



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).

WBH Crisis programs use the Roberts 7 Stage Crisis Intervention Model as a foundation to our intervention work. Prevention and postvention strategies and efforts are as listed below and include collaboration with community prevention efforts and direct work with schools and other community members and entities. In addition much of our prevention work is based in principles from the "Connect" program for suicide prevention and response.

WBH has a representative that serves on the Prevention Coalition at the OSUMH. Information is then integrated into a comprehensive vision at WBH. We are involved in training, education, and community awareness. We are members of the HOPE 4 Utah task force and are represented on the Hope4Utah board. We partner with the HOPE squads in many of the schools. We have representatives who attend weekly meetings with local law enforcement. In addition, we hold two Crisis Intervention Team (CIT) academies with the police, county jail, dispatchers every year. The following are prevention activities that WBH has participated in:

1. The Annual Rocky Mountain Suicide Prevention Conference
2. The Annual Utah County Suicide Prevention Walk
3. Campus Suicide Prevention Walk
4. Many community meetings where we present in schools to educate parents and students on suicide prevention
5. Participated in suicide prevention training for religious groups

Community Suicide Prevention

6. A resource for local newspapers on suicide prevention-intervention-postvention
7. Helped create a statewide performance improvement project on suicide prevention
8. We use and promote the Live On campaign and materials with clients and staff
9. Connect Suicide Prevention and Response Program

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

WBH has integrated the Columbia Suicide Severity Rating Scale (C-SSRS) and the Stanley/Brown Safety Plan into our electronic chart. We are also using the Y/OQ as a screening tool for the initiation of the C-SSRS if the client answers "Frequently" or "Always" on the suicide questions within the Y/OQ. By the client answering "Frequently" or "Always" it triggers an alert within our electronic chart indicating that the staff member needs to evaluate for the potential suicidal ideation with the C-SSRS and then possibly create a Stanley/Brown Safety Plan with that particular client.

Other interventions include the FAST – Family Assessment Stabilization Team is a new innovative way of thinking about mental health treatment. FAST as it implies, focuses on timely intervention and prevention to both youth and adults. FAST includes 24-hour access to care, Mobile Crisis Outreach in the community, 24 hour Receiving Center services at the Receiving and Outreach Center (ROC), Crisis Residential Support, and Inpatient Hospitalization when necessary. We provide assessment, prevention, crisis resolution, consultation, and follow-up services. We additionally have an CY-FAST team "Children and Youth Family Assessment Stabilization Team" which is quite similar to the state SMR mode. They work closely with our youth MCOT team, Vantage Point crisis program, and all of our youth programming to assist and collaborate in times of more intense level care needs. Often providing in home services while the regular treatment teams are doing on site work.

WBH works in concert with other community agencies, physical health providers, and law enforcement, to provide a holistic treatment approach to mental health care.

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

Community Suicide Prevention

WBH is currently developing a written postvention plan that will provide an overview of the components we currently use. Again we follow principle from Connect Suicide Prevention and Response program

WBH is involved in developing a model of postvention support for suicide survivors with other community partners, agencies and interested individuals. We have been involved with postvention in the schools throughout our community as suicides occur to help schools, families, religious communities and communities in general deal with the death of person(s) who died by suicide. The following are prevention activities that WBH has participated in this last year:

1. Provided staff to help local schools screen and provide treatment for students affected by peers who died by suicide.
2. Have a response team of therapist to help communities with postvention services
3. Participate with several businesses in the area to help their staff process employee suicide or other tragic deaths.
4. Facilitate a Grief due to Suicide Loss group at our crisis center. The hope is to provide one group quarterly at no cost to the consumer.
5. Facilitate an internal debrief team of dedicated therapists who can help staff members debrief after traumatic events at work or home.

WBH uses its annual conference to train staff on topics such as Suicide Prevention, Intervention, Postvention, C-SSRS, Stanley Brown Safety Plan, using the Y/OQ as a screener and alerts within Junction (WBH's EHR) and other important topics related to mental health.

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.

Community Suicide Prevention

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)

Laura Oaks, Program Manager loaks@wasatch.org

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.

Hope 4 Utah Task Force and Board, State Suicide Prevention Coordinators Meeting, Utah County Health Department, Alpine School District, Provo School District, Nebo School District.

Intervention with mental health/suicide crisis is strong form of prevention that we provide to the community. Our crisis responses and post crisis responses are described well in many programs in our agency presented in this plan. In addition to our intervention and postvention services these same programs provide specific prevention efforts too with multiple partners. Programs involved in this work include MCOT, Adult Receiving and Stabilization Beds, Vantage Point programs, School Based Services, Youth/Adult Family Assessment and Stabilization teams (FAST & CY-FAST).

We provide prevention presentations to all county school districts, municipal law enforcement and EMS, Western Region DCFS groups, DJJS groups,

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.

Community Suicide Prevention

WBH's suicide screening and response policy is provided to and required to be reviewed by all employees at hire through our electronic training system. Employees must read it and attest to doing so. In addition, all staff are required to take a suicide screening/assessment course annually.

Family clinics utilize the OQ family of instruments to screen for suicide on a regular basis. The crisis programs utilize clinical assessment and ask every client regarding suicidal ideation, no matter the reason they are presenting in crisis. WBH has integrated the CSSRS into our electronic chart and train staff on how to use the screening portion as well as the full assessment to help identify early the clients who are contemplating suicide and then create a safety plan with the client. The Stanley Brown safety plan has also been integrated into our electronic chart to help develop safety plans for people who are at risk for suicide.

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

WBH has lock boxes that can be distributed and used for means safety for prescription medications, firearms and other types of weapons. We also have gun locks for firearms. All these are distributed by MCOT as well as are available at the Receiving Center. Other departments also have access to these items.

