currently 59 total certified and available in all catchment areas; **Target:** Maintain 55-65 total FRFs through LMHAs
- **Family Peer Support** - New certification, **Target:** 10 throughout DHS in collaboration with each Division
- **Wraparound Specialists** - New certification, **Target:** 10 through LMHAs and SOC

**SBBH:** Grow number of schools and youth served by 5% each year

**Mobile Crisis Teams:** 5% increase in the number served

**OUTCOMES - UPDATES:**

**4.5.1 FY2018:**

- Reporting positive OQ outcomes - N/A
- Children/Youth
  - Avoiding police involvement: 54.58%
  - Avoiding out-of-home placement: 67.74%
  - Improved GPA: 1.13% or DIBELS: 37.74%
  - Reduced office of disciplinary referrals: 44.86%
  - At home with proper supports: 52.94%
| Goal 4.6 Increase system knowledge and ability to provide services to children and youth with co-occurring mental health and intellectual/developmental disabilities | Enrolled at school: 7%
Staying out of legal trouble: 71%

4.5.2
FY2018
FRF: 59 FRFs statewide in each catchment area
SBBH: 342 Schools served; 89 IGP Schools; 3,504 total youth served with MHEI
Mobile Crisis Teams: Provide in 4 counties (Salt Lake, Utah, Iron, and Washington; Davis County shifted funding to School Based Behavioral Health); 3,639 children and youth served

| Objective 4.6.1 DSAMH will collaborate with the Division of Services for People with Disabilities, Family Advocacy Agencies, System of Care, UNI Home, and Department of Health to identify gaps and barriers in service delivery

Objective 4.6.2 DSAMH will partner with allied agencies to increase workforce development to improve competencies and skills in providing services to children and youth with complex issues | Indicator: Gaps and barriers are identified and shared with partners
Baseline: Zero gaps and barriers formally identified
Target: One coordinated plan identifying gaps and barriers. Plan will include ways to improve workforce development across systems
Timeframe: SFY18
Responsible: Children, Youth, and Families Program Administrator (Eric Tadehara)

Update July 2018: Gap in services identified for individuals with co-occurring mental health and intellectual/developmental disorders. Individuals with co-occurring disorders have difficulty accessing treatment to address their complete needs. Often, the services they receive only address the Mental Health or the Intellectual/Developmental Disabilities and professionals do not feel adequately prepared to provide co-occurring treatment. |
Funding has been secured to provide a professional development training in the State of Utah. Preliminary plan involves 2 single day trainings to go over the best practices for working with this population occurring in October/November 2018. January/February 2019 will then introduce a train the trainer model for professional development for those working with these populations.

Goal 4.7  Improve collaboration among child serving entities and provide consultation for early childhood mental health

Objective 4.7.1 DSAMH will participate in statewide and inter-agency councils focused on early childhood health

Objective 4.7.2 DSAMH will lead efforts to engage with community partners and include national technical assistance to develop a formal structure and model for early childhood consultation

Indicator: Formalized structure for collaboration and consultation for early childhood mental health is established, as well as ongoing workforce development opportunities

Baseline: Limited collaboration among child serving entities for early childhood mental health as well as limited access for early childhood mental health training

Timeframe: SFY18-SFY20

Responsible: Children, Youth, and Families Program Administrator (Eric Tadehara and Codie Thurgood)

Update July 2018: A previous needs assessment for infant and early childhood mental health services was reviewed and updates made. A vision statement and goals have been developed to begin efforts to create a clear structure for collaboration and consultation, as well as workforce development. Community partnerships have also been developed to bring national infant and early childhood competencies and endorsements to Utah. No direct funding is supporting infant and early childhood mental health.
childhood mental health at this time; but efforts are being made to secure needed funding.

**Update July 2019:** Input on infant and early childhood mental health has been provided for a qualitative and quantitative statewide needs assessment being completed by the Office of Child Care through a Preschool Development Grant. Efforts are being made towards workforce development around infant and early childhood mental health. No direct funding is supporting infant and early childhood mental health at this time; but efforts are being made to secure needed funding.

### Strategic Initiative #5 – Health System Integration

<table>
<thead>
<tr>
<th>GOALS</th>
<th>OBJECTIVES</th>
<th>METRICS</th>
</tr>
</thead>
</table>
| **Goal 5.1** Increase partnerships with Department of Health, accountable/ care organizations (ACOs), federally qualified health centers (FQHCs), and the Local Authorities | **Objective 5.1.1** DSAMH will collaborate with Department of Health/Medicaid to facilitate at least three meetings to discuss integration with Local authorities, ACOs and FQHC representatives annually | **Indicator:** Number of local authorities that submit integration area plan.  
**Baseline:** in SFY 2016, 100% of local authorities submitted integration plan.  
**Target:** 100% in SFY 2018  
**Timeframe:** 2015-2018  
**Responsible:** Shanel Long, Jeremy Christensen |
|  | **Objective 5.1.2** Require each local authority to develop an annual plan that describes their efforts to integrate services |  |
|  | **Objective 5.1.3** Local authorities will contract for services with FQHCs |  |
|  | **Objective 5.1.4** Local authorities will contract for services with ACOs |  |
|  | **Objective 5.1.5** Educate FQHCs regarding trauma-informed care  
- Find out what is already being done |  |

**OUTCOMES - UPDATES:**

**July 2018**

5.1.1 DSAMH Leadership meeting with Medicaid regularly to discuss integration.  
DSAMH hosted 3 Webinar trainings provided by Medicaid to educate on TAM (Justice Involved, SUD providers, OTP’s)  
5.1.2 All FY19 Local Authority Area Plans have been printed.
<table>
<thead>
<tr>
<th>Goal 5.2</th>
<th>Objective 5.2.1 Provide or arrange for a diabetes/HIV/TB screening, as indicated.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Objective 5.2.2 Identify tobacco use in the assessment and offer resources as indicated.</td>
</tr>
<tr>
<td></td>
<td>Objective 5.2.3 Provide services in a tobacco free environment.</td>
</tr>
<tr>
<td></td>
<td>Objective 5.2.5 Provide information to individuals on physical health concerns and ways to improve their physical health including referrals where needed.</td>
</tr>
<tr>
<td>Indicator:</td>
<td>Percent of clients using tobacco at discharge will decrease from admission.</td>
</tr>
<tr>
<td>Baseline:</td>
<td>FY16 based off outcome data for each LA.</td>
</tr>
<tr>
<td>Target:</td>
<td>Decrease by 1% by each LA in FY20- outcome data.</td>
</tr>
<tr>
<td>Timeframe:</td>
<td>SFY17-SFY21</td>
</tr>
</tbody>
</table>

5.2.1 New **Indicator:** Number of Local Authorities trained by the Health Department to conduct communicable disease testing or that has the health department coming to provide testing directly.

**Baseline:** 2019 None officially

**Target:** 2020 4 Local Authorities will be trained or have...
<table>
<thead>
<tr>
<th>Objective 5.2.6</th>
<th>Incorporate wellness and physical care into individual person centered Recovery Plans as needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objective 5.2.7</td>
<td>Increase coordination of care between physical health providers and behavioral health providers</td>
</tr>
</tbody>
</table>

**OUTCOMES - UPDATES:**

**July 2018**

- FY18 Site monitoring included review of assessment of tobacco use, review of agency as a tobacco free zone, priority populations engagement and services provided including education and referrals, emphasis of physical health and wellness within the treatment plan, and have included screenings for need of MAT.
- DSAMH STR grant year one end and year 2 starting. SOR application for FY19 being submitted (Opioid prevention and treatment funding)
- MH/SUD/Prevention meet monthly with DOH Tobacco Prevention and Control Program Outreach Coordinator
- All FY19 Local Authority Area Plans have been approved. LAs were required to provide more detail regarding integrated care and tobacco cessation referrals/services
- DOH provides needle exchange services and programs.
- State MASOB installing Non-Tobacco signage at entrances as indicated by law.
- Increase Coordination of Care and provide education between behavioral health and physical health: June 2018- Addictions Update Conference.
- 5.2.8 Working with Health Department based on CDC agreement with Health department to provide communicable disease testing.

