



Utah Department of
Health & Human Services
Integrated Healthcare

SUMH Local Authority Area Plan

State Fiscal Year 2027

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OVERVIEW

The purpose of this document is to meet contract compliance with the Local Authorities (LA) “Evergreen Contract” Article 1.2: “Area Plan” means a plan prepared and submitted by the LA in accordance with Utah Code §17-77-201(5)(b) and §17-77-301(5)(a)(ii) for funding and service delivery that includes a provision of services and programming for prevention, crisis, treatment, and recovery support services. Please note that the prevention portion of this requirement is located in a separate document.

This document is designed to capture the above outlined programmatic requirements of the LA in the contract and SUMH Office Directives. Sections in this document are inclusive of the sections in which a descriptive response is needed. Please review the full “Evergreen Contract” and SUMH Office Directives for all contractual requirements. Please do not delete any questions or sections; if a section does not apply to the LA, please note that in the section. Please note when completing this document that any embedded links must be viewable by the reader.

SUICIDE PREVENTION SERVICES

Community Suicide Prevention

The following sections are the **Community Suicide Prevention** requirement from both the LA contract and the SUMH Office Directives.

Suicide Prevention (Contract requirement 4.1)

Does the LA have current strategies for suicide prevention, intervention and postvention that are evidenced-based and align to the Utah Suicide Prevention State Plan?

☒ Yes

☐ No, not at this time.

Describe strategies and evidence based programs being implemented for:

1) Prevention - Please include a public-facing link to the plan in the space below (if available).

- Working on shared risk and protective factors using evidence-based primary prevention programs.
- Promoting the Live On campaign at events, training, and community coalitions and partners.
- Increase public knowledge of suicide warning signs and that it is preventable.
- Promoting suicide prevention message to higher risk populations through tailored communication strategies.
- Reducing access to lethal means among individuals at risk of suicide by providing gun safes, gun locks, medication safes and promoting proper disposal. Offering firearm safety training and educational materials to the community.

2) Intervention - Please include a public-facing link to the plan in the space below (if available).

- Implementing comprehensive suicide prevention into workplace culture. This is accomplished by implementing policies, procedures and practices to prevent suicide and mitigate further harm.
- Providing a variety of suicide prevention trainings in workplaces and other community settings.

3) Postvention - Please include a public-facing link to the plan in the space below (if available).

A written postvention plan is in place for Salt Lake County. There is a written plan for both the Salt Lake County Health Department and another for the community at large. We are currently working towards convening a postvention coalition to enhance the current postvention plan.

Community Suicide Prevention

Please see the uploaded documents "Salt Lake County Community Postvention Plan_FINAL 2025" and "Guideline AB Suicide Prevention Appendix F Postvention Guideline".

Suicide Prevention Training (Contract requirement 4.1.a)

Does the LA have at least one staff member with suicide prevention responsibilities trained in the following suicide prevention programs: (1) Suicide Prevention 101 training; (2) Safe and Effective Messaging for Suicide Prevention; (3) Suicide Prevention gatekeeper training, such as Question-Persuade-Refer, Mental Health First Aid, Talk Saves Lives, or Applied Suicide Intervention Skills Training; and (4) counseling on access to lethal means.

☒ Yes

☐ No, not at this time.

If yes, please document the LAs staff name, job title, and email for this contract requirement (if multiple, please note which programs each are trained in)

- Alyssa Burnham – Suicide Prevention Coordinator - aburnham@saltlakecounty.gov
QPR, MHFA, YMHFA, Vital Cog, Messaging Matters, Creating Safety
- Emma Blake – Suicide Prevention Health Educator – eblake@saltlakecounty.gov
QPR, Vital Cog, Messaging Matters, Creating Safety
- Linsey Miller – Injury Prevention Program Manager – lpmiller@saltlakecounty.gov
QPR, Vital Cog

Community Suicide Prevention Coordination (Contract requirement 4.1.b)

Does the local authority coordinate with local health departments and local education agencies for suicide prevention, intervention, and postvention within their communities.

☒ Yes

☐ No, not at this time.

Please identify the partners, and describe the role and responsibility of each partner in suicide prevention, intervention, and postvention within their communities. This must include the following partners: LHD, LMHA, LEAs. LAs may include other community partners, organizations, etc as applicable.

The SLCoHD works with local school districts to address risk and protective factors. Granite School District is implementing the CREST (Creating Resilient Students) program.

Community Suicide Prevention

Suicide Risk Policy (SUMH Office Directives Governance and Oversight general provisions)

LAs shall have a written policy and procedures for screening and responding to suicide risk. The policy must contain a suicide screen, suicide risk assessment, and a suicide/crisis safety plan, when indicated, that includes indication of lethal means counseling when clinically indicated.

Please describe how staff are trained in the policy for screening and responding to suicide risk or provide a public-facing link to the plan.

Providers within the DBHS/Optum network are mandated to provide a systematic approach in their efforts with suicide follow-up by administering the C-SSRS/Suicide Risk Assessment upon intake and admission. If a client initially screens negative for suicide but later suicidal risk is suspected by the clinician or other staff member during the course of treatment, a C-SSRS/Suicide Risk Assessment will be re-administered. Safety plans are created and updated when clients demonstrate an affirmative response to question #2 or to subsequent questions on the C-SSRS.

Safety plans are also used as a tool to assist members with other safety issues or to improve their ability to manage the symptoms of their mental illness. DBHS/Optum adheres to a Sentinel Events policy and procedure to investigate serious suicide attempts requiring hospitalization while members are receiving treatment and when members complete suicide during or shortly after completing treatment. Each of these reported incidents are reviewed to determine if any quality of care issues exist and to partner with the provider to improve treatment for all members. Most of our providers have submitted verification of completed Counseling on Access to Lethal Means (CALM).

The use of the C-SSRS and safety planning is monitored during DBHS' annual monitoring. Additionally, please see the Optum SLCo Provider Manual, Pg. 25, [provider-manual-slco.pdf](#). Optum audits providers on these requirements.

Firearm Safety (SUMH Office Directives)

LAs shall purchase and distribute means safety materials and implementing education. Means safety includes firearm safes, ammunition boxes, medication lockboxes, and other means of disposal.

Please describe the LAs plan for:
Purchasing and distributing means safety devices

We have purchased handgun safes, lockable long-arm gun storage, ammunition boxes, cable gun

Community Suicide Prevention

locks, medication safes, and medication disposal products. These items have been distributed at the Rocky Mountain Gun Show, the Rocky Mountain Elk Foundation Gala, and other community events as needed. Plans for additional distribution at 4 county libraries between April-June 2026.

Approach to community education

Attending events where the intended audience is already present. Reaching populations at an elevated risk by attending events in those communities. Distributing literature and information regarding crisis services, and discussing the importance of lethal means safety in community trainings.

Garrett Lee Smith Grant (GLS)

Does the LA have a GLS Grant?

- ☐ Yes/
☒ No, not at this time.

If yes, describe how the LA intends to implement GLS as described here or insert document link:

Comprehensive Suicide Prevention Grants

Does the LA have a Comprehensive Grant award?

- ☒ Yes
☐ No, not at this time.

If yes,

Please identify LA primary contact name and email

- Linsey Miller – Injury Prevention Program Manager – lpmiller@saltlakecounty.gov
- Alyssa Burnham – Suicide Prevention Coordinator - aburnham@saltlakecounty.gov
- Emma Blake – Suicide Prevention Health Educator – eblake@saltlakecounty.gov

Describe describe how the LA intends to implement the Comprehensive Grant as described here or insert document link:

The SLCoHD intends to use the RFA to inform the development and implementation of the

Community Suicide Prevention

Community Comprehensive Suicide Prevention Plan. A draft of this plan will be submitted by June 2026.

Technical Assistance

Is technical assistance requested for Community Suicide Prevention programming or requirements?

☐ Yes

☒ No, not at this time.

Please indicate sections requested.

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CRISIS SERVICES

Behavioral Health Crisis Services

The following sections are **Behavioral Health Crisis Response** requirements from both the LA contract and the SUMH Office Directives. This section also includes the 24/7 crisis care and services mandated service requirement.

Crisis Line Coordination, MCOT and Receiving Centers Services shall provide services in accordance with UCA 523-18 and 523-21. The LA shall refer to the [SAMHSA National Guidelines for a Behavioral Health Coordinated System of Crisis Care](#) as guidance for development, implementation, and quality improvement efforts.

24 Hour Crisis Care and Services (Mandated Service)

Will the LA provide 24-hour Crisis Care and Services directly, through a contracted provider, or both? (provide public-facing link to or list of contractor(s) below)

	Youth	Adult
Directly	☐	☐
Contracted	☒	☒

Behavioral Health Crisis Services

Link to or list of contracted providers:

Huntsman Mental Health Institute is Salt Lake County Division of Behavioral Health's only provider for these crisis services. [Community Crisis Intervention & Support Services, Salt Lake City Area | University of Utah Health](#)

Mental Health Crisis Outreach Teams (MCOT) (Contract 7.2.b)

Does the LA operate MCOT services 24 hours a day, seven days per week providing community based crisis intervention, and assessment?

- ☒ Yes
☐ No, not at this time.

Does the LA deploy MCOT from the statewide crisis line when requested without reassessment or re-triage?

- ☒ Yes
☐ No, not at this time.

Do the LA MCOT teams give priority to law enforcement, emergency medical services, Fire, 911 dispatch, and the statewide crisis line?

- ☒ Yes
☐ No, not at this time.

Do the LA MCOT teams connect individuals to facility-based care as needed through warm handoffs and coordination of transportation?

- ☒ Yes
☐ No, not at this time.

Please detail the following for the LA:

The interdisciplinary makeup of the LA's MCOT and the community's accessibility to MCOT during regular business hours, after hours, weekends, and holidays

- The Salt Lake County MCOT team utilizes a two-person interdisciplinary model consisting of:
 - A licensed clinician (LCSW, CMHC, CSW, or ACMHC)
 - A certified crisis worker/peer support specialist
- MCOT provides services to individuals of all ages and demographics throughout Salt Lake County.
- Services are available 24 hours a day, 7 days a week, including:

Behavioral Health Crisis Services

- Regular business hours
- After hours
- Weekends
- Holidays
- The MCOT team does not close at any time.
- Telehealth crisis interventions are available as needed to enhance access to services.

How MCOT supports connection to ongoing care through follow-up outreach

- The Salt Lake County MCOT team conducts follow-up outreach within 48 hours of an MCOT response.
- Follow-up contact allows the team to:
 - Check in on the individual's current mental health status
 - Provide additional referrals and resources as needed
 - Answer questions that may arise after the initial crisis intervention
- When appropriate and with client consent, the team may offer additional follow-up contact to further support connection to ongoing care.

How the LA engages and educates first responders to MCOT services

- The Salt Lake County MCOT team regularly engages with first responders, both during field responses and through community-based outreach and training.
- Law enforcement has access to a dedicated phone line that connects directly to the Salt Lake County MCOT dispatcher, allowing officers to bypass the crisis line when requesting MCOT support.
- MCOT responds on scene within 30 minutes to law enforcement requests.
- While on scene, the MCOT team coordinates closely with law enforcement to address the individual needs of each situation.
- Community Crisis Intervention & Support Services (CCI&SS) provides presentations at CIT trainings for the county, and MCOT participates in CIT Metro trainings, including scenario-based exercises and officer peer engagement during lunch.
- CCI&SS is currently in collaboration with Salt Lake Valley Emergency Communications Center (VECC) to implement protocols to more efficiently route mental health-related calls to 988 and improve utilization of MCOT services. MCOT partners with VECC's dispatch teams to increase access and efficiency of handing off appropriate mental health calls for our team and for the caller to get the most appropriate care needed.

MCOT Exemption Request (Contract 7.2.b.7)

Behavioral Health Crisis Services

The MCOT Rule is linked here - [R523-18](#)

Does the LA have an exemption request for any MCOT requirements?

- ☐ Yes
☒ No, not at this time.

If applicable, please document the request for review and approval.

Receiving Centers (Contract 7.2.c)

Does the LA have a Receiving Center?

- ☒ Yes
☐ No, not at this time.

Service Delivery Framework: *Describe operational and clinical implementation of the service, outreach, training, access procedures, assessment tools, eligibility criteria, family engagement, transition planning. Please include any prioritization of first responders.*

Crisis Care Center (CCC) (i.e., Receiving Center) Intake Process (Summary)

- Patients present via law enforcement/EMS or independently. Upon arrival, all patients receive a medical screening exam (MSE) by a provider in compliance with EMTALA and hospital bylaws. Law enforcement may leave after a safe handoff.
- Patients complete registration and a non-invasive security check, then proceed to the assessment or observation area. Intake flow may vary based on acuity and staffing but includes both clinical crisis assessment and nursing triage/intake.
- If substance use (alcohol/benzodiazepines) is suspected, standardized withdrawal assessments are completed, and appropriate care pathways are followed. Patients requiring medical clearance are transferred to the emergency department per protocol.
- A Crisis Worker conducts a psychosocial evaluation, including risk assessment and disposition planning. If a recent evaluation exists, a reassessment is completed. Documentation must be finalized in the EHR.
- The nursing intake includes vitals, safety procedures (search and belongings inventory), and clinical screening (e.g., Urine Drug Screen if indicated). Patients are then connected with providers and social workers to address treatment and care planning needs.

All patients have access to core services, including:

- Crisis evaluation and risk assessment
- Psychiatric evaluation and medication management

Behavioral Health Crisis Services

- Brief therapy, peer support, and case management
- Observation (up to 23 hours) if needed
- Discharge planning and connection to ongoing care

Eligibility Criteria

1. Patients must be residents of Salt Lake County. There is no cost to the patient for these services. All patients who present to the Crisis Care Center regardless of their place of residence are evaluated and provided treatment in accordance with their mental health and medical needs. The HMHI CCC follows EMTALA rules and does not turn away patients. All patients are served regardless of ability to pay.
2. If a patient presents, is assessed, and requires medical interventions or a level of care that we cannot accommodate, we facilitate access to and coordinate care for those necessary services.
3. Patients who cannot be safely served in the Receiving Center due to risk of harm to self or others, acute emergent medical needs, complex medical issues, or communicable diseases are received, assessed, & facilitated to access the appropriate level of care.

Development of the Discharge Plan/Crisis Plan

1. A treatment team member will work with the patient and/or their guardian when appropriate, to develop a Discharge Plan/Crisis Plan
2. The Plan shall include, but is not limited to:
 - Date of discharge or transfer
 - Community resources to be utilized by the patient
 - Any follow-up appointment
3. The plan shall be written so it can be understood by the patient,
 - The plan shall be documented on the discharge instructions.
 - Upcoming appointments and referrals will be documented in the discharge instructions.
 - The discharge instructions shall be signed by the treatment team member and the patient or their guardian when appropriate.
 - If the patient or their guardian when working with a minor chooses not to sign the discharge instructions, this will be documented in lieu of the needed signature.
 - The patient or their guardian will receive a copy of the discharge instructions.
 - A copy of the signed instructions will also be maintained in the patient's medical record.

Assessment Tools

The BH Clinical Intake Assessment (Psychosocial) includes:

- Mental Status Exam
- Columbia Suicide Risk Assessment
- Adjusted Risk Assessment
- Violence Assessment

Behavioral Health Crisis Services

- Social and Medical History

CCC has initiated Measurement Based Care Tools:

- Distress Thermometer
- Modified Colorado Symptom Index
- PHQ-9
- GAD-7
- Patient Global Impressions Scale – Severity
- Social Determinants of Health

Outreach

Clinical Leaders and Administrators conduct ongoing, intentional outreach with key community partners to strengthen collaboration and appropriate utilization of Receiving Center services. This includes regular quarterly and monthly meetings, as well as tours of the facility, with a focus on law enforcement, first responders, EMS/Fire, and internal and external hospital partners.

Outreach efforts emphasize education on access points, inclusion/exclusion criteria, and care capabilities to ensure patients are directed to the most appropriate level of care. Services are actively promoted across the community, and utilization has significantly increased since program launch, reflecting growing awareness and trust among partners.

Training

Staff receive comprehensive, ongoing training to ensure high-quality, safe, and evidence-based care. This includes all required University of Utah Health clinical trainings, in addition to specialized education tailored to behavioral health crisis settings. Topics include de-escalation techniques, suicide risk assessment and prevention, HOPE principles, community resource navigation, clinical supervision, and emerging best practices. Training is reinforced through case studies, interdisciplinary collaboration, and continuous learning opportunities, supporting staff in managing high-acuity situations with confidence and consistency.

Family Engagement

Family engagement is a key component of care within the Receiving Center, balanced thoughtfully with strict adherence to HIPAA privacy practices. Patients are empowered to define the level of involvement of their support system. Upon admission, patients may complete a Release of Information (ROI) and/or indicate a desire for loved ones to be notified or involved in their care.

When consent is provided, staff actively engage family members or identified supports as appropriate throughout the episode of care. This may include gathering collateral information to better understand the patient's history and current needs, involving supports in safety and discharge planning, and providing education on next steps and available community resources.

Behavioral Health Crisis Services

Our multidisciplinary team prioritizes a family-centered, trauma-informed approach, recognizing that engaging natural supports can improve patient outcomes, continuity of care, and overall experience.

Transition Planning

Transition planning is an essential component of care within the Receiving Center and begins at the point of admission. From the outset, the multidisciplinary team works to identify the most appropriate next level of care based on the patient's clinical needs, safety, and preferences.

Crisis Workers lead the development of an individualized discharge and transition plan, incorporating input from providers, nursing, peer support specialists, and when appropriate, family or natural supports. Plans are focused on ensuring continuity of care and reducing the likelihood of repeat crises.

Transition options may include discharge to outpatient services, connection to community-based resources, coordination with existing providers, referral to higher levels of care such as inpatient hospitalization, or linkage to substance use treatment services. For patients requiring additional stabilization, observation services (up to 23 hours) allow time for further assessment, medication management, and care coordination.

The team prioritizes warm handoffs whenever possible, including direct communication with receiving providers or programs, scheduling follow-up appointments, and providing patients with clear, actionable next steps. Barriers such as transportation, access to medications, and social determinants of health are assessed and addressed to the extent possible prior to discharge.

Prioritization of First Responders

First responders are encouraged to call ahead so staff can prepare for patient arrival and ensure a smooth transition of care. Upon arrival, they access a private, secure entrance and are met promptly by the clinical team. The goal is to facilitate a warm, efficient handoff, allowing for timely exchange of critical information to guide care pathways while enabling first responders to return to the community as quickly as possible.

Ongoing collaboration is supported through monthly meetings with law enforcement and other first responder partners, fostering open dialogue, shared problem-solving, and review of complex or challenging cases. In addition, tours and educational sessions are routinely offered by Receiving Center staff to promote understanding of services, strengthen relationships, and ensure accurate, consistent information sharing.

Behavioral Health Crisis Services

Outcomes Framework: *Describe specific metrics used to track performance (e.g., recidivism, length of stay, discharge barriers), process for analyzing data to drive continuous quality improvement.*

Metrics include but are not limited to:

- Census
- Left without being seen
- Inpatient admissions
- Length of stay
- Recidivism
- Number of Boarders (i.e., clients)
- Door to doctor time
- Arrivals by time/weekday
- Disposition
- Wait time by arrival mode
- Diagnoses
- Trends
- Injuries
- Incident reporting
- Safety events
- Patient engagement metrics
- Acuity

These data are analyzed and reviewed a minimum of monthly in operational meetings attended by Clinical Directors and senior leaders.

Youth Crisis Programming (Office Directives, Crisis Services)

Does the LA have a Youth MCOT program/team?

- ☒ Yes
☐ No, not at this time.

Does the LA have a formal Memorandum of Understanding (MOU) with local school districts to allow MCOT/Stabilization and Mobile Response (SMR) teams to respond directly to school campuses to prevent student arrests/suspensions?

- ☐ Yes

Behavioral Health Crisis Services

☒ No, not at this time.

Does the LA have a SMR program/team?

☐ Yes

☒ No, not at this time.

How are the following implemented:

Ongoing care coordination and referrals between MCOT and SMR staff to ensure continuity for families

Ongoing care coordination and referrals between MCOT and Intermountain Healthcare's (IHC) SMR staff to ensure continuity for families

The only SMR team in Salt Lake County is IHC's SMR, which is not under the purview of DBHS. However, MCOT maintains ongoing collaboration with IHC's SMR to ensure individuals receive the most appropriate and effective care for their specific circumstances. For instance, if a school contacts the Crisis Line or if the call involves a youth-specific case, the referral is directed to IHC's SMR. In most situations, MCOT does not initiate direct outreach to IHC's SMR. However, in cases where MCOT is on scene with an individual or has had multiple interactions and determines that IHC's SMR would be a more suitable resource, MCOT will coordinate directly with IHC's SMR team to facilitate a seamless transition of services for the individual and their family.

Additionally, MCOT has the authority to initiate involuntary commitments, whereas IHC's SMR does not. In situations where an involuntary commitment is necessary, MCOT serves as the primary response and may collaborate with IHC's SMR afterwards to connect the family with ongoing supportive services.

Coordination of Safe-Fam hotline calls and youth needs during times when primary SMR services are unavailable (e.g., late evenings, holidays)

When calls are received through SafeFam and SMR is unavailable, we will coordinate with SMR to determine whether the caller can be scheduled for a later time, provided the situation is not acute and does not require immediate intervention. If more immediate assistance is needed, or if the call occurs outside of SMR's normal operating hours, our Crisis Line team will manage the call directly and dispatch MCOT as appropriate to ensure the caller receives timely and appropriate care.

Behavioral Health Crisis Services

Technical Assistance

Is technical assistance requested for Behavioral Health Crisis Response programming or requirements?

- ☐ Yes
☒ No, not at this time.

Please indicate sections requested

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MENTAL HEALTH TREATMENT SERVICES

Mental Health Mandated Services (UCA17-77-301(5)(b))

The following sections are mandated mental health services. Each LA must complete with an overview of how each service for adults and youth, as indicated, will be implemented in their catchment area. If you use a contractor for a service, please attach an excel or google sheet with all contracted providers for the service, a template has been provided.

For the Service Delivery Framework, describe operational and clinical implementation of the service, outreach, training, access procedures, assessment tools, eligibility criteria, family engagement, transition planning.

For the Outcomes Framework, describe specific metrics used to track performance (e.g., recidivism, length of stay, discharge barriers), process for analyzing data to drive continuous quality improvement.

Inpatient Care and Services

Describe how the LA provides Inpatient Care and Services to adults and youth:

Service Delivery Framework:

Psychiatric inpatient treatment is a covered service under Salt Lake County Medicaid. The service is available for adults and youth. It is available at both in- and out-of-network hospitals.

In network hospitals

- Huntsman Mental Health Institute (Adults, adolescents, children)
- Aspen Grove Behavioral Hospital (Adults, adolescents)

Mental Health Mandated Services (UCA17-77-301(5)(b))

- St. Marks (Adults)
- Holy Cross Hospital - Jordan Valley (Adults)
- Holy Cross Hospital - Davis and Salt Lake Behavioral Health (Adults)

Any out-of-network hospital can be approved for emergent inpatient services when in-network beds are full. Over the next three years additional hospitals will be vetted to come in-network for both youth and adults, and updates will be provided during the annual OSUMH audits.

Outcomes Framework:

Optum SLCo produces monthly inpatient utilization management (UM) reports. The reports include admissions by provider, bed days by provider, the average length of stay by provider, admissions by age group, 30-day readmissions by provider and percentage rate, the total number of enrollees, discharges, and the penetration percentage rate of inpatient and all services. This data is reviewed by the director of clinical operations, the medical director, and the UM committee to evaluate inpatient provider outcomes and create plans to address any deficiencies in these areas. Additionally, follow up after hospital discharge reports are created, giving percentages of 7- and 30-day follow-ups. Discharge barriers are evaluated, and plans to address the barriers are created to support members' engagement in follow-up services and improve community tenure.

Residential Care and Services

Will the LA provide Residential Care and Services directly or through a contracted provider? Please describe the frameworks in place for adults and youth, and include a list of contractor(s) or a public-facing link to the list.

	Youth	Adult
Directly	☐	☐
Contracted Provider	☒	☒

Service Delivery Framework:

Mental health residential treatment is an available service in the Optum Salt Lake County Medicaid network of providers for both youth and adults. Access to this level of care is determined by medical necessity review from provider referrals. The LOCUS criteria is used for

Mental Health Mandated Services (UCA17-77-301(5)(b))

adults and CALOCUS-CASI criteria is used for youth for the medical necessity review. While a member is in residential services, Optum care advocates and care coordinators support the transition discharge planning and family engagement needs while doing concurrent reviews for ongoing treatment. Below is a list of the current in-network mental health residential treatment providers.

Utah Behavior Services – Turning Point: A residential program for men and women with serious mental illness.

Volunteers of America: Co-occurring Residential Program for Men

Valley Behavioral Health: Co-occurring Reentry and Empowerment (CORE) program offers residential treatment services to adult male and female criminal offenders with co-occurring substance abuse and mental health disorders.

Odyssey House: Men's and Women's residential treatment for co-occurring mental health and SUD illness

Wasatch Behavioral Health (Aspire): A high-needs mental health adolescent female-only level 6 residential program with intermediate secure care. This program is for individuals who require intensive psychiatric, behavioral, medical, and other structured rehabilitative interventions as well as continuous monitoring.

Youth Care: Youth Care provides residential services to adolescents in Salt Lake County. They are a new network provider with Optum Salt Lake County. They serve both males and females and work with both mental health and substance use issues.

Some examples of more detailed service delivery frameworks

Odyssey House

- Clients must have significant mental health symptoms in order to be eligible.
- Clients are placed on the waitlist according to requirements and enter treatment as soon as a bed becomes available. Referrals can come from any source.
- They are assessed at the admissions department with a full biopsychosocial, C-SSRS, Severe Outcome Questionnaire (SOQ), GAD7, PHQ9, Lifetime Adverse Events, etc.
- Once admitted, clients begin working on a transition plan to identify living arrangements, employment, entrance to ACT, etc.
- Clients work on IMR curriculum to improve symptoms and their understanding of their illness(es).

Mental Health Mandated Services (UCA17-77-301(5)(b))

- Family engagement is encouraged and determined by the client's willingness to have family participation as well as the family members' willingness to participate.

