Southwest
FORM B - SUBSTANCE USE DISORDER TREATMENT BUDGET NARRATIVE
3 Year Plan (2024-2026)

Local Authority: Southwest

Instructions:

In the cells below, please provide an answer/description for each question. **PLEASE CHANGE THE COLOR TO BLUE, OF SUBSTANTIVE NEW LANGUAGE INCLUDED IN YOUR PLAN THIS YEAR!**

1) Early Intervention ***Program Manager*** Holly Watson

Describe local authority efforts you propose to undertake over the three year period to provide for individuals convicted of driving under the influence, a screening; an assessment; an educational series; and substance abuse treatment as required in Utah Code § 17-43-201(5)(m).
SBHC works closely with the justice system to provide services for those who meet these criteria. An initial assessment is provided for individuals and a recommendation for services is given to the client and sent to the referrer. If a Prime for Life class is recommended the client is given a list of providers who offer that class.
Identify evidenced-based strategies designed to intervene with youth and adults who are misusing alcohol and other drugs.
SBHC proudly supports a 'world-class' Prevention Program; with many effective Prevention Coalitions, Hope Squads, a robust suicide prevention program (Question Persuade Refer (QPR)) and heavy involvement in School-based prevention.
Describe work with community partners to implement brief motivational interventions and/or supportive monitoring in healthcare, schools and other settings.
SBHC works with numerous service providers, including; Family HealthCare (FQHC), Beechtree Lab, Cherish Families, Law Enforcement (facilitation of Crisis Intervention Team (CIT) training), Intermountain Health, Drug Court, Mental Health Court, Switchpoint (Homeless shelter) and Utah Rural Opioid Healthcare Consortium (UROHC), various inpatient programs, SUD residential programs, IOP programs and private outpatient therapists.
Describe any outreach and engagement efforts designed to reach individuals who are actively using alcohol and other drugs.
Our programs are 100% referral based and the majority of referrals come from the specialty courts.
Describe effort to assist individuals with enrollment in public or private health insurance directly or through collaboration with community partners (healthcare navigators or the Department of Workforce Services) to increase the number of people who have public or private health insurance.

Clients work with a case manager who helps them navigate the Medicaid application process. Clients who attend the Recovery Court program are provided with a Medicaid application at orientation and a drug court case manager is available to help the client navigate the application process.

Describe activities to reduce overdose.

1. **educate staff to identify overdose and to administer Naloxone;**
2. **maintain Naloxone in facilities,**
3. **Provide Naloxone kits, education and training about overdose risk factors to individuals with opioid use disorders and when possible to their families, friends, and significant others.**

Naloxone is available in every SUD office. The front desk staff, clinical staff and case managers have naloxone kits available. Staff has been trained how to use the Naloxone kits. Clients and family members are educated in overdose risk factors and encouraged to have a Naloxone kit.

Describe how you measure or determine success of these programs or services? Please identify and define measures and benchmarks you are working to achieve.

Please refer to the Prevention Form C Narrative.

2) Ambulatory Care and Withdrawal Management (Detox) ASAM IV-D, III.7-D, III.2-D, I-D or II-D) Shanel Long

Describe the activities you propose to undertake over the three year period to assist individuals prevent/alleviate medical complications related to no longer using, or decreasing the use of, a substance. For each service, identify whether you will provide services directly or through a contracted provider. Please list all contracted providers.

The determination that a client needs detoxification services is made at the time of screening and/or evaluation. The client is then referred to a medical provider to help make a determination for the appropriate level of detoxification service. When a client does not have an identified medical provider, SBHC will help the client find one who can provide the service. In some instances, such as in the case of pregnancy, clients may simultaneously receive services while participating in outpatient detoxification.

Southwest Behavioral Health Center (SBHC) has not directly provided inpatient detoxification services, but has sub-contracted for this service. Medically stable clients who are withdrawing from substances who have been admitted to Horizon House or Desert Haven are closely monitored during the initial period of residential care. With the opening of our Crisis Stabilization Center in early FY24, we anticipate that some detoxification services may also be provided by SBHC staff moving forward. Our private provider contracts will remain in place for when needed.

If this service is not provided by the Local Authority, where are individuals accessing this level of care when needed? Who in your community provides this service? How is the service paid for?

In most cases, clients (adults and adolescents) needing this service are referred to their private physician for hospitalization in local facilities or out-of-area facilities specializing in acute detoxification

services. SBHC helps facilitate referrals to the following for detoxification services:

- Mountain View Hospital in Payson,
- Provo Canyon Behavioral Hospital for Medical Detoxification.
- Hope Rising Detox and Rehab in Hurricane

The services are paid for by Medicaid and grant funds when appropriate and available.