**Timeframe:** SFY19-SFY21

**Responsible:** SUD Administrator- Shanel Long
determination of Need on HIV/Hep C for outreach, screenings, referrals and treatment of infections diseases (New 2018/2019 Block Grant requirements)

**FY2019 Updates:**
- 5.2.8 Working with Health Department based on CDC determination of Need on HIV/Hep C for outreach, screenings, referrals and treatment of infections diseases (New 2018/2019 Block Grant requirements)
  
  2/2019 Meeting with Health Department to discuss testing for Communicable Disease testing and identification of gaps. 6/2019 Discussion with Health Department to address gaps in the system for Communicable Disease testing and available funding to LA’s.
- Site visit monitoring included review of assessment of tobacco use, review of agency as a tobacco free zone, priority populations engagement and services provided including education and referrals, emphasis of physical health and wellness within the treatment plan, and have included screenings for need of MAT.
- DSAMH STR grant year 2 ended April 2019 and SOR grant began October 2018. MH/SUD/Prevention meet monthly with DOH Tobacco Prevention and Control Program Outreach Coordinator
- All FY20 Local Authority Area Plans have submitted and reviewed. LAs were required to provide more detail regarding integrated care and tobacco cessation referrals/services
- DOH provides needle exchange services and programs.
- State MASOB has installed Non-Tobacco signage at entrances as indicated by law as identified in FY18.
- Increase Coordination of Care and provide education
between behavioral health and physical health: June 2019- Addictions Update Conference.

- The Promoting Integration of Primary and Behavioral Health Care (PIPBHC) grant has begun and has a target to serve 350 individuals in SFY19.
Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

DSAMH operates under four guiding principles:

Systems, services, programs, activities, strategies, and policies should be trauma-informed, evidence-based, sustainable and culturally and linguistically competent.

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

Evidence-based Practices: Utah's publicly funded behavioral health system is committed to provide the best possible services to individuals, families and communities. DSAMH provides training and consultation designed to promote evidence based practices. "Evidence-based" stands in contrast to approaches that are based on tradition, convention, belief, or anecdotal evidence.

Sustainable: Utah's Publicly funded system must be sustainable over time and be organized to provide a stable level of services.

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

DSAMH has set the following priorities to emphasize specific goals and strategies in the coming years:

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

Sub State Organization: Utah State Statute specifically mandates the Local Substance Abuse Authorities (LSAA) provide a "continuum of services for Adolescents and Adults" aimed at substance abuse prevention and substance use disorder treatment. Utah's Local Mental Health Authorities (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 Division of Substance Abuse and Mental Health. Short-term acute hospitalization is provided through contracts with local private hospitals in most areas. Local Authorities set the priorities to meet local needs, but at a minimum must provide ten statutorily mandated mental health services and a continuum of substance use disorder services either directly or through contracts and agreements.

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 DSAMH. The Area Plans are submitted in May of each year, and describe the Local Authority’s plan to provide services for the coming Fiscal Year. Each Area Plan describes what services will be provided and how Federal and State requirements will be met. This plan is based on statutory requirements and Division Directives that are provided each year to the Local Authorities shortly after the Legislative Session ends in March. The current Division Directives are located at https://dsamh.utah.gov/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 Division 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 Division Director.

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

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

   a) Physical Health
      • 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-occurring M/SUDs
      • Yes ☑ No

   Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.) DSAMH’s Division Directives require Local Mental Health Authorities (LMHAs) assess for physical health, mental health, and substance use disorders for individuals receiving treatment. This evaluation includes questions on primary care providers, all medication, current and desired state of employment and education (including accommodations), housing situation and need for support services. A case management needs assessment is completed to ensure coordination of care across multiple providers and to provide access to support services (Peer Support, Employment Services, Housing Providers).

3. Describe your state’s case management services

   Case managers (CM) are certified by DSAMH and provide a Medicaid billable service to adults with SMI and children with SED. Case management provides coordination, advocacy, linking and management for individuals in treatment. Case management is a service that assists clients to gain access to needed medical (including Mental Health), social, educational, and other services. The overall goal of the services is not only to help 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.

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

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

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

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>144903</td>
<td>20300</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>131892</td>
<td>10500</td>
</tr>
</tbody>
</table>

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Utah uses the SAMSHA numbers for the prevalence, and create the incident numbers by looking at the past years and making a prediction based on those years.
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<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Social Services</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>b)</td>
<td>Educational services, including services provided under IDE</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>c)</td>
<td>Juvenile justice services</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>d)</td>
<td>Substance misuse prevention and SUD treatment services</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>e)</td>
<td>Health and mental health services</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>f)</td>
<td>Establishes defined geographic area for the provision of services of such system</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
**Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults**

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

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**Criterion 4**

**a. Describe your state’s targeted services to rural population.**

In Utah, 9 of 13 Local Authorities are classified with regions that are rural or frontier. In SFY20, 31% of the individuals served by the public mental health system were in one of these rural or frontier regions. This includes 7.9% justice referred clients and 263 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 has received funding to stand up a no-refusal receiving center, the only receiving center in a rural/frontier area. 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, DSAMH 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 the homeless population.**

The Continuum of Care (CoC) is the primary decision-making entity that is defined as the official body representing a community plan in each of the LMHAs catchment areas to organize and deliver housing and services to meet the specific needs of people who are 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. The CoCs have a variety of responsibilities such as oversight of the Homeless Management Information Systems (HMIS), developing and implementing strategic plans, identification of housing and service capacity and gaps, ensuring broad and inclusive participation, and applying for CoC program funding.

Providers within the CoC structure provide shelter, outreach, basic needs, housing and housing support, employment, and case management services, among others. Providers utilize local and federal funding to provide such a wide array of services. Among these funding sources is the Projects for Assistance in Transition from Homelessness (PATH) grant, which is awarded to three LMHAs, both urban and rural, in Utah. These funds are used for outreach, screening and diagnostic treatment, habilitation and rehabilitation, behavioral health services, and referrals for primary care, job training, educational services, etc.

The LMHAs provide an array of services from outreach to engagement, case management, EBPS in mental health and substance use treatment, peer support services and other supports and recovery services based on individual needs.

**c. Describe your state’s targeted services to the older adult population.**

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

DSAMH works with the Division of Aging and Adult Services, who administers a wide variety of home and community-based services for Utah residents who are 60 and older. Programs and services are primarily delivered by a network of 12 Area Agencies on Aging which reach all geographic areas of the state.

The Department of Human Services has a goal to provide services that allow people to remain independent. These services include:

- Meals on Wheels – to homebound seniors
- Senior Centers – community-based center where seniors gather for services and activities
- Caregiver Support – short-term program that supports and assists caregivers
- Healthcare benefits and fraud prevention information and assistance
- Investigations of vulnerable adult abuse, neglect and exploitation

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

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

DSAMH has developed a Disaster Counseling Certification Program that supports short term interventions with individuals and groups experiencing psychological reactions to small and large scale disasters. These interventions involve using Psychological First Aid and Skills for Psychological Recovery with the goals to assist disaster survivors in understanding their current situation and reactions, mitigating additional stress, promoting the use of coping strategies, providing emotional support, and 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 DSAMH 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 has continued as the pandemic has ebbed and flowed, providing critical support to individuals both requiring 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 funneled through the Local Mental Health Authorities to provide individual crisis response services to those who are unfunded.
# 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/social)**
         - 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:

      - Targeted services for veterans?
        - Yes  
        - No

      - Adolescents?
        - Yes  
        - No

      - Other Adults?
        - Yes  
        - No

      - Medication-Assisted Treatment (MAT)?
        - Yes  
        - No
Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 8. Primary Prevention - Required SABG.
Criterion 3: Pregnant Women and Women with Dependent Children (PWWDC)

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  Yes  No

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

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  Yes  No

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

5. Has your state identified a need for any of the following:
   a) Open assessment and intake scheduling  Yes  No
   b) Establishment of an electronic system to identify available treatment slots  Yes  No
   c) Expanded community network for supportive services and healthcare  Yes  No
   d) Inclusion of recovery support services  Yes  No
   e) Health navigators to assist clients with community linkages  Yes  No
   f) Expanded capability for family services, relationship restoration, and custody issues?  Yes  No
   g) Providing employment assistance  Yes  No
   h) Providing transportation to and from services  Yes  No
   i) Educational assistance  Yes  No