In addition to the above, for the Women's residential treatment facility:

Women's Trauma Groups – Via a psychosocial assessment, clients have to self-identify as having trauma to be placed in The Trauma Recovery and Empowerment Model (TREM) and/or Seeking Safety. Facilitators are trained on the evidence-based model and implement it to fidelity.

VBH

VBH Steps is a male-only, 16-bed, primary mental health residential treatment program designed to help stabilize and support adult clients experiencing minimal or no substance use disorder through medication management, therapy, case management, and benefits coordination. This program provides the same services as our CORE programs. The only difference is that Steps will accept clients with a co-occurring SUD that meets the placement criteria for ASAM 1.0-2.1 level of care, while CORE will only accept clients with a co-occurring SUD that meets the placement criteria for 3.1 level of care. The screening process for Steps is the same as the CORE screening process, including that these clients receive help with medications, obtaining Social Security and Medicaid benefits, as well as a treatment plan for further assistance and housing. Admission to the Steps program is determined by the Steps intake team (clinical team, medical team, unit leadership, and access coordinator) looking at eligibility (sex offender and age), mental health symptoms and SMI, medical symptoms, substance use needs, and involvement in court-ordered treatment.

A mental health diagnosis is a requirement to receive treatment at Valley Steps, and each individual is evaluated based on eligibility. A LOCUS (Level of Care Utilization System) is also administered to assess level of care needs.

CORE

VBH CORE 1 and CORE 2 offer services to adult male and female individuals suffering from co-occurring disorders, including substance use disorders and serious mental illness. These 16-bed residential facilities are designed to provide wraparound services at the time of discharge. CORE 1 and CORE 2 clients can choose to engage in CORE Recovery Management at the time of discharge, where they are offered a lower level of care, case management, and are either living in referred housing or in other housing. The case managers work with clients to help get permanent housing and other services needed to help the clients maintain independence after residential treatment. These programs were implemented due to community requests and have demonstrated impressive outcomes over the years with the ultimate goal of successful reentry and a reduction in jail recidivism.

Mental Health Mandated Services (UCA17-77-301(5)(b))

Outcomes Framework:

Optum SLCo produces a monthly Mental Health Higher level of Care Utilization Management report. The report includes admissions by provider, admissions by age group, discharges by provider, the average length of stay by provider, bed days by provider, number of enrollees, and the penetration percentage rate of mental health residential services. This data is reviewed by the director of clinical operations, the medical director, and the UM committee to evaluate mental health residential provider outcomes and create plans to address any deficiencies in these areas.

Some examples of provider-specific outcome frameworks

Odyssey House

Length of stay

Success rates

Hospitalizations

SOQ scores

Metrics are reviewed monthly and quarterly with the clinical team as well as the agency leadership. Plans are made to address any metrics that are outside of the goals set.

VBH

Valley Steps and CORE 1 & 2:

- We track returning clients on an internal tracking sheet
- Outcomes are produced through the OQ
- We internally track where clients go at discharge
- We use the RANT to screen for criminogenic risk
- Average Length of Stay has reduced from 6-9 month to 2-3 months

Please reference the attached "AP Provider Metrics & Outcomes Sample", from 5 of the network's largest providers, for a detailed sample of data for a wide range of services throughout the network.

Outpatient Care and Services

Describe how the LA will provide Outpatient Care and Services for adults and youth:

Service Delivery Framework:

Optum Salt Lake County Medicaid has a network of 136 outpatient providers serving both adults and youth. Outpatient mental health care and services for adults include general outpatient

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therapy, intensive outpatient treatment (IOP), day treatment (PHP), psychological testing, and Transcranial Magnetic Stimulation (TMS). Outpatient mental health care and services for youth include general outpatient therapy, intensive outpatient treatment (IOP), day treatment (PHP), and psychological testing.

Some examples of provider-specific service delivery frameworks

FSH

First Step House operates an outpatient mental health program that provides services to tenants at both of their permanent supportive housing projects (Central City Apartments, Stratford Apartments, and Medina Place) and to individuals from their SUD programs and the community. Services include prescribing, crisis intervention, personal services, skills development, and individual and group therapy. They also provide supportive living services at Central City Apartments.

VBH

Adults

Valley Behavioral Health (VBH) provides services for adults 18 and older that begin with screening to determine eligibility, funding options, initial services needed, and next steps. A full clinical assessment is then provided to determine needs and level of care. Clients are referred to the most appropriate treatment unit and level of care needed. Once in treatment, the client may receive a medication evaluation, ongoing medication management, individual/group therapy or psychoeducational groups, case management, and peer support services.

We encourage family involvement, but many clients do not have healthy support systems and have burned these bridges with past behaviors.

The RANT and, for older adults, the MoCA are used as assessment tools. While in treatment, client care is monitored through a care plan and the OQ to determine progress.

Additionally, in coordination with the Salt Lake County Division of Aging & Adult Services, VBH provides counseling at senior centers throughout the county, and we provide lectures at 11 senior centers in the county to help support behavioral health issues experienced by these seniors. We also use PEARLS to assess and treat depression in older adults.

Youth

Valley Behavioral Health (VBH) provides outpatient mental health and medication management services for children and youth through Children, Youth, and Family Outpatient Services (CYF OP). Services are delivered from a centralized campus (3725 W 4100 S), which houses outpatient, day treatment, and psychological services to improve access, coordination, and continuity of care. CYF

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OP, CYF Day Treatment, and ACES are CARF-accredited programs.

- CYF OP includes outpatient therapy, medication management, and intensive outpatient services (ACES)
- Day Treatment programs tracks include KIDS, AIM, and DBT tracks for youth ages 5–17
- Same Day Access improves timeliness of assessment and connection to services
- Services are CARF accredited and aligned with evidence-based practices

VBH implemented a Same-Day Access Clinic in early 2024 to improve timely access to care. Youth and families can walk in to receive a clinical assessment, determine level of care, and be connected to appropriate services. Services include individual therapy, family therapy, group therapy, and psychiatric evaluation and medication management. VBH is continuing to expand Substance Use Disorder (SUD) services within both outpatient and day treatment programs.

Eligibility is determined through a full clinical assessment completed by a licensed clinician. A mental health diagnosis is required for treatment, and level of care is determined based on clinical presentation and functional impairment. Standardized tools are used to support assessment and treatment planning. Treatment plans are developed and reviewed by a mental health therapist in collaboration with the youth and family.

Family engagement is a core component of care and includes family therapy, parent skills training, and involvement in treatment planning. Transition planning is incorporated throughout treatment to support step-down to lower levels of care and coordination with schools and community providers.

VBH also provides services for youth with intellectual and developmental disabilities through the Pingree School for Autism (ages 2–22), serving individuals with autism and co-occurring mental health conditions in a day treatment setting. Pingree is a Cognia accredited private school in Pre-K and K-12 and CARF Accreditation. Clients received ABA and mental health support at the program.

Outcomes Framework:

Optum requires the majority of the network's outpatient, mental health treatment providers to use OQ® Measures' tools to monitor treatment progress and improve outcomes using statistically significant measures. When appropriate, providers use other outcome tools for specialized populations.

Some examples of provider-specific outcome frameworks

FSH

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For our mental health services provided through our housing projects, we have the following outcome goals:

- Track average of unique clients served per month compared to last year
- 90% of tenants will maintain housing stability for at least 6 months (all housing)
- 50% of tenants will maintain housing stability for at least 2 years (All permanent housing)
- 65% Veterans exit to permanent housing
- Maintain a negative exit rate of 20% or less
- 55% Veterans exit the program employed

VBH (Adult)

- Outcomes are measured using the OQ (Outcome Questionnaire), GAD, PHQ-9
- Functional improvement is tracked using the DLA-20
- We track length of stay and successful step-down to lower levels of care

VBH internally tracks discharges and next steps after discharge.

VBH (Youth)

VBH tracks outcomes across outpatient and day treatment services using standardized tools and internal data monitoring processes.

- Outcomes are measured using the YOQ (Youth Outcome Questionnaire), GAD, PHQ-9
- Functional improvement is tracked using the DLA-20
- We track length of stay and successful step-down to lower levels of care
- We monitor hospitalizations and higher levels of care to assess stabilization
- We track attendance, engagement, and family participation
- We internally track discharge disposition and barriers to care

Pingree School for Autism outcomes include:

- Use of curriculum-based and skills-based assessments through RethinkEd to measure progress in communication, social, and adaptive functioning
- Individual skill acquisition and behavior reduction tracking aligned with ABA treatment goals
- Progress monitoring tied to Utah Early Learning Standards (Pre-K) and K-12 educational benchmarks
- Ongoing data collection on daily performance, skill generalization, and behavioral outcomes
- Parent engagement and training outcomes to support carryover in the home

VBH reviews data regularly at the program and leadership level to inform continuous quality improvement.

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VBH has implemented a DBT fidelity program, which includes:

- Review of recorded sessions by clinical leadership
- Monitoring adherence to DBT model components (skills training, coaching, structure)
- Ongoing staff training and supervision
- Use of outcome data (YOQ) to assess effectiveness

Please reference the attached “AP Provider Metrics & Outcomes Sample”, from 5 of the network’s largest providers, for a detailed sample of data for a wide range of services throughout the network.

24-hour Crisis Care and Services

See Behavioral Health Crisis Services section above

Psychotropic Medication Management

Does the LA provide psychotropic medication management for adults and youth:

☒ Yes

☐ No, not at this time.

Psychosocial Rehabilitation (*vocational training, skills development*)

Describe how the LA will provide Psychosocial Rehabilitation for adults and youth:

Service Delivery Framework:

Psychosocial Rehabilitation Services (PRS) are primarily delivered in higher levels of care such as intensive outpatient (IOP), day treatment (DAYT), and residential (RES) treatment programs. As the impact of these services is difficult to measure separate from all the other methods used in the milieu, Optum is able to measure the volume of PRS used in these levels of care when billed as a discreet service.

Some examples of provider-specific outcome frameworks

VBH

Adults

VBH provides psychosocial rehabilitative and psychoeducational services for adults based on the

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client's care plan. Services are provided individually or in a group setting. We provide these services mostly in our residential treatment programs. They are offered when needed in outpatient treatment, but organizing groups can be challenging.

VBH

Youth

VBH provides psychoeducation and psychosocial rehabilitation services through structured day treatment and intensive outpatient programming for youth with significant behavioral and emotional challenges. These programs are designed to stabilize symptoms, improve functioning, and prevent higher levels of care.

Program Tracks Include:

ACES (Acute Children's Extended Services)

An after-school partial day treatment program serving youth ages 5–12 for short-term stabilization of acute emotional and behavioral concerns. Services include group therapy, family therapy, parent training, and psychiatric evaluation.

KIDS Intensive Day Services

A short-term, intensive day treatment program for youth ages 5–12 with significant behavioral and emotional challenges. The program focuses on maintaining youth in their homes and communities and preventing more restrictive placements.

DBT Day Treatment

An intensive program serving adolescents (up to 12 at a time) focused on building DBT skills including emotional regulation, distress tolerance, and interpersonal effectiveness. VBH is expanding this program to include a track for youth with mild to moderate eating disorders.

AIM Day Treatment

A structured day treatment program for youth experiencing behavioral health challenges across home, school, and community settings. Services include individual therapy, group therapy, family therapy, and skills training.

Pingree School

Is an MH day treatment facility that supports individuals with autism and co-occurring mental health conditions in a day treatment setting. Pingree is a Cognia-accredited private school in Pre-K and K-12 and CARF-accredited. Clients received ABA and mental health support at the program.

All programs utilize evidence-based practices and are highly structured to support skill development and behavioral stabilization. Psychoeducation is embedded throughout services,

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teaching coping skills, emotional regulation, and behavioral management strategies.

Family engagement is a key component and includes regular family therapy, parent training, and collaboration to support generalization of skills across settings. Transition planning supports reintegration into school, outpatient care, and community-based services.

- Programs are designed to prevent out-of-home placement and higher levels of care
- Services include individual, group, and family-based interventions
- Psychiatric support and medication management are available as needed

Treatment plans are developed and overseen by licensed clinicians

Outcomes Framework:

Through the DBHS' and Optum's treatment record auditing process, PRS group notes are reviewed to ensure required leader-to-client ratios are met, group topics and delivery methods are in alignment with PRS requirements, and the service aligns with the client's treatment goals. The treatment plan is expected to be updated to include methods that reflect the member's current situation and discharge plan. A provider pattern analysis is also conducted to identify the proper use of these codes when billed separately.

An example of a provider-specific outcome framework

VBH

Adults

- Care plan
- OQ
- DLA-20

VBH

Youth

VBH monitors outcomes for psychoeducation and psychosocial rehabilitation programs using both clinical and operational measures.

- Outcomes are measured using YOQ and DLA-20
- We track reduction in crisis behaviors and need for higher levels of care
- We monitor length of stay and successful program completion
- We track school attendance and functioning when applicable
- We monitor family engagement and participation
- We track discharge outcomes and step-down success

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Programs are reviewed regularly to assess effectiveness and identify areas for improvement.

The DBT Day Treatment program includes a formal fidelity monitoring process, including session review and adherence tracking. VBH is expanding fidelity monitoring practices across additional programs, including ABA services, to improve consistency and outcomes.

Case Management

Describe how the LA will provide Case Management for adults and youth:

Service Delivery Framework:

Case management is an available and encouraged service at all levels of care within the Optum Network of providers. Rendering providers are either certified case managers or professionals with licensure allowing for this billable service.

Youth case management: Youth case management providers are listed below with a link to the resource guide for additional providers. Youth case management includes working with parents and caregivers to support the family system needs along with the youth's individual needs. There are no other youth-specific case management adaptations at this time. A list of in-network case management providers can be found here (all "Youth Higher Levels of Care Providers" provide case management to various degrees): [slco-resource-guide.pdf](#)

An example of a provider-specific service delivery framework

VBH

VBH offers an Access Team for adult clients to walk into our Valley Access Clinic at 1020 So. Main location to be assessed for outpatient level of care. This has been operational since the end of December 2023. The clinic is open Monday through Friday, 8:30-2:00. Individuals visiting the clinic receive a clinical assessment. The Access Team can also help connect and link members to the services needed or make referrals to other programs in the community that might be able to assist the client.

Outcomes Framework:

Through DBHS' and Optum's treatment record auditing process, case management activities are monitored, including when the client should have received case management but did not, and findings are made if the agency did not follow through with case management efforts.

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Additionally, through DBHS/Optum's clinical PIP focusing on improving follow-up after hospitalization rates for adults aged 18-64, the effectiveness of members engaging in case management services vs. other types of services can be measured.

An example of a provider-specific outcome framework

VBH

- We have 10 full-time staff who manage the Adult Access.
- All court-involved clients get a RANT.
- We assess alcohol use in the initial screening.
- We help clients determine what funding is available to them.
- A full clinical assessment is provided and level of care is recommended.

Services to Incarcerated Individuals

See Combined Mental Health and Substance Use section below

Coordinate with the Dept of Corrections to Provide Services to High-Risk Habitual Offenders
(UCA 64-13-21(8)(a).

See Combined Mental Health and Substance Use section below

Community Supports

Will the LA provide Community Supports directly or through a contracted provider?

- ☐ Directly
- ☒ Contracted provider (list contractor(s) below)

Service Delivery Framework: Please include in home services, housing supports, family support services and respite. Please note if there are any additional agency processes to access this level of clinical care.

Optum SLCo's network of providers includes those who offer in-home therapeutic services and personal services as prescribed. Optum assists members meeting SMI criteria to receive supportive living services while engaged in ACT programming. Multiple providers offer SLCo Medicaid youth respite services for any family who meets criteria, even if they do not receive other services from the agencies with respite services. Referrals for Family Peer Support Services are received by the SLCo Division of Youth Services who hire certified FPSS to deliver wrap-around services.

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DYS

YS Milestone Transitional Living Program

The Transitional Living Program (TLP) assists in ending the cycle of homelessness and dependency by helping young adults become self-sufficient through access to safe housing, stable employment, and connections to ongoing support and resources. Milestone TLP serves young adults ages 18 to 21 who are experiencing homelessness in Salt Lake County. By providing housing and connecting youth with community resources, participants will move toward self-sufficiency, shifting their lives in a positive direction to break the cycle of homelessness and dependency. YS has three homes in Sandy, a 4-plex apartment in West Valley City, and an apartment complex in Millcreek.

Homeless Youth Walk-in Program

This program provides 24-hour access to food, clothing, laundry, shower facilities, and overnight shelter for homeless youth under age 18. Referrals, crisis counseling, and therapy are also available resources.

Christmas Box House

This program provides 24-hour, 7-day-a-week emergency intake, assessment, and interim residential care for children ages 0 to 21 who are taken into temporary protective custody by DCFS or law enforcement for alleged abuse and neglect.

Shelter Group Home

This program provides 24-hour, 7-day-a-week emergency intake, assessment, and interim residential care for children ages 12 to 21 who are taken into temporary protective custody by DCFS or law enforcement for alleged abuse and neglect.

Crisis Residential

Offers 24/7 crisis timeout service to runaway and ungovernable youth ages 10 to 17. These services can only be accessed as part of the JRC.

Juvenile Receiving Center (JRC)

This program offers screening, evaluation, and referral services to youth, families, and law enforcement 24/7. Services are for youth ages 8 to 17 who need a crisis timeout, are runaway, homeless, or ungovernable, or have committed minor offenses.

FSH

Those with behavioral health conditions can be housed in any of the following locations:

- 46 units of permanent supportive housing at 169 East 200 South
- 75 permanent supportive housing units 439 S Denver St

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- 40 permanent supportive housing units at 426 S. 500 E.

DBHS funds these units through the H2016 supportive living rate. In FY27 through FY29, DBHS intends to support up to four additional permanent supportive housing projects with FSH through the H2016 rate (if projects are granted LIHTC awards).

Fisher House (owned by First Step House) and other MH Court Housing

DBHS supports 6 units of housing at First Step House's Fisher House (a single-family residence for SMI male clients of Mental Health Court). Tenants are supported with onsite case management, food assistance, assistance with medications, and housekeeping. DBHS provides a monthly subsidy for the program tenants.

Additionally, DBHS provides a voucher subsidy for two master-leased units of housing for SMI participants of Mental Health Court. Clients are case managed by community-based outreach teams (most often with VOA and VBH).

RIO Housing

DBHS funds approximately 58 master-leased units for SMI individuals, most often with significant criminal justice involvement/history, which largely inhibits the ability to find safe, reliable housing options in the community. Referrals come to this program from residential mental health programs, ACT/FACT teams, and other outpatient mental health programs. DBHS provides the full subsidy and deposits for these units.

HARP Housing

DBHS provides voucher subsidies (rental assistance and deposits) for up to 30 individuals at any given time who are largely referred into the HARP program from residential SUD treatment. Five of the vouchers are utilized currently (will change in FY27) for VOA ACT consumers. All clients housed on a HARP voucher are provided the opportunity to find their own housing (lists of eligible locations are provided through the intake process), and they must be provided ongoing in-home case management to maintain their vouchers. This is not permanent housing, and as such, clients typically participate between nine months and two years on the HARP voucher.

VBH

Operational and Clinical Implementation

VBH operates 11 supportive housing properties across the Salt Lake Valley, serving 280 individuals with Severe Mental Illness (SMI). Programs range from 24/7 staffed, high-support environments (e.g., Valley Plaza, Valley Woods, Safe Haven, and Valley Oaks) to community-based housing with weekday on-site services. Clinical services include on-site mental health treatment, case management, and, in some programs, Assertive Community Treatment (ACT). Services are

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individualized, recovery-oriented, and designed to support stability, independence, and skill development. DBHS supports these programs through the H2016 supportive living rate.

Outreach

VBH coordinates referrals through partnerships with local hospitals, behavioral health providers, homeless service systems, and community organizations. Outreach prioritizes individuals experiencing homelessness or housing instability who have an SMI diagnosis.

Training

Staff receive ongoing training in mental health treatment, crisis intervention, trauma-informed care, de-escalation, and case management best practices. Specialized training supports delivery of ACT services and independent living skill development.

Access Procedures

Access to housing is primarily referral-based. Prospective residents are screened through the Valley Access Team with referrals from coordinated entry systems, clinical providers, or community partners. Intake includes review of clinical history, housing needs, and program fit.

Assessment Tools

VBH utilizes standardized behavioral health and functional assessments to determine acuity, service needs, and appropriate housing placement. Ongoing assessments inform individualized service planning and track progress in mental health stability and independent living skills.

Eligibility Criteria

Participants must have a documented Severe Mental Illness diagnosis. Priority is given to individuals with high service needs, including those experiencing homelessness or frequent system utilization. Additional criteria may include income eligibility and ability to meet basic tenancy requirements.

Family Engagement

Family involvement is encouraged when appropriate and client-approved. VBH supports family engagement through care coordination, communication, and inclusion in treatment planning to strengthen support systems and promote recovery.

Transition Planning

VBH emphasizes progression toward greater independence. Transition planning begins at intake and includes skill-building (e.g., independent living and vocational training), connection to community resources, and step-down options into less intensive housing. Discharge planning ensures continuity of care and ongoing support in the community.

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PATH (Projects for Assistance in Transition from Homelessness)

Operational and Clinical Implementation

The VBH PATH program delivers community-based outreach, engagement, and wraparound behavioral health services to individuals with Serious Mental Illness (SMI) who are experiencing homelessness or are at imminent risk. Services are anchored by Safe Haven 1 (25-unit supportive housing) and Safe Haven 2 (24-unit supportive housing), which provide low-barrier, housing-focused environments. Clinical services include mental health treatment, substance use services, medication management, and psychosocial rehabilitation. Case management is central to service delivery, with individualized service plans reviewed at least every 90 days to support recovery, stability, and housing retention.

Outreach

PATH-funded outreach prioritizes individuals who are literally homeless, using street outreach and coordination with shelters, community partners, and crisis systems. Engagement is persistent and relationship-based, with a focus on connecting high-need individuals to services and housing.

Training

Staff are trained in trauma-informed care, harm reduction, mental health and substance use treatment, crisis intervention, and engagement of unsheltered populations. Ongoing training ensures fidelity to PATH requirements and best practices in serving chronically homeless individuals.

Access Procedures

Access begins with outreach, screening, and enrollment into PATH services. Individuals may also be referred through community partners. Eligibility is verified prior to enrollment, and clients are connected to Safe Haven or community-based services based on acuity and housing needs.

Assessment Tools

Clients receive screening and diagnostic assessments to determine mental health and substance use needs, functional impairments, and service priorities. Ongoing evaluations inform individualized treatment and service plans, including habilitation, rehabilitation, and supportive service needs.

Eligibility Criteria

Participants must be:

- Experiencing literal homelessness or at imminent risk of homelessness (priority given to those literally homeless)
 - Diagnosed with a Serious Mental Illness
- Safe Haven 1 specifically serves individuals who have been homeless at least three of the

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previous six months, while Safe Haven 2 prioritizes those with chronic homelessness and co-occurring conditions.

Family Engagement

Family engagement is incorporated when appropriate and client approved. Staff support communication, education, and involvement in recovery planning to strengthen natural support systems.

Transition Planning

Transition planning focuses on moving individuals from homelessness to stable, permanent housing and mainstream services. PATH supports transitions to programs such as the Housing Choice Voucher (Section 8) Program, Medicaid, and other public benefits. Clients receive assistance with housing placement, income stabilization, and connection to ongoing community-based care to ensure continuity of services and long-term stability.

VOA

Volunteers of America, Utah, operates permanent supportive housing programs for individuals with serious and persistent mental illness, including Denver Apartments and Theodora. These programs provide 24/7 support, life skills development, and assistance with daily living needs. DBHS supports these programs through the H2016 supportive living rate, and a monthly housing subsidy.

Housing services are delivered using a supportive housing model with multidisciplinary teams. Clients are referred through community partners or internal programs and must meet eligibility criteria related to housing instability and behavioral health needs. Services include case management, skills training, and coordination of care. Transition planning focuses on movement to independent or less intensive housing settings when appropriate.

VOA also provides housing case management services at the Geraldine E. King Women's Resource Center, supporting transitions from homelessness to stable housing. The Homeless Youth Resource Center serves youth ages 18–23, supporting housing, education, and employment.

Clinical Consultants

Clinical Consultants offers up to 40 units of supportive housing for SMI individuals through their Featherstone boarding home. Like other boarding homes, this program provides 24/7 support, life skills development, and assistance with daily living needs. In FY27, Clinical Consultants will be opening a new boarding home with approximately 30 additional units. The facility provides food, weekly housekeeping support, pest control, and medication assistance (medications are prescribed and delivered by ACT teams and are then safely stored and provided during medication times by the facilities). DBHS supports these programs through the H2016 supportive

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living rate and a monthly housing subsidy.

Odyssey House

Odyssey House currently operates 28 units of supportive housing for SMI individuals (broken into a 10-unit and an 18-unit facility, both of which serve males). These programs provide 24/7 support, life skills development, and assistance with daily living needs. In FY27, Odyssey will be opening two new boarding homes with approximately 30 beds each (one male and one female program). In all of their homes, Odyssey House provides food, weekly housekeeping support, pest control, and medication assistance (medications are prescribed and delivered by ACT teams and are then safely stored and provided during medication times by the facilities). DBHS supports these programs through the H2016 supportive living rate and a monthly housing subsidy.

Additionally, during FY26, Odyssey House has operated a pilot program offering recovery housing (as a transitional step between residential mental health treatment and access to more permanent housing) for SMI individuals. Their program has a capacity of 22 (two adjacent buildings with separate male and female units). They provide some food and medication assistance, along with a reduced support staff (as compared to the boarding home model funded through H2016). Clients can stay rent-free for up to four months while awaiting their more permanent housing and must be referred from one of DBHS's residential mental health programs.

Friends of Switchpoint

Switchpoint operates two separate boarding homes for SMI consumers. Canyon Rim is a 41-unit facility for SMI females, and Jordan Trails is a 26-unit boarding home for SMI males. Both programs offer 24/7 support, life skills development, and assistance with daily living needs. Additionally, Switchpoint provides meals, professional cleaning, and assistance with medication (medications are prescribed and delivered by ACT teams and are then safely stored and provided during medication times by the facilities). DBHS supports these programs through the H2016 supportive living rate and a monthly housing subsidy.