Approach to community education

At WBH we are aware of the importance of means safety. We educate first responders on the importance of this while we are presenting to them about various topics. We also coordinate with the Health Department regarding QPR presentations.

Garrett Lee Smith Grant (GLS)

Does the LA have a GLS Grant?

☐ Yes

☒ No, not at this time.

Community Suicide Prevention

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

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

Technical Assistance

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

- ☐ Yes
☒ No, not at this time.

Please indicate sections requested.

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

Behavioral Health Crisis 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	☐	☐

Link to or list of contracted providers:

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?

Behavioral Health Crisis Services

- ☒ Yes
☐ No, not at this time.

Please detail the following for the LA:

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

WBH's MCOT teams are composed of clinical therapists, peer support specialists and case managers. All staff have completed the State Crisis Worker certification training as required. Adult and Youth MCOT coverage is provided 24 hours a day, 7 days per week. WBH employs teams onsite in the Recovery Outreach Center from 8am to 8pm Monday through Friday which include separate adult and youth MCOT teams. Additional Saturday and Sunday coverage begins on Friday evening at 8pm. The weekend teams are on call and respond when dispatched, this includes holidays coverage. The community is able to access WBH MCOT services in multiple ways. WBH provides a local number dedicated to allied agencies and first responders. This allows our community partners accessibility and ease in ability to dispatch to the scene, 24/7. WBH MCOT services are also dispatched through the Statewide Crisis Line.

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

MCOT follow-up occurs through a peer support or case manager. If acute needs are identified through MCOT or the initial follow-up call, a case manager is assigned to provide further assessment and link resources.

If the MCOT client is too decompensated to be able to follow up on their own, someone from a Family Assessment and Stabilization Team (FAST/CYFAST) will be assigned temporarily to help follow up and provide care until they are able to return to an outpatient or previous level of care. This may include the person seeing the provider at our crisis center temporarily for medication management.

Youth and family MCOT follow-ups are completed by a member of the Children and Youth Stabilization Team (CYFAST). Depending on the needs identified during the MCOT response, the follow-up may be conducted by a clinician, case manager, and/or peer support specialist who contacts the family or caregiver by phone to check on safety, current stressors, and immediate support needs. After each youth/family MCOT encounter, the team reviews the information gathered and coordinates next steps, assigning services based on level of need, risk, and available natural supports. Follow-up support may include coaching caregivers on de-escalation and coping strategies, connecting the family to community resources, community-based crisis supports (e.g., crisis lines/988, mobile crisis services, crisis stabilization programs, and respite), and outside providers, coordinating appointments, and offering in-home support through WBH when

Behavioral Health Crisis Services

appropriate. Stabilization services are typically offered over the course of several weeks, with ongoing check-ins to help ensure the youth and family are connected to the right resources and have the support needed to maintain crisis stability.

How the LA engages and educates first responders to MCOT services

There are multiple law enforcement meetings that we attend. There is a South County meeting that involves all of the law enforcement south of Provo. There is also a central meeting for Provo and Orem law enforcement. We receive information from different law enforcement agencies regarding people they are seeing frequently and who may need outreach and intervention. Law enforcement participate in responding to calls alongside MCOT to outreach people in an effort to connect them to services. WBH recently worked with local EMS agencies around the county to train officers about MCOT services as well as other crisis services they can utilize. WBH attends department shift briefing meetings to re-train officers to Crisis Services.

MCOT Exemption Request (Contract 7.2.b.7)

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.

Behavioral Health Crisis Services

(Note: For information on youth crisis shelter/receiving services please refer to the Residential Care & Services section).

As the local mental health authority, WBH provides crisis services to anyone in our catchment area, regardless of funding. If clients from other catchment areas present at the Receiving Center we serve them as well but work to coordinate services and refer to the area in which they reside once client safety is achieved. The Crisis Receiving Center is open 24 hours per day. People can be self referred or referred through professional channels. We also allow the clients to define the crisis. We get a wide array of issues from college students struggling to adjust to being on their own to highly psychotic clients. As an agency, if we can intervene prior to the crisis escalating, it is better for the client as well as the situation. At admission, each client is assessed by a nurse to determine medical issues as well as possible illicit drug use. They also verify prescribed medications and make sure people are receiving the medications they need. There are also standing medication orders that are provided by our Medical Director for use by anyone checked into the Receiving Center. We also have a prescriber on call that can be consulted on cases after hours and on weekends as needed. The client then meets with a clinical therapist to discuss the current crisis, stabilize as possible and discuss possible next steps. The therapists utilize the CSSRS as well as the Stanley Brown Safety Plan for suicidal ideation as well as questions every client regarding suicidal ideation for screening purposes. The clinical therapist utilizes natural supports (frequently family) to help with safety planning as well as some crisis family therapy to help de-escalate family issues and create needed boundaries depending on the situation. Depending on the severity of the crisis and client's desires, they can stay at the center for up to twenty four hours. This can provide time and space from the crisis to help de-escalate the situation. The therapist also utilizes the Outcome Rating Scale (ORS) at admission as well as at discharge to see reduction of symptoms. We utilize line staff as well as Peer Support Specialists to provide safety in the environment and help people see hope in recovery. A prescriber is available 20 hours a week to help with medications if needed. The goal is to increase prescriber time up to 40 hours per week to make this service more available to clients at the Receiving Center. The Receiving Center employs case managers who work with individuals on applying for needed resources such as Medicaid, SNAP benefits, disability and follow up care after discharge. They also work to link people to residential care or other levels of care as needed. All staff from peer support specialists to therapists are certified as Statewide Crisis Workers as required. WBH recently participated in changing the EMS protocols in the county so that EMS can transport to the Receiving Center. WBH presented to all shifts of Provo Fire and EMS as well as the County Coalition of EMS providers to discuss crisis services and how to utilize them. Protocol is that if Law Enforcement or EMS pull up to the Receiving Center, the therapist is notified and they meet them in the front of the building to discuss transitional information as well as keep their drop off time

Behavioral Health Crisis Services

as short as possible. After discharge, Peer Support Specialists do follow up calls to check in on clients and see if they need any further assistance with resources or their crisis.