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

   The Utah State Division of Substance Abuse and Mental Health (DSAMH) conducts annual site visits for the Local Authority Substance Use and Mental Health Disorder Treatment Providers, which either provide direct or contracted services for Women, Pregnant Women and Women with Dependent Children's Programs. SAPT Block Grant Requirements for PWWDC are reviewed during the Annual Site Visit and throughout the year to ensure that programs are meeting these requirements. Utah also passed legislation that requires the following: (1) A local substance abuse authority to ensure that all substance abuse treatment programs that receive public funds provide priority for admission to a pregnant woman or a pregnant minor; (2) Requires a local substance abuse authority to provide a comprehensive referral for interim services to a pregnant woman or pregnant minor that cannot be admitted for substance abuse treatment within 24 hours of the request for admission; (3) Provides that, if a substance abuse treatment program is not able to accept and admit a pregnant woman or pregnant minor within 48 hours of the time that request for admission is made, the local substance abuse authority shall contact, and the Division of Substance Abuse and Mental Health shall provide assistance in providing services to the pregnant woman or pregnant minors; (4) Requires a local substance abuse authority to provide counseling on the effects of alcohol and drug use during pregnancy. DSAMH’s Monitoring Protocol has different level of findings for the Local Authorities that require a correction action plan which needs to be submitted to DSAMH for approval. DSAMH also hosts a quarterly Women's Treatment Provider Meeting, where providers learn best practice for the PWWDC and network with other providers. Finally, DSAMH provides ongoing training and technical assistance for the Local Authority Providers regarding the PWWDC and ensure that their needs are being met. Each year, DSAMH hosts annual training regarding gender specific and trauma-informed approaches, including the following (1) Trauma and Recovery Empowerment Model; (2) Seeking Safety; (3) Beyond Trauma: A Healing Journey for Women; (4) Helping Women Recover: A Program for Treating Addiction. A Copy of DSAMH monitoring can be found at https://dsamh.utah.gov/contracts-and-monitoring. During the Pandemic Monitoring was conducted virtually which may continue thru 2022 with COVID-delta variant numbers increasing in Utah.
Criterion 4, 5 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:
   a) 90 percent capacity reporting requirement  
      ☑ Yes ☐ No
   b) 14-120 day performance requirement with provision of interim services  
      ☑ Yes ☐ No
   c) Outreach activities  
      ☑ Yes ☐ No
   d) Syringe services programs, 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, older adults)?  
      ☑ Yes ☐ No

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

   The State conducts annual monitoring visits with each Local Authorities in which all Block Grant requirements including PWID are monitored and reviewed. The Local Authorities also conduct interagency monitoring and are encouraged to conduct NIATx reviews of their own agency and procedures. The state also reviewed data submissions, conducts monthly meetings with Directors and Clinical Directors and provides TA if requested or required. Based on the findings from the annual monitoring visits a report is written and provided that outlines any areas of concern to be addressed and a written response is required on how the issue will be resolved. Areas identified as problems can result in a finding, the findings range from recommendations, Minor/Significant/Major Non-compliance issues that require action plans.

Tuberculosis (TB)

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

2. 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 the service delivery?  
   ☑ Yes ☐ No

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

   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

   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.
Establishment of EIS-HIV service hubs in rural areas  
Establishment or expansion of tele-health and social media support services  
Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes (42 U.S.C. § 300x-31(a)(1)(F))?  
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  
3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?

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

NA
Criterion 8, 9 & 10: Service System Needs, Service Coordination, Charitable Choice, Referrals, Patient Records, and Independent Peer Review

Service System Needs

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

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

Service Coordination

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

2. Has your state identified a need for any of the following:
   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
      - Yes ☐ No ☑
   b) Establish a program to provide trauma-informed care
      - Yes ☐ No ☑
   c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education
      - Yes ☐ No ☑

Charitable Choice

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

2. Does your state provide any of the following:
   a) Notice to Program Beneficiaries
      - Yes ☐ No ☑
   b) An organized referral system to identify alternative providers?
      - Yes ☐ No ☑
   c) A system to maintain a list of referrals made by religious organizations?
      - Yes ☐ No ☑

Referrals

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

2. Has your state identified a need for any of the following:
   a) Review and update of screening and assessment instruments
      - Yes ☐ No ☑
   b) Review of current levels of care to determine changes or additions
      - Yes ☐ No ☑
   c) Identify workforce needs to expand service capabilities
      - Yes ☐ No ☑
d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background

Patient Records
1. Does your state have an agreement to ensure the protection of client records?

2. Has your state identified a need for any of the following:
   a) Training staff and community partners on confidentiality requirements
   b) Training on responding to requests asking for acknowledgement of the presence of clients
   c) Updating written procedures which regulate and control access to records
   d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure

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?

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

   Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.
   13 Local Substance Abuse Authorities (14 Local Authorities all together including MH authorities). They each conduct Peer to Peer Reviews on one another annually, giving feedback verbally and written. These Peer reviews are used to make changes to improve quality, service delivery, efficiency and overall system improvement. We also include the Department of Corrections in our Peer Review.

3. Has your state identified a need for any of the following:
   a) Development of a quality improvement plan
   b) Establishment of policies and procedures related to independent peer review
   c) Development of long-term planning for service revision and expansion to meet the needs of specific populations

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?

   If Yes, please identify the accreditation organization(s)
   i) [ ] Commission on the Accreditation of Rehabilitation Facilities
   ii) [ ] The Joint Commission
   iii) [ ] Other (please specify)

   Utah does not require sub-recipients to have independent accreditation however we do have several that have gone through to become CARF certified and have several others that are currently going through the process.
**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 ☐
Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Utah Code 62A-15: Substance Abuse and Mental Health A

Utah Code 62A-15 Part 1: Division of Substance Abuse and Mental Health
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 SABG.

In the 2021 Legislative session a bill was passed merging the Utah Department of Human Services with the Utah Department of Health. We anticipate this merger will affect aspects of the Division: Organizational chart and flow, Administrative oversight, contracts and Monitoring process, service delivery, financial operations, monitoring and oversight, data collection processes, etc.
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 2020-FFY 2021?  
   - Yes  - No

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

   The Utah Division of Substance Abuse and Mental Health does not have a formal CQI plan. However, both CQI and TCM concepts are integral to the way that DSAMH measures performance of its Behavioral Health Care. The DSAMH collects and utilizes extensive data on the “health of the mental health and addictions systems.”

   Providers and contract compliance.

   The DSAMH uses a variety of scorecards measuring for all publicly funded behavioral health services. These documents allow the State to monitor and audit providers by tracing penetration rates, amounts of service, duration of services, service outcomes and evidence based Outcome Questionnaire (OQ), trends; comparisons to other providers, etc. In the spirit of efficient and effective systems, as defined in the good and modern guidance, Utah believes this scorecard an effective use of data. These scorecards compare the Local Authorities on their performance, both across all sites and within urban and rural sites. Results are provided to the County governmental officials and are publicized on the DSAMH website. Targets for each performance indicator are published in the Division Directive and attainment of those targets is reviewed during each contract compliance review. Targets are based on meeting National norms, improvement on past performance, and/or reaching a set level of performance and maintaining that standard. The score cards are color coded for easy reading. They indicate successful achievement (green), improvement needed (yellow), or performance below the state standards (red).

   Additionally, Consumer Surveys are distributed each year and a consumer report card is also published, comparing the Local Authorities on their results. The reports are broken down by substance abuse and mental health, as well as by adult, youth and family satisfaction. These are also color coded for easy reference.

   Each year, Local Authorities develop an Area Plan to describe service provision throughout the following state fiscal year. This plan includes the ten mandated services, services for specific populations, recovery supports and quality improvement plans. The Local Authority is not funded until the Area Plan has been approved. A major portion of the quality improvement process in Utah is based on the yearly contract monitoring audits that the DSAMH conducts with each Local Authority. These audit visits are a combination of audit, technical assistance, and performance review. These extensive reviews include on-site visits, client interviews, extensive review of clinical charts and records, inspections of administrative and financial records, meeting with local stakeholders, comprehensive discussions with program managers, reviews of program schedules and policies, and discussions about progress towards meeting goals set out in the DSAMH Division Directives. A review of corrective actions taken since the last review is also an integral part of the process. At the conclusion of these 1 to 2 day visits, the Local Authority Directors are provided feedback in preparation of a formal written report that is sent to the County Government Representative for each Local Authority. Findings are graded as being Significant, Major, or Minor Findings as well as deficiencies and positive programmatic comments.