Oasis Housing

Oasis Housing, Inc. operates two separate boarding homes for SMI consumers. Both homes are single-family residences: a 6-bed female home and a 12-bed male home. Oasis provides 24/7 support, life skills development, and assistance with daily living needs. Additionally, assistance is provided for food and preparation and medication assistance (meds are all provided and managed by clinical teams but may be safely stored and provided at medication times by the facilities). DBHS supports these programs through a monthly housing subsidy.

Sober Living Program

The Sober Living Program (described in greater detail in the Recovery Support Services section) is

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generally an SUD focused program but often houses individuals dealing with mental health or co-occurring disorders. DBHS manages this program internally and contracts with various recovery residences to provide housing for over 300 individuals monthly.

Outcomes Framework: *Please include in home services, housing supports, family support services and respite.*

At this time, Optum has the ability to measure the volume of these services delivered to Optum SLCo members. Additional reporting may be developed to identify how many individuals receiving these reports maintain community tenure and for how long. Optum will work with DBHS to determine what outcomes measurements would be most valuable for these specialized services.

DYS

- Track percentage of homeless young adults who are successfully discharged with safe and stable housing
- Track percentage of homeless young adults who are successfully discharged with employment and/or school plan
- Follow-up interviews at 3, 6, 9 and 12 months after exiting TLP to determine if young adults remain housed
- Risky Behaviors Teen Questionnaire
- Education and employment tracked at entrance and exit from program

VBH

Performance Metrics

VBH tracks a range of housing stability, clinical, and operational metrics across its 11 supportive housing properties serving 280 individuals with SMI. Key indicators include the following:

- Housing stability and retention rates (length of stay, successful tenancy duration)
- Recidivism and system utilization, including returns to homelessness, hospitalizations, and crisis service use
- Length of stay by program type (transitional vs. permanent supportive housing)
- Discharge outcomes and barriers, including reasons for exit (successful transition, eviction, higher level of care)
- Engagement in services, such as participation in mental health treatment, case management, and ACT services where applicable
- Progress in independent living skills and vocational outcomes

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- Occupancy rates and program capacity utilization across properties

Data Analysis and Continuous Quality Improvement (CQI)

VBH utilizes centralized data to collect and monitor program and client-level outcomes across all properties, including both 24/7 staffed sites (e.g., Valley Plaza, Valley Woods, Safe Haven, Valley Oaks) and community-based programs with outpatient support. Data is reviewed on a regular basis (monthly and quarterly) by program leadership and clinical teams to identify trends, gaps, and opportunities for improvement.

CQI processes include:

- Routine performance reviews and dashboard reporting to monitor key metrics across sites
- Case review and interdisciplinary team meetings to address high-utilizers, discharge barriers, and service engagement challenges
- Program comparisons to evaluate effectiveness across varying levels of care (e.g., 24/7 staffed vs. community-based models)
- Targeted quality improvement initiatives, such as enhancing service engagement, reducing returns to homelessness, and improving transition outcomes
- Staff feedback and training adjustments based on data trends and identified needs

Findings from data analysis directly inform program modifications, resource allocation, and staff training to ensure services remain responsive, effective, and aligned with best practices in supportive housing and behavioral health care.

PATH

Performance Metrics

The PATH program tracks key performance indicators aligned with outreach, engagement, housing stability, and clinical outcomes for individuals with SMI experiencing homelessness.

Metrics include:

- Outreach and engagement rates, including number of unsheltered individuals contacted, enrolled, and successfully connected to services
- Housing outcomes, including placement into permanent housing, and housing retention rates
- Length of stay in transitional housing and time to placement in permanent housing
- Recidivism, including returns to homelessness, crisis services, or inpatient care
- Service utilization and engagement, including participation in mental health treatment, substance use services, and case management
- Benefit acquisition, such as enrollment in SSI/SSDI, Medicaid, and other income supports
- Discharge outcomes and barriers, including reasons for exit, delays in housing placement, and challenges related to documentation, income, or clinical stability
- Transition to mainstream services, including successful linkage to housing subsidies, Medicaid,

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and other long-term supports

Data Analysis and Continuous Quality Improvement (CQI)

PATH program data is collected through a centralized system and reviewed regularly (monthly and quarterly) to monitor performance across outreach, Safe Haven programs, and community-based services. Program leadership and clinical teams analyze trends in engagement, housing placement, retention, and service utilization.

CQI activities include:

- Routine data review and performance dashboards to track progress toward program goals
- Case conferencing and multidisciplinary team reviews to address high-need clients, service gaps, and discharge barriers
- Monitoring timeliness and effectiveness of referrals to mental health, substance use, medical, and housing services
- Evaluation of transition outcomes to ensure successful linkage to mainstream resources
- Targeted quality improvement initiatives, such as improving outreach engagement, reducing time to housing placement, and increasing benefit acquisition rates
- Ongoing staff training and supervision informed by data trends and identified service gaps

Findings from these processes are used to refine outreach strategies, improve service coordination, reduce barriers to housing, and strengthen long-term stability outcomes for PATH-enrolled individuals.

VOA

- Housing stability
- Length of stay
- Successful transitions to permanent housing
- Transitions to residential treatment services, if needed.

Data is reviewed to identify barriers to housing retention and inform program improvements.

All other housing programs described above are reviewed through onsite and desk audits for quality of housing. Housing Connect utilizes various HUD tools to ensure all laws, regulations, and local statutes are being followed. DBHS receives monthly housing utilization reports from Housing Connect (one sample included in the report compilation) which monitors adherence to any contract requirements, capacity, and financial spend. Additional client-based reports are provided as well by Housing Connect. These are reviewed with Housing Connect, as well as with individual providers as any issues arise.

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Metrics for the Sober Living Program are described in the Recovery Support Services section.

Consultation and Education Services

Will the LA provide Consultation and Education Services directly or through a contracted provider?

- ☒ Directly
☐ Contracted provider (list contractor(s) below)

Service Delivery Framework: Please include case consultations and collaboration with county agencies, public education and public information.

Consultation and education services are provided in combination with DBHS and Optum Salt Lake County Medicaid. Optum has a Recovery and Resiliency (R&R) team that consists of peer support specialists (adult services). This team provides education and consultation to consumers, consumer-run organizations, their contracted providers, community partners and stakeholders, and centers of learning.

This team continues to conduct numerous trainings in the community, such as:

- Adult Mental Health First Aid (MHFA).
- Certified Peer Support Specialist trainings continue to be offered by Optum each year
- Peer support supervisors' training
- Forensics Peer support training.

Optum has a provider training platform for network providers to access training that supports better service delivery.

DBHS is deeply rooted in the community with many allied partners. Through these partnerships, DBHS and Optum provide consultation to multiple agencies and providers in the community regarding shared clients and concerns. Staff have frequent opportunities to educate the public through all forms of media, community fairs, and other venues.

Technical Assistance

Is technical assistance requested for Mental Health Mandated Services programming or requirements?

- ☐ Yes
☒ No, not at this time.

Mental Health Mandated Services (UCA17-77-301(5)(b))

Please indicate sections requested

MENTAL HEALTH OFFICE DIRECTIVES

Mental Health Office Directives

The following sections stem from the FY27 SUMH Office Directives that require a LA response.

For the Service Delivery Framework, describe operational and clinical implementation of the service, outreach, training, access procedures, assessment tools, eligibility criteria, family engagement, transition planning.

For the Outcomes Framework, describe specific metrics used to track performance (e.g., recidivism, length of stay, discharge barriers), process for analyzing data to drive continuous quality improvement.

Mental Health Office Directives Clinical Care

Assertive Community Treatment (ACT)

Will the LA provide ACT team programming (more than one box can be checked if multiple teams)?

- ☒ Yes, with a DACTS/TMACT score greater than 4.0
- ☒ Yes, with a DACTS/TMACT score between 3.0 and 4.0.
- ☐ No, not at this time

Please indicate the number of ACT or ACT-like teams in the catchment area and how many individuals are served. For network models, please note the provider agencies who deliver this service.

Currently, DBHS has five ACT teams with three agencies. These agencies are Odyssey House, with two ACT teams (one is a Forensics ACT team); Volunteers of America, with two ACT teams; and Valley Behavioral Health, with one ACT team. Each team has a capacity of 100 clients, so the total capacity with the current ACT teams is 500 clients. The combined census for all ACT teams as of this writing is 460, with three ACT teams at full capacity and two ACT teams accepting clients.

Because the ACT teams are nearing capacity for all, we are in the process of contracting with First Step House for a 100-person ACT team. They are very close to finalizing a building and hope to be

Mental Health Office Directives

operating on or about July 1, 2026.

Additionally, because we like to have a minimum of two ACT teams for providers to refer into, we are presently in the beginning stages of talks with another agency for another 100-person ACT team. That team will most likely not be operational until January 1, 2027.

High-Need Client Care Plan

Does the LA have an agency plan, as defined in the SUMH Office Directives, to address appropriate service provision for individuals with complex behavioral health conditions who require frequent engagement, have multiple systems involvement, and who are clinically indicated to need multiple mental health supports to remain in the community?

- ☐ Yes for adults
- ☐ Yes for youth
- ☒ No, not at this time

Please submit or insert a public-facing link to the agency plan

At this time there is no public-facing plan to link to, but it will be available on both the Optum Salt Lake County and DBHS websites by July 1, 2027. There are multiple ongoing activities to support the service provisions of high-needs clients.

Adults:

- Optum Complex needs UM Committee
- Provider case staffings
- Civil Commitment court Liaison
- Member follow-up after hospitalization
- ACT referrals

Youth:

- Optum Complex needs UM committee
- Multi-agency Staffing (MAS)
- Provider case staffings
- Member follow-up after hospitalization
- Intensive Care Coordination referrals
- JJS Youth Services Model high-fidelity wrap program referrals

Data is collected on hospital readmission rates, follow-up after hospitalization percentages,

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inpatient lengths of stay, discharge barrier analysis, and civil commitments dropped to evaluate outcomes.

Utah State Hospital (USH) Coordination

Please document the LAs identified USH liaison name and email for compliance with administrative rule UCA R523-2-11.

Adult

Jennifer Goodson, LCSW, jennifer_goodson@optum.com, and Daniel Amosa, RN, daniel_amosa@optum.com.

Youth

Sandy Meyer, LCSW, sandy.meyer@optum.com.

Technical Assistance

Is technical assistance requested for any components of SUMH Office Directives Clinical Care programming or requirements section?

- ☐ Yes
☒ No, not at this time.

Please indicate sections requested

Mental Health Office Directives - Quality and Access Improvement

First Episode Psychosis (FEP) (service code: EBI)

Will the LA provide First Episode Psychosis (FEP) services ?

- ☐ Directly
☒ Contracted provider (list contractor(s))
☐ No, not at this time

If yes, are services provided to fidelity?

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- ☒ Yes
☐ No, not at this time

Service Delivery Framework:

Volunteers of America, Utah, is the only DBHS agency that provides FEP services through a Coordinated Specialty Care (CSC) PREP Team serving individuals experiencing early psychosis or at high clinical risk. Services include case management, psychiatric care, therapy, peer support, family education, and supported employment and education, delivered in clinic and community settings.

Services are delivered in alignment with the CSC PREP model, emphasizing early identification, rapid access, and coordinated, team-based care.

Referrals are accepted from community partners, with screening conducted using PRIME and eligibility confirmed through SIPS. Family involvement is incorporated throughout treatment, and transition planning supports step-down to appropriate levels of care.

Outcomes Framework:

- Engagement
- Symptom improvement
- Participation in education and employment, with the NOMS tool, using data to support ongoing quality improvement and fidelity.

Clinical High-Risk for Psychosis (CHRP) (Service Code EBI1/EBI2)

Will the LA provide Clinical High-Risk for Psychosis (CHRP) services ?

- ☐ Directly
☒ Contracted provider (list contractor(s))
☐ No, not at this time

Service Delivery Framework:

VOA

See “**First Episode Psychosis (FEP)** (service code: EBI)”

Additionally, Individuals referred to the Clinical High Risk for Psychosis (CHRP) programs undergo specialized screening and assessment to determine program eligibility and

Mental Health Office Directives

treatment needs. The Structured Interview for Psychosis-Risk Syndromes (SIPS) is used to assess the presence of psychosis-risk symptoms and determine whether an individual meets criteria for a clinical high-risk syndrome or first episode psychosis. The SIPS is required for CHRP participants.

Assessment results are reviewed by the multidisciplinary team to ensure individuals are connected to the most appropriate level of care and evidence-based intervention.

Outcomes Framework:

VOA

See “**First Episode Psychosis (FEP)** (service code: EBI)”

Transition-age youth (TAY, 14-26 years of age)

Please identify the LAs identified TAY liaison for this SUMH office directive including name, email address and job role/title:

Teresa Baker, CMHC, teresa.baker@optum.com, Care Advocate/UM supervisor-Optum Salt Lake County Medicaid.

Infant and Early Childhood Mental Health (IECMH)

Does the LA have a provider(s) trained in IECMH.

- ☒ Yes
- ☒ Contracted provider
- ☐ No, not at this time

As applicable,

Please identify a public-facing link or a list of the provider(s) or team trained (direct or contracted). For network models, please identify contracted agencies who specialize in this service

The Children’s Center is an in-network provider with Optum Salt Lake County Medicaid and has providers trained in IECMH.

Describe the training that the provider(s) have received on developmentally appropriate screening, diagnosis, and evidence-based treatment modalities.

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The training received by providers at the Children's Center includes:

- Diagnostic Training - DC:0-5™: Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood
- Child Parent Psychotherapy (CPP)
- Attachment, Regulation, and Competency (ARC)
- Attachment, Biobehavioral Catchup (ABC)
- Child Adult Relationship Enhancement (CARE)
- Facilitating Attuned Interactions (FAN)

The Children's Center provides monthly training and teleconsultation webinars on screening, diagnosis, and evidence-based modalities. These are shared with the Salt Lake County network on a monthly basis.

Behavioral Health Home (Service Code: BHH)

Does the LA provide behavioral health home services ?

- ☐ Directly
- ☐ Contracted provider (list contractor(s))
- ☒ No, not at this time; **only Weber County receives these funds**

Service Delivery Framework:

Outcomes Framework:

Intellectual and Developmental Disabilities (IDD)

Please identify the LAs identified IDD liaison for this SUMH office directive. Include name, email and job role/title:

Sandy Meyer, LCSW, sandy.meyer@optum.com, youth care coordinator and Utah State Hospital liaison.

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Does the LA have a provider(s) trained in IDD and co-occurring mental health.

- ☒ Yes
- ☒ Contracted provider
- ☐ No, not at this time

As applicable,

Please identify a public-facing link or a list of the provider(s) or team trained (direct or contracted). For network models, please identify contracted agencies who specialize in this service. LAs are encouraged to have a provider listed on the IDD provider list website.

In the Optum Salt Lake County Medicaid network, there are trained providers to work with individuals with IDD and co-occurring mental health. These providers include:

- Aspen Ridge Counseling
- Volunteers of America
- Valley Behavioral Health
- Fourth Street Clinic
- Psychiatric and Behavioral Solutions
- Silverado Counseling services

A public-facing link of a list of the IDD providers will be available on the Optum Salt Lake County and DBHS websites by July 1, 2026.

Mental Health Early Intervention (Service Code: EIM)

Will the LA implement Mental Health Early Intervention (MHEI) programming for the population outlined in SUMH Office Directives?

- ☐ Directly
- ☒ Contracted/partnership provider (list contractor(s) below)
- ☐ Not at this time

Please indicate what allowable services under the EIM service code will be used for:

- ☒ School based behavioral health services
- ☐ Youth MCOT
- ☒ Family Peer Support Services
- ☐ Other pre-approved early mental health interventions

Service Delivery Framework:

Odyssey House is the only provider who receives MHEI funding for school-based behavioral health

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services.

- School administrators, teachers, and parents can submit referrals for the school-based program.
- Referrals are reviewed by the intake specialist and clinical director.
- Students are eligible as long as they are willing to participate, their guardians provide approval, and the issue the student is facing is something they can address in a general outpatient setting.
- An intake assessment is completed by the therapist embedded in the school, and treatment recommendations are made regarding frequency of sessions and family therapy. Students are typically seen once a week with family therapy as needed and if parents are willing to participate.
- The intake assessment includes a full biopsychosocial with several evidence-based questionnaires, including GAD7, PHQ9, CSSRS, and outcome questionnaires.
- Transition planning begins once the client enters treatment and includes formal and informal supports the student can access.

Salt Lake County Division of Youth Services (DYS) is the only provider who receives funding for Family Peer Support Services (FPSS).

Families/clients experiencing mental health, behavioral, or substance misuse issues are identified by the various agencies within the Salt Lake County region as a family who could benefit from the services the FPSS program offers. Families experiencing barriers to services such as lack of understanding and/or navigation skills for systems such as child welfare, juvenile courts, and schools are identified and referred.

The continuum of care within the Salt Lake County region is structured in a way to support an appropriate referral. Any youth under the age of 24 still living at home with a behavioral health need, WITHOUT 2 arms of DHS systems involved, would be an appropriate referral. Peer support services are rendered to the parents of a youth under the age of 16 per Medicaid. No income verification or insurance coverage is required of the family to receive services. FPSSs take youth/children ages 3 years – 21 years but can make exceptions for clients still living at home up to age 24 years.

There are currently 8 FPSSs placed with 5 agencies throughout Salt Lake County. FPSSs are anchored at the following agencies or organizations:

- 1 FTE Salt Lake County Youth Services
- 1 FTE Granite Connections and Roosevelt Continuation School
- 2 FTE State of Utah Division of Child and Family Services (DCFS)
- 1 FTE Family Support Center

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- 3 FTE General (fill in when demand becomes too great for existing FTEs within above sites and handle requests for services from consumers who are not part of the above sites)

Please identify name, email and title of the individual who will submit quarterly and annual outcome reporting:

Brian L. Currie, LCSW, Associate Director of Treatment Services

Older Adults

Has the LA developed and is it maintaining a strategic plan for service delivery programming for the older adult population outlined in SUMH Office Directives?

- ☐ Yes
☒ No, not at this time

If applicable, please include a link to a summary document or website to address this question or briefly summarize how the LA intends to provide service delivery to this population.

Services are available in the Optum Salt Lake County Medicaid network of providers specific to older adults for outpatient treatment in-office or at care facilities. The service providers include:

- Valley Behavioral Health - Master's program
- Valley Behavioral Health – SRS Program (skilled nursing and assisted living)
- Beacon Therapy
- Thrive On
- Deborah Christensen and Associates

Perinatal Mental Health

Identify the provider(s) trained in perinatal mental health to the requirement outlined in the SUMH Office Directives. For network models, please identify contracted agencies who specialize in this service.

- Aspen Ridge Counseling Center
- Child and Family Empowerment Services
- Reach Counseling
- Wasatch Behavioral Health

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Is this provider(s) listed on the Utah Maternal Mental Health Network website?

- ☒ Yes
☐ No, not at this time

Utah Behavioral Health Planning and Advisory Council (UBHPAC)

Please identify the LAs identified UBHPAC representative for this SUMH office directive including name, email address and job role/title:

Lisa Hancock / Recovery & Resiliency Supervisor, lisa.hancock@optum.com.

***Please note that UBHPAC meets every other month for 2 hours. The agency should consider a person with lived experience who is a consumer of services or peer as the LA representative.*

Unfunded clients

Describe how the LA intends to deliver the services/programs to **unfunded clients**. This must include:

1) The LAs process to help the client access to insurance

Efforts to assist the uninsured population occur through a coordinated and concerted effort to enroll in Medicaid, CHIP, Marketplace Plans and Medicare.

For many years, DBHS has funded a Department of Workforce Services (DWS) Medicaid eligibility specialist, drawing down federal dollars as a match to assist DBHS' network of providers with enrollment into Medicaid. Additional DWS assistance is housed in one of the network's largest providers, Valley Behavioral Health (VBH).

Additionally, each DBHS provider is well versed and required by contract to screen all individuals admitted for services for Medicaid eligibility. The individual is screened as part of the intake process, or very shortly thereafter, by the provider. If the individual meets Medicaid eligibility requirements, then the provider will assist the individual to complete the necessary paperwork. The providers have become very adept with enrolling individuals into Medicaid.

In the fall of 2022, DBHS began assisting the Road Home's Homeless Resource Centers (HRCs) in developing collaborations with Take Care Utah to enroll clients in Medicaid or other health plans. Volunteers of America (VOA) HRC already had a process in place.

Today, Take Care Utah works in some capacity with around 100 organizations and sources of

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clients, many of which are individuals with behavioral health conditions. They enroll clients from many of these partner agencies, but the specific process takes different forms. At the jails and prison, for example, they are at multiple sites on a weekly basis. Others are less frequent. With others they have arranged a referral process so they get spreadsheets of uninsured folks from various organizations to do follow-up. They meet both in person and remotely depending on what works best for their partners.

Utah's Justice Involved Medicaid waiver was approved to allow the billing of Medicaid for eligible individuals 90 days pre-release from jail. The CATS program, beginning 3-1-26, began utilizing this benefit. Eligible individuals are enrolled in the Justice Involved Medicaid plan while incarcerated, and upon successful completion of the program, a TAM Medicaid application change form is submitted to the Department of Workforce Services (DWS) to ensure continuity of benefits upon release.

The Salt Lake County jail is actively planning for additional enrollment efforts in preparation for the rollout of this process for the broader population.

Unfortunately, HR1 is anticipated to impact Medicaid enrollment dramatically. Through new community engagement requirements, new retroactive eligibility changes, more frequent redeterminations, and the elimination of lawfully present immigrant populations (refugees, asylees, humanitarian parolees, and survivors of trafficking or domestic violence), 7,600 - 16,000 (depending on how these are implemented) individuals in Salt Lake County are expected to lose their Medicaid benefit. Already, ~17,000 individuals fell off Marketplace plans in Salt Lake County between the time the bill was signed and 2026. It seems evident that the number of low-income uninsured and underinsured will increase, and we will see an increase in administrative burden to our provider network as they attempt to help clients navigate these new requirements.

We will continue ongoing enrollment trainings for the provider network during monthly provider network meetings as needed.

2) LAs policies related to unfunded client service provision (ie. sliding scale, time limited services)

DBHS does have a sliding fee scale, which includes the ability to waive all fees if the client does not have the ability to pay. Services are not time-limited and are always based off of medical necessity.

3) Service continuum accessible to unfunded clients.

Those without funding have access to the full continuum of services that DBHS provides. This

Mental Health Office Directives

includes anything from inpatient care to standard outpatient treatment. However, funding for the DBHS' uninsured mental health clients is extremely limited, and therefore Salt Lake County carefully prioritizes the funding to the following programs.

- HMHI - Inpatient hospitalization
- Odyssey House, VOA, and VBH for ACT, with FSH expected to start accepting clients on July 1, 2026.
- VBH for the various services that they provide. This includes coordination with the Salt Lake County Division of Aging & Adult Services, providing counseling at senior centers throughout the county. VBH provides lectures at 11 senior centers in the county to help support behavioral health issues experienced by these seniors. They also use PEARLS to assess and treat depression in older adults.
- DYS provides services for youth/children ages 3 years to 21 years but can make exceptions for clients still living at home up to age 24 years. Services include individual or family therapy. Additionally, Youth Services Prevention offers two programs for parents, Guiding Good Choices and Staying Connected with Your Teen, offering parents an opportunity to reduce the risk factors associated with teenage drug use and improve communication with their teens to strengthen family bonds. Youth Services Prevention offers three programs for youth including Mood Enhancement (ME) Time and the Body Project. DYS also offers afterschool programs at 11 different sites, K-12, in West Valley, Magna, and Kearns. DYS also offers The Body Project online and at various schools and community locations throughout Salt Lake County.
- The Utah Department of Health and Human Services (DHHS) Refugee Health and TB Control Program subcontracts with four different organizations: AAU, Catholic Community Services, International Rescue Committee, and THRIVE Center for Survivors of Torture (formerly Utah Health and Human Rights) to provide mental health services for refugees and new arrivals.
- Volunteers of America, Utah, operates the Homeless Mental Health Outreach Program centered at the main Salt Lake City Library on 400 South and 200 East and additional branches throughout Salt Lake County. Services include behavioral health support, housing coordination, and staff training for library personnel. Additionally, services are voluntary and accessible without formal enrollment.

Technical Assistance

Is technical assistance requested for any components of SUMH Office Directives Quality and access improvement programming or requirements section?

☐ Yes

☒ No, not at this time.

Please indicate sections requested.

Mental Health Office Directives

SUBSTANCE USE DISORDER TREATMENT SERVICES

Substance Use - Adults

The following sections are the **Substance Use Adult services** requirement from both the LA contract and the SUMH Office Directives.

For the Service Delivery Framework, describe operational and clinical implementation of the service, outreach, training, access procedures, assessment tools, eligibility criteria, family engagement, transition planning.

For the Outcomes Framework, describe specific metrics used to track performance (e.g., recidivism, length of stay, discharge barriers), process for analyzing data to drive continuous quality improvement.

Early Intervention

Will the LA provide Early Intervention directly or through a contracted provider?

- ☐ Directly
☒ Contracted provider (Please include a list or a link of contracted provider)

Service Delivery Framework: Please also include services provided to an individual not seeking clinical treatment for substance use, including education, skills development, services to reduce the harms associated with substance misuse and to reduce risk behaviors before they lead to injury, etc.

The Salt Lake County Division of Behavioral Health Services (DBHS), acting as the local substance use authority in Salt Lake County, has contracted with Assessment & Referral Services (ARS) at the University of Utah's Department of Psychiatry and the Huntsman Mental Health Institute (HMHI) since 2003 to provide comprehensive screening and assessment for individuals who have been charged with or convicted of Driving Under the Influence (DUI) of Alcohol/Drugs or Impaired Driving. ARS is the only agency contracted with DBHS to provide assessments for DUI, early intervention.