3) Residential Treatment Services: (ASAM III.7, III.5, III.3, III.1) Shanel Long

Describe the activities you propose to undertake over the three year period and identify where services will be provided. Identify whether you will provide services directly or through a contracted provider. Please list all contracted providers and identify the population served (Men, Women, Youth).

Adolescents:

Adolescents needing residential services are referred to Odyssey House, a co-ed, clinically managed, residential treatment program for adolescents (ages 13-18), ASAM PPC-2R Levels III.1--III.5, with whom SBHC has a contract.

Adults:

Residential services are provided locally in two locations; Horizon House and Desert Haven. Horizon House is a 24-hour clinically managed, residential substance abuse treatment facility, located in Cedar City, Utah which provides ASAM PPC-2R Levels of Care III.1. Desert Haven is a Clinically Managed Low-Intensity Residential Service program located in St. George, Utah providing Level III.1 care to women, pregnant women and women with children.

Both programs conduct multidimensional assessments to ascertain stages of readiness to change, progression of abuse/addiction, and to determine if there is a co-occurring mental health problem. Clients are assessed for medical stability by a physician, which is obtained as part of the admission procedure. Local physicians provide medical assessment and clients have historically had no difficulty in obtaining this service. Where necessary, SBHC helps facilitate the service by referring clients to local physicians. If a client is unable to pay for this service, SBHC has the ability to use vouchers at Family Health Care (the local FQHC). Clients can be brought into residential treatment without the requirement of obtaining a physical if getting one presents a barrier to treatment entry. This can be arranged after entry into residential care. Medically stable clients who are withdrawing from substances are closely monitored during the initial period of residential care.

When clients have needs for medical services, SBHC facilitates the setting of appointments, arranging transportation and facilitates communication when needed.

SBHC has a contract with Odyssey House in Northern Utah.

4) Treatment for Opioid Use Disorder (OTP-Methadone) VaRonica Little

Describe the activities you propose to undertake over the three year period and identify where services will be provided. Identify whether you will provide services directly or through a contracted provider. Please list all contracted providers and summarize the services they will provide for the local authority. If you plan to use SOR funding please identify how you will implement GPRA initial, 6-month and discharge requirements.
Clients requiring Methadone replacement therapy are referred to private providers in St. George who specialize in administering that service. SBHC supports clients in treatment who wish to be on Methadone and other Medication Assisted Therapies. These clients are integrated into groups with other clients on MAT and clients not receiving MAT. Clients who are on MAT or seeking MAT are referred to the medical department of SBHC for consultation as part of the MAT protocol. This is to ensure that all clients on MAT have the support of the medical staff for expertise and consultation. SBHC has contracted with True North, Family Healthcare, St. George Metro and Hope Rising to provide MAT. Unfunded clients who are seeking funding for MAT may be referred to SBHC case manager who will conduct required GPRAs to assess if appropriate for SOR funding.
Describe how you measure or determine success of these programs or services? Please identify and define measures and benchmarks you are working to achieve.
SBHC utilizes Contingency Management through urine drug screens.

5) Medications for Opioid Use Disorder-(Vivitrol, Naltrexone, Buprenorphine) VaRonica Little

Describe activities you propose to undertake over the three year period to ensure community members have access to MOUD treatment, specific types of treatment and administration, and support services for each? If you plan to use SOR funding please identify how you will implement GPRA initial, 6-month and discharge requirements for these services.
SBHC has worked with Family Healthcare (FHC), the local FQHC, to develop a program for providing MAT, including Vivitrol and Suboxone, to SUD clients utilizing FQHC pricing and pharmaceutical assistance so that MAT is affordable and sustainable. SBHC will collaborate with FHC during clients' treatment.
Describe how you measure or determine success of these programs or services? Please identify and define measures and benchmarks you are working to achieve.
SBHC utilizes Contingency Management through urine drug screens. Case collaboration with FHC and other community providers.

6) Outpatient (Non-methadone – ASAM I) Shanel Long

Describe the activities you propose to undertake over the three year period and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. Please list all contracted providers.

Outpatient, individual and co-ed group treatment services are offered during the day and/or after work or school for both adolescents (ages 13-18) and adults (over age 18) who meet ASAM criteria for Level I treatment. These services are provided in all of the 5 counties that SBHC serves. Outpatient groups are generally continuing care groups from Phase I IOP or Residential treatment, using EBP curriculum such as DBT, Dual Diagnosis, Seeking Safety, Relapse Prevention, EMDR and MRT.

Gender specific DBT groups are provided at each of the residential centers and individuals who are not in residential treatment are able to attend on an OP basis. Gender specific groups for adolescents are offered utilizing Seeking Safety, DBT, Why Try and Life Skills.