   Clinical directors from each Local Authority and Division Program Administrators meet monthly to review pertinent issues.

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Footnotes:

In the 2021 Legislative session a bill was passed merging the Utah Department of Human Services with the Utah Department of Health. We anticipate this merger will affect aspects of the Division: Organizational chart and flow, Administrative oversight, contracts and Monitoring process, service delivery, financial operations, monitoring and oversight, data collection processes, etc.
Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing business as usual? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

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

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

58 Ibid

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

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? ☐ Yes ☐ No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? ☐ Yes ☐ No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? ☐ Yes ☐ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ☐ Yes ☐ No

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

Utah has developed a Certified Peer Support Specialist program which includes course materials, code of Ethics, ongoing CEU’s, Certification application, etc. For more details go to https://dsamh.utah.gov/peer-support.

The Utah State Division of Substance Abuse and Mental Health (DSAMH) has been providing ongoing training and consultation for public and private providers across the state of Utah since 2009 regarding the Trauma-Informed Approach and evidence-based trauma specific interventions, including the following: (1) Trauma Recovery and Empowerment Model for Women and Girls (2) Trauma Recovery and Empowerment Profile (3) Trauma-Recovery and Empowerment Model for Men (4) Seeking Safety (5) Beyond...
DSAMH has worked with Dr. Stephanie Covington, Gabriella Grant, MA, Director of the Center of Excellence for Trauma-Informed Care and Treatment Innovations to receive ongoing training and consultation on trauma, Trauma-Informed Approach and Seeking Safety. DSAMH is also working with the Utah Department of Human Services (DHS) and community partners to further efforts on the Trauma-Informed Approach through the implementation on policies, procedures and statewide training and consultation on Trauma-Informed Supervision and program evaluation.

Utah continues to work on becoming a Trauma-Informed State through Resilient Utah. Resilient Utah provides training, technical assistance and resources to providers on trauma and the trauma-informed approach. Found at https://trcutah.org/

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

NA

Footnotes:
Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.59

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.60

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

60 http://csjusticecenter.org/mental-health/

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

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

In FY15 Utah legislatures passed the Justice Reinvestment Initiative (JRI) for adults and in FY17 HB 239 Juvenile Justice Reform was passed. The State has been working with community partners to enhance diversion, re-entry and integration of care. The legislature also passed requirements for the Division to oversee program certification for all agencies treating individuals that have been compelled to seek behavioral health services this also encourages the use of Evidence Based screening and assessments tools and the use of EBP to fidelity. 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. DSAMH is committed to addressing these concerns and has already implemented 2 new screenings tools including the LSI-R:SV and the SURE tool. DSAMH and other agencies are working on MOU’s for the purpose of data sharing.

Utah has increased Mobile Crisis Outreach Teams (MCOT) for SUD and MH in Counties areas across the state, Their has been 2 receiving centers that started in 2020 and 2021 and we anticipate adding additional ones over the next 2 years. The state has also hired several forensic evaluators to perform forensic evaluations for Youth and Adults.
Please indicate areas of technical assistance needed related to this section.

NA

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Footnotes:
Environmental Factors and Plan

14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question
There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], 49[4], and 63[5].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

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


Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  
   - Yes  
   - No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?  
   - Yes  
   - No

3. Does the state purchase any of the following medication with block grant funds?  
   - Yes  
   - No
   a) Methadone
   b) Buprenorphine, Buprenorphine/naloxone
   c) Disulfiram
   d) Acamprosate
   e) Naltrexone (oral, IM)
   f) Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*?  
   - Yes  
   - No

5. Does the state have any activities related to this section that you would like to highlight?
   - DSAMH coordinates with the following organizations to ensure that education and Quality Assurance (QA) is provided on MAT and FDA-Approved medications for Utah State Opioid Treatment Providers and Office Based Opioid Treatment Providers:
   - Education on Evidenced-Based MAT:
   - (1) Utah Department of Health soon to be Department of Health and Human Services as the merger is finalized.
   - (2) Commission on Accreditation of Rehabilitation Facilities (CARF)
Joint Commission on the Accreditation of Healthcare Organizations (JACHO)

Department of Professional Licensing, DOPL, through Academic Detailing for prescribers

FDA Approved Medications:
1. Drug Enforcement Agency (DEA)
2. Utah Division of Occupational Licensing - Pharmacy Board
3. Department of Professional Licensing, DOPL, through the Controlled Substance Database (Utah’s PDMP) and Academic Detailing

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

1. Opioid Treatment Providers: There are 18 Opioid Treatment Providers (OTP’s) throughout Utah that provide medication-assisted treatment (MAT) for individuals diagnosed with opioid-use disorders. They serve approximately 5418 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.
2. Opioid Community Collaborative: IHC, Davis, Salt Lake and Weber County have an Interdisciplinary approach to providing MAT 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 MAT programs in Country (248 Participants). The first shot administered within County jail.
4. Certified Peer Support Specialists are offered an Integrated Care Enhancement, a 12 hour training focused on supported clients as they manage the combination of behavioral health and physical health challenges.
5. DSAMH received a Primary Care and Behavioral Health Integration grant from SAMHSA. The grant provides funding to three Local Authorities (urban and rural) and has multiple goals related to system change to improve integrated services.
6. One of the 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 MAT prior to release to Parolees at the Utah State Prison. This is a project that the State has been working on for many years and was finally started in 2020.

With the new DEA Mobile Clinic guidelines just being released the State anticipates supporting the use of a mobile clinic for rural areas and areas in greatest need due to lack of access, health care services, transportation, etc. We anticipate a mobile clinic to be operational in the next 2 years. We also anticipate starting a collaborative effort to implement MAT in urgent care settings with warm-handoffs to community providers. This will support an easy access point.

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

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Footnotes:
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 will be called the Department of Health and Human Services.
Environmental Factors and Plan

15. Crisis Services - Required for MHBG

Narrative Question
In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful. SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA’s publication, *Practice Guidelines: Core Elements for Responding to Mental Health Crises*, “Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization.”

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

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Please check those that are used in your state:

1. **Crisis Prevention and Early Intervention**
   - [ ] Wellness Recovery Action Plan (WRAP) Crisis Planning
   - [ ] Psychiatric Advance Directives
   - [ ] Family Engagement
   - [ ] Safety Planning
   - [ ] Peer-Operated Warm Lines
   - [ ] Peer-Run Crisis Respite Programs
   - [ ] Suicide Prevention

2. **Crisis Intervention/Stabilization**
   - [ ] Assessment/Triage (Living Room Model)
   - [ ] Open Dialogue
   - [ ] Crisis Residential/Respite
   - [ ] Crisis Intervention Team/Law Enforcement
   - [ ] Mobile Crisis Outreach
   - [ ] Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. **Post Crisis Intervention/Support**
   - [ ] Peer Support/Peer Bridgers
   - [ ] Follow-up Outreach and Support
   - [ ] Family-to-Family Engagement
   - [ ] Connection to care coordination and follow-up clinical care for individuals in crisis
   - [ ] Follow-up crisis engagement with families and involved community members

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f) Recovery community coaches/peer recovery coaches

g) Recovery community organization

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

With the ever changing pandemic response, Utah elected to discontinue efforts to host continued Mental Health Crisis Response Summits in 2020 and 2021. Utah has continued to remain engaged in continued education efforts with at least quarterly Crisis Worker Certification training held for the crisis worker workforce. Other collaborative efforts include, but are not limited to, active participation in the bi-monthly legislatively appointed Behavioral Health Crisis Commission and monthly technical assistance meetings with the Utah Crisis Line local Mobile Crisis Outreach Teams, and Receiving Centers.

December 2019 saw the opening of a Zero-Refusal Receiving Center in Davis County, The program maintains a co-occurring focus and offers community members, stakeholders, and law enforcement a critical access point for diversion from criminal justice settings and emergency departments. In February of 2021 a similar program was opened in Utah County. Additional sites are expected in Salt Lake County and Washington County in the next 2 years as well.