ARS provides assessments only; thus, they are able to provide objective assessments, eliminating any conflict of interest to the individual related to referrals for education or treatment. ARS screens for an offender's ability to pay for education and treatment services and refers to

Substance Use - Adults

resources (such as applying for Medicaid) to ensure that finances are not a barrier to completing referrals. If an offender has health insurance or the ability to self-pay for services, they are referred to an agency that accepts their insurance or can provide appropriate treatment services that are affordable. ARS has also been given authority to grant Salt Lake County subsidies to individuals who do not have the means to pay for treatment services, do not qualify for Medicaid, and have little to no income and no health insurance. Thus, finances, or the lack thereof, do not present a barrier for compliance with the court-ordered assessment or ARS recommendations related to their DUI.

ARS assessments include a full biopsychosocial interview, the SASSI-4, the Risk & Needs Triage, information from the Bureau of Criminal Investigation, the Colombia-Suicide Severity Rating Scale, GAD-7, PHQ-9, LS/CMI information when applicable and provided by their supervised probationer, collateral information from a multitude of sources when required, The Diagnostic & Statistical Manual of Mental Health Disorders, Fifth Edition, and the American Society of Addiction Medicine Placement Criteria.

If individuals do not meet the criteria for a substance use disorder, they are referred to Prime for Life, the minimum mandatory requirement for DUI offenders. ARS refers only to providers certified to administer Prime for Life and those listed on the Department of Human Services website.

If an offender meets criteria for a substance use disorder requiring treatment, they are referred to an agency that is licensed by the State to provide substance use disorder treatment.

ARS estimates that approximately 30% of DUI offenders do not meet the criteria for a substance use disorder and thus are referred to Prime for Life, while approximately 70% of individuals meet diagnostic criteria for one or more substance use disorders and are referred to treatment.

ARS is located in a University of Utah building that also houses the HMHI Downtown Clinic, primarily specializing in mental health services, and can also provide substance-related services, as well as the Utah Naloxone Wellness Center for additional recovery support services.

Outcomes Framework:

- Completion of biopsychosocial assessment.
- Referral to Prime for Life private provider.

Substance Use - Adults

Ambulatory Care and Withdrawal Management (Detox) ASAM IV-D, III.7-D, III.2-D, II-D or I-D (Contract 5.2 b)

Will the LA provide Ambulatory Care and Withdrawal Management

- ☐ Directly
- ☒ Contracted provider (Please include a list or a link of contracted providers)
- ☐ Referral (non contracted provider, service is unfunded but referrals provided)

What level of Ambulatory Care and Withdrawal Management service are funded by the LA?

- ☐ ASAM IV-D Medically Managed Intensive Inpatient Detoxification
- ☐ ASAM III.7-D Medically Monitored Inpatient Detoxification
- ☐ ASAM III.2-D Clinically Managed Residential Detoxification
- ☒ ASAM III.D Residential/Inpatient Detoxification
- ☒ ASAM II-D Ambulatory Detoxification with Extended on-site monitoring
- ☒ ASAM I-D Ambulatory Detoxification without Extended on-site monitoring
- ☐ None of these levels are available.

If not available, what are the plans to develop and provide this level of care?

N/A

Service Delivery Framework:

Volunteers of America is the only agency contracted with DBHS to provide residential withdrawal management services.

1. Setting & Population: Social-model, residential withdrawal management for adults, including women with dependent children, serving homeless and low-income individuals.
2. Access & Admissions: 24/7 walk-in access; withdrawal-risk screening; admission for up to 14 days when medically necessary, with an additional 7 days available for treatment linkage; immediate connection to case management.
3. Assessment Tools: ASAM criteria, biopsychosocial assessment (via partners), withdrawal monitoring, safety screening, and treatment readiness evaluation.
4. Eligibility: Adults 18+, Salt Lake County residents in need of withdrawal management services. We use federal and county priority guidelines for SUD treatment.
 - Trauma-informed, recovery-oriented environment
 - Case management for treatment linkage, Medicaid enrollment, housing, legal needs, and family reconnection
 - Peer support, 12-step meetings, harm reduction services
 - Access to MAT through community partners
 - Detoxification Access Transportation Team: In partnership with law enforcement and

Substance Use - Adults

community providers, VOA offers transportation for individuals experiencing intoxication to ensure timely and safe access to detoxification services.

5. Family Engagement: Women may bring children (ages 10 and under), reducing childcare barriers.
6. Transition Planning: Warm handoffs to SUD treatment, primary care, housing, and community supports, with priority on direct transitions to treatment when possible.

White Tree Medical is an Optum provider and currently the only provider specializing in outpatient medical detoxification in Utah. They ensure people understand, both clients and providers, that they do not offer any treatment beyond this. They do have a small staff of clinicians whose main focus is to assess the clients and provide case management services. They also emphasize that formal SUD treatment is not a requisite for the outpatient medical detox. While they do encourage a person to seek treatment through an ASAM-based assessment, there is a certain population that is currently only ready to be detoxified from whichever substance(s) they are misusing, and so White Tree Medical's mission is to give clients an avenue to do this without the requirement of treatment. They are located on the south end of the Salt Lake Valley but are very accustomed to providing services via telehealth, also.

Outcomes Framework:

Volunteers of America

1. Key Metrics Tracked:
 - Completion of withdrawal management episode
 - Linkage to SUD treatment
 - MAT engagement
 - Length of stay
 - Discharge barriers (e.g., lack of housing, benefits, treatment access)
 - Recidivism/return to detox
 - Medicaid enrollment success
2. Data Review & CQI:
 - Monthly review of census, internal success reports, LOS, referral outcomes, and discharge patterns
 - Identification of bottlenecks in admissions, internal flow, and treatment linkage
 - Adjustments to workflows, staffing, and referral pathways based on trends
 - Collaboration with county and community partners to improve access and clear service connection pathways

White Tree Medical

- Completion of withdrawal management episode

Substance Use - Adults

- MAT engagement
- Length of stay
- Discharge barriers (e.g., lack of housing, benefits, treatment access)
- Recidivism/return to detox
- Medicaid or other payer enrollment success

The above items are reviewed internally on a regular basis, and adjustments to the treatment model are made accordingly.

Please reference the attached “AP Provider Metrics & Outcomes Sample”, from 5 of the network’s largest providers, for a detailed sample of data for a wide range of services throughout the network.

Residential Care and Services (ASAM III.7, III.5, III.3, III.1) (Contract 5.2 b)

Will the LA provide Residential Care and Services directly or through a contracted provider?

- ☐ Directly
- ☒ Contracted provider (Please include a list of providers or a link to contracted providers below)
- ☐ Referral (non contracted provider and service is unfunded but referrals provided)

What level of Residential Care services are funded by the LA?

- ☒ ASAM III.7 Medically Monitored Intensive Inpatient Services
- ☒ ASAM III.5 Clinically Managed High-Intensity Residential Services
- ☒ ASAM III.3 Clinically Managed Population-specific High-Intensity Residential
- ☒ ASAM III.1 Clinically Managed Low-Intensity Residential
- ☐ None of these levels of care are available.

If not available, what are the plans to develop and provide this level of care?

N/A

Service Delivery Framework: *Please also include the list of providers or a link to contracted providers.*

DBHS and Optum currently contract with five residential treatment providers for ASAM 3.1, 3.3, and/or 3.5 services. A process of pre-authorization and utilization review is in place in order to utilize residential services appropriately. The following agencies perform this pre-authorization

Substance Use - Adults

function:

- Optum for Medicaid clients;
- ARS for ISP (Intensive Supervision Probation), and Family Recovery Court; and,
- DBHS for all other adults and youth.

Contracted Providers and the associated ASAM level of care (LOC) they provide:

- First Step House – Men only 3.1, 3.3, 3.5
- House of Hope – Women; Parents with Children 3.1, 3.3, 3.5
- Odyssey House – Adult, Parents with Children 3.1, 3.3, and 3.5; Youth 3.1 and 3.5
- Valley Behavioral Health – Adult 3.5 and 3.1
- Youth Care - Youth 3.5 (must have primary co-occurring MH diagnosis)

Outcomes Framework:

All providers are required to collect the National Outcomes Measures (NOMS) on all DBHS-funded clients (i.e., Block Grant funds, legislative specialty funds, and Medicaid PMPH/Legacy funds).

DBHS receives annual NOMS scorecards. These scorecards are reviewed and discussed internally for potential areas of improvement and potential barriers that may be preventing the threshold from being reached.

Additionally, internally DBHS produces monthly scorecards per individual provider, and these are sent out to each corresponding provider. Should scores be found to be lower than the acceptable threshold, this results in an audit finding that requires a corrective action plan to resolve.

Please reference the attached “AP Provider Metrics & Outcomes Sample”, from 5 of the network’s largest providers, for a detailed sample of data for a wide range of services throughout the network.

Intensive Outpatient (ASAM II.5 or II.1) (Contract 5.2 b)

Will the LA provide Intensive Outpatient and Services directly or through a contracted provider?

☐ Directly

☒ Contracted provider (Please include a list or a link of contracted provider)

Service Delivery Framework:

Substance Use - Adults

DBHS and Optum contract with 8 agencies to provide ASAM 2.1 and/or 2.5 for youth, women, mothers with dependent children, and general adult patients in multiple sites across Salt Lake County. Psychiatric medication evaluation services are provided by VOA/FCC, Odyssey House, and VOA/CCC for all levels of care and can be accessed by any client currently served.

Contracted Providers:

- Clinical Consultants – Adult 2.1
- First Step House – Adult 2.1
- House of Hope – Women; Children with Parents 2.1, 2.5
- Next Level Recovery – Adult; Youth 2.1, 2.5 (Medicaid only)
- Odyssey House – Adult; Youth; Children with Parents 2.1, 2.5
- Valley Behavioral Health – Adult 2.1, 2.5;
- Volunteers of America / Cornerstone Counseling – Adult; 2.1, 2.5
- Youth Care - Youth 2.5 (must have primary co-occurring MH diagnosis)

Outcomes Framework:

All providers are required to collect the National Outcomes Measures (NOMS) on all DBHS-funded clients (i.e., Block Grant funds, legislative specialty funds, and Medicaid PMPH/Legacy funds).

DBHS receives annual NOMS scorecards. These scorecards are reviewed and discussed internally for potential areas of improvement and potential barriers that may be preventing the threshold from being reached.

Additionally, internally DBHS produces monthly scorecards per individual provider, and these are sent out to each corresponding provider. Should scores be found to be lower than the acceptable threshold, this results in an audit finding that requires a corrective action plan to resolve.

Outpatient Care and Services (Non-methadone – ASAM I) (Contract 5.2 b)

Will the LA provide Outpatient Care and Services directly or through a contracted provider?

- ☐ Directly
- ☒ Contracted provider (Please include a list or a link of contracted provider)

Service Delivery Framework:

Substance Use - Adults

DBHS and Optum contract with 17 agencies to provide the full continuum of outpatient ASAM LOCs. These programs provide services for youth, women, mothers and fathers with dependent children, and general adult patients in multiple sites across Salt Lake County. Psychiatric medication evaluation services are provided by VOA/Family Counseling Center (FCC), Odyssey House, and VOA/CCC for all levels of care and can be accessed by any client currently served.

Contracted Providers:

- Asian Association of Utah Refugee & Immigrant Center – Adult; Youth
- BayMark - BAART Programs – Adult (Medicaid only)
- Beacon House – Adult (Medicaid only)
- Bonneville Family Practice – Adult; Youth; (Medicaid only)
- Clinical Consultants – Adult; Youth
- Discovery House – Adult (Medicaid only)
- First Step House – Adult
- House of Hope – Women; Children with Parents
- Next Level Recovery – Adult; Youth; (Medicaid only)
- Odyssey House – Adult; Youth; Children with Parents
- Project Reality – Adult
- Salt Lake County Division of Youth Services – Youth
- Tranquility Place – Adult (Medicaid only)
- True North – Adult
- Utah Harm Reduction – Adult (Medicaid only)
- Valley Behavioral Health – Adult
- Volunteers of America/Cornerstone Counseling/Family Counseling Center – Adult; Children with Parents

Outcomes Framework:

All providers are required to collect the National Outcomes Measures (NOMS) on all DBHS-funded clients (i.e., Block Grant funds, legislative specialty funds, and Medicaid PMPH/Legacy funds).

DBHS receives annual NOMS scorecards. These scorecards are reviewed and discussed internally for potential areas of improvement and potential barriers that may be preventing the threshold from being reached.

Additionally, internally DBHS produces monthly scorecards per individual provider, and these are sent out to each corresponding provider. Should scores be found to be lower than the acceptable threshold, this results in an audit finding that requires a corrective action plan to resolve.

Substance Use - Adults

Please reference the attached “AP Provider Metrics & Outcomes Sample”, from 5 of the network’s largest providers, for a detailed sample of data for a wide range of services throughout the network.

Treatment for Opioid Use Disorder (OTP-Methadone)

- ☒ OTP-Methadone is available .
- ☐ OTP-Methadone is not available.

If not available, what are the plans to develop and provide this level of care?

Will the LA provide Treatment for Opioid Use Disorder directly or through a contracted provider?

- ☐ Directly
- ☒ Contracted provider (Please include a list or a link of contracted provider)

Service Delivery Framework: *Please also note if there are any additional agency processes to access this level of clinical care, including if the LA agency serves “Meds only” clients.*

Baymark (BAART)

See “**Medications for Opioid Use Disorder (Vivitrol, Naltrexone, Buprenorphine)**”.

Discovery House (Medicaid only)

See “**Medications for Opioid Use Disorder (Vivitrol, Naltrexone, Buprenorphine)**”.

Project Reality

Outreach

- Maintains partnerships with VOA, Salt Lake County Jail, and House of Hope to provide daily off-site dosing and coordinated care.
- Engages underserved populations through integrated care services designed to reduce barriers and expand access.

Training

- Staff receive training in ASAM criteria, integrated care models, trauma-informed care, and coordination of care practices.
- Ongoing training supports competency in evidence-based practices and interdisciplinary

Substance Use - Adults

collaboration.

Access Procedures

Service locations:

- Murray
- Downtown Salt Lake City

Additional access is supported through off-site service delivery and coordinated referral pathways to ensure timely entry into care.

Assessment Tools

- Utilizes ASAM criteria to guide level of care determinations and service planning.
- Conducts comprehensive biopsychosocial assessments, including standardized screening tools such as the PHQ-9 and GAD-7, along with substance use, mental health, and medical evaluations.

Eligibility Criteria

- Individuals who meet DSM-5 criteria for moderate to severe Opioid Use Disorder are eligible for services.
- Patients requiring higher levels of care are identified and referred through established partnerships.

Family Engagement

- Family engagement is encouraged as clinically appropriate, including family counseling services provided by clinical staff.
- Families may participate in treatment planning and receive education and support to strengthen recovery outcomes.

Transition Planning

- Coordinates transitions to higher or lower levels of care through established community partnerships and referral processes.
- Provides discharge planning and post-hospitalization follow-up to ensure continuity of care and patient stability.

True North

- Integrated service delivery model combining medication-assisted treatment with counseling, case management, and recovery support services.
- Medication-assisted treatment (MAT) options including methadone, buprenorphine, extended-release buprenorphine (Sublocade, Brixadi), and naltrexone (Vivitrol).

Substance Use - Adults

- Ongoing medication management, dosing, and monitoring by qualified medical providers.
- Ongoing staff training in evidence-based practices, regulatory requirements, trauma-informed care, and cultural competency and person-centered care.
- Low-barrier access procedures, including centralized intake and timely admission scheduling
- Admission pathways, including self-referral, provider referral, and agency-specific intake processes (e.g., pre-admission screening or orientation requirements).
- Screening and assessment tools for MOUD, biopsychosocial needs and level of care.
- Eligibility criteria based on medical necessity, diagnostic criteria, and level-of-care determination.
- Individualized treatment planning with ongoing reassessment and adjustment based on client progress.
- Case management services to address social determinants of health (housing, employment, transportation, insurance).
- Group psychoeducation sessions.
- Availability of both comprehensive services and “meds only” tracks, with appropriate clinical oversight and monitoring requirements.
- Family engagement through education, support, and inclusion in treatment planning when appropriate.
- Coordination of care with internal programs and external providers to ensure continuity and comprehensive support.
- Transition and discharge planning initiated at admission and updated throughout treatment to support step-down care and long-term recovery.
- Continuous quality assurance and oversight to monitor service delivery, access, and client outcomes.
- Active outreach through community partnerships, healthcare providers, and referral networks to support engagement.

Outcomes Framework:

Baymark (BAART)

See “**Medications for Opioid Use Disorder (Vivitrol, Naltrexone, Buprenorphine)**”.

Discovery House (Medicaid only)

See “**Medications for Opioid Use Disorder (Vivitrol, Naltrexone, Buprenorphine)**”.

Project Reality

- Data is reviewed by the Quality Assurance Committee monthly, with findings analyzed for trends, patterns, and areas for improvement.

Substance Use - Adults

- Implements continuous quality improvement through root cause analysis, policy review, and corrective action planning, with results used to update procedures, improve clinical practice, and guide staff training.
- Quality improvement efforts are overseen through a formal QA process, with results reported to leadership and used to refine operations, improve outcomes, and support CARF compliance.

True North

- Performance metrics including client retention, length of stay, and treatment adherence
- Monitoring of medication compliance and engagement in counseling services.
- Measurement of reduction in illicit opioid use through routine toxicology screenings.
- Analysis of discharge outcomes, including successful completion, transfer, and AWOL rates.
- Identification and tracking of discharge barriers (e.g., housing instability, transportation, insurance gaps, limited social support).
- Collection of data through electronic health records and standardized reporting systems.
- Routine data analysis conducted on a monthly and quarterly basis to identify trends and service gaps.
- Review of outcomes by leadership and clinical teams through quality assurance and performance improvement meetings.
- Implementation of data-driven interventions such as workflow adjustments, staff training, and enhanced care coordination.
- Continuous quality assurance and oversight to monitor service delivery, access, and client outcomes.

Medications for Opioid Use Disorder (Vivitrol, Naltrexone, Buprenorphine) (Contract 5.2 c)

Will the LA provide Medications for Opioid Use Disorder directly or through a contracted provider?

☐ Directly

☒ Contracted provider (Please include a list or a link of contracted provider)

Does your agency have a Medication for Opioid Use Disorder (MOUD/MAT) policy in place? When was it last reviewed and updated to ensure the use of best practices?

Bonneville Family Practice:

Has several policies in place regarding MOUD/MAT services. Last review: June 2025

Baymark (BAART)

Policy M-002: Criteria for Admission outlines the criteria for MOUD admission. Additional details

Substance Use - Adults

and related processes are further addressed within the Medical and Dispensing policies. Policies are reviewed and updated regularly to ensure continued compliance with operational needs and regulatory requirements. As they transition into a new system, this review process is actively underway.

Discovery House:

The agency has multiple program policies that guide admissions, medication used in medication-assisted treatment and prescription guidelines for induction (if applicable) dosing strategies, and the safe handling and storing of medication. The policies below conjointly describe MAT medication:

- Methadone Management: Liquid Methadone Last reviewed 04/2026 and due for review 12/2027.
- Buprenorphine, Buprenorphine Naloxone Last review: 12/2025. Next review: 12/2026.

Project Reality

Project Reality maintains a formal MOUD/MAT policy supporting the use of FDA-approved medications, including methadone, buprenorphine, and naltrexone (Vivitrol), as a core service within our OTP. Policies are reviewed and updated regularly to ensure alignment with best practices and were most recently updated in November 2025.

Tranquility Place:

Tranquility Place has an MOUD/MAT policy in place. It was last reviewed July 2025 in preparation for the annual DHHS audit and the three-year Joint Commission re-accreditation. The policy is found in the Tranquility Place Policy and Procedures manual, available to all staff online.

True North

True North has an MOUD/MAT policy in place that is reviewed annually. They are presently reviewing the 2026 policies and procedures, and this specific policy is being reviewed today, 4/28/2026.

Service Delivery Framework: Please also note if there are any additional agency processes to access this level of clinical care, including if the LA agency serves "Meds only" clients.

- As explained in the Justice Services section (in more detail), Vivitrol has been offered in our jail since 2015 and expanded in 2019 to offer all 3 FDA-approved medications (methadone, buprenorphine, and naltrexone).
- DBHS contracts with Clinical Consultants in West Jordan to further expand the availability of Buprenorphine and Naltrexone and other office-based MAT services to county residents

Substance Use - Adults

eligible for federal SSOR funding. In 2023, the federal parameters of SSOR expanded to include medications and treatment to support individuals struggling with a stimulant use disorder as well. Clinical Consultants subsequently began utilizing SSOR funds to support stimulant use disorder clients as well. Link [here](#) for additional details.

- True North offers all 3 FDA-approved medications: methadone, buprenorphine, and naltrexone. Link [here](#) for additional information.
- BayMark (BAART Programs) offers access to methadone and buprenorphine as an Optum provider. Link [here](#) for additional information.
- Odyssey House provides access to Naltrexone within their Martindale Medical Clinic. Link [here](#) for additional information.
- It should also be mentioned that there are many additional providers (outside of our network) of MAT services that utilize other funding streams, such as Targeted Adult Medicaid through the state or Adult Expansion Medicaid through the Accountable Care Organizations (ACOs). These services may be sought through a person's primary care physician, a federally qualified health center, and other programs.

Baymark (BAART)

BayMark does not serve med-only clients.

Bonneville Family Practice:

Access to care relies on the medical provider to determine the most appropriate type of MAT for the individual client. We serve Med-only clients, therapy-only clients, as well as a combination of both.

Discovery House:

There are no additional agency processes to access this level of clinical care. Patients can be assessed for appropriateness of this level of care, and clinical justification is determined by our medical directors.

Tranquility Place:

There are no additional agency processes to access this level of care other than those found in the policy and procedures manual. Tranquility Place currently has no "meds only" clients.

Project Reality

See "Treatment for Opioid Use Disorder (OTP-Methadone)".

True North

See "Treatment for Opioid Use Disorder (OTP-Methadone)".

Substance Use - Adults

Outcomes Framework:

- DBHS utilizes State Opioid Settlement funding for a portion of the Jail MAT program. Outcome metrics are reported quarterly to OSUMH to comply with legislative requirements of these dollars.
- Should a provider be funded through SOR funding, they are trained by the state on stringent federal grant data reporting requirements. This includes the GPRA initial, 6-month and discharge data collection processes.
- DBHS audits all programming within our contracted network.
- The state scorecard is also used to address access and client counts. With enhanced payer plans and resources, monitoring success and access becomes much more challenging, as clients shift payers mid-episode of care.

Examples of provider-specific outcomes:

Baymark (BAART)

- Length of Stay
- High discharge rates
- Issues with discharge barriers

These things are reported at an executive level for the clinic and the region on a monthly basis. The root cause and focus groups follow for any metrics under a key performance indicator (KPI) goal. This data is collected and reviewed in two catalogs:

- Monthly OTP Operations Review
- OTP Monthly Excellence and KPI Roundtable.

Bonneville Family Practice:

- OQ 45
- LSI-R
- Patient satisfaction surveys to help determine and drive continuous quality improvement

Discovery House:

- Access to care and financial performance:
 - Time to respond to inquiries
 - Conversion rates
 - Length of Stay
 - Average daily census
- Service level participation
 - Patient engagement through minimum times spent in counseling.
 - Patient, employee and other stakeholder satisfaction

Substance Use - Adults

- Post-discharge program evaluation
- Complaints and grievances
- Services received
 - Medication peer review
 - Quality Record Review
 - Billing reconciliation
 - Risk reporting analysis.
 - Performance related to health and safety emergency drills.

Project Reality

See "Treatment for Opioid Use Disorder (OTP-Methadone)".

Tranquility Place:

- Individual Brief Addiction Monitor (BAM) assessments with counselor and clients every six months
- Discharge reviews every two weeks
- UA outcome monitoring monthly to assure all clients receive a drug screen and are chemically safe to remain in MOUD/MAT treatment.

Tranquility Place is currently working with AI Google Data Analytics, suggested by our Joint Commission auditors, to analyze outcomes for continuous quality improvement.

True North

See "Treatment for Opioid Use Disorder (OTP-Methadone)".

Women's Treatment Services (Directives) (Contract 5.2)

Will the LA provide Women's or Parent services directly or through a contracted provider?

- ☐ Directly
- ☒ Contracted provider (Please include a list or a link of contracted provider)

Service Delivery Framework:

House of Hope

See "Pregnant Women and Women with Dependent Children" and "Parents' and Children's Residential Treatment".

Odyssey House

Substance Use - Adults

- The Parents with Children drug treatment program offers single moms and single dads substance use and mental health treatment through group, individual, and family therapy from highly specialized staff. Parents learn, perhaps for the first time, how to be good moms and dads, as bonding grows almost daily with their kids. They strive for parents and children to leave treatment as a healthy, reunified family.
- While parents engage in services during the day, kids attend Children's Services daycare. Little ones receive childcare from specially licensed staff immediately (even if they are newborns) to help rebuild attachment and heal childhood trauma. Kids do lots of activities to experience a healthy childhood with a healthy parent. School-age children attend a local elementary and receive daycare services in the afternoon.
- Aftercare and Housing
 - Parents and children can continue in outpatient therapy after they leave residential care and offer family sober housing units.
- Parenting Skills
 - Parents engage in special education on parenting, vocational prep, life skills, and physical fitness.
- Mental Health
 - Along with an individual therapist, the treatment team includes psychiatric providers who help with assessments and medications.
- Fathers with Children
 - OH offers a residential treatment program that serves dads and their kids.
- Medical Care
 - These programs have access to the OH Martindale Clinic which provides integrated medical services during and after a client's treatment stay.
- Trauma
 - Most of the adults and children in this program have trauma. Specially trained staff address these unique and sensitive issues.

Project Reality

Project Reality provides services to women, including pregnant and parenting individuals, within the same Service Delivery Framework as "Treatment for Opioid Use Disorder (OTP-Methadone)", including integrated medical, behavioral health, and substance use disorder services. All standard operational and clinical processes apply, including assessment, treatment planning, medication management, and care coordination with external providers.

Project Reality prioritizes admissions for individuals with opioid use disorder in the following order:

1. Pregnant and parenting individuals who inject drugs

Substance Use - Adults

2. Pregnant and parenting individuals with substance use disorders

The agency maintains active collaboration with obstetric and high-risk pregnancy providers across Salt Lake County, including SUPeRAD at the University of Utah and Intermountain Medical Center, to support coordinated prenatal, perinatal, and postpartum care. OTP medication is delivered to the University of Utah “rooming-in” program to support mothers remaining with their infants after delivery.