If the client needs longer stabilization on medications or in order to get into a residential program, they are transferred to a stabilization bed.

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.

The Receiving Center and Crisis Residential Support utilize the Outcome Rating Scale (ORS) which is a brief, four item measure of client functioning across personal, social and overall wellbeing domains. Where possible we use a client centered approach to track performance. Stabilization and crisis can look so different for each client, we consistently discuss progress with clients who return several times and what they can do between admission to help stabilize in the least restrictive environment possible. We work hard to tailor the treatment/safety plan to their individual needs and experiences. Discharge criteria varies depending on reduction of symptoms and need for further stabilization and how that can be obtained.

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
- ☐ No, not at this time.

Does the LA have a SMR program/team?

- ☐ Yes
- ☒ No, not at this time.

How are the following implemented:

Behavioral Health Crisis Services

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

Please note the CY-FAST team is very similar to an SMR team. In addition WBH collaborates regularly with the IH SMR team in Utah County which includes quarterly check-in's and ability to refer directly to the SMR representative. Provo City School District also contracts with WBH/CYFAST under a risk assessment agreement to help with immediate/ongoing needs for students involved with crises and/or threats of harm to self/others.

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

HMHI/988 is aware that our Youth MCOT team or regular MCOT team are always available when SMR is not. In addition, HMHI/988 is supposed to be trained to screen for the callers who may already be open to WBH services and/or have Medicaid, so they will be routed to our MCOT teams first.

Technical Assistance

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

- ☐ Yes
☒ No, not at this time.

Please indicate sections requested

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

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

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:

WBH provides acute psychiatric stabilization through contracted community-based hospitals for youth and adult members. WBH has contracts with the following hospitals: Mountain View Hospital (Payson, UT), Utah Valley Hospital (Provo, UT), Aspen Grove (Provo, UT), and Huntsman Mental Health Institute (Salt Lake City, UT). Additionally, other area hospitals may be utilized as needed such as Lehi Primary Children's, McKay Dee, etc..

WBH uses a standardized utilization review and performance monitoring framework outlined below. UR functions are primarily completed by an SSW-level staff member with LCSW clinical oversight, including clinical review for medical necessity at admission and throughout the stay. Inpatient admissions and continued stays are authorized based on medical necessity (e.g., imminent risk to self/others, inability to maintain safety at a lower level of care, or severe symptom acuity requiring 24/7 structured treatment) and aligned with established authorization documentation (pink/blue sheet criteria). UR is completed at admission and continues throughout hospitalization to monitor progress, identify and address discharge barriers, coordinate with hospital teams, and support timely transition to step-down or community-based care. WBH also conducts routine access review to monitor referral flow, timeliness, and appropriate level-of-care placement, and provides ongoing outreach and training with hospital partners to support consistent criteria use and discharge coordination. Transition planning includes active engagement of family and natural supports when available, early aftercare linkage, and confirmed follow-up appointments at discharge.

Outcomes Framework:

Outcomes are monitored through an inpatient performance framework (e.g., length of stay, discharge barriers, timeliness of discharge planning and follow-up scheduling, and post-discharge

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

utilization such as ED return/readmission), with trends reviewed with hospital partners and WBH leadership to guide targeted quality improvement. WBH provides post-discharge outreach at 7 and 30 days to support engagement, identify emerging needs, and reduce avoidable ED return/readmission.

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:

Vantage Point is a multiple service, short-term crisis residential program for adolescents ages ten to seventeen. VP provides three vital community services: (1) Youth Services & Juvenile Receiving; (2) DCFS Emergency Shelter Care; and (3) Crisis Shelter for youth. Vantage Point is primarily funded through Medicaid as well as state funds through JJYS and DCFS. Youth who come to Vantage Point are screened by phone or in person, with staff assessing if services are appropriate. Youth's safety risks, including suicide and self-harm, are assessed at intake as well as throughout their stay. Services prevent youth homelessness, divert a hospital or higher level of care, and act as a JRC and shelter for child welfare. A youth's safe exit and family stabilization are prioritized, and aftercare services offered to close the gap in services beginning or collaborating with current treatment teams.

Services are provided for adolescents and families in crisis due to youth's behavioral or runaway status, or where there is complex and serious parent-child conflict. Individual, group, and family therapy is provided to maintain or reunite youth with their families. Especially for children at risk of entering or re-entering the juvenile system, services help divert vulnerable youth to higher levels of services or hospitalization. Essential services include 24-hour, 7 days per week crisis intervention, short-term shelter/time out placement, individual and family therapy, and 90-day aftercare (therapy and/or groups) for continued stabilization. In addition to clinical therapy services, case management, skills development, and behavioral modification are offered.

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

Furthermore, access to school is provided through agreements with Provo and Alpine School Districts. Outpatient (aftercare) and community groups are also offered (SUD, anger management, LGBTQ+ support, and parent support). There are 12 beds per location, American Fork and Provo. Both locations provide access to families across Wasatch and Utah Counties.

Juvenile Receiving:

Vantage Point is also a 24-hour, 7 days per week reception for youth detained by law enforcement. These are youth who do not meet the criteria for secure juvenile detention. Vantage Point provides relief from law enforcement's detainment of the youth, with VP staff connecting to parents/guardians, screening for risks and needs, and facilitating referrals. Oftentimes, these youth are referred to Youth Services programming at Vantage Point and are then signed in by their guardians.

DCFS Emergency Shelter:

Vantage Point provides temporary, emergency placement for youth in the custody of the Division of Child and Family Services when the youth has experienced a disruption of placement or at the time of removal. Youth are removed due to abuse or neglect and may have experienced a disruption in their current living arrangement.