Additionally, Utah has heralded continued expansion of Mobile Crisis Outreach team, and beginning in July of 2021 a mobile crisis outreach team is available statewide, regardless of population density.

Utah has also been aggressively preparing for 988 and in 2021 saw the passing of SB155, allocated ongoing resources to support the crisis line, mobile crisis outreach teams and receiving centers statewide. The bill also required the legislatively mandated BHCC to formulate a report on the crisis system in its entirety to include recommendations on policy and financing. Utah has also participated in Vibrant’s state planning grant process, both informing federal partners on gaps and resources, but also strategically planning for implementation and resourcing within Utah.

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

None at this time.

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Footnotes:
Environmental Factors and Plan

16. Recovery - Required

Narrative Question
The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports); purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual’s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see [SAMHSA’s Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

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

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

Please respond to the following:

1. Does the state support recovery through any of the following:
5. Does the state have any activities that it would like to highlight?

The Utah Substance Abuse Advisory Council (USAAV) and Utah Behavioral Health Planning Advisory Council (UBHPAC) consist of members of the community including family/peers and individuals in recovery. The UBHPAC reviews the State’s Division Directives, Strategic Plan and Block Grant application. They also give insightful feedback and advice on priority initiatives they would like to see addressed. DSAMH hosts Peer Support Specialist (PSS) meetings in which Peers give input on system implementation and changes. DSAMH has also emphasized the use of Peer Support Specialists at each Local Authority. All Local Authorities have Peer Support Specialists and/or Family Resource Facilitators (FRFs) on staff, and some use peer volunteers that assist with local MH/SUD system evaluations and input. DSAMH conducts Clubhouse and Day Program visits annually, including focus groups consisting of peers who are encouraged to provide feedback regarding the MH/SUD system. DSAMH works closely with the Peer organizations in Utah including National Alliance on Mental Illness (NAMI), Utah Substance Abuse Recovery Advocates (USARA), Latino Behavioral Health (LBHS - Hispanic PSS), Utah American Foundation for Suicide Prevention (AFSP) and Peers working with the National Guard and Veteran Affairs Medical Center. Local Authorities also host alumni groups for individuals that have completed treatment in Drug Court programs for feedback and input. SAMHSA grants to develop employment (Supported Employment/Individual Placement and Support) Pete’s grant, Ming’s grant YESS, AOT, Utah saw the importance of Recovery Support services and continues to strive to provide these services. We anticipate the expansion 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.

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

NA

Footnotes:
Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

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

Please respond to the following items

1. Does the state’s Olmstead plan include:
   - Housing services provided. ○ 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

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

Utah incorporates the ADA community integration mandate into all of its practices. DSAMH PASRR Program (Preadmission Screening and Resident Review) helps to ensure that individuals are not inappropriately placed in nursing facilities, that individualized services are offered depending on their needs and to help determine the most appropriate setting. The PASRR program also works with the Utah Department of Health Waiver Program to help individuals transition into community based settings.

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, DSAMH 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.

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Footnotes:
Environmental Factors and Plan

18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death. It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children’s needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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

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

According to data from the 2015 Report to Congress on systems of care, services:

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

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

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

For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.
residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

62 The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED?
   b) The recovery and resilience of children and youth with SUD?

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
   a) Child welfare?
   b) Juvenile justice?
   c) Education?

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization?
   b) Costs?
   c) Outcomes for children and youth services?

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?
   b) Mental health treatment and recovery services for children/adolescents and their families?

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult M/SUD system?
   b) for youth in foster care?

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

The Utah Department of Human Services (DHS) provides integrated services through a Systems of Care Approach through close collaboration with the Division of Substance Abuse and Mental Health, Division of Child and Family Services, Juvenile Justice Services, Utah State Board of Education, Law Enforcement, and other community partners. The Utah State Division of Substance Abuse and Mental Health (DSAMH) provides integrated services for mental health (MH) and substance use disorder (SUD) needs for children and youth through the Local Authority Substance Use and Mental Health System and contracted providers. Integrated approaches are being evaluated to better serve individuals with physical health and intellectual/developmental disabilities and needs.

There are fourteen Local Authorities in Utah, which provide integrated services. One geographic area is divided into separate MH and SUD Local Authorities: 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.

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.
The System of Care Expansion and Planning Grant, 2012 – Present (SAMHSA funding): DSAMH collaborates with all of the child serving agencies within the Utah Department of Human Services (DHS) including the Division of Child and Family Services (DCFS), Division of Juvenile Justice Services (DJJS), Division of Services for People with Disabilities (DSPD), and the Executive Director's Office (EDO), who directly oversees System of Care in Utah, to develop a comprehensive statewide strategic plan to improve and expand services using a system of care approach for children and youth from birth to 21 years of age who have, or are at risk of developing, serious mental health conditions and have other complex needs.

The Division'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 22-24, CYF plans to enhance the support of recovery and resilience of children and youth with mental health, substance use disorders, and intellectual, developmental, and autism disorders within a System of Care approach. Through continued work with DHS divisions, Local Mental Health and Substance Abuse Authorities, the Utah Family Coalition (UFC), the Utah State Board of Education (USBE), and other providers throughout the state, DSAMH will continue to work collaboratively to ensure children, youth, and their families have their needs supported.

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

DSAMH contributes and provides integrated services through following action steps and activities:

a. Collaborate with the DHS child serving agencies to develop an integrated family and youth development plan across the department. The plan will address issues of staff development, training, and family and youth leadership training.

b. Support the Utah Family Coalition's (UFC) effort to expand family and youth involvement activities, including family and youth peer support, to the other systems within Utah. The UFC is a network of family advocacy organizations that advance family-driven and youth-guided approaches. Members include Allies with Families (Utah chapter of the Federation of Families for Children's Mental Health, which also merged with New Frontiers for Families during FY17) and the National Alliance on Mental Illness (NAMI) – Utah Chapter. In FY20, UFC intends to increase family and youth representation from the child welfare and juvenile justice systems to create a greater reach of family and youth network to advance Utah’s system of care approach and to provide greater access for families and youth in need. UFC also plans to continue to develop workforce through trainings supported by DSAMH that will reach each child serving division in DHS. UFC also plans on working collaboratively with DSAMH and the DHS divisions to further develop and evolve the training methods used to develop roles such as Family Resource Facilitators (FRF), family peer support, youth peer support, and Wraparound facilitators. DSAMH will support UFC's effort by taking part in discussions with UFC, DCFS, DJJS, DSPD, and SOC that focus on family and youth development and peer support.

c. Increase the number of Certified Family Peer Support Specialists (CPSS). FRF are family members who are trained to provide resource facilitation and family to family peer support services to children, youth, and families regardless of insurance coverage.

DSAMH oversees the certification process and works with UFC to ensure the trainings continue to improve and provide the best possible workforce throughout the State of Utah. The certification process includes an initial 40-hour training, certification exam, on-going training, and 152 hours supervised practicum. In FY 2012, there were 15 CPSS throughout the state who completed the supervised practicum. As of June 2019, there are 58 CPSS statewide. The number of CPSS will continue to grow through the collaborative efforts with Utah's System of Care and involvement with other child serving agencies throughout the state. With continued DHS collaboration, the number of peer support should also increase as each child serving agency is able to hire and support their own focused peer support staff.

d. Increase the number of Certified Wraparound Facilitators throughout the state to provide wraparound facilitation services to children, youth, and families regardless of insurance coverage. Certified FRFs receive additional 152 hours supervised practicum in wraparound facilitation to become Certified Wraparound Facilitators. Each FRF is in the process of being fully certified as a Wraparound Facilitator through the new training performed by UFC.

e. Support a Youth-in-Transition focused Certified Peer Support Specialist (CPSS) program: The Division is collaborating with the CPSS program to develop a supplemental training and supervision curriculum to support: i) young adults to become a CPSS, and ii) CPSS to develop the knowledge and skills to work with youth in transition age (15 to 26-years-old).

f. Support School Based Behavioral Health through partnerships with the LMHAs, the USBE, and the local schools throughout Utah. The USBE continues to be a key partner and helps provide technical assistance on collaborating with Local Education Authorities and on gathering outcome data. This technical assistance helped the mental health system understand schools' governing requirements and policies. It also helped the LMHAs strengthen referral practices and options to gather outcomes. Parent consent and involvement is integral for all school-based services. Services vary by school and may include individual, family, and group therapy; Parent Education; Social Skills and other Skills Development Groups; Family Resource Facilitation and Wraparound; Case Management; and Consultation Services.