Where needed, clinical staff provide case management services to link clients to allied agencies who provide other needed services such as medical/dental care, school, educational testing for learning disorders, transportation, vocational rehabilitation, etc.

SBHC provides most of the outpatient services directly, but some services are contracted with local providers for clients with Medicaid.

7) Intensive Outpatient (ASAM II.5 or II.1) Shanel Long

Describe the activities you propose to undertake over the three year period and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. Please list all contracted providers.

Adult Intensive outpatient, co-ed, treatment services are offered in all counties in the SBHC catchment area. Telehealth is now available for clients who need to travel a great distance (or have other circumstances that limit their ability to travel to an appointment) and can be offered for individual and group services. For adolescents (ages 13-18) IOP services are offered in Washington county on a regular basis. Adolescent clients in the other counties have the option of attending IOP in Washington. IOP services are offered during the day and/or after work/school. Those offered IOP services meet ASAM criteria for Level II treatment. ASAM Level II programs provide at least nine hours of structured programming per week to adults and at least six hours of structured programming per week to adolescents.

Treatment consists of group and individual counseling, using evidence based practices, such as motivational interviewing, cognitive behavioral therapy, 12 Step Facilitation, Moral Reconation Therapy (MRT), Seeking Safety, DBT, EMDR and other services such as adult recreational activities and youth respite services, and education about substance-related and mental health problems. Programs link clients to community support services such as health care, public education, vocational training, child care, public transportation, and 12-step recovery group support.

SBHC will continue to offer a dual-diagnosis group for clients who are in Outpatient or IOP SA services and also have a serious or persistent mental illness.

Washington County Youth team provides IOP services for both males and females. We also provide drug testing through Beechtree. SBHC isn't currently contracting out any IOP Substance Abuse Services for Youth. SBHC IOP program utilizes DBT, Seeking Safety, TF-CBT, Relapse prevention

curriculum, Healthy Relationships and Life Skills Curriculum.

8) Recovery Support Services Thom Dunford

Describe the activities you propose to undertake over the three year period and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. For a list of RSS services, please refer to the following link: https://sumh.utah.gov/services/recovery-supports/recovery-resources

SBHC provides and participates in outpatient-associated services which fall under the definition of Recovery Support services. These occur prior to client's admission into active treatment, during treatment and on an ongoing basis after the acute episode of treatment has concluded:

SBHC refers all clients in IOP & Residential Services to 12-step groups, or other community based support groups. 'Addict to Athlete' has chapters in both Iron and Washington counties and clients are encouraged to attend and participate. USARA has opened a community recovery center in St. George and offers SMART meetings, CRAFT meetings, and Refuge Recovery. USARA also offers peer coaching and clients are referred to this program.

Clients that have completed treatment can be on the Alumni Association or become a peer mentor. The association supports current and discharged clients in a variety of ways, including ongoing mentoring and support.

SBHC will meet with any discharged client upon request.

Describe how you measure or determine success of these programs or services? Please identify and define measures and benchmarks you are working to achieve.

Currently we measure success by client involvement and completion of treatment, ongoing involvement with mentoring groups. We will explore the most effective way to identify success during this next FY24..

9) Peer Support Services-Substance Use Disorder Thom Dunford

Describe the activities you propose to undertake over the three year period to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

SBHC plans to offer life skills groups led by CPSS.

USARA has a community recovery center in St. George and clients can be referred to them for Peer Coaching, among other services.

Describe how clients are identified for Peer Support Specialist services. How is the effectiveness of the services measured?

During the initial evaluation, ongoing assessments and case by case needs.

10) Quality & Access Improvements Shanel Long

Describe how you will increase access to treatment services. Is there a waiting list for certain levels of care? What interim or contingency services are available to individuals who may be on a wait list?
SBHC has a centralized waiting list for all residential services. Those clients on the waitlist may be admitted to IOP. Adolescent clients on the waitlist for IOP programs will receive intensified OP treatment by increasing number of individual therapy and family therapy. SBHC is working to expand our adolescent teams in both Washington and Iron County.
Please describe policies for improving cultural responsiveness across agency staff and in services, including "Eliminating Health Disparity Strategic Plan" goals with progress. Include efforts to document cultural background and linguistic preferences, incorporate cultural practice into treatment plans and service delivery, and the provision of services in preferred language (bilingual therapist or interpreter).
Refer to Form A – MH Narrative.
Service Capacity: Systemic approaches to increase access in programs for clients, workforce recruitment and retention, Medicaid and Non-Medicaid funded individuals, client flow through programming. Please describe how the end of the Public Health Emergency and subsequent unwinding is expected to impact the agency's services and funding.
Refer to Form A – MH Narrative
Describe efforts to respond to community feedback or needs. Describe your participation with key community partners (e.g.: Multi-Agency Coordinating Committees, Regional Advisory Councils, High Fidelity Wraparound teams, Local Interagency Councils, Local Recovery Community, Local Homeless Coordinating Committees, Peer Advocacy Groups, County Attorney, Law Enforcement, Local Education Agencies, Courts, Regional Healthcare Coalitions, and other partnership groups relevant in individual communities) shall occur consistently.
Staff has frequent meetings with the below listed partners • Washington County Behavioral Health Network • State Transition Team YESS program • Opioid Community Collaborative • Inaugural Washington County Criminal Justice Coordinating Council • All Things Peer • UBHPAC General Meeting • RAC • Switchpoint • FHC • Cherish Families • MH Court (Washington and Iron County) • LE (Five Counties)