Mental Health Crisis Shelter:

Vantage Point provides crisis shelter services for youth experiencing a mental health or behavioral crisis which has contributed to the short-term separation from home and community. Frequently, this is related to suicidal ideation, school disruptions, or other unsafe behavior.

Adolescent Female Residential Treatment Center, Aspire:

Aspire Academy provides intensive, high needs mental health services for adolescent females ages 12–17 who are covered under Utah Medicaid. Aspire Academy operates as a locked, secure Level 6 residential treatment facility. The program primarily serves youth who are in the custody of the Division of Children and Family Services (DCFS) and the Division of Juvenile Justice Services (JJS), as well as those placed through post adoption arrangements by Local Mental Health Authorities (LMHA) across Utah. These clients present significant psychiatric, behavioral, and medical needs and require structured therapeutic interventions and continuous monitoring to ensure safety, stability, and effective treatment progress. Aspire Academy is dedicated to delivering clinically effective services that address the therapeutic needs of the youth and families we serve. The program strives to operate with efficiency and accountability, ensuring that resources are used responsibly so high quality, accessible care can be sustained over time. Our commitment is to maintain a treatment environment that promotes positive outcomes while supporting the long term stability and continuity of the program. Aspire Academy maintains a

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

multidisciplinary treatment team to ensure comprehensive clinical oversight and continuity of care. The treatment team includes a board certified child psychiatrist, licensed clinical social workers, registered nurses, case managers, peer support specialists, and human service workers. Each discipline functions within its respective scope of practice and in accordance with state licensing regulations, professional standards, and agency policy. The team collaborates to assess clinical needs, implement individualized treatment plans, monitor client progress, and ensure the delivery of safe, effective, and developmentally appropriate services within the residential milieu.

Intensive Residential Treatment (IRT) Program

Intensive Residential Treatment (IRT) is a 24-hour, structured, therapeutic residential program serving adults with serious and persistent mental illness who require a level of care as an alternative to, or step-down from, inpatient psychiatric hospitalization. Services are designed to stabilize acute symptoms, improve functioning, and support individuals in transitioning to more independent, community-based settings.

IRT is a 16-bed, co-ed facility serving adults age 18 and older, with accommodations to support gender-specific needs. The program operates within a recovery-oriented, trauma-informed, and least-restrictive care framework, promoting skill development, autonomy, and community reintegration.

The program provides continuous 24/7 staffing, including nursing support, within a structured therapeutic milieu. An interdisciplinary team delivers a comprehensive array of services, including:

- Psychiatric and diagnostic evaluations
- Individual and group therapy
- Skills training (e.g., coping, daily living, social/interpersonal functioning)
- Case management and care coordination
- Medication management and psychopharmacological services
- Nursing support and health monitoring

A licensed psychiatric prescriber provides ongoing medication evaluation and management, with frequency adjusted based on clinical need, symptom acuity, and treatment response. Nursing staff ensure coordination of both psychiatric and general medical needs, including medication administration and monitoring, supporting integrated whole-person care.

Treatment is guided by individualized service plans informed by ongoing assessment, with a focus on symptom stabilization, improved functional capacity, and readiness for community living. Services emphasize building sustainable skills and supports to reduce future

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

hospitalizations and promote long-term recovery.

Outcomes Framework:

Aspire Academy

Aspire Academy provides an ongoing process for evaluating clinical progress and monitoring treatment effectiveness to ensure interventions remain responsive to each client's needs. The assessments and measures described above are administered continuously throughout treatment, allowing the clinical team to evaluate progress, adjust interventions, and ensure treatment remains responsive to each client's needs. Weekly treatment team rounds are conducted to review each client's progress, evaluate both short and long term treatment goals, and determine whether adjustments to interventions, supports, or placement needs are warranted. During these meetings, the team collaborates to ensure continuity of care, discuss therapeutic strategies, and address any emerging concerns. The rounds also provide an opportunity to offer guidance and consultation to parents and caregivers, guardians and line staff, promoting coordinated care across home and program environments. Additionally the Y-OQ is administered routinely for continued evaluation purposes.

IRT Outcomes Framework

IRT provides individualized, data-informed treatment aimed at reducing psychiatric symptoms and improving overall functioning. Treatment plans are developed using standardized assessments and are regularly reviewed to track progress in key domains, including psychological functioning, behavioral stability, and interpersonal relationships.

Client progress is measured through validated tools such as their individualized recovery plan, CSRRS, as needed when indicated,, OQ, SURE, and MHSIP, allowing for ongoing evaluation of symptom reduction, coping skill development, and functional improvement. At discharge, clients typically demonstrate measurable gains in symptom management, increased use of adaptive coping strategies, and improved stability in daily functioning.

IRT also emphasizes sustained recovery outcomes. Follow-up and continued engagement with Wasatch services indicate that many clients maintain or continue to build upon gains achieved during treatment. These sustained improvements are reflected in continued progress across mental health, behavioral, and social functioning domains.

Outpatient Care and Services

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

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

Service Delivery Framework:

Family Clinics

In all of WBH's Outpatient and Family Clinics, the following takes place: When a client presents at WBH for a new episode of care, an assessment is completed. This assessment will determine the client's symptoms and functional challenges that need attention and establish a diagnosis. The clinician will determine which level of care is most appropriate for the client and will best meet their clinical needs. A recovery plan is developed and appropriate referrals are made to the level of care that is appropriate for the client, which may include therapy, medication management, case management, skills development, crisis services, and peer support.

The goal of outpatient services is to intervene early in the course of mental illness to ameliorate the detrimental effects of mental illness in the lives of individuals and their families. Licensed Mental Health Therapists and interns provide assessments, individual, group, marital, and family therapies. Social Service Workers provide general case management assistance and wellness coordination for clients.