After receiving school-based services, parents identified several barriers that prevented them from seeking mental health services previously. Barriers included transportation and lack of access, lack of awareness of treatment options, parents feeling overwhelmed, time away from school for the child and work for the parent, and cost of treatment. Behavioral health services in schools overcome these barriers and promote healthy children and youth, and in turn increases academic success. As of June 2021, School-Based Programs were accessible in 323 schools. This includes access to services via telehealth, provided during the COVID 19 pandemic. These partnerships are meant to creatively serve more students while reducing barriers for the clinical teams and youth and families.

An area of focus has been schools with high rates of Intergenerational Poverty as identified by the Utah Department of Workforce Services (DWS). The Intergenerational Poverty Mitigation Act has helped to strengthen partnerships with agencies outside of DHS, including DWS, the USBE, and local schools. As of June 2019, the funding allocated for this project is no longer available, but the support for schools with high rates of intergenerational poverty still exists. DSAMH has supported LMHA school based work in 71 current schools with identified high rates of Intergenerational Poverty (schools where 10% or more of the student body are
experiencing intergenerational poverty). DSAMH plans to continue to increase the number of schools supported by School Based Behavioral Health.

g. Collaborate with DHS child serving agencies to create a state driven plan to increase the services for children, youth, and their families who are experiencing co-occurring mental health and intellectual/developmental/autism related disabilities. Beginning in FY17, DSAMH received a Transformation Transfer Initiative (TTI) grant and began efforts with DSPD, UFC, and the Utah Parent Center to find innovative approaches to provide services to children, youth, and their families who are presently awaiting services from DSPD. The current programming includes providing two CFPSSs (one representing rural areas and one in urban areas) to families who are pursuing DSPD services. In addition, DSAMH meets with the group regularly and plans to develop training and technical assistant opportunities for provider agencies who serve individuals with each of the above listed concerns. DSAMH plans to continue to support the program as funding is still available and will be working with other partners to increase the access to both the parent training and the CFPSS services.

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

Through the collaborative efforts to provide a system of care in Utah, there are multiple technical assistance opportunities that DSAMH and the state are utilizing. DSAMH has partnered with The Children’s Center, DWS, and The Utah Department of Health (DH) to gain technical assistance for mental health consultation and service delivery for early childhood populations. The focus is helping Utah strengthen the system of early childhood providers who can focus on providing the best possible array of services to youth ages 0-5.

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

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

b. School based services. SAMSHA has identified schools as being a primary access point for providing mental and behavioral health services and has worked with the Mental Health Technology Transfer Centers to create trainings for schools and mental health systems. In addition to these resources, Local Authorities ask for more assistance to better prepare and train their workforce when they are working within school settings and with school based populations and to improve the continuum of care provided in conjunction with school systems.

c. Continued assistance for intellectual/developmental/autism disabilities and treating comorbid issues. Although the providers throughout Utah are able to sufficiently address the mental health problems or the intellectual/developmental/autism related problems, often there are questions about serving the co-occurring problems most effectively. Better training and workforce development are primary concerns for this type of technical assistance.

Footnotes:
Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies to play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state’s suicide prevention plan in the last 2 years?  
   - Yes  
   - No

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

   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.

   DSAMH has youth/school based initiatives (described in detail in the youth section) that contribute to prevention efforts including school-based mental health and youth mobile crisis outreach teams. DSAMH partners with our local crisis centers to provide 24/7 support including with the local National Suicide Prevention Lifeline (NSPL) affiliate who also provides application-based chat/text crisis support to youth needing support. The Trevor Project line is also promoted within DSAMH efforts.

   DSAMH has been working on building out a continuum of crisis services and recently awarded a contract for a statewide crisis line and expansion of mobile crisis outreach teams into five new counties/regions of the state. MCOT response is now available statewide, including more rural locations. DSAMH has also developed and implemented a required crisis worker certification training.

   DSAMH contracts with National Alliance for Mental Illness (NAMI) Utah and local coalitions statewide to help them review data and choose local suicide prevention strategies for implementation through an RFP process. DSAMH currently provides funding and technical assistance to 18 local coalitions who have implemented suicide prevention activities ranging from awareness and gatekeeper training, to school based programming, to reducing access to lethal means. Through an RFP process, DSAMH 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/.

   DSAMH leads a robust firearm safety for suicide prevention effort including providing leadership to a committee of firearm related partners. Through this, DSAMH has developed education and training materials specific to firearm suicide prevention, distributed over 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, DSAMH intends to develop lethal means training (similar to CALM) for the public, in addition to a more clinical focus.

   DSAMH works extensively on implementing the Zero Suicide (ZS) model in the public behavioral health care system with a focus on individuals with SMI/SED. We also work to implement 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. DSAMH has several ZS-focused training initiatives including providing training and case consultation in Brief Cognitive Behavioral Therapy for Suicide Risk, the Collaborative Assessment and Management of Suicidality, Counseling of Access to Lethal Means, and Crisis Response Planning. In 2021, DSAMH began targeted Zero Suicide technical assistance to four local behavioral health authorities to further develop the framework within their organizations.

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

5. Have you begun any targeted or statewide initiatives since the FFY 2020-FFY 2021 plan was submitted?  
   - [ ] Yes  
   - [ ] No

   If so, please describe the population targeted.

   Utah completed a multi-year statewide Medicaid Improvement Project to improve suicide screening and same day interventions. Data outcomes for the Utah Performance Improvement Project:

   Screening rate from Baseline to 2018 = 816% increase
   Safety Plan Rate from Baseline to 2018 increased 55%

   2015 Baseline Screening Rates: 6%
   2015 Baseline Safety Plan Rates: 40%
   2016 Year 1 Screening Remeasurement: 24%
   2016 Year 1 Safety Plan Remeasurement: 47%
   2017 Year 2 Screening Remeasurement: 50%
   2017 Year 2 Safety Plan Remeasurement: 54%
   2018 Year 3 Screening Remeasurement: 55%
   2018 Year 3 Safety Plan Remeasurement: 62%

   DSAMH has contracted with two local mental health authorities to provide structured follow up/caring contact outreach to individuals discharging from emergency department and inpatient units after being seen in these setting for suicide risk or behaviors for adults age 25 and older.

   DSAMH was awarded SAMHSA Garrett Lee Smith (GLS) Youth Suicide Prevention grant and will be expanding the structured follow up/caring contact outreach program into three new rural counties and expanding to youth 10-24 in the urban county. We will also be partnering with several school districts on several suicide prevention activities.

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

   None at this time.

Footnotes:
Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

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

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;

- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;

- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;

- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;

- The state public housing agencies which can be critical for the implementation of Olmstead;

- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and

- The state’s office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state’s ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  ✔ Yes  ☐ No

If yes, with whom?
As integrated health is emphasized and Medicaid Expansion has been implemented (began on April 1, 2019), DSAMH has recognized the need to strengthen relationships with primary care providers, Federally Qualified Health Centers, Accountable Care Organizations, and other 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 ongoing partnerships that the Division is currently involved in.

a. Utah Behavioral Health Planning and Advisory Council (UBHPAC) is a council composed primarily of Peers who review Block Grant activities and provide feedback to DSAMH. UBHPAC is a subcommittee of the Utah Substance Abuse Advisory Council (USAAV). USAAV is a committee established by statute to advise the Governor on Substance Use Disorder issues. The Division sits on the council and provides membership to all four of the Council’s Committees.