- School Districts
- Drug Court (Washington and Iron County)

What evidence-based practices do you provide (you may attach a list if needed)? Describe the process you use to ensure fidelity?

Evidence-Based Practice Fidelity and Measures/Methods utilized

1. DBT
    a. Weekly consultation with DBT Certified Therapists
2. CBSST
    a. Working on scheduling consultation groups with USH.
3. EMDR
    a. Documentation of what phase of the 8-phase protocol is used as well as monthly group supervision. Occasional recorded sessions are reviewed.
4. Seeking Safety
    a. Group Sessions following the manual. We will implement the use of the validity tool this FY24.
5. MRT
    a. Facilitators follow the facilitator manual when conducting groups.
6. Why Try
    a. Facilitator/s: Certified Prevention Specialist
    b. Training: Facilitators completed Why Try facilitator training
    c. Target population: 6-7 Grades
    d. Frequency: once per week
    e. Duration: 45 minutes
    f. Implements Why Try curriculum & resources
    g. Evaluation: Pre-Posts & school admin satisfaction surveys
7. PC Care
    a. Written protocol and session checklist for each session. The trainer uses this checklist as a fidelity measure when providing supervision. The trainer progress notes are also used as a fidelity measure.
    b. Handouts including coding sheets, strategies that worked, Using Strategies at home and progress logs are also used as they ensure providers are completing the important components of session and documenting this in EHR.
8. TBRI
    a. Staff are continuing to complete training in this modality and we plan to implement it during FY24.

Describe your plan and priorities to improve the quality of care.

Continue having a well-trained staff and hiring adequate staff to provide rapid access to needed services.

Describe your agency plan in utilizing telehealth services. How will you measure the quality of services provided by telehealth?

Zoom is integrated in our EHR system. MHSSIP, YOQ/OQ, SURE and client self reports are used to measure quality of services.
What outcome measures does your agency use to address substance use services? How often does your agency review data and outcome measures? How do you identify if services are effective, efficient and improving lives? I.e., How much did we do? (Quality), How well did we do? (Quality) and Is anyone better off? (Impact).
DLA-20 is completed and then reviewed by case managers. Clients are staffed during weekly team meetings to review progress in treatment. Appropriate changes in levels of services are identified by the ASAM throughout treatment. Clinicians administer and review the SURE with clients monthly. PHQ9 and GAD7 are frequently used as part of treatment. We deem clients are successful once they have completed assignments, have participated in random urinalysis tests indicating abstinence and participated in group and individual treatment at the level required. We work with clients to ensure employment and housing is in place upon discharge from services.

11) Services to Persons Incarcerated in a County Jail or Correctional Facility Thomas Dunford

Describe the activities you propose to undertake over the three year period and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider, and how you will coordinate with the jail to ensure service delivery is adequate.
When requested SBHC staff conduct Substance Abuse evaluations of inmates in each of the counties SBHC services. In the Frontier counties, the frequency of these visits to the jails varies, based on demand. After completing the evaluations, SBHC staff make recommendations for the level of care based on ASAM placement criteria that will suit the individual's needs. When recommended by SBHC and the decision of the courts and the jail is to get the person into treatment with SBHC, arrangements are made for the individual to begin receiving services at SBHC upon discharge from incarceration.
Describe any significant programmatic changes from the previous year.
No significant changes.
Describe current and planned activities to assist individuals who may be experiencing withdrawal (including distribution of Naloxone) while incarcerated or any efforts to use Medication-assisted treatment within a county jail or Prison. Identify all FDA approved medications currently provided within the jail(s).
Iron County SBHC staff, Iron County jail staff & FHC staff have developed protocols for assessing and treating incarcerated individuals with Opioid dependence in the jail and beginning MAT treatment prior to being released. This has been working in the Washington County jail for several years and will continue. The following medications are currently provided within the jail: Buprenorphrine, Methadone, Vivitrol, Naltrexone and Librium.
The SAPT block grant regulations limit SAPT expenditures for the purpose of providing

treatment services in penal or correctional institutions of the State. Please identify whether your County plans to expand SAPT block grant dollars in penal or correctional institutions of the State.
We do not have plans for expansion in this area.