Experienced therapists work with children, adolescents, adults, and families to address the mental health disorders and co-occurring disorders such as: victims and perpetrators of domestic violence (DV) (In the Wespark Family Clinic only), treatment of the dually diagnosed, those with mental illness and substance abuse (MI/SA), mental illness and intellectual disabilities (ID), treatment of various personality disorders, sexual abuse victims, and treatment of other serious and persistent mentally illnesses. The Outpatient Clinics offers an excellent training environment for social work, mental health counselor, marriage and family, and doctoral level psychology interns.

Recreational Therapy

WBH hired a Rec Therapist and is excited to add this important intervention to our programming. While these services may be part of our programming in multiple levels of care (outpatient, day treatment, residential, crisis), we elected to mention it here. We will be doing a careful exploration to evaluate the most effective place and way to introduce this service into our agency.

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

We anticipate many programs will be excited to use Rec Therapy to enhance programming.

Youth Day Treatment Programs

WBH currently provides 4 different day treatment programs for children and youth.

Giant Steps Autism Pre-School: GIANT Steps is a day treatment program for preschool children aged 3 to 5 who have been diagnosed with an Autism Spectrum Disorder in addition to a mental health diagnosis. The program is located in six classrooms Utah County: three are within Foothill Elementary School in Orem, one is adjacent to Thunder Ridge Elementary School in Saratoga Springs, another is located within Canyon Crest Elementary School in Provo, and our 6th classroom is located in the Nebo school District Summit Center in Springville. The program runs from August through July and children attend Tuesday through Friday between 9:00 a.m. and 3:30 p.m., daily. GIANT Steps currently serves 72 children and their families.

The purpose of the program is to restore age appropriate functioning for young children and provide coping strategies for parents and preschool aged children with co-occurring Mental Health Disorders and Autism Spectrum Disorders. Giant Steps helps clients overcome their delays in social, emotional, and daily living skills development. The program also helps children develop age appropriate social and communication skills to help alleviate their comorbid mental health diagnoses (e.g., anxiety, depression, etc.), and to reach their developmental goals. GIANT Steps provides a broad spectrum of services to help families have success in their own homes. This includes helping parents better understand their child's diagnosis and learn how to better advocate for their child's needs in the future. Parent training and involvement in the treatment milieu is a core component of the program.

GIANT Steps employs a multi-faceted treatment approach that includes evidence-based methods of treatment for co-occurring mental health and autism spectrum disorder. Some of these include ABA Discrete Trial Sessions, TEACCH, Naturalistic treatment, relationship intervention strategies, developmental social training, KinderMusic, sign language, skills development (group/individual), and a variety of augmented or alternative communication systems including PECS.

The PEP-3 and CARS-2 assessments are used as pre- and post-testing instruments to evaluate the progress made by each child. These instruments are used after the child has received a diagnosis of co-occurring mental health and autism from a psychologist using the ADOS or ADIR testing instruments and other testing. Giant Steps also utilize various Outcome Questionnaire instruments like the parent report YOQ, along with the Ages and Stages Questionnaire, PEAK assessment, and kindergarten readiness instruments.

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GIANT Steps has enjoyed a cooperative working arrangement with all three school districts in the county. This has historically included the districts being able to provide services like Speech Therapy, Occupational Therapy, and Adapted Physical Education which was integrated into the Giant Steps clinical experience. Beginning FY2027, however, parents in the Alpine and Provo districts will not be able to have their children access these kinds of services from the district while the child is attending Giant Steps. Families will need to seek these kinds of services outside the program and we will be doing what we can to bolster activities that promote growth and improvement in those areas.

Children are referred to the program through family members, primary care physicians, and early intervention programs, and school district assessment centers. Parent Support and Education groups are offered throughout the treatment year. A sibling camp is offered for the brothers and sisters of the children in GIANT Steps so they can better understand co-occurring mental health issues and autism spectrum disorder. It allows children to learn skills for interacting with their siblings who have extra needs. A variety of therapeutic modalities is offered to children in the program who can benefit, and is also offered as a support to parents of children in the program. Case Management services are offered to children and their families so they can be linked with the appropriate community resources. Each child and their parents are given the opportunity to meet with a psychiatrist/APRN if medication management services are appropriate. The school nurse tracks and maintains vaccination records of the children enrolled in the program.

Past outcome research has shown that about 1/3 of all children involved in the GIANT Steps program improve enough to only require one hour or less of special education services per week after transitioning into school district placements. For children with mild to moderate symptoms who were able to attend GIANT Steps for two years, almost 2/3 of them required only one hour or less of special education services per week following their transition to kindergarten, etc. Also, about 1/3 of all children who attend GIANT Steps for two years improved enough to not require any extra special education services.

New Vista: New Vista provides day treatment and outpatient services to male and female youth who have experienced trauma and/or have engaged in sexual misconduct. Day treatment clients range from 12-17 years old. Outpatient clients can be any age, although the majority are also between 12-17 years old. Clients attend school at the middle school or high school of Provo School District. While at New Vista, they receive individual, family, group therapy, and skills services. The average length of stay for a day treatment client is 9 months. Services are funded through Medicaid.

Attachment IOP: This program was created in September of 2025 by WBH personnel. It is an 8-week intensive outpatient program specifically for youth and their families that have

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experienced adoption. Client age range is 10-17 years old. A different adoption-related topic is explored each week such as loss, grief, rejection, and identity. Clients receive individual, family, group therapy, and skills services. Parents also attend a weekly multi-family parent group with their child. Attachment IOP operates out of the Provo Family Clinic; however, clients live in all parts of Utah county. Staff are trained in Training for Adoption Competency (TAC) or National Adoption Competency Mental Health Training Initiative (NTI) through the Center for Adoption Support and Education (C.A.S.E.) Foundation. Services are funded through Medicaid.