Women in the program have access to specialized women’s groups addressing gender-specific and perinatal recovery needs, as well as referrals to women’s residential and supportive programs such as House of Hope, Odyssey House Women’s and Children’s Program, and the YWCA. Parenting support is also provided through parenting classes and access to childcare-related resources (e.g., diapers and toys) to support engagement in treatment.

Outcomes Framework:

House of Hope

See “Pregnant Women and Women with Dependent Children” and “Parents and Children’s Residential Treatment”.

Odyssey House

- Decrease in ASAM risk levels
- Success rates
- OQ scores

Metrics are reviewed monthly and quarterly with the clinical team as well as the agency leadership. Plans are made to address any metrics that are outside of the goals set.

Project Reality

See “Treatment for Opioid Use Disorder (OTP-Methadone)”.

Pregnant Women and Women with Dependent Children - SAMHSA Priority Population (Contract 5.2d a & 45 CFR Part 96 Subpart L)

Will the LA provide Pregnant Women and Women with Dependent Children services directly or through a contracted provider?

☐ Directly

Substance Use - Adults

- ☒ Contracted provider (Please include a list or a link of contracted provider)

Select the Women's Service Requirements that the LA meets or provides:

- ☒ Pregnant women admitted within 48 hours.
- ☒ A comprehensive referral for interim services if treatment admission for pregnant women is not available within 24 hours of the time the request for services is made.
- ☒ Block Grant funds are used to support pregnant women, parenting women, and women working to regain custody.
- ☒ Primary medical care for individuals including referrals for prenatal care.
- ☒ Primary Pediatric care for children of individuals in SUD treatment including immunizations.
- ☒ Therapeutic interventions for children in custody of individuals in SUD treatment that address development needs, issues of sexual and physical abuse and neglect.
- ☒ Sufficient case management and transportation services (clients and children).

Service Delivery Framework:

House of Hope

- House of Hope (HOH) specializes in serving women in treatment for substance use and mental health disorders complicated by a history of abuse/trauma, domestic violence, homelessness, incarceration/criminality, self-harm or suicidal ideation, disordered eating, chronic health conditions, or other significant life events.
- Strengthening families (however the client defines "family") is a significant emphasis, especially due to negative impacts of SUD with additional advocacy for mothers with Division of Child and Family Services (DCFS) cases or other complex custody issues. Family, couples, and relationship-building services are prioritized.
- HOH utilizes ASAM criteria for assessment and placement. An Eligibility Specialist works with clients to ensure benefits are in place and sustained for self-sufficiency in the community. Criteria for admission are individualized; the only clients automatically excluded are those on the sex-offender registry or convicted of violent crimes.
- Transition planning begins at intake and continues throughout the treatment episode.
- HOH treatment philosophy: a strengths-based, trauma-informed community model of building capacity for individual and family healing; expanding resilience; accountability as empowerment; accessing internal and systemic resources; and accelerating progress with interaction with healthy communities of women.
- Clinical models include CBT-based therapies (DBT, ACT, MI, etc.) and experiential treatment (EMDR, ART, AEDP, IFS, somatic therapy, etc.) in group, individual, and family therapy.
- Extensive behavior management, psychosocial rehabilitation, and case management services offer individual and group services focused on self-regulation, healthy relationships, relapse planning, life-skills, stress-management, conflict resolution, etc.

Substance Use - Adults

- Continuum of care includes residential, day treatment, intensive outpatient, and weekly outpatient services. After completion, aftercare, alumni activities, retreats, on-call phone, and outreach services are offered for sustaining recovery, especially for the first five years of sobriety. The Amaryllis Recovery House for Women provides supportive housing for women in the first stages of transitioning into the community.
- HOH has the only non-hospital-based Zero Suicide grant (five years) in Utah, is in the second year of the Recreation for Recovery pilot, and started a new family program to reach more families impacted by addiction as well as actively participating in many other community initiatives.
- The HOH Choir for Women in Recovery (established in 2003) helps women express themselves proactively at community events and is a part of the Music Therapy program at HOH.
- HOH is the process of re-opening the Provo Campus with additional intensive outpatient services; renovating the original House of Hope facility in SLC; seeking funding to purchase a facility for recovery housing/sober living for families with children; planning to purchase a new facility to significantly expand outpatient services for women in the next three years; and a special project in FY27 to prioritize women's health issues in early recovery.

Outcomes Framework:

House of Hope

- TEDS
- MHSIP
- NH-SUMHSS
- Satisfaction surveys bi-annually for internal improvement
- NOMS
- HOH's internal MIS system tracks data needed for all grants
- Ongoing partnership with U of U for pregnant women with SUD data collection and research
- Partnership with U of U social research institute to track specific data for program improvement and analysis.

Internally, we use measures to evaluate criminality, suicide risk, depression/anxiety, the ACE study, recreational therapy scales, and House of Hope Recovery Indicators scale for women in early recovery.

Parents and Children's Residential Treatment (Service Code: WTX). (Directives)

Will the LA provide Parents and Children's Residential Treatment directly or through a contracted provider?

Substance Use - Adults

- ☐ Directly
☒ Contracted provider (Please include a list or a link of contracted provider)

LAs receiving these funds must ensure they meet the requirements of the SUMH Directives for WTX services and data collection, including a three year application and a budget by March 27th. Contact Becky King (rbarnett@utah.gov) for more information.

Children with Parents in Residential Treatment Services (Service Code: CFT) (Directives)

Will the LA provide Children with Parents in Residential Treatment Services directly or through a contracted provider?

- ☐ Directly
☒ Contracted provider (Please include a list or a link of contracted provider)
☐ Not receiving CFT funds

Check the boxes for all the services for Children with Parents in Residential Treatment that are available.

- ☒ Therapeutic Day Care- which provides developmentally focused care for young children whose parent is in treatment, offering support, early learning, and a safe, nurturing environment.
☒ Case Management & Transportation - for behavioral and physical health services.
☒ Ongoing Assessment- covers development, health, interactions, and overall functioning.
☒ Residential Therapeutic Services- supports children in care with a goal of reunification.

Service Delivery Framework:

House of Hope

- Assessment, developmental evaluation, treatment planning, and transition goals for children of parents with SUD/MH disorders.
- Intensive coordination with DCFS, court/legal entities, foster and kinship care for visitation, reunification, and family relationship-building services for children ages birth-14 years.
- Hope Center for Children provides daily care for children aged 0-8, Monday through Friday, while mothers attend residential or outpatient treatment, 8:30-5 pm, using age-appropriate curriculum and best practices for children impacted by parental addiction.
- Coordination with over fourteen local service providers/resources for families and children in the community; many agencies work on site with children in care. Family case managers work to coordinate care of children and safety net building in preparation for family self-sufficiency in the community.

Substance Use - Adults

- Educational coordination for school-age children who attend Wasatch Elementary.
- Three residential facilities for Mothers and Children (birth to eight years) All age-appropriate physical, social, developmental, and emotional needs are met in a supervised setting that allows children in State custody to be placed safely with high-risk mothers due to intensive monitoring and contingency planning. Newborns may remain with mothers at birth in order to prevent removal if residing in residential care.
- Current initiatives include advocacy on behalf of children in the custody of DCFS with the courts, attorneys, caseworkers, guardian ad-litem (GAL) and State employees to improve protocols and partnerships serving high-risk children of SUD parents; raising funds to allow travel to visit parent programs nationwide to share best practices and improve HOH and Odyssey parent programs; and working toward the financial sustainability of Children's Services in SUD programs.

Odyssey House

- Therapeutic Day Care: All children at the Parents Program attend our Children's Services therapeutic day care if not school-aged and, for those that are school-aged, after-school care. This is done as part of their admissions process. Parents are included in their child's daycare and participate in family therapy. They are assessed by the child therapist, and treatment goals are created. Children have to be 12 years old or younger to be eligible.
- Case Management & Transportation: All children in the Parents Program receive case management services, including ensuring appropriate medical insurance coverage, appropriate medical care, coordination with DCFS, etc.
- Ongoing Assessment: The children in the Parents Program are being assessed regularly by the child therapist through age-appropriate tools including ACES, CSSRS, and ASQ-3. Treatment goals are created and updated based on the ongoing assessments.
- Residential Therapeutic Services: Children whose parents are in SUD treatment are housed in residential treatment with their parents. They receive parenting support and reunification services.

Outcomes Framework:

House of Hope

In addition to the outcome measures listed under **"Pregnant Women and Women with Dependent Children"**:

Ages and Stages: DE & Ages and Stages SE are utilized to evaluate children's development as well as evaluation provided as needed for individual children if behavioral or mental health needs arise.

Substance Use - Adults

Odyssey House

- Ages and Stages Questionnaire (ASQ-3) scores
- ACES
- Metrics are reviewed monthly and quarterly with clinical team and agency leadership. Plans are made to address any metrics that are outside of the goals set.

Both of these programs report the following outcomes quarterly to DBHS, which is then forwarded to OSUMH to meet legislative intent language for this funding.

- 1) Children served
- 2) Families served
- 3) % that had an open DCFS case
- 4) % of the children that resided with the parent at discharge
- 5) % of parents that were abstinent from substances at discharge
- 6) % that had stable housing at parent discharge
- 7) % of parents that had a job or were enrolled in a job training program at discharge
- 8) The average LOS for children discharged in the quarter
- 9) The number of children born in the program

Persons who Inject Drugs - SAMHSA Priority Population (Contract 5.1 a, 5.2 e)

Describe how the LA identifies and ensures that persons who inject drugs are prioritized for admission in accordance with federal requirements (within 14 days from request of admission or 120 days after the request is made if there is no program capacity and interim services are provided until treatment becomes available)?

DBHS mandates in the contract with each provider the federal priority requirements. During the annual audit, this is also monitored for compliance.

When an individual contacts a provider for SUD services, they are screened for use of drugs via injection. If the individual identifies as such, then they are immediately prioritized for treatment. As part of the above-mentioned monitoring, during the audit process, DBHS makes a “cold call” to the agency posing as either a client or a family member requesting services. Our findings have been that providers are very good at screening for injection drug use, and it is almost non-existent that they do not screen the caller for this.

Providers understand the seriousness of prioritizing persons who inject drugs and are able to consistently admit persons who inject drugs within the required timeframes and actually usually admit within 24-48 hours, per the surveys we have conducted.

Substance Use - Adults

Communicable Disease Testing, Education and Resources (TB) - SAMHSA Priority Population (Contract 4.2f)

Check the boxes of services that are provided for individuals who may be or are infected by mycobacteria tuberculosis (TB)?

☒ Screening and testing.

Who is responsible for providing screening and testing for TB

All contracted DBHS providers.

For Optum

- Tranquility Place
- BAART

☒ Education services.

Who is responsible for providing education for TB

All DBHS contracted providers.

☒ Counseling services.

Who is responsible for providing counseling in respect to TB

All DBHS contracted providers.

For Optum

- Tranquility Place
- BAART
- Discovery House
- Bonneville Family Practice

☒ Referral for medical evaluation and treatment.

Technical Assistance - Adult SUD

Is technical assistance requested for any components of the Adult Substance Use programming or requirements section?

☐ Yes

☒ No, not at this time.

Please name sections requested and provide description of requested TA.

Substance Use - Adults

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Substance Use - Youth

The following sections are the Substance Use Youth services requirement from both the LA contract and the SUMH Office Directives.

For the Service Delivery Framework, describe operational and clinical implementation of the service, outreach, training, access procedures, assessment tools, eligibility criteria, family engagement, transition planning.

For the Outcomes Framework, describe specific metrics used to track performance (e.g., recidivism, length of stay, discharge barriers), process for analyzing data to drive continuous quality improvement.

Early Intervention

Will the LA provide Early Interventions directly or through a contracted provider?

- ☐ Directly
☐ Contracted provider (Please include a list or a link of contracted provider)

Service Delivery Framework:

See "Prevention Area Plan".

Outcomes Framework:

See "Prevention Area Plan".

Residential Care and Services (ASAM III.7, III.5, III.3, III.1) (Contract 5.2 b)

Will the LA provide Residential Care and Services - Youth directly or through a contracted provider?

- ☐ Directly
☒ Contracted provider (Please include a list or a link of contracted provider)
☐ Referral (non contracted provider and service is unfunded, but referrals provided)

What level of Residential Care service are funded by the LA?

Substance Use - Youth

- ☐ ASAM III.7 Medically Monitored Intensive Inpatient Services
- ☒ ASAM III.5 Clinically Managed High-Intensity Residential Services
- ☐ ASAM III.3 Clinically Managed Population-specific High-Intensity Residential
- ☐ ASAM III.1 Clinically Managed Low-Intensity Residential
- ☐ None of these levels of care are available.

If not available, what are the plans to develop and provide this level of care?

Service Delivery Framework:

See "**Substance Use - Adult**" section

Outcomes Framework:

See "**Substance Use - Adult**" section

Intensive Outpatient (ASAM II.5 or II.1) (Contract 5.2 b)

Will the LA provide Intensive Outpatient Services directly or through a contracted provider?

- ☐ Directly
- ☒ Contracted provider (Please include a list or a link of contracted provider)

Service Delivery Framework:

See "**Substance Use - Adult**" section

Outcomes Framework:

See "**Substance Use - Adult**" section

Outpatient Care and Services (ASAM I) (Contract 5.2 b)

Will the LA provide Outpatient Care and Services directly or through a contracted provider?

- ☐ Directly
- ☒ Contracted provider (Please include a list or a link of contracted provider)

Substance Use - Youth

Service Delivery Framework:

See “**Substance Use - Adult**” section

Outcomes Framework:

See “**Substance Use - Adult**” section

Access and Quality of Youth Treatment Services

What plans does the LA have to coordinate, support and increase access and quality care for youth services?

DBHS/Optum will continue to search for a provider(s) who meets credentialing requirements who can provide higher levels of care for SUD treatment. In the interim, we will make use of Single Case (Accommodation) Agreements as necessary.

Technical Support - Youth SUD

Is technical assistance requested for any components of the Youth Substance Use programming or requirements section?

☐ Yes

☒ No, not at this time.

Please name sections requested and provide description of requested TA

Substance Use - Quality Improvement

The following sections are the Quality Improvement requirement from both the LA contract and the SUMH Office Directives.

Drug Testing (Directives)

Will the LA provide Drug Testing directly or through a contracted provider?

Substance Use - Quality Improvement

☐ Directly

☒ Contracted provider (Please include a list or a link of contracted provider)

- Asian Association
- Clinical Consultants
- Division of Youth Services
- First Step House
- House of Hope
- Odyssey House
- Project Reality
- True North
- Valley Behavioral Health
- Volunteers of America

When was the last time your Drug Testing policy was updated?

DBHS' drug testing policy was last updated on 6/7/22 and reviewed on 4/27/26. However, each contractor is required by contract to maintain a drug testing policy and to review it each year.

What is the LA process to ensure that all drug testing done directly or via a contract follows SAMHSA-recommended guidelines and the requirements as outlined in the SUMH Directives in the Quality Improvement section for Drug Testing Requirements?

All contractors are mandated by contract to follow the drug testing requirements outlined in <https://dsamh-training.utah.gov/documents/contractsandmonitoring/2026/FY26OfficeDirectivesFinalVersion.ada.pdf>.

Outreach to Individuals Who are Using Alcohol and Other Drugs- Overdose Prevention and Education (Contract 5.3.4)

What is the process used to ensure staff are educated in the identification of overdoses and how to administer naloxone?

DBHS has an office policy for the storage and use of naloxone. The policy also outlines the annual training requirements for all staff. DBHS provides an annual training during their staff retreat. Topics include the policy itself, stocking supplies, storage, overdose signs and symptoms, and administration of naloxone. Once trained, staff sign an annual acknowledgement of this training.

Does the LA maintain naloxone in each facility?

Substance Use - Quality Improvement

Yes. It is purchased and stored, as identified in the office policy.

What is the process in providing naloxone kits, education and training to individuals with Opioid Use disorder and their family and friends regarding overdose prevention?

Each treatment and housing (sober living and those subcontracted through our Housing Connect contract) agency is required to maintain naloxone kits and information on the use of kits nearby in all of their facilities. Additionally, in contract DBHS requires treatment agencies to provide kits, training, or if not possible, to provide education on where kits can be obtained for themselves and for friends and families of those at risk of opioid overdose.

Policy Review (Directives)

What is your process for the development and review of agency policies?

For DBHS, contracted providers must submit current policies with every annual monitoring visit that occurs.

DBHS issues its policies through contracts and amendments.

Optum has an internal policy review committee consisting of members from each Optum SLCo department. We also have a policy titled *Development and Approval of Policies and Procedures*. When a new policy is determined to be necessary, the appropriate Optum SLCo policy review team member(s) draft(s) a policy that conforms to the requirements of DHHS and DBHS, as well as applicable regulatory and organizational requirements.

How often are policies reviewed and updated?

DBHS issues its policies through contracts and amendments, and the latter are updated every year.

All Optum SLCo policies are on a rotating schedule for review by the committee at least annually.

Technical Assistance- Quality Improvement

Is technical assistance requested for any components of the Quality Improvement section?

☐ Yes

☒ No, not at this time.

Substance Use - Quality Improvement

Please name sections requested and provide description of requested TA

COMBINED MENTAL HEALTH AND SUBSTANCE USE SECTIONS

Mental Health and Substance Use Services

The following section stems from both the LA contract and the FY27 SUMH Office Directives that require a LA response. Each LA must complete with an overview of how components of the directives will be implemented in their catchment area.

For the Service Delivery Framework, describe operational and clinical implementation of the service, outreach, training, access procedures, assessment tools, eligibility criteria, family engagement, transition planning.

For the Outcomes Framework, describe specific metrics used to track performance (e.g., recidivism, length of stay, discharge barriers), process for analyzing data to drive continuous quality improvement.

Integrated Care Programming (Contract 2.4, 5 & Directives)

Will the LA implement Integrated Care Programming directly or through a contracted/partnership provider?

☐ Directly

☒ Contracted provider (Please include a list or a link of contracted provider)

- Clinical Consultants
- Fourth Street Clinic
- First Step House (FSH)
- Odyssey House (OH)
- Valley Behavioral Health (VBH)
- Volunteers of America (VOA)

Service Delivery Framework: Please also include how the LA will cooperate with efforts to promote integrated programming that address individuals' mental health, substance use, and physical health

needs. This must include, but is not limited to, the wellness education of all ages for obesity, HIV, TB, Hep-C, diabetes, pregnancy, and dental.

Adult

Clinical Consultants

- Clinical Consultants employs Certified Case Managers who screen for medical and dental needs at intake.
- Clients with medical needs are referred to our integrated medical clinic or given other options to meet their healthcare needs if they would prefer.
- Dental and pregnancy resources are offered to those in need.

Fourth Street Clinic

- Inclusion of the medical histories of individuals and their families.
- Providers are to consider the member's culture and living conditions which may also influence their physical, social, emotional and spiritual wellbeing.
- Providers are expected to request a release of information to collaborate with the individual's primary care physician, behavioral health prescriber and other key medical and behavioral health providers to encourage coordinated care.

FSH

- First Step House's Medical Services Department includes a medical clinic and nursing services.
- Provides medical care and preventive health services to clients in their residential SUD treatment program as well as care coordination for primary care, MAT, and other medical needs.
- Clinic staff can address clients' immediate medical needs, beginning treatment in the clinic or referring out for treatment.
- An in-house psychiatric nurse also provides consultations for new clients with acute psychiatric needs.
- Includes an onsite immunization program and onsite waived laboratory testing. The clinic offers seasonal influenza vaccines and year-round COVID-19 vaccines.
- The clinic also screens for sexually transmitted infections, orders Hepatitis A and B vaccines as needed, and provides Hepatitis C treatment.
- Staffed by two registered nurses and five medication technicians,
- Nursing staff work with clients during medical orientation to establish care with a primary care provider if they do not already have one.
- Nursing staff teach about medication transfers and guidelines for use, immunization education, how and why to find a primary care provider, COVID-19, and other health and safety precautions.
- As needed, nurses make referrals to partner providers such as Fourth Street Clinic, UofU School of Dentistry, Salt Lake VA Medical Center, Martindale Clinic, Project Reality, and others.

Odyssey House

- **Integrated Service Delivery Model**
 - Operates a fully integrated primary care and behavioral health clinic (Martindale Clinic) serving individuals with co-occurring mental health, substance use, and physical health needs
 - Behavioral health (BH) and medical providers collaborate closely to deliver coordinated, whole-person care
 - Services are provided in both clinic-based and community-based (street outreach) settings to reduce barriers to access
- **Comprehensive Medical & Behavioral Health Services**
 - Primary care services: chronic disease management, lab work, wound care, diabetes and blood pressure management
 - Mental health care: psychiatric evaluation and medication management
 - Substance use treatment: Medication-Assisted Treatment (MAT) prescribing and administration
 - Women's health services: family planning, pregnancy-related care
 - Infectious disease treatment: Hepatitis C (Hep-C) treatment (one of the largest providers in the state)
- **Wellness Education & Prevention Across the Lifespan**
 - Provides education and prevention services for individuals and families of all ages, including:
 - Obesity and healthy lifestyle management
 - HIV and TB prevention and education
 - Hepatitis C screening, treatment, and prevention education
 - Diabetes prevention and self-management education
 - Pregnancy and reproductive health education
 - Dental health education and referrals
 - Harm reduction education, including safe injection practices and overdose prevention
- **Harm Reduction & Public Health Initiatives**
 - Operates a syringe exchange program providing:
 - Clean syringes
 - Fentanyl test strips
 - Disease prevention education (HIV, Hep-C, TB)
 - Linkage to treatment and recovery services
- **Community Outreach & Engagement**
 - Provides weekly street-based medical care in partnership with Soap to Hope for:
 - Individuals experiencing homelessness
 - Sex workers
 - Services include wound care, STD treatment, MAT access, and health education
 - Outreach model engages individuals who may avoid traditional healthcare settings, improving access and trust
- **Care for High-Risk and Medically Complex Populations**

- Residential programs integrate medical and behavioral health care for high-acuity clients
- Provides specialized care for PICC line patients requiring long-term IV antibiotics due to infections from IV drug use
- Coordinates closely with hospital systems to ensure continuity of care and safe treatment outside hospital settings Reduces hospitalization while improving outcomes and minimizing overdose risk
- **System Collaboration & Continuity of Care**
 - Partners with multiple hospital systems statewide to coordinate referrals and ongoing care
 - Ensures seamless transitions between inpatient, residential, outpatient, and community-based services
 - Promotes integrated programming by aligning medical, behavioral health, and substance use treatment plans for each individual
- **Commitment to Integrated Programming**
 - All services are designed to simultaneously address mental health, substance use, and physical health needs
 - Emphasizes prevention, early intervention, and ongoing wellness education
 - Focuses on improving overall health outcomes through coordinated, accessible, and patient-centered care

VBH

VBH will continue to work with community partners for possible options for integrated care. In the meantime, VBH will work with community clinics to ensure clients are addressing their physical health needs.

VOA

Volunteers of America, Utah (VOA) provides integrated primary and behavioral health care through established community partnerships. VOA partners with Fourth Street Clinic to provide onsite triage and medical care at detoxification facilities and Homeless Resource Centers. Outpatient clinics partner with Utah Partners for Health and other nearby clinics to ensure access to primary care services.

Integrated care is delivered through coordinated screening, referral, and follow-up processes through a registered nurse that VO employs. Clients receive initial health screenings at intake, with ongoing monitoring as clinically indicated. Staff are trained to identify co-occurring medical and behavioral health needs and coordinate care with external providers. Services are accessible through VOA programs with referrals made internally and externally based on need.

Adaptations for YOUTH programming

Clinical Consultants

Case Managers work with the client and their parent/caregivers at intake to understand needs

and offer resources, including referral to our integrated medical clinic.

N/A for all other providers listed.

Outcomes Framework: *Please also outline the screening tools and assessments for physical health and social determinants, and physical health documentation.*

Adult:

Clinical Consultants

- A complete psycho-social history, physical history, and pertinent physical exam is completed for each patient.
- Screening tools used include the GAD-7, PHQ-9, PCL-5, and CSSRS in addition to laboratory testing to assess nutritional, hormone, and metabolic balancing. Gene Sight testing is used for clients who have a history of resistance to medication response to identify effective interventions.

Fourth Street Clinic

- PHQ-9
- GAD 7
- Quarterly patient surveys
- Adult ADHD Self Report Scale
- MOCA
- AIMS

FSH

Nursing services program outcome goals

- Document nursing encounters compared to last year (excluding medical orientation)
- Audit each medication room (4) monthly for 70% of months
- 90% of new residential treatment clients will receive resources and assistance establishing primary care during orientation if they do not have a primary care provider upon admission
- 90% of new residential treatment clients who complete orientation will participate in a medical orientation class.
- 100% of residential treatment clients with medication needs will participate in the medication management program

Medical clinic outcomes goals

- Track the number of visits compared to last year
- Track the number of immunizations compared to last year
- 90% of new residential treatment clients will have a routine medical visit to review health history, identify urgent health needs, and receive preventive services, including STI and Hepatitis C screening

These metrics are reviewed monthly by our executive team, and strategic planning and support are provided to the team to assist them with reaching the metrics if they are not being met. This fiscal year, FSH has consistently been on track to meet or exceed each of the metrics.

Odyssey House

- Nutrition screening
- Pain screening
- Mental Status Exam
- Social Determinants of Health
- Physical exam
- Health history including Cardiovascular assessment, Respiratory assessment, Gastrointestinal assessment, Allergy assessment

VBH

Currently VBH does not use any physical health tools or assessments. We use the DLA-20 to assess clients' social determinants.

VOA

- Access to primary care
- Successful referral linkage
- Follow-through on medical appointments.

Data is reviewed regularly to identify barriers to care and improve coordination. Quality improvement efforts focus on increasing successful linkages and reducing gaps in care.

Adaptations for YOUTH programming

Clinical Consultants

The same approach is used for youth, but parents/caregivers are involved in the process as appropriate.

N/A for all other providers listed.

Evidence-Based Practice Tracking

Please review and update the SUMH provided list of clinical evidence-based practices and assessments to include practices and assessments across the lifespan and service continuum.

 FY27 LA EBP Matrix

Telehealth (Contract 2.5)

Does the LA provide Telehealth services?