12) Integrated Care Shanel Long

Describe your partnerships with local Health Departments, accountable care organizations (ACOs), federally qualified health centers (FQHCs) and other physical health providers. Please include a list of community agencies you partner with to provide integrated services.
SBHC works closely with Family Healthcare and Four Points Clinic who are associated with the local tribe. Their providers are able to access our electronic health record as well as a relationship where they call medical and mental health providers directly on shared client concerns. SBHC has access to Intermountain Health's electronic records. SBHC meets monthly with Selecthealth case managers to discuss shared client concerns. We utilize the local health department for client and employee TB testing and appropriate vaccinations.
Describe your efforts to integrate care and ensure that children, youth and adults have both their physical and behavioral health needs met, including screening and treatment and recovery support. Identify what you see are the primary barriers to implementing integrated care at your agency and your efforts to overcome those barriers. Please also describe how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy).
Primary barriers are having separate locations and client follow through. Billing for physical codes and documentation with current EHR. SBHC case managers schedule and attend medical appointments for high needs clients. SBHC staff also have access to FQHC's and Intermountain Health (IH) for coordination.
Describe your efforts to incorporate wellness and wellness education into treatment plans for children, youth and adults. Please consider social determinants of health in your response.
When clients are seen in Medical, they are asked some general medical questions and if they have a primary care provider. If they do not have one, they are given several options in the community (FQHCs, Intermountain Health, Revere Health or Doctors' Volunteer Clinic) or assistance in making an appointment.
Describe your plan to reduce tobacco and nicotine use in SFY 2024, and how you will maintain a *nicotine free environmen*t at direct service agencies and subcontracting agencies. For ongoing engagement, it is recommended to use an evidence-based nicotine dependence tool such as the Fagerstrom scale. SUD Target= reduce nicotine use to 4.8 in 2021 in TEDs.
Clients are asked about tobacco use and interest in cessation at each appointment. A referral to HELP line and if clients want additional cessation options, we refer to FQHC's or PCP's.
Quality Improvement: What education does your staff receive regarding health and wellness for client care including children, youth and adults?
All medical staff maintain current knowledge of health and wellness by reading journals, verified studies and education from prescribers.

Describe how you measure or determine success of these programs or services? Please identify and define measures and benchmarks you are working to achieve
Client report and SURE.

13) Women's Treatment Services **Rebecca King**

Describe the evidence-based services provided for women including gender-specific substance use disorder treatment and other therapeutic interventions that address issues of trauma, relationships, sexual and physical abuse, vocational skills, networking, and parenting.
Women's treatment services for substance use disorders are provided in several locations at SBHC. Services are planned according to ASAM placement criteria, following a comprehensive assessment. Women with young children who are appropriate for residential treatment are placed in Desert Haven when space is available. This is an ASAM III.I program designed for pregnant women and women with their young children (most often up to age 8, although this varies). Women receive gender specific and responsive care including group therapy, group skills development, group behavior management, individual therapy, case management, and referral to community resources. Women in residential treatment are taken to gender specific community support meetings when available, and women not in residential treatment are referred to these meetings. The children of these women are assessed by the Youth Services team to determine if they have needs that could be met through SBHC and are given services accordingly, including the practice of Attachment, Regulation and Competency (ARC). The women also participate in parenting training and coaching. Upon completion of Desert Haven, clients are given the option of continuing care in gender specific groups or co-ed groups. Women who meet ASAM II criteria are given the option of attending a gender specific and responsive IOP group. This group also has gender specific and responsive continuing care groups as a follow up. Horizon House West provides gender specific/responsive residential or day treatment for women. DBT and Seeking safety are provided in the women's residential centers & are offered to OP clients when indicated. EMDR is also available to women in SUD services
Describe the therapeutic interventions for children of clients in treatment that addresses their developmental needs, their potential for substance use disorders, and their issues of sexual and physical abuse and neglect. Describe collaborative efforts with DCFS for women with children at risk of, or in state custody.
We address these needs primarily through parent support groups to which parents in recovery are encouraged to attend. Moms from Dessert Haven are regularly attending this group. We have had great feedback and attendance. The model that is taught is ARC and TBRI which are both evidence-based.
Describe the case management, child care and transportation services available for women to ensure they have access to the services you provide.