Stride: Stride is a 12-week behavior management group for elementary-aged children that focuses on developing coping skills, forming healthy relationships, and building resilience. Principles of Trust-Based Relational Intervention are woven into behavior plans to help clients make the best possible gains. Parents can attend parent groups and receive one-on-one services from their Stride case manager. Stride operates after school during the school year and has extended hours during the summer. There are currently five Stride groups located in Payson, Provo (2), American Fork, and Saratoga Springs. Services are funded through Medicaid.

Outcomes Framework:

Family Clinics: Treatment team will utilize the OQ/YOQ at every visit or once a week, whichever is less frequent, to assess for progress and screen for suicidal ideation or other critical items. Clinical staff will review the results of the OQ/YOQ with the client or client's parent. Clinical staff will use the results of the OQ/YOQ to inform treatment planning.

New Vista: Treatment team will conduct regular clinical reviews of the client's progress and treatment plan. Additionally, the Y/OQ is taken by the client every visit or once a week whichever is less frequent. This Outcome Questionnaire works to provide the therapist with the client's voice, provide feedback to the therapy process and to monitor outcomes. Clinical staff will utilize the clinical information derived from the Y/OQ with clients. The significant therapeutic issues assessed from the questionnaire will be processed with the client in an effort to help them reach their goals. Staff will report the numeric data and the process discussion in the session notes. Through these processes, clinicians work with the client to ensure that they receive the right amount of treatment. The primary goal is to foster independence in all areas of the client's lives.

Attachment IOP: Clients complete a pre and post Adoption Communicative Openness (ACO) Scale and a Peer Scale. Parents complete a pre and post TSM-Parent Scale. Pre and post scales are compared to evaluate for improvement(s) in openness around adoption, attachment to adoptive parents, and peer relationships. Parents also complete a qualitative survey upon completion of

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the group regarding their overall experience in Attachment IOP.

Stride: Treatment team will conduct regular clinical reviews of the client's progress and treatment plan. Additionally, the Y/OQ is taken by the client every visit or once a week, whichever is less frequent. This Outcome Questionnaire works to provide the therapist with the client's voice, provide feedback to the therapy process and to monitor outcomes. Clinical staff will utilize the clinical information derived from the Y/OQ with clients. The significant therapeutic issues assessed from the questionnaire will be processed with the client in an effort to help them reach their goals. Staff will report the numeric data and the process discussion in the session notes. Through these processes, clinicians work with the client to ensure that they receive the right amount of treatment. The primary goal is to foster independence in all areas of the client's lives.

24-hour Crisis Care and Services

See Behavioral Health Crisis Services section above, including MCOT/Youth MCOT, Receiving and Sub Acute Shelters, Vantage Point (Residential Care Section) , CY/FAST teams.

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:

The Skills Development Services program is housed at Wasatch House (Clubhouse) located at 605 E. 600 S., Provo, UT and is a specialized intensive Skills Development program that uses a certified Clubhouse Model.

Wasatch House receives client referrals from Wasatch Behavioral therapists, case managers and prescribers. Client employment data is collected monthly. Wasatch House staff attend various department meetings to help identify clients who might be interested in attending. They also teach and remind staff of other departments about their services. Other department staff will

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invite or have the client go over and walk through Wasatch House for a tour and explanation of the program which is usually completed by a Wasatch House member. Interested individuals can also learn about our program through the Wasatch House website.

Services are available to adults 18 years of age and older living with the effects of mental illness and are currently receiving services from WBH. Wasatch House is open five days a week from 8:00 am until 5:00 pm as well as one evening per week, most of the major holidays, and some weekends for programming. Services are designed to help clients work in a “work ordered day” following the Clubhouse model. Clients participate in meaningful work roles at Wasatch House to learn the skills that allow them to transition to a level of employment appropriate for them. (see employment types listed below) Opportunities for education and socialization skills are focused on employment opportunities that are offered at Wasatch House. Wasatch House focuses on increasing the general overall physical wellness of our clients. Services assist members to focus on their wellness by involving them in various wellness activities during the day and after hours, providing healthier lunch options and tracking their exercise as a unit each week. Exercise equipment is available for members to work out on and staff and members together teach the importance of being healthy, as it significantly impacts their mental health. Services are provided for both males and females who have a diagnosed mental illness and require that a person’s intellectual functioning level be such that he/she is able to participate and benefit from the programming provided.

Family Clinics and School-based Services provide psychosocial rehabilitation in individual and group settings. The therapist and case manager work with the individual to develop the emotional, social and/or intellectual skills needed to live, learn and work in the community with the least amount of professional support. When more intense services are needed, the individuals are referred to the Stride Program for children 5 to 12. This is a partial day treatment program that teaches skills and behavior management. There are Stride programs available in Provo, Payson, Saratoga Springs, and American Fork. During the summer months for eight-ten weeks, these are expanded to have longer hours and do more day treatment.

Vantage Point offers 90 days of aftercare to help with continued stabilization and support upon discharge from Vantage Point. This includes individual and family therapy, and psychosocial rehabilitation services if needed.

Outcomes Framework:

The Wasatch House program will continue to aid in the recovery of individuals with severe mental illness by assisting members with their overall health by continuing a “Wellness” educational

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program. Wasatch House will see an improvement in the physical health of its members. Wasatch House will also see an increase in the number of members working in the community, quitting smoking, going back to school and obtaining their GED, and living independently.

For youth, the effectiveness of the services are measured through daily review of the clients behaviors through their home note, regular administration of the YOQ, as well as intentional communication and engagement with the parents and school teachers. If the child and family needs extra support, then in-home services can be provided.