- ☐ Yes, directly - LA agency staff provide therapeutic services to clients directly
- ☒ Yes, via contracted provider is utilizing telehealth services
- ☐ Not not at this time, but we would be interested
- ☐ No

What Telehealth platform does the LA utilize for telehealth services?

Providers are required to use a HIPAA compliant platform.

If applicable, list services are available through telehealth. Please include mental health and substance use treatment services in this response.

Services include SUD and MH outpatient and some IOP. Services can include individual, group, family therapy and skills development.

Translation Services

Does the LA have a provider(s) that utilize languages in addition to English, including ASL, in services.

- ☒ Yes
- ☐ No, not at this time

Does the LA have a policy and process for utilizing **translation services** to meet the communication needs of clients who receive services and those who seek services with the LA?

- ☒ Yes
- ☐ No, not at this time

Smoking Cessation (Directives)

Does the LA implement Smoking Cessation best practices as outlined in the SUMH Office Directives?

- ☒ Yes
- ☐ No, not at this time

Will the LA provide tobacco-free classes directly, a contracted provider or in collaboration with a health organization?

- ☐ Directly
- ☐ Health Organization (Health Department or other clinic)
- ☒ Contracted provider (Please include a list or a link of contracted provider)

- Asian Association
- Clinical Consultants
- Division of Youth Services

- First Step House
- House of Hope
- Odyssey House
- Project Reality
- True North
- Valley Behavioral Health
- Volunteers of America
- Optum's providers

Does the LA maintain a nicotine-free environment?

☒ Yes

☐ No, not at this time

If deemed applicable, please add additional information about the LAs smoking cessation or nicotine free environment.

By contract, all providers are to have a nicotine-free environment and promote smoking/nicotine cessation.

Community Assessment

Describe how the LA assesses service continuum access for the community they serve. This must include: population demographics (both in services and in LA catchment), location of provided services, and a plan for improving access to care for Medicaid members, unfunded, underfunded individuals not currently receiving services.

DBHS/Optum reviews quarterly Geomaps created by Optum's IT Reporting Team as we review network needs for both time and distance standards as well as client demographics within each zip code within the county.

Collaboration and partnerships

Describe the collaboration efforts the LA will be doing over the next 1-3 years in order to increase client engagement and outcomes and community partnerships (i.e, Hospital, FQHCs, Receiving Centers, Health Department, Clinics, State, City and County agencies, community partners, committees, other, etc).

DBHS strives to ensure that community stakeholders are aware of the services DBHS provides and how to access them. The primary way DBHS ensures this awareness is by regular attendance at community stakeholder meetings and presentations when requested. Some of the meetings DBHS representatives attend are (but not limited to):

- The Mental Health Court Advisory Committee
- The Family Investment Coalition (attendees include The Utah Housing Coalition, Voices for Utah Children, The Disability Law Center, the YWCA, AARP, ACLU, AUCH, Community Action Program, Crossroads, The Road Home, United Way, Utah DV Council, Health Policy Project, Salt Lake City, Utah Legal Services, Housing Connect and other housing authorities, and others)
- The Utah Health Policy Project Healthcare Meetings
- The Medical Care Advisory Committee
- The Salt Lake Valley Coalition to End Homelessness Health and Wellness Core Function Group
- The Adult Drug Court Steering Committee
- The Family Recovery Court Steering Committee
- Bi-annual boarding home/ACT team Housing Roundtable meetings hosted by Optum. Attendees include ACT teams, boarding homes, Housing Connect, DBHS, and Optum.
- The DBHS Behavioral Health Services Advisory Council Quarterly Meetings (attendees include many diverse stakeholders such as the county council, Accountable Care Organizations, NAMI, USARA, The Sheriff's Office/Jail, Optum, Utah Health Policy Project, HMHI, and others.
- The Intensive Supervision Probation Coordination Meetings (stakeholders include DBHS, community providers, USARA, RSS, CJS, and the Sheriff's Office)
- DBHS is a member of the Criminal Justice Advisory Council, where ongoing systemic needs are addressed monthly, coordinated, and planned for. The committee includes representatives from the courts, law enforcement, mayors, county council, state legislators, Legal Defenders Association, District Attorney's office, Department of Corrections, Criminal Justice Services, Human Services, Diversity Affairs, and an individual with lived experience in the criminal justice system. One example is the new Receiving Center. This item is periodically on the agenda to provide updates and receive feedback from stakeholders.
- Our attendance is not needed on a regular basis at the Salt Lake Juvenile Court Multi-Agency Staffings & Salt Lake City School District Mental Health Roundtable, but we have committed to attending them upon request whenever they would like our help.
- USARA (Utah Support Advocates for Recovery Awareness)
 - Operates a Recovery Community Center in Salt Lake County, open seven days per week, providing recovery support services and community recovery meetings for adults 18 and older.
 - Utilizes a community-based, peer-led model staffed by full-time Certified Peer Support Specialists who deliver non-clinical recovery support across hospitals, emergency departments, clinics, and social detox settings.
 - Provides services through scheduled appointments and on-call response to ensure timely engagement at critical intervention points.
 - Prioritizes low-barrier access to services for individuals and families, ensuring support is available when needed.
 - Maintains broad, inclusive eligibility for individuals with substance use-related needs, with targeted outreach to justice-involved populations including Drug Court, Family Recovery Court, and Intensive Supervision Probation.

- Delivers community-based services including recovery outreach, naloxone distribution, support navigation for physical and behavioral health care needs, resource referrals, housing support, and social connection to recovery community services.
- Engages families through CRAFT-informed support groups and education, recognizing the role of family support in recovery outcomes.
- Ensures service quality through state-approved Certified Peer Support Specialist training, ongoing professional development, and supervision emphasizing ethics and cultural responsiveness.
- Implements continuous transition planning for participants from initial contact through ongoing engagement, including warm handoffs to treatment, healthcare, and recovery supports, with voluntary follow-up contact to promote continuity of care and sustained recovery.
- USARA's commitment to evidence-informed practice and statewide leadership in peer services, the organization integrates evaluation findings into program refinement, workforce development, and strategic planning.

DBHS is fortunate to have a diverse network of providers in SL County that also do considerable outreach to the community and attend many community and governmental events and help spread the word throughout the community regarding their services and how to access them.

Additionally, staff at DBHS provide regular training and educational opportunities to providers and community stakeholders regarding services offered and DBHS programs administered. One example was a presentation made at a Department of Corrections Staff In-service Training in April, highlighting the three primary Medicaid plans, the DBHS Network of Providers, how to support their clients in accessing services, anticipated impacts from HR1, and the offer to work together to mitigate harm to our clients as these provisions roll out.

Another example of these efforts involves outreach into the community and with cities, as new housing programs are opened. Leading up to the opening of the Canyon Rim Boarding Home, DBHS participated in town hall meetings in Millcreek City regarding the 43-bed Canyon Rim facility for SMI women. These meetings were held to help the community understand the type of program being sited in their community and the proposed population being served. Through the community feedback process, several key aspects of the program were adjusted, including changing the population served from males to females. Switchpoint and the Division provided data and answers for several hours on multiple occasions. Although not required to hold such meetings or to make any changes to the policies and operating procedures at Canyon Rim, the commitment to transparency and a willingness to listen and adjust to community feedback was instrumental to the early success of Canyon Rim. Millcreek monthly boarding home meetings occur now, which include Millcreek City administration; law enforcement from UPD and their social work team; representation from our two boarding homes there; and DBHS.

DBHS recently had the opportunity to present to the State Homeless Services Board regarding boarding home models and Assertive Community Treatment (ACT) teams. Collaboration with these stakeholders will be instrumental in the upcoming effort to bring on 3 new group homes and 2 new ACT teams in the near future.

Mental Health and Substance Use - Justice Services

The following sections are the Mental Health and Substance Use Justice Services requirement from the Code and SUMH Office Directives. Each LA must complete with an overview of how each service will be implemented in their catchment.

For the Service Delivery Framework, describe operational and clinical implementation of the service, outreach, training, access procedures, assessment tools, eligibility criteria, family engagement, transition planning.

For the Outcomes Framework, describe specific metrics used to track performance (e.g., recidivism, length of stay, discharge barriers), process for analyzing data to drive continuous quality improvement.

Justice Involved Individuals (including JRI funds) (Mandated Services, Directives)

For Justice Involved Individuals, please describe:

Service Delivery Framework: *Please also include what criminogenic screening tools are utilized and do you include criminogenic risk goals in the client treatment plans?*

Project RIO (Right Person In/Right Person Out) began in 2006 when the Salt Lake County Criminal Justice and Mental Health Systems concurred with Munetz and Griffin that in the ideal case, persons with mental illness would have the same rate of contact with the criminal justice system as does any other person. Systemic improvements were implemented that involved all five of the “sequential intercepts” in which persons with behavioral health conditions contact the criminal justice system, with the goal of diverting persons who have mental illness or substance use disorders and who are non-dangerous offenders from incarceration. These programs supported an already active CIT program and Mental Health Court and were the product of a rich collaboration of numerous agencies. Below, please find an array of federal, state, and county funded programs that exist today. Programs supported in varying degrees by JRI funds have a **red *** next to them.

DBHS is a member of the Criminal Justice Advisory Council, where ongoing systemic needs are addressed monthly and coordinated and planned for. One example is the new Receiving Center. As this program was developed, it was periodically addressed in this setting to provide updates and receive feedback from stakeholders.

CJAC Membership Includes:

Mayor Jenny Wilson	Salt Lake County Mayor
Sheriff Rosie Rivera	Salt Lake County Sheriff's Office
Hon. Brendan McCullagh	Judge, West Valley City Justice Court
Jiro Johnson	Salt Lake County Council
Dea Theodore	Salt Lake County Council
Coleen Jacobs	Chief of Police, West Valley, LEADS Chair
Kelly Colopy	Director, Salt Lake County Human Services
Sim Gill	District Attorney, Salt Lake County
Kele Griffone	Director, Criminal Justice Services
Representative Jim Dunnigan	Utah House of Representatives
Senator Stephanie Pitcher	Utah State Senate
Matt Dumont	Chief, Salt Lake County Sheriff's Office
Rich Mauro	Executive Director, Salt Lake Legal Defenders Assoc
Honorable Susan Eisenman	Third District Juvenile Court
Tyler Clancy	Coordinator, Utah State Office of Homeless Services
Honorable Laura Scott	Third District Court, Presiding Judge
Jim Peters	State Justice Court Administrator
TBD (In transition)	City Mayor
Tim Whalen	Director, Salt Lake County Behavioral Health Services
Pamela Vickrey	Utah Juvenile Defender Attorneys, Executive Director
Scott Fisher	Salt Lake City Municipal Prosecutor
Andrew Johnston	Salt Lake City Homelessness Director
Brian Redd	Police Chief, Salt Lake City
TBD (In transition)	City Mayor
Mark Paradise	Third District Court Trial Executive
Rebecca Brown	Deputy Dir, Utah Dept of Corrections
Wendy Isom	Program Director, SLC Police Department Victim Advocate
Honorable Mark Flores	South Salt Lake Justice Court

Sequential Intercept #0-1 - Crisis Services & Law Enforcement & Emergency Services

- **Crisis Line & Warm Line** - The Huntsman Mental Health Institute (HMHI) Crisis Line, in affiliation with the National Suicide Prevention Lifeline, is in operation 24/7, 365 days of the year, acts as the front door to the HMHI Crisis System, and is staffed by experienced certified crisis

workers. The Crisis Line team coordinates Mobile Crisis Outreach Teams as needed. The Warm Line is a peer-run phone line staffed by individuals in recovery. Peer operators are trained to attentively and empathically listen to callers, offer compassion and validation, and assist callers in connecting with their own internal resources, strengths, and direction.

- **Mobile Crisis Outreach Teams (MCOTs)** - HMHI interdisciplinary teams of mental health professionals (a licensed mental health practitioner and peer support specialist) who provide face-to-face crisis resolution services for individuals in Salt Lake County who are experiencing or at-risk of a mental health crisis and who require mental health intervention. MCOT staff often provide law enforcement with alternatives to incarceration or hospitalization when responding to patients in crisis, allowing the individual to remain in the least restrictive setting. These teams serve both adults and youth, 24/7 throughout the county.

- **Receiving Center (RC)** - The HMHI Crisis Care Center is a short-stay facility (up to 23 hours) designed as an additional point of entry into the Salt Lake County crisis response system for assessment and appropriate treatment of adult individuals experiencing a behavioral health crisis. Clients may receive assessments, medications, and other support. It may be used by law enforcement officers, EMS personnel, and others as a receiving facility for individuals who are brought there voluntarily or on an involuntary hold. The RC is an innovative program that provides a secure crisis center featuring the “Living Room” model, which includes peer support staff as well as clinical staff. The goal of the center is to reduce unnecessary or inappropriate utilizations of ER visits, inpatient admissions, or incarceration by providing a safe, supportive, and welcoming environment that treats each person as a “guest” while providing the critical time people need to work through their crisis.

HMHI, in partnership with the county, state, and private donors, opened this new non-refusal 30-chair facility in March 2025. This new center replaces the original RC, which, although progressive for its time upon opening in 2012, was not centrally located and underutilized by law enforcement and emergency services due to a combination of issues.

The Crisis Care Center also houses a new 24-bed rapid stabilization inpatient acute care unit, a medication-assisted treatment clinic for individuals with opiate use disorders and intensive outpatient treatment for adults needing support for mental health and substance use disorders.

A Youth Crisis Care Center is now open in the old RC location, serving children and teens ages 5-17 (18 if still in high school) 24/7 as a walk-in location.

- **Volunteers of America Detox Programs**

DBHS contracts to provide social detoxification services through Volunteers of America (VOA). These programs partner with multiple law enforcement agencies to offer individuals who have been picked up for public intoxication an alternative to jail and a safe environment focused on

recovery. Officers can call for bed availability, van pick-up hours and availability. To meet the criteria for the Jail Diversion Program, clients must be intoxicated, non-combative, medically stable, and willing to go to the detox center.

Volunteers of America Men's Adult Detoxification Program:

VOA Utah's Men's Detoxification Center is a social model residential center for men 18 years and older seeking detox & withdrawal management services. It is a non-medical, client-centered detox program in a safe and trauma-informed environment where clients can manage their intoxication and withdrawal symptoms to prepare them for long-term recovery.

Clients are able to stay up to 14 days when medically necessary, with an additional 7 days available for treatment linkage. They receive three meals a day, case management services, access to medication-assisted treatment, Seeking Safety groups, peer support, and 12-step meetings. Qualifying clients who are interested in treatment for substance use disorders will be able to be screened and/or assessed for treatment. This program is located at 1875 S. Redwood Road, Salt Lake City, UT, 84104.

Volunteers of America Center for Women and Children:

The Center for Women and Children provides a safe place for women to non-medically detox from alcohol and drugs, where they connect clients with providers who can assess for medically assisted treatment. Clients are able to stay up to 14 days when medically necessary, with an additional 7 days available for treatment linkage. The program utilizes a trauma-informed approach and allows women to bring children 10 years old and younger with them.

During their stay, women will have the opportunity to meet with a case manager to discuss their eligibility for substance abuse treatment, as well as get connected to other needed resources. Clients receive three meals a day, access to an outdoor area, and peer support services. Women will be able to attend supportive programming activities, including recovery-focused support groups and working in an onsite garden. This program is located at 1875 S. Redwood Road, Salt Lake City, 84104.

Sequential Intercept #2 – Jail

- **Jail Behavioral Health Services** - Mental health and substance use disorder (SUD) services are provided to inmates of the SLCo Jail.

- **Mental Health Services** are funded through a direct appropriation from the County Council to the SLCo Sheriff's Office. Licensed mental health therapists conduct mental health assessments, individual and group therapy, daily triage, and crisis response, in addition to other duties. Psychiatrists and APRN's provide medication management. In addition to those services, mental health case managers assist in the coordination of services and releases for

the severely mentally ill population. This includes such things as verifying medications, obtaining outside treatment records, providing post-release planning, community resources, connecting clients to in-reach services as available, and collaborating/communicating with community stakeholders such as community behavioral health providers, the Legal Defenders Office social workers, and participating in Mental Health Court staffings, and Project RIO (frequent utilizer) staffings.

The Salt Lake County Jail has four dedicated units that can address more severe mental health needs. One is a 17-bed acute mental health unit for individuals who have been identified as high-risk for suicide; an 8-bed overflow acute mental health unit; a 48-bed sub-acute unit for individuals with a mental health diagnosis that would benefit from a more therapeutic setting; and a newly established sub-acute mental health unit with 48 additional beds.

Clients are identified for services through referrals/requests from jail staff nurses and sworn staff (primarily), but all jail staff are able to refer a patient to mental health staff if they have concerns. Inmates may also request mental health services (and are seen by an MH therapist immediately) if they are experiencing a crisis. A therapist will then assess/complete a suicide risk assessment with the patient and provide services/referrals to a case management/psych provider for med management/therapy as clinically indicated. For patients deemed to be a risk to self or others (due to suicide risk or psychosis), MD orders are obtained, and the patient is admitted to the acute mental health unit on full suicide precaution. Assessments/interventions and the patient's response to treatment are documented.

Additionally, each unit is assigned a Pod therapist, who triages inmates daily. The therapist will ask patients to complete a sick call request when needed. The therapist will respond to the request. A case manager will also meet to complete a Release of Information (ROI) for medication verification or clinical assessments. Additional information may come from community partners such as the Legal Defenders Office, community mental health centers, etc. Referrals are made to the Jail's psychiatrist or psychiatric providers for medication management as clinically indicated. Additional clients are identified through behavioral health providers reaching out to the jail to facilitate continuity of care; through the jail reaching out to behavioral health providers in the community to gather information; through a monthly Project RIO (formerly Top Ten) frequent utilizer staffing; through communications with the 4th Street Clinic, LDA, Mental Health Court, Optum, Criminal Justice Services, and other stakeholders. Peer reviews are completed as a means to validate the care they prescribe, patient feedback and CQI study information

The Jail's healthcare services, including mental health services, have been awarded accreditation from the National Commission on Correctional Health Care (NCCHC).

DBHS has developed a strong partnership and relationship with our jail and has established a formal data-sharing agreement. The jail is currently reporting collected data from the jail offender management system to DBHS for submission to OSUMH. There continues to be excellent collaboration with the jail, and we will continue to collaborate with them on our Alternative to Incarceration programs.

- **Withdrawal Services** - The Salt Lake County Jail has an intoxication and withdrawal policy to ensure safe and effective drug and alcohol withdrawal and clinical management of patients in withdrawal. A program of medical detoxification will be initiated for each patient incarcerated in the jails who is physically and/or psychologically dependent on the following: alcohol, opiates, stimulants, sedatives, hypnotics, or hallucinogenic drugs.

Health Services within the jail are responsible for providing procedures for the clinical management of these patients. The protocols for intoxication and detoxification are approved by the responsible physician, are current, and are consistent with nationally accepted treatment guidelines. Medical detoxification is performed at the jail under medical supervision or at a local hospital depending on the severity of symptoms.

Patients are screened by a registered nurse and mental health professional for drug and alcohol abuse or dependence in processing at the nurses' pre-screen and during the comprehensive nurse and mental health screenings.

These screenings will include a detailed history of the type of drug; duration of use; frequency of use; approximate dose; last dose; history of prior withdrawal; history of prior treatment for withdrawal; and current signs or symptoms of withdrawal.

All patients found to be withdrawing from a physiologically addicting drug will be treated in accordance with recommended medical practice. Treatment will be determined by the individual needs of the patient as well as the type and severity of the drug withdrawal. Patients at risk for progression to more severe levels of withdrawal are transferred to the Acute Medical, Acute Mental Health, or Sub-Acute Mental Health units or to an outside medical provider for observation, treatment, and stabilization.

- **DBHS funds the following SUD services** in the jail:

Corrections Addictions Treatment Services (CATS) operates within the Oxbow Jail and Adult Detention Center (ADC) in South Salt Lake. CATS is an evidence-informed substance use treatment program delivered at an intensive outpatient level of care, providing 9–19 hours per week of therapeutic and skill-based services. The program is grounded in a therapeutic community model.

The program has a capacity of 160 beds, including 128 beds for males and 32 beds for

females, all located within the Oxbow Jail Programs Division. CATS follows a therapeutic community model with an average length of stay of approximately three months.

While enrolled in CATS, individuals are screened for Medicaid eligibility, and the program may access funding through the Justice 1115 Medicaid Waiver, which covers medical and treatment services for up to 90 days prior to release. CATS also serves as a direct referral partner for the Vivitrol program and the Division of Behavioral Health Services (DBHS) housing programs.

Upon successful completion of the program, a TAM Medicaid application change form is submitted to the Department of Workforce Services (DWS) to ensure continuity of benefits. Participants are also provided with a clinical referral to a county-approved treatment provider to support ongoing recovery.

CATS currently includes a psychoeducational component, **Prime for Life**, serving up to 1,500 individuals. In addition, the program offers a broader continuum of care through interim group services known as **Drug Offender Group Services (DOGS)**, which are available in both medium- and minimum-security settings. All CATS-related services, including DOGS and Prime for Life, are delivered under contract with Odyssey House.

Future Plans

- Implement random drug testing within the CATS program to promote abstinence from illicit substances during incarceration.
- Explore the expansion of an additional 32 treatment beds over the next year in partnership with the Jail Programs Division.

DBHS does not spend any SAPT funds on jail-based programming. The division utilizes County funds, SSOR Grant (previously STR and SOR) dollars, and other State funds for these programs.

Jail Medication-Assisted Treatment Program - MAT programming in the jail began in 2015, utilizing one medication, and later expanded to all three FDA-approved medications in 2019. Qualifying program participants with opioid or alcohol use disorders have access to medication-assisted treatment, substance use disorder behavioral therapies, and coordinated referrals to community treatment services upon release. MAT program medications may include methadone, buprenorphine, or naltrexone. The MAT program provides a whole-patient approach to the treatment of substance use disorders and is clinically driven with a focus on individualized patient care. Services are provided through the jail's health services staff and through a contract with Project Reality. Naloxone kits are provided to qualifying participants upon release (as supplies last).

- **Community Treatment Outreach Services (CTOS) *** - This Valley Behavioral Health (VBH) team

works with severely mentally ill (SMI) clients who are currently in jail, recent releases, and also clients in the community who may be diverted from jail. CRT staff visit inmates prior to release to develop an APIC (Assess, Plan, Identify, and Coordinate) plan, a pre-release relationship with the inmate, assure medication continuity upon release, pre-determine eligibility for benefits, and assist with transportation from the jail through the ATI Transport.

• **Salt Lake County Criminal Justice Services Pretrial Services**

- Interviews clients booked to determine eligibility for release.
- When appropriate, provides a non-financial release from jail and case management throughout the pretrial phase.
- Utilizes validated risk assessment (PSA) to determine supervision level.
- Utilizes evidence-based tools to assist in behavior change throughout supervision.
- Provides court case and hearing information and reminders.
- Provides referrals to community resources to help reduce barriers to client success.
- Monitors court-ordered special conditions and notifies the court of compliance when appropriate.

• **County Prefile Intervention Program (“CPIP”)**

Since August 2019, the Salt Lake County District Attorney's Office, in partnership with Salt Lake County Criminal Justice Services (CJS), has operated the County Prefile Intervention Program (“CPIP”), a formalized diversion program targeting low-risk offenders.

- Individuals appropriate for CPIP are generally those with no criminal record or a minimal criminal record who are alleged to have committed a non-public safety offense.
- Cases involving restitution may be accepted, and restitution must be repaid within the term of the diversion.
- Once accepted, CPIP participants meet consistently with their CJS case manager and complete required classes, such as thinking errors, courage to change, etc., depending on their individual needs.
- Successful completion of the program offers clients the opportunity to avoid formally entering the criminal justice system via the diversion agreement.

Sequential Intercept #3 – Courts

• **Mental Health Courts** - Mental Health Courts (MHCs) are a collaboration between criminal justice and mental health agencies in Salt Lake County. Mental Health Courts coordinate case management, treatment services, and community supervision for the purpose of improving the mental health and well-being of participants, protecting public safety, reducing recidivism, and improving access to mental health resources. MHC participants complete a criminogenic risk assessment, which providers have access to and can use as a means of targeting client-specific areas of risk. Providers provide interventions at the individual, group, and case management levels to target areas of risk as well. DBHS funds coordination of care, treatment services, and

housing programs for this population. Please reference the specialty court section of this area plan and the attached MHC Policies & Procedures Manual for additional information.

● **Family Recovery Court** - The mission of the Family Recovery Court is to treat individuals with substance use disorders through an intense and concentrated program to preserve families and protect children. This is achieved through court-based collaboration and an integrated service delivery system for the parents of children who have come to the attention of the court on matters of abuse and neglect. A team, including the Judge, Guardian Ad Litem, Assistant Attorney General, parent defense counsel, DCFS drug court specialist, HMHI Assessment and Referral specialist, case managers, and the court's drug court coordinator, collaborates to monitor compliance with treatment and court-ordered requirements. DBHS funds treatment services and care coordination for this population. Please reference the specialty court section of this area plan for additional information.

● **Adult Recovery Court** - The establishment of drug courts in the State of Utah is part of an ongoing effort to increase public safety by supporting recovery. Judges observed the same offenders appear in their courts time and time again, and it became evident that traditional methods of working with individuals with a substance use disorder, such as strict probation or mandatory imprisonment, did not address the fundamental problem of addiction. Drug Court teams work through a close collaboration between the court system, supervising agencies, and treatment providers. DBHS funds services and care coordination for this population. Please reference the specialty court section of this area plan for additional information.

● **HOME Court** - HB 421 (2024 GS) directs the establishment of a Salt Lake County HOME Court Pilot Program to provide comprehensive, court-supervised treatment and services to individuals in Salt Lake County with mental illness. The bill requires the Third District Court of Salt Lake County to implement this court and for Salt Lake County to coordinate participants' treatment, housing, social services, case management, peer support, and exit or transition services. Costs of all services provided, including the costs of the multidisciplinary team, are to be paid for by Salt Lake County. A one-time appropriation of \$2M was appropriated to the Salt Lake County MH Authority for a 5-year pilot (~\$400,000 a year). Additional funds, \$488,800 ongoing, were appropriated to the court for their role.