b. Office of Licensing: The Division has worked closely with the Office of Licensing to update rules and requirements for Opioid Treatment programs as well as a workgroup that created a Recovery Residence Licensing process to assist in providing safe sober housing for individuals in recovery. DSAMH staff sit on the Comprehensive Review Committee to review appeals submitted to the Office of Licensing.
c. Criminal Justice: The Division has a long history of collaboration and cooperation with the Criminal Justice workers, to include the Administrative Office of the Courts, the Programming Division in the Department of Corrections which provides SUD services inside the prison system, with Adult Probation and Parole, and with the judges and other Drug Court Team Members. The collaboration with the Department of Corrections and the Commission on Criminal and Juvenile Justice (CCJJ) has already been discussed in section 13. DSAMH and the Department of Corrections are currently working together to create a Forensic Peer Support specialty certification.
d. Board of Education (BOE) staff sitting on DSAMH committees related to employment. One staff member works directly as a liaison between the two government agencies focused on early intervention programs.
e. University of Utah. The Division 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.
f. Recovery Support: The Division contracts with and meets with the following Recovery support organizations on numerous issues on a monthly basis: Allies with Families (AWF), 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) and Child and Family Empowerment Services (CFES).
g. Utah Department of Veterans Affairs and the Utah National Guard: The Assistant Division Director sits on a statutory mandated Veteran’s Affairs Committee, and monthly meetings are held with the VA and UDOVA to coordinate on issues such as Suicide Prevention, Mental Health Conferences, and improving service to Veterans and National Guard members. DSAMH also partners with the Department of Veteran Affairs and other organizations serving Service Members, Veterans and their Families (SMVF) on the Governor’s and Mayor’s Challenges to prevent suicide among Service Members, Veterans and their Families.
h. Department of Health (DOH). A few of the committees and workgroups that the Division either attends with the DOH, co-chairs with the DOH or has DOH membership on its committees are:
   1) Nicotine Cessation
   2) Prescription Drug Abuse Task Force
   3) Narcan Distribution Work Group
   4) Care Management Work Group
   5) Prevention Coalitions statewide
   6) Community Health Workers Workforce Development Workgroup
   7) Utah Community Health Worker Coalition
   i. DSAMH and other DHS divisions meet regularly with Department leadership, these include the Division for Child and Family Services, Division for the Aging, Division of Services for People with Disabilities, Division of Juvenile Justice Services
   j. Department of Workforce Services, Vocational Rehabilitation
   k. Insurance Commissioner
   l. Opioid Treatment Programs
   m. Private Health Care and Managed Care Organizations
   n. Department of Professional Licensing (DOPL)
o. Utah Behavioral Health Care Council (UBHC )

Children’s mental health and support of state partners:
DSAMH partners with child serving agencies throughout the state of Utah to ensure that children and youth are allowed to receive care in the least restrictive setting. According to the Foster Care Mental Health Treatment Restructuring Initiative Guiding Principles developed by the Division of Child and Family Services (DCFS) and the Division of Juvenile Justice Services (DJJS), Principle 1.3 reads: Each child is cared for in the least restrictive setting and for the shortest, appropriate duration to help the child achieve outcomes defined for that child, such as safety, connection to a permanent family or other caring adults, progress towards treatment plan goals, prevention of recidivism, or increasing skills and ability to function in society successfully as an adult. Children should grow up in family settings not institutions. 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, DSAMH, in partnership with LAs, DCFS, DJJS, System of Care (SOC)/High Fidelity Wraparound (HFW), the Division for Services with People with Disabilities (DSPD), the State Board of Education, Local Education Authorities, and other necessary providers and community partners collaborate to find effective transition services. Collaboration occurs throughout all levels of the state with individualized staffings at a local level to high level staffings at the state level. DSAMH and the LMHAs will ensure that services are in place for a child and youth’s mental health. The collaboration that occurs also allows for a focus on family and peer needs (with the help of 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.

DSAMH 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 Division of Substance Abuse and Mental Health (DSAMH) 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 (USAAAV+) and the Governor’s Suicide Prevention Task Force.

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

None at this time.

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Footnotes:
Environmental Factors and Plan

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

Narrative Question

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

Planning Councils: The Road to Planning Council Integration

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

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

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

      The Division of Substance Abuse and Mental Health (DSAMH) presents on and provides the State Plan to the Utah Behavioral Health Planning and Advisory Council (UBHPAC). UBHPAC is composed of mental health, substance use disorder, and prevention members from the community and state agencies. On August 1st, when the plan is submitted for public comment, a printed version of the plan is distributed to members for continued discussion and feedback. Subcommittees have been formed, including a prevention, treatment, and recovery committees, to look over the State Plan and provide feedback. The DSAMH 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 meeting (August 1, 2020), a hard copy of the State Plan is provided at the front desk of the DSAMH, and a copy is posted on the DSAMH Bulletin Board. The public is encouraged to provide feedback via email or calling DSAMH.

      Minutes for UBHPAC and the UBHPAC executive meetings are posted on the DSAMH website, along with an audio recording of each meeting: https://dsamh.utah.gov/providers/behavioral-health-planning-council

      DSAMH provides guidance to all of the Local Substance Abuse Authorities and Local Mental Health Authorities during a combined Area Plan training in the spring of each year. The Local Authorities use that guidance to develop their Area Plans, in conjunction with their local partners. Each Local Authority also has consumers involved in the development of their plans and priorities. The Local Authorities are responsible for planning for and providing MH and SUD services to the residents of their counties.

      Clinical directors for each of the Local Authorities, in conjunction with DSAMH, have a monthly Recovery-Oriented System of Care (ROSC) meeting to facilitate movement of the public behavioral health system to a recovery-oriented model. This includes review and discussion of cost, quality, access, outcomes, integration, engagement and retention for mental health, substance use disorders and prevention, with an emphasis on identifying gaps.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

3. Please 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

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recommendations. The Council monitors, reviews and evaluates the allocation and adequacy of mental health services in the state; and serves as an advocate for adults with serious mental illness (SMI), children with serious emotional disturbances (SED) and other individuals with mental illness or emotional disturbances. UBHPAC is comprised of mental health and substance use disorder providers, peers in recovery, family members of individuals in recovery, advocates, state agencies, and other agencies that interact with the mental health system. From each member’s perspective, issues and concerns are brought up during the meeting and the council works together to better serve individuals with SMI and SED. An Executive subcommittee has been formed and UBHPAC is currently reformatting the final hour of the monthly meeting to target topics of interest for more in-depth review. In addition, a subcommittee focused on cultural responsivity has been formed and reports to UBHPAC monthly. Communities United for Racial and Ethnic Integration and Equality (CUREIE) is a community-based committee that is assisting DSAMH address the membership which does not currently represent the service area population (see 2 above).

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

N/A

*Additionally, please complete the Advisory Council Members and Advisory Council Composition by Member Type forms.*

70 There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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**Footnotes:**
Environmental Factors and Plan