Case Management

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

Service Delivery Framework:

Adult Case Management services are located in the various clinics throughout the WBH continuum of care, including the Westpark Family Clinic, Intensive Residential Treatment, Payson Family Clinic, Provo Family Clinic, American Fork Family Clinic, South Provo Clinic, BRIDGE team (ACT model), PREP team, Wasatch House (Skills Development Services), etc. Service hours are generally 8:00 a.m. until 5:00 p.m., Monday - Friday. However some programs, including BRIDGE, provide case management services on the weekends and holidays as well. The purpose of Case Management is to assist individuals with serious mental illness to optimize their adjustment in the community. Case managers provide continuity of care for the client in the mental health system and address not only the manifest symptoms of the illness, but may also address psychosocial problems such as housing, transportation, application/attainment of benefits, attainment of food, activities of daily living, integrated health care, education, employment, and other activities. Case Managers provide assistance for consumers by coordinating services with other agencies, follow-up regarding compliance with the WBH recovery plan, and/or advocacy assistance. Case management is usually done in the community as opposed to an office type setting and may be done in the client's home, place of employment, shelter, on the streets, or in residential settings. The frequency of contact between the case manager and the client is typically higher than the frequency of contact in a customary outpatient setting dependent on acuity of need. Case managers are given some latitude and flexibility in managing their schedules and may work after hours to meet client needs.

Case Managers and Human Service Workers act as Representative Payees to work with clients to budget their money on a monthly basis, pay bills on the client's behalf and partner with them to

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become more independent in the management of their funds. The goal is to assist clients in becoming responsible enough with their money that they are able to become their own payee or reduce their reliance on the WBH payee system to the extent possible.

Each department has established its own referral criteria for Youth Case Management Services. Youth Case Management staff are distributed across the following departments: Payson Family Clinic, Provo Family Clinic, American Fork Family Clinic, Westpark Family Clinic, Stride, Attachment IOP, CY-FAST, Vantage Point, Aspire, and GIANT Steps. The goal of youth case management services is to work with parents and other community services providers to develop a plan that builds on the child's strengths and skills while assisting them with their mental health needs. The primary function of Youth Case Managers is the assessing, coordinating, linking, and monitoring of services and progress with Alpine, Nebo, and Provo school districts, outside agencies, Youth Behavioral Health Court and other service providers. Case managers provide services in a child's home, at school, in a clinical setting, or in the community. Case managers provide case management transition services for children who have been released from the Utah State Hospital. Services include assessment, case planning, coordination, and assistance in daily living. Youth Case Managers are generally involved with SED youth. Our CYFAST team also provides case management for families on a crisis basis for those involved with crisis situations.

Each case manager is a licensed Social Service Worker or has met the requirements to be such or is working towards their SSW license. WBH only hires employees with the ability to be licensed as an SSW.

Outcomes Framework:

Eligibility is determined through assessment of the needs of clients. A regular review process is done to determine their effectiveness, including OQ and YOQ.

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

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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.

In-home Services: WBH therapists, case managers, Peer Support Specialists, and human services workers provide in-home services that include crisis intervention, family therapy, psychosocial rehabilitation, behavior management and medication management services. WBH believes it is important to provide services to children in their natural environments. In crisis situations or crisis follow-up, the Mobile Crisis Team, Vantage Point, or CY-FAST frequently provide in-home services and respite care.

Housing Supports: Supported Residential Treatment (SRT) consists of several levels of supervision within a 32-bed apartment complex located in Payson, UT. All of these apartments are shared housing and are owned and operated by WBH. Housing services includes: housing attendants, case managers, daily pillboxes, and supported independent living. Supported Residential Services is a continuation of Intensive Residential Treatment (IRT) and other programs to provide and practice daily living skills, self-care, and symptom management.

The following residential facilities provide non-treatment or quasi-treatment living for WBH clients:

Alpine House*

Alpine House is a non-treatment, 18-bed, home-style facility with bedrooms and family meals for WBH clients. It is owned and operated by Utah County United Way. The 24-hour house parents are their employees. Residents are required to be actively involved in productive activities during the day. Most residents participate in the day treatment model of the Clubhouse at WBH during the day. In addition, WBH provides daily pillboxes, case management and Skills Development/psychoeducational services during the daytime.

Independent Living*

Independent Living consists of four non-treatment housing complexes. 1) Maplevue Apartments, a 24-bed apartment complex run by Provo City Housing, 2) Payson Independent Living Apartments, a 16-bed apartment complex owned and operated by WBH, 3) Yarrow Apartments, a 17-bed apartment complex managed by Utah County Housing, and 4) Provo duplex (4-beds), managed by Provo City Housing. Each of these apartment complexes have case managers assigned to monitor and tend to the client's needs such as money management, connecting with

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community resources, and general mental health care. Clients are encouraged to participate in Skills Development Services.

Referrals for admission to residential care services come from various sources such as Inpatient facilities, the Utah State Hospital, crisis workers, sister agencies within the community and other departments within WBH. We coordinate with Alpine House, Utah County Substance Abuse, Provo Food and Care Coalition, Provo City Housing, Utah County Housing and various other agencies in providing individualized treatment for each resident.

Family Support Services: Family support services are offered throughout the agency in a variety of ways. This includes groups Collateral therapy focused on parenting and parent-child relationships (Trust-Based Relational Intervention, Child Parent Psychotherapy, Parent Management Training and other topics that programs identify as a needed area of support. Case Managers help clients and their families be connected to appropriate resources.