In addition to ~\$700K in HOME Court appropriations, DBHS dedicated ~\$1.6M to expand the capacity of ACT Teams to 500 and remodel and reopen a 30-unit group home called Featherstone. The ribbon cutting for the group home occurred on March 26, 2025.

Team members include: The Third District Court, Salt Lake County Behavioral Health Services & their network of providers, the Salt Lake County District Attorney's Office, USARA, Legal Defenders Association, Division of Services for People with Disabilities, Housing Connect, Utah Legal Services & The Law Office of Julie George.

The Civil Commitment (CC) HOME Court opened February 2025, with recurring sessions every 3 weeks. Many potential candidates were screened, but of those approved, none showed and/or became HOME Court participants. This is a civil court, with no adverse consequences if a client is unwilling to participate. Reasons for those that received denials upon screening included: Already on civil commitment, already engaged in treatment, already engaged in services in another county, on civil commitment in another county, or engaged in competency proceedings in their criminal case.

Due to low participation, the 2nd pipeline, Eviction Court, opened July 18, 2025, with the added bonus of having a housing authority as a partner to engage new clients facing eviction (or at risk of eviction) due to their mental illness; help transport them to court, etc.; and Utah Legal Services representing clients in court. As of this writing, there are 5 active clients, with mediocre results. The court plans to move to Grace Mary Manor to support client attendance.

In late 2025, due to low participation in the 2nd pipeline, the HOME Court team met to consider implementing a 3rd pipeline, the Criminal Court pipeline. Populations considered were:

- **Individuals Not Competent/Not Restorable**

Individuals meeting the HOME Court statutory requirements (unlikely to survive or remain safe without supervision, assistance, services, etc.) that have criminal cases but are not competent/not restorable and may benefit from the black robe effect as we try to engage them in services. In this pipeline, the DA's office would work to identify potential candidates, the LDA's office would appear in court to represent participants, and the rest of the process would flow as previously described in the HOME Court Overview attached.

- **Low-Risk High-Need Clients Denied MHC**

Individuals meeting the HOME Court statutory requirements (unlikely to survive or remain safe without supervision, assistance, services, etc.) that were screened for Mental Health Court and are high-need but were denied due to being low-risk.

After lengthy deliberations and considerations, the stakeholders were unable to agree to implementing this pipeline. The reasons were:

- The lack of a "carrot" (needed in a civil court with voluntary participation). With no guarantee of immediate housing (a myth promoted by the name of the court as "HOME" Court), the only other carrot would be a stipulation in the criminal case that if an individual participates, charges would be dismissed/stayed/plea in abeyance, etc. This option was not considered a viable pathway, given the current environment and pressures to hold this population "accountable" (incarcerated, not released early, etc.).
- Additionally, one stakeholder expressed that these individuals will not benefit from the black robe effect, as they are in front of judges all the time and are "frequent flyers", so seeing a judge will not lead to compliance on their case.

- Last, this court is not needed for individuals to access treatment; we have immediate openings right now in all levels of care, with the exception of MH residential, with a 1-3 month wait list (due to lack of housing – causing residents to stay longer in residential care).

For more information on the structure, criteria, and pipelines, please reference the **HOME Court Overview** and **Civil Commitment Court HOME Court and Eviction HOME Court Flyers** attached to this Area Plan.

- **Social Services Position Housed in the Legal Defenders Office** - this position coordinates connecting individuals with severe mental illness involved in the criminal justice system to community treatment, Alternatives to Incarceration (ATI) releases, referrals to Mental Health Court, etc. Additional social services positions are housed in the legal defenders' office, offering invaluable assistance in connecting large numbers of clients to treatment.
- **Case Resolution Coordinator** - An attorney funded through Salt Lake County, housed in the Legal Defenders Office, that helps individuals with behavioral health conditions resolve multiple court cases throughout the valley (in coordination with other court orders). Through close coordination of treatment and judicial oversight, individuals may be diverted from incarceration, avoiding changes or lapses in their medications and loss of housing and associated emergency room visits or hospitalizations.

Sequential Intercept #4 – Reentry

- **Project RIO (formerly Top Ten)** - Through new federal grant funding, Top Ten transitioned to Project RIO through the Legal Defenders Association (LDA), allowing a more hands-on approach to serving this population and to serve more clients. Once a month, the LDA's office facilitates a group that meets to staff frequently booked individuals with severe mental illness. Partners include the Legal Defender's Association (LDA), Valley Behavioral Health, HMHI Crisis Programs, Jail Mental Health, DBHS, Optum, The Road Home, Volunteers of America, the SLC PD Community Connections Center, 4th Street Clinic, Criminal Justice Services, Division of Services for People with Disabilities (DSPD), and Odyssey House. Team goals are
 - Ensure jail mental health is aware of an individual's diagnosis and medications prescribed in the community prior to arrest, and vice-versa, ensure community mental health programs are aware of an individual's diagnosis and medications prescribed in jail prior to release.
 - Develop a pre-release relationship with the inmate prior to release whenever possible.
 - Work to assertively engage the client in treatment upon release, address continuity of care/medications and transport if appropriate.
 - Refer into appropriate programs (Mental Health Court, ACT Teams, dual-diagnosis residential programs, Jail Diversion Outreach Team, other outpatient services, housing, DSPD services, etc.).
 - Communicate with the individual's attorney.

- Communicate with county supervising case managers, state AP&P officers or other private supervising agencies.
- Coordinate jail releases when appropriate.
- Support the client to resolve open court cases.
- Coordinate with medical providers when appropriate.
- Coordinate with other community providers (VA, private providers, etc.).
- Assist with housing, entitlements, and other needed supports.
- Address individuals as pre-contemplative rather than non-compliant when unable to engage them in services. That is, try, try again.

IT support was provided by the Salt Lake County Mayor's Office of Criminal Justice Initiatives, providing real-time information regarding bookings, charges, court cases, and other pertinent information.

• **CORE (Co-occurring, Re-Entry & Empowerment) *** - VBH CORE 1 and CORE 2, offer services to adult male and female individuals suffering from co-occurring disorders, including substance use disorders and serious mental illness. These 16-bed residential facilities are designed to provide wraparound services at the time of discharge. CORE 1 and CORE 2 clients can choose to engage in CORE Recovery Management at the time of discharge, where they are offered a lower level of care and case management and are either living in CORE housing or in other housing. The case managers work with clients to help get permanent housing and other services needed to help the clients maintain independence after residential treatment. These programs were implemented due to community requests and have demonstrated impressive outcomes over the years with the ultimate goal of successful reentry and a reduction in jail recidivism.

DBHS utilizes multiple funding streams, including JRI, for the VBH CORE 1 & 2 programs.

A 2020 report found a 78.6% reduction in criminal recidivism for CORE 1 (men) and a 92.5% reduction for CORE 2 (women), when comparing 3 years prior to 3 years post-program admission.

JRI dollars also support housing for the CORE programs and CTOS clients. DBHS contracts for these housing resources through Housing Connect. Valley Behavioral Health provides mental health and substance use disorder services and in-home case management visits throughout the client's residency in these units.

• **Odyssey House Women's MH Residential Program *** - This 16-bed facility is a dual-diagnosis residential facility for women, providing mental health stabilization services and medication management to women with primary mental health diagnoses. Due to high demand from Mental Health Court and other stakeholders, this new program was brought online in 2020.

• **Odyssey House Men's MH Residential Program *** - This 16-bed facility opened on April 27,

2022, and is a dual-diagnosis residential facility for men, providing mental health stabilization services and medication management to men with primary mental health diagnoses. Due to high demand from Mental Health Court and other stakeholders, this new program was brought online.

- **VBH Steps** - is a male-only, 16-bed, primary mental health residential treatment program designed to help stabilize and support adult clients experiencing minimal or no substance use disorder through medication management, therapy, case management, and benefits coordination. This program provides similar services as the CORE programs.

- **VOA Men's MH Ballington House Residential Program** - This 16-bed facility opened in 2024 and is a dual-diagnosis residential facility for men, providing mental health stabilization services and medication management to men with primary mental health diagnoses. Due to high demand from Mental Health Court and other stakeholders, this new program was brought online.

- **ATI Transport *** - This VBH program transports severely mentally ill inmates released from the jail at a specific time (avoiding nighttime releases) and transports them to a community-based treatment provider for assessment and services. They measure success by tracking the number of individuals successfully transported to the right program. Currently this is 100%.

- **The Fourth Street Clinic (FSC)** - Collaborates with the jail health system to help provide continuity of care for individuals who are registered patients at FSC, supporting these patients to continue the medications and treatment they were receiving prior to incarceration. Staff at FSC are also able to coordinate with the jail health system to help provide continuity of care when individuals experiencing homelessness are released from jail and want to re-establish care with the clinic.

- **DWS Medicaid Eligibility Specialists** - DBHS funds a Medicaid Eligibility Specialist to assist with enrollment into Medicaid. Currently these services are provided both remotely and on-site in the DBHS offices 2 days a week. Another DWS Medicaid Eligibility Specialist is embedded within the largest behavioral health provider.

- **Navigator and Certified Application Counselor Assistance** - DBHS providers, the jail, Criminal Justice Services, the Legal Defenders Association, Homeless Resource Centers, state corrections programs, and others collaborate with navigators and certified application counselors to enroll individuals in Marketplace Plans, Medicaid, and other health plan options. Many partner with Take Care Utah for enrollment assistance. Currently they are a blend of in-person and remote services. DBHS worked aggressively throughout the years to develop a coordinated response to enrollment efforts within the criminal justice and behavioral health populations.

- **Gap Funding** - DBHS provides gap funding to assist with medications and treatment for uninsured severely mentally ill individuals being released from jail.

● **Jail Resource Reentry Program (JRRP)** - The Jail Resource and Reentry Program (JRRP) is voluntary and offers support to individuals as they transition back into the community from jail. Salt Lake County Criminal Justice Services assists individuals in navigating the complexity of the criminal justice and social services systems. Clients are informed of their upcoming court dates and given contact information if on community supervision. They have access to phone charging stations; snacks, water, and female personal hygiene products; SNAP/Medicaid enrollment; Naloxone; Department of Workforce Services (DWS) information; a safe place to wait for services; transport options (bus tokens, taxi service, VOA van service, and homeless van services); treatment referrals; homeless housing referrals; donated clothing items; and other resources.

Sequential Intercept #5 - Community

● **VOA, Odyssey House (OH) & VBH, Assertive Community Treatment (ACT) Teams & Odyssey House Forensic ACT Team** - Salt Lake County/Optum has contracted with VOA, VBH, and OH to implement Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) team service delivery models for up to 500 Salt Lake County residents. The teams provide intensive home and community-based services. The ACT teams offer a “hospital without walls” with a multidisciplinary team. The emphasis is to provide support to those who are high utilizers of services and to offer stabilization within the community. ACT teams work toward fidelity per SAMHSA requirements and are monitored every 1-2 years. DBHS also funds housing for these programs. A large portion of these individuals are justice-involved. Please reference the ACT Flyer attached to this Area Plan for additional information regarding these teams.

● **Housing Programs *** - DBHS funds multiple housing programs for individuals involved in the justice system (and others). Some serve individuals with severe mental illness, while others are tailored towards supporting individuals with primary SUD conditions. These programs are a combination of scattered units throughout the valley, boarding homes, rental assistance vouchers, sober living homes, and partnerships on tax credit housing projects. DBHS sometimes funds Medicaid supportive living rates, rental subsidies, and even some capital expenses. Please reference the housing section of this area plan for additional information.

JRI funding is used for a portion of these housing programs.

● **Intensive Supervision Probation (ISP)** - DBHS continues to partner with the Sheriff's Office and CJS on ISP. ISP targets high-risk, high-need (SUD) individuals sentenced to county probation at CJS. Clients are evaluated using the LS/CMI risk tool, along with an ASAM assessment to determine the appropriate level of supervision and care. In 2026, ISP has become much more objective, especially in regard to placements. Following the 2025 program overhaul, all clients are placed into ISP solely based on their risk and need, rather than through judicial order or alternative even (revoked from existing probation and reinstated into ISP because of past probation failures, regardless of risk/need

profile). Clients continue to be supervised in the community by deputies from the Sheriff's Office and receive intensive case management services through CJS. DBHS provides dedicated assessment staff working in coordination with the deputies and case managers, as well as prioritized access to treatment services for the uninsured and underinsured populations.

Through this model there has been an increase in the number of clients who present for an assessment and treatment, reductions in the wait times associated with accessing treatment, and lower attrition rates when compared to the overall system. Through the expansion and evolution of the program, Recovery Support Services (case managed at DBHS), access to evidence-based MAT (case managed at DBHS and offered through a network of providers), and peer-led recovery coaching (through a contract with USARA) are accessible to ISP participants.

- **Mental Health Court Housing** – beginning in FY22, mental health court housing units (2 master leased units and 6 units at First Step House's Fisher House) transferred from Salt Lake County Criminal Justice Services to DBHS.
- **Rep Payee Services** - a supportive service to individuals in need of assistance in managing their finances. Many individuals with severe and persistent mental illness, cycling through the criminal justice system, benefit from this type of service.
- **Supported Employment Programs** – multiple Salt Lake County network providers operate successful employment assistance programs for justice-involved populations. Please reference the Supported Employment section of this area plan for additional information.
- **USARA** - DBHS assists with funding for this program. This organization provides peer recovery support services, delivered by peer recovery coaches, a non-clinical support that brings the lived experience of recovery along with training and supervision to assist individuals in initiating and/or maintaining recovery. They also provide support groups for families and friends who are concerned about someone with a substance use disorder, mutual aid groups in multiple recovery pathways, and social events.

This program has targeted efforts for justice-involved populations such as the Intensive Supervision Probation Program, Family Recovery Court, Drug Court, and others.

- **Medication-Assisted Treatment Programs** - In past years, DBHS utilized federal dollars to expand medication-assisted treatment access within the community. Salt Lake County had six out of the top ten hotspots identified within the state for opioid-related emergency room visits and overdose deaths. In an effort to address these hotspots, capacity in the existing Project Reality location was increased, and two new clinics were opened in other areas of the county.

One of the additional clinics is located in West Jordan, through Clinical Consultants; the other is

located in Murray, through Project Reality. Federal grant dollars are utilized to maintain some of these clinics. Several other MAT providers exist within the network.

- **Community Mental Health and SUD programs** - there are many other mental health or substance use disorder treatment programs in all levels of care that serve the criminal justice population. Medicaid expansion has enabled an unprecedented expansion of these services.

As an example, in Salt Lake County, ~170 SUD residential beds existed in 2016 and currently exceed 600, more than tripling capacity within the Salt Lake County network. In 2015, 32 mental health co-occurring residential beds existed; by 2024, there were ~100 beds, again more than tripling capacity.

Criminogenic Screening and Assessment Tools

In Salt Lake County, services are provided through a network of public and private providers within the community. The criminogenic screening and assessment tools utilized by these programs may be varied. The Intensive Supervision Probation Program, for example, employs the LS/CMI with each program participant, while the University of Utah Assessment and Referral Services utilizes the RANT. Unfortunately, even though Salt Lake County Criminal Justice Services and Adult Probation and Parole complete the LS/CMI with participants, the full results are not shared with providers within our system (based on proprietary concerns), requiring duplication within the network.

Strategies used with low and high-risk offenders

All clients are screened for criminogenic risk using validated, JRI-recommended tools (either the LS/CMI, the LSI, or the RANT) depending on the agency. Based on capacity at each agency and the ability to stratify residential and outpatient programs by risk, clients are separated into the most appropriate setting. For example, Odyssey House places all “intense” and “very high” risk clients at their Millcreek campus. All “high” risk clients go to the downtown facility. All “moderate” clients attend Lighthouse, and all “moderate-low” clients attend the Meadowbrook facility. Because of the size of the programs at Odyssey House, they would not have low-risk clients in service with high-risk clients. For the outpatient side of services, OH places all lower-risk clients in the weekend IOP/OP Expedition Program. Not as much flexibility exists for outpatient clients. Other agencies do not have as much flexibility because of the size of their programs and other financial constraints. First Step House, for instance, does not serve many, if any, low-risk clients. They do have some higher and intense risk programs that will serve only clients scoring in the 25+ range of the LS/CMI (REACH Program). Lower-risk clients at FSH are typically referred to other programs for services, where they can receive differentiated services based on their lower risk scores. In our criminal justice programs (such as the ISP Program), many different EBPs are utilized to work with higher-risk clients (all clients are at least a 30 on the LS/CMI). These include EPICS (Effective Practices in Community Supervision), BITS (Brief Intervention Tools), Seeking Safety, and risk-based case planning based on the Risk, Needs, Responsivity (RNR) model.

Programs working with children and youth involved with the juvenile justice system, local DCFS, DJJS, Juvenile Courts, and other agencies include the following:

- **The Odyssey House Parents with Children Program** – this program works with DCFS custody youth to reunify them with their parents while concurrently providing mental health and developmental services.
- **Salt Lake County Youth Services** – Their Youth Hub offers screening, evaluation, and referral services to youth, families, and law enforcement 24/7. Services are for youth ages 8 to 17 who need a crisis timeout; are runaway, homeless, or ungovernable; or have committed minor offenses. This program tracks the number of runaway/homeless youth who were released back to their parent/guardian, safe exits for runaway/homeless youth, and outcomes around youth connections with peers and professional support.
- **Volunteers of America, Utah's Treatment Services Division (Cornerstone Counseling Center/Family Counseling Center - VOA/CCC/FCC)** - Volunteers of America, Utah provides behavioral health services to justice-involved children and youth through Cornerstone Counseling Center and Family Counseling Center. Services are based on a client-centered biopsychosocial assessment and delivered by licensed clinicians, therapists in training, and Advanced Practice Registered Nurses (APRNs).

Services include individual therapy (including play therapy), family therapy, group therapy as indicated, and medication management for youth ages 16 and older. Evidence-based practices, including Parent-Child Interaction Therapy (PCIT), are utilized for younger children. Services are coordinated with referring systems, including DCFS, DJJS, and juvenile courts. Services are delivered through coordinated, multidisciplinary care, with referrals from justice and child welfare systems. Treatment is individualized based on assessment, with family engagement and collaboration with involved systems to support continuity of care and successful community functioning.

VOA monitors TEDS outcomes data, access to services, completion of services, and functional improvement. Data is reviewed to support quality improvement and coordination with referring partners.

- Please also refer to the Drug Court section for additional information on support to Family Recovery Court and collaborations that occur there with Third District Juvenile Court.

Outcomes Framework:

Data and outcomes collected in this type of programming are gathered through different avenues. Please reference the attached "AP Provider Metrics & Outcomes Sample" for a detailed

list from 5 of the network's largest providers.

The Correctional Program Checklist (CPC) is a tool developed to assess correctional intervention programs and is used to ascertain how closely those programs meet known principles of effective intervention. Several studies conducted by the University of Cincinnati—of both adult and juvenile programs—were used to develop and validate the indicators on the CPC. These studies found strong correlations with outcomes between overall scores, domain areas, and individual items.

As a network system, multiple agencies within the DBHS network have worked with the CPC to assess and then implement strategies to improve their services, in particular around individuals with current or past justice involvement. In recent years, First Step House and Odyssey House have worked extensively with the CPC, among other agencies. In 2025, the Utah Criminal Justice Center reached out to additional agency partners to work with to provide an initial or CPC reassessment. Agencies who had previously been assessed felt they had enough insight from those previous assessments to continue working on improvements without a reassessment. We now have Volunteers of America and Valley Behavioral Health participating in the CPC process. Their initial assessment began in spring 2025 and will continue the evaluation.

Additionally, DBHS has developed multiple outcome measures that vary from program to program. Please reference the attached compilation with examples of reporting metrics and sections in this narrative above for some examples. Data DBHS has collected in the past include hospital diversion rates, treatment engagement, graduation rates, reductions in Risk Scores, positive drug testing rates, number of bed nights funded for individuals in permanent supportive housing, changes in census in co-occurring residential programs, changes in ACT Team census numbers, and NOMS data such as employment, housing, and "frequency of use" changes. New outcome measures for ACT teams were developed in FY22 and continue to be monitored on baselines and targets established in FY23. DBHS has also tracked reductions in jail recidivism for certain cohorts through a data sharing agreement with the Salt Lake County Jail.

Although Medicaid expansion has been a huge benefit to the behavioral health population we serve, it is important to understand that since November 2017 (the implementation of TAM), April 2019 (the Medicaid Expansion to 100% FPL), and finally January 2020 (expanding up to 138% FPL), DBHS lost the ability to track many of the metrics above for a large portion of these programs.

Will JRI funding be used to provide services to individuals that are or were incarcerated directly or through a contracted provider?

- ☐ Directly
- ☒ Contracted provider (Please include a list or a link of contracted provider)
- ☐ Organized by Jail Facility

Providers include Valley Behavioral Health; Odyssey House; and Housing Connect. Additional providers serve the justice-involved population through alternative funding sources.

Department of Corrections (UDC) (Directives, Mandated Service)

Will the LA provide services to individuals referred or approved by the Department of Corrections directly or through a contracted provider?

- ☒ Directly
- ☒ Contracted provider (Please include a list or a link of contracted provider)

A list of RSS providers may be found in the Area Plan attachments.

UDC funding can be utilized for Mental Health, Substance Use and/or Recovery Support Services (RSS). Please describe the services the LA intends on providing with the use of these funds. If RSS services will be provided, please indicate this will be covered in the RSS section.

This will be covered in the RSS section. Additional details may also be accessed in the attached RSS PDF.

Drug Courts (ADC) (Directives)

Will the LA provide services to individuals involved in a Drug Court directly or through a contracted provider?

- ☒ Directly
- ☒ Contracted provider (Please include a list or a link of contracted provider)

Please reference the provider list attached for a complete listing of contracted BH treatment providers within our county. Drug Courts are also a referring partner into supportive services such as Sober Living and RSS. Case managers in our office meet with these clients (and others) and connect them with resources.

Select the drug court(s) that the LA provides services to:

- ☒ Family Dependency Court (***In SL Co, this is called Family Recovery Court***)
- ☐ Youth Specialty Court
- ☒ Adult Specialty Court (***In SL Co, these are called Adult Recovery Courts***)
- ☐ DUI Court
- ☒ Mental Health Court (MHC)
- ☒ Vet Court (***If a client were to utilize Legacy Medicaid in addition to VA benefits***)
- ☒ Other Courts? Please specify what other courts

There are numerous specialty courts throughout the county, at both the District Court level and the Justice Court level. While we fund a MHC Coordinator for the two District Court MHCs through Optum (agnostic of the client's payer) and other staff that are involved with Family Recovery Court (1 court) and Adult Recovery Courts (5 courts); clients in these courts and any other specialty

courts (such as the SLC Justice Court Familiar Faces Court); and clients funded through Legacy Medicaid or unfunded would access services through our provider network.

Service Delivery Framework: Please also include validated criminogenic screening tools used to screen drug court participants, federally approved Medication Assisted Therapy (MAT) allowed, and any restrictions to MAT. Include plans to remove/reduce barriers.

Salt Lake County Adult Recovery Court Track A (4 high-risk courts) and Salt Lake County Recovery Court Track B (1 medium-risk court)

All Recovery Courts utilize an evidence-based service delivery framework grounded in the Risk-Need-Responsivity (RNR) model, ensuring that participants receive interventions matched to their criminogenic risk level, clinical needs, and individual responsivity factors. Participants are identified early and engaged in a continuum of services that include screening, assessment, treatment, supervision, and recovery support. The program uses a validated criminogenic risk assessment tool, the Level of Service/Case Management Inventory (LS/CMI), to inform eligibility, case planning, and supervision intensity. Consistent with national best practices, services are coordinated through a multidisciplinary team and adjusted based on ongoing assessment results and participant progress.

The program supports the use of all FDA-approved medications for opioid and alcohol use disorders, including methadone, buprenorphine, and naltrexone. MAT decisions are made by licensed medical providers and are not restricted by recovery court policy. Participants are not sanctioned for appropriately prescribed use, and the program works to reduce barriers by supporting access to providers, assisting with insurance and transportation, and promoting education to reduce stigma.

Family Recovery Court (FRC)

The Third District Juvenile Court Family Recovery Court has undergone some significant changes over the last fiscal year, which was July 1, 2025-June 30, 2026. The program took a pause on accepting referrals from July 2025 through October 2025. The Family Recovery Court resumed accepting referrals to Judge Diaz, Judge Flater, and Judge Jan's FRCs on October 13, 2025. At that time, it was communicated that Judge Johnson would not be accepting new referrals and his FRC would no longer be active following the graduation of his remaining two participants in November 2025.

Up until March 25, 2026, Third District Juvenile Court had three Family Recovery Court dockets: Judge Diaz, Judge Flater, and Judge Jan. The decision to consolidate the three FRCs into one was made after careful analysis of referral trends, judicial resource allocation, and treatment court best practices. Additionally, due to the decline in participant numbers, the Division of Child and Family Services (DCFS) began redistributing workload assigned to FRC specialists. Collectively, these factors underscored the need to realign program structure.

The goal of consolidation is to preserve the integrity, effectiveness, and long-term sustainability of the program while maintaining high-quality outcomes for participants. Consideration was also given to the importance of judicial relationships and the peer support, accountability, and community that are central to the success of Family Recovery Court participants.

- Judge Jan held her final FRC calendar on March 17, 2026. Her one remaining participant transitioned to Judge Flater's FRC on March 25, 2026.
- Judge Diaz held her final FRC calendar on March 9, 2026. Her four participants transitioned to Judge Flater's FRC on March 25, 2026.

The Service Delivery Framework:

The FRC utilizes a "one family, one judge" approach to case management, meaning all cases involving the same family are handled by a single judge to improve efficiency, promote consistent rulings, and reduce family stress. The framework relies on a multi-disciplinary, collaborative, and non-adversarial team that includes a Judge, Assistant Attorney General, Guardian Ad Litem, Parent Defense Attorney, DCFS Specialist, Clinical Coordinator, Treatment Provider Representatives, USARA Peer Support Specialists, and Program Administrators. The program delivers services across four phases of treatment, typically lasting 12 to 18 months, which monitor progression, establish advancement standards, and integrate with child welfare permanency timelines. Participants are referred to a continuum of substance use disorder treatments ranging from ASAM level 1.0 (standard outpatient) to 3.5 (residential treatment) based on their clinical needs.