Transportation to and from appointments is provided to women and children of Desert Haven. Taxi vouchers and bus passes can be arranged for those not in Desert Haven. Case management for women with children is available to Desert Haven and IOP clients weekly, for those in OP on a bi-weekly or monthly basis, more if needed.

In Iron County, case management services are provided by clinicians and case managers. This includes helping clients access healthcare resources, apply for benefits, find housing and transportation resources. Taxi vouchers are arranged for when needed. When available, the family support center assists with child care.

Describe any significant programmatic changes from the previous year.

NA

Residential Women & Children's Treatment (WTX) (Salt Lake, Weber, Utah Co & Southwest Only)

Rebecca King

Identify the need for continued WTX funding in light of Medicaid expansion and Targeted Adult Medicaid.

Desert Haven is a Women's and Children's Substance Use Disorder Residential Support and Treatment program, with support funding coming from a variety of sources. With the advent of Utah's Medicaid TAM and Expansion (as well as historical Legacy), Southwest has found that 90%+ of the women who are receiving services at Desert Haven qualify for treatment coverage under this program. This revenue source ensures that the majority of the treatment services are covered by a funding source beyond state funding. While Medicaid will cover the discreet or bundled treatment services, SBHC must cover the costs of the Residential Support and Room and Board for these women and their children. The WTX dollars fund, firstly, the 24-hour staff that oversee the residential program (see the budget provided). These dollars also cover the facility operating costs, such as food, daycare, maintenance, insurance and other expenses associated with the residential program. These room & board costs are not covered in a capitated, bundled or discreet service rate from Medicaid. SBHC leverages other funds when available to help offset some of these additional costs; including special state funding for childcare, and food stamps of clients as legally permitted. Additionally, some Medicaid coverage requires matching funds in order to draw down federal Medicaid dollars. This match must be made from State and/or County dollars. Some WTX funds support that match

Please describe the proposed use of the WTX funds

WTX funds are used firstly to cover the 24-hour staff that support and manage the clients and oversee the residential program. These dollars are also used to cover the operating costs at the facility, such as food, daycare, maintenance, insurance and other operating expenses associated with a residential program. Additionally, these funds are used to offset some of the required Medicaid match, a combination of State and County dollars.

Describe the strategy to ensure that services provided meet a statewide need, including access from other substance abuse authorities

We coordinate with SBHC partners, letting partners know how many beds are full, how many open, and how many on the waiting list for each residential program.
Submit a comprehensive budget that identifies all projected revenue and expense for this program by email to: bkelsey@utah.gov
Please demonstrate out of county utilization of the Women and Children's Residential Programs in your local area. Please provide the total number of women and children that you served from other catchment areas and which county they came from during the last fiscal year.
None have been referred but we still make it available if needed.

14) Adolescent (Youth) Treatment Shanin Rapp

Describe services provided for adolescents and families. Please identify the ASAM levels of care available for youth.
We incorporate several modalities into both IOP groups, individual and family therapy such as Seeking Safety (which incorporates both trauma and substance use) as well as DBT, CBT, and MRT. We provide outpatient services for Level 1 and Intensive Outpatient programs for Level 2 as well as Crisis Stabilization programs.
Describe efforts to engage, educate, screen, recruit, and refer youth. Identify gaps in the youth treatment referral system within your community and how you plan to address the gaps.
Our Youth IOP team of dedicated therapists and case managers adopt a very holistic approach to care where they encourage families to participate in the different programs we provide. We continuously monitor progress through YOQs, drug testing, staffing meetings, wraparound meetings, and case management to ensure the client and the family are set up for success in treatment. There are very few SU treatments for youth in our community so the collaboration with other agencies is minimal. We will continue to provide care through our programs and explore ways to better serve our community with the resources we have as well as keep on our radar any potential collaborators for SU treatment in our region.
Describe collaborative efforts with mental health services and other state child serving agencies (DCFS, DJJS, SOC, DSPD, Juvenile Court) and any significant programmatic changes from the previous year.
We work hard on keeping good communication and collaboration with them. We prioritize providing immediate services for clients referred by these agencies and we make sure we continuously communicate with them about any issues, treatment options, etc. so that coordination of services happens in a timely manner. We anticipate some legislation might change in the coming months and so we would like to invite representatives of these agencies to present to our staff an overview of their primary functions as well as those changes we might anticipate for us to be informed and ready for any implications in our services and collaboration.

15) Drug Court Shanel Long

Describe the Drug Court eligibility criteria for each type of specialty court (Adult, Family, Juvenile Drug Courts, etc). Please provide an estimate of how many individuals will be served in each certified drug court in your area.