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

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

Start Year: 2022  End Year: 2023

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email(if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Javier Alegre</td>
<td>Providers</td>
<td>Latino Behavioral Health Services</td>
<td>3471 S W Temple Salt Lake City UT, 84115</td>
<td></td>
</tr>
<tr>
<td>Karla Arroyo</td>
<td>Providers</td>
<td>Multicultural Counseling Center</td>
<td>7625 3200 W Salt Lake City UT, 84084</td>
<td><a href="mailto:karla@mccounseling.com">karla@mccounseling.com</a></td>
</tr>
<tr>
<td>Emily Bennett</td>
<td>Providers</td>
<td>Association for Utah Community Health (AUCH)</td>
<td>860 E 4500 S, Ste 206 Salt Lake City UT, 84107</td>
<td><a href="mailto:emily@auch.org">emily@auch.org</a></td>
</tr>
<tr>
<td>Dan Braun</td>
<td>Providers</td>
<td>Wasatch Pediatrics</td>
<td>7138 S Highland Dr, Ste 103 Salt Lake City UT, 84121</td>
<td><a href="mailto:danb@wasatchpeds.net">danb@wasatchpeds.net</a></td>
</tr>
<tr>
<td>Nettie Byrne</td>
<td>Parents of children with SED/SUD</td>
<td>Allies with Families</td>
<td>230 W 200 S, Ste 138 Salt Lake City UT, 84101</td>
<td><a href="mailto:nettieb@allieswithfamilies.org">nettieb@allieswithfamilies.org</a></td>
</tr>
<tr>
<td>Pete Caldwell</td>
<td>State Employees</td>
<td>Housing and Homelessness/DSAMH</td>
<td>195 N. 1950 W, Salt Lake City UT, 84116</td>
<td><a href="mailto:pgcaldwell@utah.gov">pgcaldwell@utah.gov</a></td>
</tr>
<tr>
<td>Lori Cerar</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td></td>
<td>261 E 300 S, Ste 210 Salt Lake City UT, 84111</td>
<td><a href="mailto:lori@allieswithfamilies.org">lori@allieswithfamilies.org</a></td>
</tr>
<tr>
<td>Donald Cleveland</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td></td>
<td>50 W 200 N LaVerkin UT, 84745</td>
<td><a href="mailto:Theillustrator62@gmail.com">Theillustrator62@gmail.com</a></td>
</tr>
<tr>
<td>Cathy Davis</td>
<td>State Employees</td>
<td>State Education Agency - Utah Board of Education</td>
<td>250 E 500 S Salt Lake City UT, 84111</td>
<td><a href="mailto:cathy.davis@schools.utah.gov">cathy.davis@schools.utah.gov</a></td>
</tr>
<tr>
<td>Whitney Geertsen</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td>2526 Lake Park Blvd</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organization</th>
<th>Address</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisa Hancock</td>
<td>Providers</td>
<td>OptumHealth Inc</td>
<td>West Valley City UT, 84120</td>
<td>PH: 385-529-8014</td>
</tr>
<tr>
<td>Terry Harrison</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peggy Hostetter</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>135 S 500 W, Apt 603 Salt Lake City UT, 84120</td>
<td>PH: 801-355-3570</td>
<td><a href="mailto:phostetter@gmail.com">phostetter@gmail.com</a></td>
</tr>
<tr>
<td>Ryan Hunsaker</td>
<td>Others (Advocates who are not State employees or providers)</td>
<td>PO Box 581287 Salt Lake City UT, 84158</td>
<td>PH: 801-634-9463</td>
<td><a href="mailto:mrhunsaker@icloud.com">mrhunsaker@icloud.com</a></td>
</tr>
<tr>
<td>Jason Jacobs</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>8483 S 1275 E Sandy UT, 84094</td>
<td>PH: 801-577-6893</td>
<td><a href="mailto:jasonsJacobs77@gmail.com">jasonsJacobs77@gmail.com</a></td>
</tr>
<tr>
<td>Jane Lepisto</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>277 E 350 N Alpine UT, 84004</td>
<td>PH: 801-368-0271</td>
<td><a href="mailto:janellep1@gmail.com">janellep1@gmail.com</a></td>
</tr>
<tr>
<td>Shanel Long</td>
<td>State Employees</td>
<td>SUD Treatment/DSAMH</td>
<td>195 N. 1950 W. Salt Lake City UT, 84116</td>
<td><a href="mailto:shlong@utah.gov">shlong@utah.gov</a></td>
</tr>
<tr>
<td>Richard Lovato</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jennifer Marchant</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>National Alliance for Mental Illness Utah</td>
<td>1408 W Harris Ave Salt Lake City UT, 84104</td>
<td>PH: 901-971-6410</td>
</tr>
<tr>
<td>Julia Martinez</td>
<td>Providers</td>
<td>3471 S West Temple Salt Lake City UT, 84115</td>
<td>PH: 801-935-4447</td>
<td><a href="mailto:julia.lbhs@gmail.com">julia.lbhs@gmail.com</a></td>
</tr>
<tr>
<td>Mary Jo McMillen</td>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td></td>
<td>180 E 2100 S Salt Lake City UT, 84115</td>
<td>PH: 801-839-9950</td>
</tr>
<tr>
<td>Martha Mendes</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
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<tr>
<td>Sarah Miles</td>
<td>State Employees</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Teresa Molina</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rafael Montero</td>
<td>State Employees</td>
<td>State Vocational Rehabilitation Agency - USOR</td>
<td>926 W Baxter Dr South Jordan UT, 84095</td>
<td><a href="mailto:rmontero@utah.gov">rmontero@utah.gov</a></td>
</tr>
<tr>
<td></td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>650 N 300 W, Apt</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Role</td>
<td>Contact Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Cyndie Moore           | adults with SMI who are receiving, or have received, mental health services | 127 Salt Lake City UT, 84103  
PH: 801-688-7556  
cyndiemoore12@gmail.com |
| Kim Mueller            | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | 1350 E. 1450 S  
Clearfield UT, 84015  
amyers@utah.gov |
| Aubrey Myers           | State Employees                           | State Social Services Agency - DCFS  
10238 Snow Iris Way  
Sandy UT, 84092  
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  
jjpark9958@gmail.com |
| Jeanine 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  
parkjeanie60@gmail.com |
| Kylee Porter           | Providers                                 | 6771 S 900 W  
Midvale UT, 84047  
kyleep@nextlevelrecovery.com |
| Shanin Rapp            | State Employees                           | SUD Youth/DSAMH  
195 N. 1950 W.  
Salt Lake City UT, 84116  
slrapp@utah.gov |
| Andrew Riggle          | Providers                                 | Disability Law Center  
205 N 400 W Salt Lake City UT, 84103  
ariggle@disabilitylawcenter.org |
| Kyli Rodriguez-Cayo    | Youth/adolescent representative (or member from an organization serving young people) | 230 W 200 S, Ste 142  
Salt Lake City UT, 84101  
kylirc@allieswithfamilies.org |
| Ken Rosenbaum          | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | 882 Foxboro Dr, Apt J304 North Salt Lake UT, 84054  
unclekkenny99@yahoo.com |
| Jacob Russell          | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | 1020 W 1020 S Provo UT, 84061  
jacob_rssll@yahoo.com |
| Yvonne Ryans           | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | 1600 W 2200 S, Ste 202 West Valley City UT, 84115  
rob@namiut.org |
| Monica Scott           | Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services) | 1600 W 2200 S, Ste 202 West Valley City UT, 84115  
rob@namiut.org |
Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2022  End Year: 2023

<table>
<thead>
<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Membership</strong></td>
<td>41</td>
<td></td>
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<tr>
<td>Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>16</td>
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<tr>
<td>Family Members of Individuals in Recovery* (to include family members of adults with SMI)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Parents of children with SED/SUD*</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Vacancies (Individuals and Family Members)</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Others (Advocates who are not State employees or providers)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Persons in recovery from or providing treatment for or advocating for SUD services</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Representatives from Federally Recognized Tribes</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
<td>23</td>
<td>56.10%</td>
</tr>
<tr>
<td>State Employees</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Providers</td>
<td>9</td>
<td></td>
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<tr>
<td>Vacancies</td>
<td>1</td>
<td></td>
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<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
<td>18</td>
<td>43.90%</td>
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<tr>
<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
<td>2</td>
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<tr>
<td><strong>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</strong></td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Youth/adolescent representative (or member from an organization serving young people)</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application? Recommendation are reflected in the letter of support provided by the Utah Behavioral Health Planning and Advisory Council Executive Committee.

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Footnotes:
Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
   a) Public meetings or hearings?  ☐ Yes  ☐ No
   b) Posting of the plan on the web for public comment?  ☐ Yes  ☐ No
      If yes, provide URL:
   c) Other (e.g. public service announcements, print media)  ☐ Yes  ☐ No

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Footnotes:
Environmental Factors and Plan

23. Syringe Services (SSP)

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](https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs).


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.
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.

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.

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)(2) 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.

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.

Footnotes:
Utah does not use Block Grant to support any syringe exchange services.
Environmental Factors and Plan

Syringe Services (SSP) Program Information - Table A

If the state is planning to expend funds from the COVID-19 award, please enter the total planned amount in the footnote section.

<table>
<thead>
<tr>
<th>Syringe Services Program SSP Agency Name</th>
<th>Main Address of SSP</th>
<th>Planned Dollar Amount of SABG Funds Expended for SSP</th>
<th>SUD Treatment Provider (Yes or No)</th>
<th># Of Locations (include mobile if any)</th>
<th>Narcan Provider (Yes or No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utah Syringe exchange Program</td>
<td>PO BOX 141010, Salt Lake City, UT -84114</td>
<td>$0.00</td>
<td>No</td>
<td>4</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Footnotes:
Utah does not use Block Grant funds to support syringe exchange services.

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