The FRC uses the following validated assessments to screen participants and determine treatment levels:

- Risk and Needs Triage (RANT) Assessment: This tool is used to establish that parents meet the high-risk and high-need threshold required for admission into the FRC.
- Clinical Substance Use Diagnostic Assessment: Administered by Assessment and Referral Services, this involves scientifically tested psychometric instruments to determine a DSM-5 diagnosis and recommend a specific American Society of Addiction Medicine (ASAM) level of care.
- Indicators of high risk include DCFS involvement, an order for reunification services, and treatment needs indicating an ASAM 2.1 or higher LOC.

FRC participants may engage in MAT support through community clinics that offer methadone, Suboxone, and Vivitrol based on client preference and clinical recommendations. FRC does not provide direct MAT services but is supportive of participants seeking MAT through a licensed provider when appropriate.

- The restrictions and rules regarding MAT and other medications include:
 - MAT must be administered and managed strictly by an approved provider.

The FRC explicitly addresses systemic barriers, primarily through financial and logistical support:

- Financial Barriers: Participants in Family Recovery Court are not assessed fees for their

participation in these specialty treatment courts. When accessing treatment, these expenses are generally covered by Medicaid. In cases where the participant does not have Medicaid and the treatment provider is within the Salt Lake County DBHS network, they will be assessed for payment based on the DBHS sliding scale fee schedule. Drug testing fees are covered through a contract with Averhealth or the treatment provider they are receiving treatment services from.

- **Housing & Basic Needs:** The program structure continuously requires participants and the FRC team to evaluate and plan for housing and employment/education. Participants are also encouraged to utilize supports like the Utah Transit Authority (UTA) for transportation and food assistance programs.

Mental Health Courts (2 Third District Courts)

Please reference the attached Mental Health Court (MHC) Policies & Procedures Manual.

Outcomes Framework:

Salt Lake County Adult Recovery Court Track A (4 high risk courts) and Salt Lake County Recovery Court Track B (1 medium risk court)

Outcomes include but are not limited to:

- Completion Rate (Success Rate): successful vs. unsuccessful discharges
- Participation Length: time from program entry to completion or exit
- Engagement: attendance at required CJS appointments
- Stability (SSM): Self-Sufficiency Matrix assessment measuring participant ability to be self-sufficient, including comparison of entry and exit scores
- Risk Reduction: overall and domain-specific scores, including comparison of entry and exit assessments

Data is reviewed on a monthly and quarterly basis using dashboards and reports. The team:

- Analyzes trends across key metrics (e.g., completion rates by risk level, demographics, or service type)
- Identifies gaps or disparities in outcomes
- Uses findings to inform program adjustments
- Implements changes and monitors impact over time

Family Recovery Court (FRC)

Specific Metrics Tracked

The FRC tracks several key performance and outcome metrics to gauge the achievement of

program goals:

- Length of Stay and Permanency Timelines: The program tracks the time participants spend in FRC, with an average length of stay being 12 months. Graduation requires a minimum of 9 months of participation (12 months including the sign-up and follow-up processes). The team closely monitors these timeframes to ensure they synchronize with federal ASFA and state statutory permanency timelines.
- Discharge Barriers and Terminations: The FRC monitors reasons for unsuccessful discharges, which typically include failure to engage in treatment, continued positive or missed drug tests, failure to attend court hearings, and the emergence of acute mental or physical conditions that preclude successful completion.
- Treatment and Sobriety Milestones: The team tracks clinical progress, including the participant's length of time in recovery, sobriety dates, results of random drug tests, current ASAM level of care, and compliance with phase advancement requirements.

Process for Analyzing Data to Drive Continuous Quality Improvement (CQI)

Data analysis and quality improvement are driven by regular reporting and collaborative committee oversight:

- Recidivism Risk: While the provided policies do not detail long-term, post-program recidivism tracking, the program actively identifies and screens parents who demonstrate a "high risk of re-involvement in the child protection and child welfare system" to measure their successful transition to providing safe, drug-free homes. This is an area that the program administrator will be focusing on to strengthen.
- Steering Committee Oversight: An FRC Steering Committee composed of key stakeholders meets quarterly to review the court's design and operations.
- Translating Data into Action: The Steering Committee uses these evaluations to drive continuous quality improvement. For example, as demonstrated in recent committee meetings, the team regularly reviews program criteria against current outcomes and best practices, leading to actionable changes such as extending the enrollment timeline criteria from 6 to 8 months to give high-need parents more time to build readiness and updating the manual section by section to ensure policies remain effective and compliant. Additionally, the updated Family Treatment Court Certification encourages incorporating a "Neutral Discharge" metric for participants who face barriers beyond their control, such as a lack of available treatment beds or loss of court jurisdiction.

Mental Health Courts (2 Third District Courts)

Metrics include:

- New Charge Rebookings Recidivism Rates
- Graduates by Recidivism Status for New Charge Rebooking
- Warrant Rebookings Recidivism Status
- Graduates by Recidivism Status for Warrants
- Any Rebooking Recidivism Rates

- Graduates Any Rebooking Recidivism Rate
- Days in Jail, Bookings Counts and New Charges: Pre- and Post- MHC
- Pre- and Post- MHC, New Charges by Degree
- Initial and Current Housing
- Residential Admissions Overall and by Program
- Successful/unsuccessful Terminations
- Residential Success Rate
- Detox Episodes
- Civil Commitment
- Current and Initial Funding

A data analyst pulls together their "Year in Review" and "Recidivism" sheets to be used to show successes as well as qualify improvement areas.

When was the last time the specialty court manuals and policies were updated?

Salt Lake County Adult Recovery Court Track A (4 high risk courts) and Salt Lake County Recovery Court Track B (1 medium risk court)

March 2026, and updates remain ongoing as the policy manual is discussed/reviewed monthly.

Family Recovery Court (FRC)

The FRC manual and policies were last updated in 2023. However, the steering committee is currently in the process of revising both the participant manual and their policies and procedures manual, which is anticipated to be completed by the end of July, 2026.

Mental Health Courts (2 Third District Courts)

April 2026

Coordinate with the Dept of Corrections to Provide Treatment Services to High-Risk Habitual Offenders

(UCA 64-13-21(8)(a)).

Will the LA coordinate with the Dept of Corrections (DOC) directly or through a contracted provider for Treatment Services to High-Risk Habitual Offenders?

- ☒ Directly
- ☒ Contracted provider (list contractor(s) below)

Service Delivery Framework:

We believe you are referring to this section of code, link [here](#), beginning with (8).

This law requires the Department of Corrections (DOC) to “coordinate with DHHS and the relevant local mental health authority to provide applicable clinical assessments and transitional treatment planning...” at least three months before termination of an offender's parole or expiration of an offender's sentence for those that are habitual offenders with a mental illness and are at a high risk of reoffending.

It is our understanding that, in 2023, the Department of Health and Human Services (DHHS) assumed responsibility for health care in Utah's prison system.

With the DOC exercising custody of this population and with DHHS as their health care provider, we are reliant upon both entities to partner in this effort, as only they have a view into

- Who is in custody
- Which members of the population have a mental illness
- Which members of the population are habitual offenders at high-risk of reoffending
- Which members are within 3 months of release from prison or within 3 months of terminating parole, and already residing in the community, and
- Which members will be residing in Salt Lake County upon release.

They also have the ability to obtain signed releases of information, allowing this information to be shared with us and for collaboration of care.

We look forward to working with them as they begin to reach out to us with these cases to coordinate care. We are hopeful that they intend to utilize Utah's new Medicaid Justice Involved Waiver for services provided 90 days prior to release and understand that as these services are implemented, the state hires pre-release case managers to coordinate reentry and connections to care, provide medications upon release, etc. This will be a huge help in coordination efforts with them!

Fortunately, thanks to Medicaid Expansion, all of their low-income clients already have access currently to our network (if they are Legacy Medicaid members or unfunded) and the TAM and UMIC networks. At the time of this writing, there are openings in Detox, Outpatient, Assertive Community Treatment (ACT) teams, SUD Residential services, and 1-3 month waits for MH Residential programming (due to a lack of housing on the front and back end of treatment). Our providers are agnostic to, and often are unaware of, whether a client is involved with the DOC. We just serve those that need help.

Please be aware that, while we've been told the DOC received additional funding for reentry work with their population, we did not. We will do our best within existing budgets to provide the coordination outlined in the bill for those who reside in Salt Lake County and who are unfunded or are members of Legacy Medicaid. It will be important for the DOC and DHHS to also engage with the other Medicaid plans (TAM & UMIC) for additional coordination of care (we do not manage their behavioral health services or their network of providers).

We have worked with the DOC on other efforts, such as implementing their new funding stream and clients into our Recovery Support Services program (helping with things such as rent, bus passes, work clothes, etc.); assisting them in the past with enrollment information and strategies for enrolling their clients in Medicaid and Marketplace Plans; and enjoy having their Deputy Director, Rebecca Brown, as a member of our SL County Criminal Justice Advisory Council. We supported them with a presentation on April 15th at an in-service training for their treatment teams in understanding the way in which Utah expanded Medicaid, how to access treatment in SL County, the anticipated impacts of HR1, and the importance of supporting our clients through these new requirements. We look forward to working with them on this effort as well!

Outcomes Framework:

We believe this provision was passed in the 2025 general session. To date, we have not received any referrals. Should we begin receiving referrals, we would develop metrics to track participants in this program. Unfortunately, due to the way in which Utah expanded Medicaid, clients often churn between payors (Legacy/TAM/UMIC) during a single episode of treatment. While our provider network is incredible at coordinating care and sharing clinical information between providers as needed with a release of information and switching payors behind the scenes (often invisible to clients), due to federal privacy law, our division will lose the ability to track outcome metrics from the beginning to the end of treatment for a large portion of this population. We would work to implement other measures to show the outcomes of the program.

Guilty with a Mental Health Condition (GMC)

Will the LA provide court-ordered evaluations, treatment plans, treatment and supervision for the GMC population?

- ☒ Yes
☐ No, not at this time

Technical Assistance - Justice Services

Is technical assistance requested for any components of the Justice Services sections?

- ☐ Yes
☒ No, not at this time.

Please name sections requested and provide description of requested TA

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RECOVERY SUPPORTS

Mental Health and Substance Use Recovery Supports

The following section stems from both the LA contract and the FY27 SUMH Office Directives that require a LA response. Each LA must complete with an overview of how components of the directives will be implemented in their catchment.

For the Service Delivery Framework, describe operational and clinical implementation of the service, outreach, training, access procedures, assessment tools, eligibility criteria, family engagement, transition planning.

For the Outcomes Framework, describe specific metrics used to track performance (e.g., recidivism, length of stay, discharge barriers), process for analyzing data to drive continuous quality improvement.

Recovery Support (non-clinical services) (Contract 8.2 & Directives)

Will the LA provide Recovery Support Services directly or through a contracted provider?

- ☒ Directly
- ☒ Contracted provider (Please include a list or a link of contracted provider)

What funding will you be using to support and provide Recovery Support Services? Check box(s)

- ☐ BJA (BJA)
- ☐ Drug Court (ADC)
- ☒ State General (SGF)
- ☐ JRI (JRI)
- ☐ Mental Health (MHBG)
- ☐ Opioid Grant (SOR)
- ☒ Substance Use Block Grant (SUBG)
- ☒ Department of Corrections (UDC)
- ☐ Other- please specify below

Please reference the attached Recovery Support Services Provider List.

Service Delivery Framework: Please include responses that address adult and youth services. Please also include what the process is for identifying and approving Recovery Support Services to ensure that services are needed and appropriate to eliminate fraud, waste and abuse of funds and that the funding is being used for allowable services based on the funding source?

Mental Health and Substance Use Recovery Supports

Beginning in FY26, DBHS no longer operates the PATR or ISP ATR programs, instead choosing to create a consolidated program with all the same rules, referral process, case management, financial caps, and service offerings. The Division is now referring to this program as Salt Lake County Recovery Support Services, or RSS. All services provided are under the direction of the OSUMH Directives, and with the support of the Utah Department of Corrections (UDC). The program is designed to serve three referral populations with recovery support: those transitioning from residential treatment within the DBHS contracted network of providers, those with an assessed behavioral health diagnosis (identified by UDC) under the jurisdiction of the UDC, and those participating in a supported employment program while participating in treatment in our network (piloting in FY26). All participants of RSS must be 18 years or older.

Once referrals are received by the Salt Lake County RSS team, clients are contacted and assigned a case manager. The case manager performs an intake and needs assessment, which includes screening for housing, employment needs, and any other barriers to recovery the client is experiencing. The client creates a recovery plan with their case manager, wherein they work on recovery goals and how to overcome the identified barriers. The case managers authorize services from contracted providers, including dental services, housing support, vision support, assistance in obtaining legal documentation (IDs, birth certificates, etc.), food handler's permits, tools, clothing, and transportation support (bus passes, bicycles, car repairs, etc.). The case manager may also provide the client with hygiene kits routinely, as the need arises, which include deodorant, shampoo, conditioner, razors, shaving cream, combs, laundry detergent, etc.

Outcomes Framework:

As soon as DBHS was notified of the closure of the PATR program as it was previously operating, we began working with UDC and SUMH to ensure there was a continuity of programming available (first discussions occurred with UDC/SUMH in February 2025). Through several discussions and correspondence with both entities, it was not until December 2025 that the new RSS program was established for residential clients transitioning to outpatient; February 2026 that funding was available for the UDC portion of the program; and April 2026 that the supported employment program pilot was initiated. We did not receive an approved ROI from the UDC until April of 2026. We have not received many referrals, but we have been spending the majority of the last few months presenting on the program to provider agencies, setting up new contracts with the Utah Transit Authority and the Bicycle Collective, and streamlining our processes. We intend to work on an outcomes framework concurrently and have agreed to provide UDC with the numbers of referrals received, the number of clients served, types and counts of services, spend per client, and total spend. SUMH has agreed that in order to more fully understand the magnitude of UDC clients being served in the behavioral health system in Salt Lake County, they

Mental Health and Substance Use Recovery Supports

will need to work with State DOH to match UDC clients across all payer plans.

Peer Support Services (PSS)

Will the LA provide Peer Support Services directly or through a contracted provider?

- ☐ Directly
☒ Contracted provider (list contractor(s) below)

- Valley Behavioral Health
- Odyssey House
- First Step House
- House of Hope
- DYS
- Silverado Counseling Services
- Believe in You Counseling
- Hopeful Beginnings
- Altium Health
- Multicultural Counseling
- Alliance House
- University of Utah Warm Line and Mobile Crisis Outreach Team
- CLD3 Counseling
- Utah BH Services Turning Point Centers
- Utah Harm Reduction Coalition
- Domestic Abuse Recovery Services (DARS)

Does the LA currently employ or contract the following for services:

- ☒ Certified Peer Support Specialists (CPSS)
☒ Family Peer Support Specialists (FPSS)
☒ Certified Peer Support Specialists (CPSS) in SUD services.

Service Delivery Framework:

Peer support services for adults (MH and SUD) and families are available in the Optum Salt Lake County Medicaid network of providers. Additionally, community programs, including the Salt Lake County Division of Youth Services, offer family peer support, and Mental Health America is a peer-run agency available in Salt Lake County. Within each agency listed above, Peers are integrated and an integral part of the treatment system.

Mental Health and Substance Use Recovery Supports

Outcomes Framework:

DBHS/Optum educates our providers and expects them to identify when PSS services could be beneficial. If providers do not offer this service in-house, they refer the case to Optum. Peer services are expected to be prescribed in a person-centered treatment plan. Documentation should include a corresponding treatment goal, the services rendered, and a clinical review of the member's progress toward that goal.

The effectiveness of services is measured through reporting by the CPSS offering services to members.

Please confirm that the LA is in compliance with the following office directive: "The LA's PSS team, or a representative peer support specialist, shall meet with LA leadership semi-annually to discuss the peer support program and peer involvement in the agency"

- ☐ Yes
☒ No, not at this time

Homeless Services Supports

Please identify the LAs identified Local Homeless Council (LHC) or Continuum of Care (COC) representative for this SUMH office directive:

Name	Jeannie Edens
Email	jedens@saltlakecounty.gov
Job role/title	Associate Director

Sober Living Program-Homeless services (SLF) (Directives)

Will the LA provide Sober Living Services

- ☒ Directly
☒ Contracted provider (Please include a list or a link of contracted providers)

- 7th Street
- First Step House
- Foundation for Family Life
- Gray Griffin
- House of Hope

Mental Health and Substance Use Recovery Supports

- Collective Recovery
- Odyssey House
- Papilion House
- Phoenix Rising
- Pivot Point
- Sober Living Properties
- Steps Recovery Center
- The Haven

Service Delivery Framework:

The Sober Living Program is operated both directly through DBHS case management and through a network of providers (listed above). Participants are referred to DBHS through four channels: VOA Journey Program, Odyssey House CATS Program, Drug Court, or through residential non-profit providers. Referred individuals meet with a case manager at DBHS, who then works to identify the best geographic location for the client, based on proximity to employment, family, treatment, and other factors. The individual is then provided three months of rent without needing to contribute any of their own income (most will not be employed at this stage). During these three months, the case manager works with the client to make sure they are seeking employment, saving money when possible, paying down debts, attending treatment, and planning for their future once program support ends after six months. Starting in months four through six, individuals provide the DBHS case manager their proof of income, their employment plan, and how they will pay their own rent or pay down debts to ORS (see approved debts in outcomes framework). Clients are also required to submit to weekly urinalysis testing and to participate in all house rules associated with their place of residence. At any given time, DBHS houses approximately 300 adult males and females in the Sober Living Program. In 2027, we anticipate growing this by about 100 additional individuals through County Opioid Settlement Funds allocated to DBHS.

Outcomes Framework:

The Sober Living Program utilizes various metrics to determine individual and program success. As part of the original state appropriation to fund the program in 2018, urinalysis rates were required to be collected and reported back to the state. The program was required to maintain a 10% or lower UA rate across the program to remain in funding compliance. Since 2018, we continue to monitor monthly UA rates by agency and gender. If any specific increase is evident, effort is taken to address the provider and to seek out solutions for the increase in positive rates. This can include virtual meetings with agencies, in-person discussions, site visits, audits, pausing any placements, and even termination of contract for non-compliance.

Mental Health and Substance Use Recovery Supports

Additionally, we code all discharges as positive (remaining housed without additional rental support, moving in with family, or being placed into other more permanent housing), neutral (return to treatment or detoxification without eviction), or negative (incarcerated, AWOL, evicted for violence or substance use). We monitor each agency based on their discharge dispositions of their clients.

Finally, as part of program participation, employment is required so that clients can begin to contribute towards rent or past ORS debts beginning in month four of their program participation. We gather all client payment data and aggregate how much has been paid towards client rent and debts. As many of these debts would never be paid back (past child support, spousal support, court fees and fines in collections, driver's license reinstatement fees, utilities in collections, and eviction orders) given the financial situation many participants find themselves in, this is a tremendous opportunity for clients to not have to decide between paying these debts or their own rent.

Supported Employment Services including Individual Placement Support (IPS)

Will the LA provide Supported Employment Services directly or through a contracted provider?

- ☐ Directly
- ☐ No, not at this time
- ☒ Contracted provider (provide link or list contractor(s) below)

Volunteers of America, Utah and First Step House deliver IPS services. Alliance House also provides supported employment services, but it is outside of the IPS model.

Service Delivery Framework: *Please also include how the LA implements collaboration with the Utah State Office of Rehabilitation/Vocational Rehabilitation Services. Also include adaptations for youth.*

Alliance House

There are currently 11 FTEs at Alliance House and 1 part-time employee.

Alliance House works directly with SUMH for all clubhouses in Utah. Alliance House has received full accreditation from Clubhouse International for meeting these Clubhouse standards and completed Clubhouse International Accreditation in January of 2026, and they are waiting on our outcome. Goals that are currently being worked on include the following:

- Visibility - Increasing our visibility in our larger community to increase membership.
- Diversify Funding - With threats to many funding streams due to the nature of the world, it is imperative that Alliance House continues to diversify funding for sustainability.

Mental Health and Substance Use Recovery Supports

- Training - Alliance House is an international training base, and they have 7 trainings scheduled, offered to Clubhouses around the world.

FSH

First Step House has an Employment Services program that provides services using the IPS model and services that are less intensive for clients who are not in need of the IPS model. The program primarily targets SUD, many with co-occurring mental health disorders, that need support with entering the workforce. Supports can range in intensity from supported employment with a job coach to help creating or updating a resume.

VOA

Supports adolescents and adults with behavioral health conditions in obtaining and maintaining competitive employment. Services are integrated with clinical care and delivered in office and community settings.

The IPS team provides rapid job search, placement, and ongoing support in collaboration with clinical providers and the Utah State Office of Rehabilitation. Youth adaptations include support with education and developmentally appropriate employment. VOA earned an exemplary rating on both fidelity reviews, in 2019 and 2025.

Services are delivered in accordance with IPS fidelity standards, emphasizing rapid engagement, client choice, and integration with treatment.

Outcomes Framework:

Alliance House

- Track the number of people who gain employment.
- Track total active members actively employed.

FSH

The specific metrics used to track success for the employment program are:

- 50% of enrollees obtain new employment
- 50% of enrollees increase their income by 20%
- 50% of enrollees complete a career profile
- Report on number of clients served compared to last year

These metrics are reviewed monthly by our executive team, and strategic planning and support are provided to the team to assist them with reaching the metrics if they are not being met. This fiscal year, FSH has consistently been on track to meet or exceed each of the metrics

Mental Health and Substance Use Recovery Supports

VOA

Employment outcomes including job starts, job retention, and engagement, with data used to guide program improvement.

Technical Assistance - Recovery Support

Is technical assistance requested for any components of the Recovery Support section?

☐ Yes

☒ No, not at this time.

Please name sections requested and provide description of requested TA

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SERVICE SATISFACTION AND OUTCOME DATA

Service Satisfaction and Outcome Data

The following section stems from the LA contract and the FY27 SUMH Office Directives that require a LA response. Each LA must complete with an overview of how components of the directives will be implemented in their catchment.

Consumer Satisfaction

Describe the LA's process for administering the Mental Health Statistical Improvement Program (MHSIP) and Youth Satisfaction Survey (YSS).

DBHS follows the survey administration process outlined in the SUMH Office Directives. MHSIP and YSS/YSS-F surveys are administered during the collection window (January 1, 2026, through May 1, 2026) at each contracted provider agency. DBHS coordinates SUD client survey collection into the online form (Qualtrics). Optum administers all surveys for mental health clients. An online link for all three surveys and paper samples of the surveys are provided to agencies. If an agency offers the form in paper format, or if a client chooses to submit a paper response, the agency is obligated to enter the information online into Qualtrics. Agency directors and navigators are given

Service Satisfaction and Outcome Data

an agency-specific password, which identifies the provider agency and identifies the client as mental health or substance use disorder. This allows them to access the survey links. Passwords cannot be used for more than one type of client (SUD and MH). DBHS provides the SUD passwords and Optum provides the mental health passwords.

The original email notice to agencies prior to the survey release, includes a message specific to the provider with implementation instructions along with their totals of adult and youth clients served in the prior fiscal year and the minimum target collection for each group. For the YSS-F, the expectation is that the returned number of caregiver responses will be equal to the number of youth surveys (YSS) returned. Agencies are notified on a weekly basis, and through monthly navigator meetings throughout the collection period, indicating updated counts of reported surveys. They are encouraged to increase engagement throughout the collection period as well. One of DBHS's goals is a 100% participation rate for all surveys. After the collection period has ended and OSUMH has tabulated all returned surveys, agencies are provided the final response rates through the final report.

Specific to Optum, Optum contacts every Optum SLCO contracted MH provider at the beginning of the MHSIP survey administration period each year. Optum instructs providers on the mandated MHSIP survey administration and gives directions, provides DHHS survey links, and individual provider MHSIP passwords (where applicable). Optum monitors completed survey numbers (reported to us by DHHS) throughout the survey period and sends reminders to providers as needed.

Mental Health Outcome Questionnaire

Does the LA have a training process for clinical teams on utilization of the Outcome Questionnaire/Youth Outcome Questionnaire (OQ).

- ☒ Yes
☐ No, not at this time

If applicable, briefly describe information on training, implementation, oversight, data analysis, and associated quality improvement.

Optum currently offers a recorded training completed by Amanda Cummins, OQ® Measures Director of Customer Support, specifically teaching providers how to use the OQ® Analyst and specifically addressing components required for Optum Medicaid providers. Optum Beginner and Advanced OQ® trainings are currently being updated with new slides in collaboration with the OQ® Measures team. These trainings will be available to clinicians on the Optum Provider

Service Satisfaction and Outcome Data

Training Platform no later than June 30, 2026. Optum has created reports to compare SAMHIS encounters to claims data to determine which members should be offered a questionnaire but does not have one entered in the system. Another report identifies clients with incorrect identification numbers within their OQ® Analyst profile. We face challenges running these reports with ongoing SAMHIS data issues. Finally, Optum audits the state mandate requirements as part of provider quality audits. Providers who are out of compliance are placed on a corrective action plan and will be required to complete OQ®-related trainings.

Recovery Support Screenings and Tools

What Recovery Support screening or tools are you utilizing? (i.e., SURE, SUD OQ, etc).

Most providers are required to use the OQ® Measures questionnaires allowed by SUMH to meet the state mandate. Other providers who serve populations with unique needs use other outcome measurements.

Optum SLCo Network Providers and SLCO DBHS Unfunded providers are instructed to use at least one of the following tools within the OQ® Analyst: OQ®45.2, OQ® 30.2, S- OQ® 2.0, Y-OQ® 2.01 PR, Y-OQ® 2.0 SR, Y-OQ®30.2 PR, Y-OQ® 30.2 SR. These tools are available in English and Spanish. Optum has obtained questionnaires in Portuguese and Arabic as requested by members. The SURE questionnaire is also available for substance use treatment providers who are interested.

If you are not utilizing any Recovery Support screenings or tools can you please provide details on the barriers?

N/A

Technical assistance

Is technical assistance requested for any components of SUMH Office Directives Service Satisfaction and Outcome Data section? This may include data submission requirements.

- ☐ Yes
☒ No, not at this time.

Please indicate sections requested

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