The Washington County Recovery Court begins with an application after a candidate is charged with a felony related to their use of substances (misdemeanors are allowed on a case by case basis). These applications are turned in to the defense attorney. The candidate is then assigned to Court Support Services for an SUD assessment. After the evaluation has been completed the client is placed on the staffing calendar for Recovery Court. The potential participant is also discussed in the staffing to determine if there are extreme reasons the candidate would be excluded (history of extreme violence for example).

The Washington County Family Recovery court begins with a DCFS referral. The participant's children must either be in state's custody, or be at risk for out of home placement. The participant is discussed in staffing to determine appropriateness and attends a court session to determine if they want to participate. If they do, they sign the agreement and begin the process of assessment and entry into treatment.

Clients enter the Iron County Recovery Court in much the same way as Washington County, the defense attorney has the client fill out an application which is submitted to the Iron County Prosecutor. If approved, the individual will participate in an assessment, including the RANT, to determine risk/need as well as appropriate placement within ASAM criteria.

Describe Specialty Court treatment services. Identify the services you will provide directly or through a contracted provider for each type of court (Adult, Family, Juvenile Specialty Courts, DUI). Describe your efforts to have Certified Peer Support specialists working with Drug Courts? How will you engage and assist individuals with Medicaid enrollment throughout their episode of care.

A comprehensive multidimensional assessment is conducted to ascertain the stage of readiness to change as well as progression of abuse/addiction and if there is a co-occurring mental health problem. Court Support Services uses the LS/RNR tool to determine risk/need. Only potential participants who meet the criteria for high risk/high need are approved for admittance into the Recovery Court. An individualized treatment plan is developed in consultation with the client, family and Recovery Court Team, and is directed toward applying recovery skills, preventing relapse, improving emotional functioning, and promoting personal responsibility. Treatment plans include formulation of the problem, treatment goals, and measurable objectives.

Recovery Court treatment is provided in phases, ranging from intensive treatment services (Intensive Outpatient or Residential treatment) in phase 1 to outpatient groups, such as continuing care, educational and relapse prevention, and individual sessions as indicated in the treatment planning in phase II and a continuing care group per week and individual sessions as needed in phase III and, where indicated, one group per month and individual counseling as needed for phase IV.

Treatment intensity and phases are directed by the client's treatment plan and may or may not match the client's Recovery Court level.

All our speciality courts have access to case managers and CPSSs which can help assist these

individuals with Medicaid enrollment, and other case management and peer support services.
Describe the MAT services available to Specialty Court participants. Please describe policies or procedures regarding use of MAT while in specialty court or for the completion of specialty court. Will services be provided directly or by a contracted provider (list contracted providers).
All medications for the treatment of addiction are allowed in the Recovery Courts. Clients can receive MAT through Family Healthcare, True North and St. George Metro, in the St. George area and Family Healthcare in the Cedar City and Beaver areas. Medications include, but are not limited to Vivitrol, Suboxone, and Methadone. Grant funding and RSS funds may be available to offset the cost if a participant is eligible and does not have insurance. SBHC has a direct contract with Family Healthcare and St. George Metro for these medications and services.
Describe your drug testing services for each type of court including testing on weekends and holidays for each court. Identify whether these services will be provided directly or through a contracted provider. (Adult, Family, Juvenile Specialty Courts, etc).
The Washington County Recovery Court has its own "UA Center" that tests on site using gas chromatography (GC) and mass spectrometry (MS). Clients are randomly tested, the frequency depending on the Phase of Recovery Court. Beechtree staff have offices in SBHC office buildings in both Cedar City and St. George for drug testing of SBHC clients. Their staff work with SBHC to develop a random schedule for clients to test. Iron County Recovery Court clients who are also SBHC clients are tested using this same system. All three Recovery Courts have testing on weekends and holidays to ensure truly random testing.
List all drug court fees assessed to the client in addition to treatment sliding scale fees for each type of court (Adult, Family, Juvenile Specialty Courts, etc).
The Washington County Recovery Court clients are not assessed fees for treatment. They are charged supervision / testing fees based on their income, typically $30/week. A hardship waiver is available to any client experiencing inability to pay. These are paid weekly through the Washington County treasurer's office. Iron County Recovery Court Clients pay a "recovery court fee" that covers Recovery Court services. In addition, clients are charged for confirmation testing at the lab if they have denied use in the case of an apparently + test determined by the dip test & the positive test is verified by the lab. If the test comes back negative from the lab there is no charge to the client.

16) Justice Services **Thomas Dunford**

Describe screening to identify criminal risk factors.
SBHC uses the RANT for all SUD clients. Washington County Recovery Court assessments are now conducted by Court Support Services. They complete the LS/RNR, the results of which are provided to SBHC. These results are scanned into our electronic health record (EHR).
Identify the continuum of services for individuals involved in the justice system. Identify strategies used with low risk offenders. Identify strategies used with high risk offenders to

reduce criminogenic risk factors.
Clients are separated according to risk vs. needs of each individual. Where possible we do not place low risk individuals with high risk individuals. Efforts are made by the staff to notify referral sources of the client's progress. We have implemented a case manager for clients who are involved with AP&P and private probation. Clients are offered a variety of options for treatment including, but not limited to: DBT, Seeking Safety, MRT, EMDR therapy and Prime Solutions.
Identify a quality improvement goal to better serve individuals involved in the criminal justice system. Your goal may be based on **the recommendations provided by the University of Utah Criminal Justice Center in SFY 2020.**
SBHC now has a dedicated case manager working more closely with pretrial services to ensure the fastest access to care.
Identify coalitions, planning groups or councils (or other efforts) at the county level working to improve coordination and outcomes for adults involved in the justice system.
We meet with a myriad of different agencies weekly, monthly and quarterly. These include; law enforcement (typically through the specialty courts and MAT services), Multi-Agency Coordinating Committees (UROHC), Local Recovery Community (Recovery Day is an amalgamation of the area treatment providers, recovery advocates, and fellowships working together to raise awareness, advocacy, and encourage interagency cooperation), Peer Advocacy Groups (USARA), County Attorney's office works closely with us on the specialty courts and on the Stakeholders Board. In Washington County, the Stakeholders meetings are held biannually. In attendance are: judges, law enforcement, Adult Probation and Parole, Southwest Behavioral Health Center, and local and state lawmakers. Iron County Drug Court meets weekly with representatives from SBHC, the county Prosecutors, Defense, and the local sheriff's department. Beaver County has meetings about every six months with the jail, local law enforcement, Family Healthcare and SBHC initiating and participating in several community-based activities, such as; Recovery Day, support of the Hidale community, community wide Mental Health First Aid training, Designated Examiner training and participation on the Fall Conference Committee.
Identify efforts as a community stakeholder for children and youth involved with the juvenile justice system, local DCFS, DJJS, Juvenile Courts, and other agencies.
We have regular meetings with all of the above agencies and regular team meetings with the above stakeholders as needed.
Describe how you measure or determine success of these programs or services? Provide data and outcomes used to evaluate Justice Services. Please identify and define measures and benchmarks you are working to achieve
SURE, client and community feedback.

17)Suicide Prevention, Intervention & Postvention (ONLY COMPLETE IF NOT COMPLETED ON FORM A)

Describe all current activities in place in suicide prevention, including evaluation of the activities and their effectiveness on a program and community level. Please include a link or attach your localized suicide prevention plan for the agency.
Please see answers on Form A MH narrative.
Describe all currently suicide intervention/treatment services and activities including the use of evidence based tools and strategies. Describe your policies and procedures for suicide screening, risk assessment, and safety planning as well as suicide specific treatment and follow up/care transition services. Describe how Describe how clients are identified for suicide specific services. How is the effectiveness of the services measured?
Describe all current strategies in place in suicide postvention including any grief supports. Please describe your current postvention response plan, or include a link or attach your localized suicide postvention plan for the agency and/or broader local community.
Describe your plan for coordination with Local Health Departments and local school districts to identify roles and support implementation of a community postvention plan in alignment with the state Community Postvention Toolkit.
For Local Authorities participating in the Garrett Lee Smith State Youth Suicide Prevention and Early Intervention Grant Program summarize your implementation plans for implementing skill based programming, gatekeeper training, community or school based screening activities, and crisis follow up services after inpatient or emergency department visits. (note: this can be done in the box below, or by linking/attaching your most current report). **For those not participating in this grant program, please indicate "N/A" in the box below.**
For Local Authorities participating in the Comprehensive Suicide Prevention grants describe your implementation plans for primary prevention progams, suicide intervention supports including gatekeeper training, and community postvention planning. (note: this can be done in the box below, or by linking/attaching your most current report). **If any of the following project deliverables are currently available, please link them here or attach them to your submission.** 1. **By year 2, funding recipients shall submit a written comprehensive suicide prevention plan that is in alignment with the Utah Suicide Prevention State Plan and by year 2, funding recipients shall submit a written postvention response plan and communication protocol for their organization.** 2. **By year 3 funding recipients shall submit a written community postvention response**

plan. **For those not participating in this project, please indicate, “N/A” below.**
For Local Authorities receiving mini grant funding for the Live On Utah statewide suicide prevention campaign, summarize your implementation and sustainability plans for the implementation of culturally appropriate suicide prevention messaging in your area. **For those not participating in this project, please indicate, “N/A” below.**