Respite Services: Respite is for the primary purpose of assisting in the rehabilitation of children with serious emotional disorders (SED). This rehabilitative service helps the SED client achieve his/her remedial or rehabilitative treatment goals by giving the parents/family respite from the challenges of caring for a mentally ill child. Without respite, parents may be at risk for neglect or abuse of the child, particularly if they suffer from a mental illness themselves. Respite care is provided for the primary purpose of giving parent(s) temporary relief from the stresses of caregiving to a mentally ill child so that they are better able to interact in appropriate ways that are not counter-therapeutic to the child's achievement of his/her remedial and/or rehabilitative goals. During the provision of this service staff has a therapeutic focus with the child. Therefore, this service is provided in tandem with the child's other mental health treatment services and also assists the child to achieve his/her rehabilitative goals and to be restored to his/her best possible functioning level. Respite services occur across many programs at WBH including Vantage Point, CY-FAST, New Vista, Stride, GIANT Steps and Case Management. These services are provided by HSWs, SSWs, nurses, case managers and other trained professionals.

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

In-Home services: Those providing in-home services will coordinate with other members of the treatment team to monitor progress and efficacy of these services. They will also work with the client and the client's family members/support system to create safety plans as needed.

Housing Supports: A continued emphasis in Supported Housing is that each of the case managers

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will share in the responsibilities as we prepare to serve these clients in teaching skills. The focus will be on improving the client's ability to care better for their daily needs and improving their quality of life. Individual and group treatment will focus on areas such as cooking, hygiene, transportation, menu planning and shopping along with budgeting, coping skills, time management, independent and life skills and relationships and boundaries.

Family Support Services: Parents of clients under 18 are asked to complete the YSS-P satisfaction survey and the YOQ-Parent questionnaires to address general satisfaction and to measure progress in treatment. Parents may also be asked to complete a clinical support tool (TSM-P) if client's YOQ scores are high and alert status is red or yellow.

Respite: Effectiveness is measured by client attendance, engagement and qualitative report from child and parents. The Youth Outcome Questionnaires is also utilized to measure progress.

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 offered in a variety of forms and contexts. Some are provided by staff to general community groups interested in learning more about mental illness or a particular facet of mental illness as well as directly to family members of clients to assist them in better understanding the mental health diagnosis of their loved one and to help them increase their understanding of coping skills, medications, treatment options, etc.

The Medical Director at WBH and Verdon Walker at Mountainlands Health Clinic, which is co-located at the Westpark Building, meet regularly to consult between the 2 agencies.

Several employees of WBH participate in numerous community activities throughout the year. WBH provides consultation and education services to the following agencies, organizations, and groups : The 15 law enforcement agencies in Utah County, including Utah County Sheriff's Department, and BYU and UVU Security, Utah State Division of Child and

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Family Services (DCFS), Utah State Department of Youth Corrections (DYC), Utah State Hospital (USH), Children's Justice Center (CJC), Division of Services for People with Disabilities (DSPD), Hope4Utah, Nebo School District and schools, Provo School District and schools, Provo School District "Hope for Utah" suicide prevention program, Alpine School District and schools, Division of Work Force Services, Utah County Health Department, Provo City Housing Authority, Utah County Housing Authority, Youth Services Multi-agency staffing, Utah County Department of Substance Abuse, Community Action, Food and Care Coalition, Fourth District Juvenile Court, DCFS 24-hour staffing, Provo Early Education Program (HeadStart), Kids on the Move, Kids who Count, Social Security, Medicaid, Partners for Infants and Children (PIC), Autism Council of Utah, Utah Association for Infant Mental Health (UAIMH), East Shore Alternative High School (Provo), BYU Department of Social Work, BYU Department of Marriage, and Family Therapy (MFT), BYU Department of Marriage, Family, and Human Development (MFHD), Utah County Jail Medical Services Unit, Fourth District Mental Health Court and National Alliance on Mental Illness (NAMI), and Utah Valley Hospital..

WBH provides C&E services to all Utah County groups, organizations, and agencies based on financial capacity and staff time availability. Those in crisis, partner agencies, and families are given first priority.

Technical Assistance

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

☐ Yes

☒ No, not at this time.

Please indicate sections requested

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MENTAL HEALTH OFFICE DIRECTIVES

Mental Health Office Directives

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

Mental Health 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.

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.

One team serving 80-100 clients.

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

[Bridge - Wasatch Behavioral Health](#)
[Crisis Services at Wasatch Behavioral Health - Wasatch Behavioral Health](#)

Utah State Hospital (USH) Coordination

Mental Health Office Directives

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

Adult

Program Manager: Amanda Stansfield, astansfield@wasatch.org
Liaison: Taylor LeDuc, tleduc@wasatch.org

Youth

Program Manager: Amanda Stansfield, astansfield@wasatch.org
Liaison: Katy Miller, katygibson@wasatch.org

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?

- ☒ Yes
☐ No, not at this time

Service Delivery Framework:

Mental Health Office Directives

The purpose of the Prevention and Recovery in Early Psychosis program (PREP) is to help youth during their first episode of psychosis with treatment for stability and hopefully prevent another episode of psychosis. The research suggests that with intensive treatment and wrap around services, this program has been successful in preventing youth from developing a psychotic disorder. Families are supported in this process as well. We currently serve youth between the ages of 14-30 for up to 2 years before they are transitioned to a family clinic for ongoing treatment. Services include individual therapy, family therapy, multi-family group, medication management, targeted case management, and family resource facilitation and peer support services. The team consists of 1 case manager, 2 therapists, a full time occupational therapist, part time peer, part time nurse, and part time prescriber. The team also has a supervisor, program manager and Care Team Assistant (administrative assistant/receptionist) The role of the occupational therapist consists of evaluating the functional living skills of clients as well as assessing social interactions in work, school or social settings. They work with the client in their environment for the most accurate assessment. They have the ability to complete full workups on the clients, which is then shared with the team as we work on the recovery plan with the client.

Outcomes Framework:

Clients use the OQ/YOQ to measure outcomes and current level of distress as well as any critical items (suicidal thoughts, aggression, disordered eating, etc). Data such as services utilized, legal issues, substance use issues, satisfaction with services, inpatient hospitalizations, and the involvement of natural supports is also collected at intake, every 6 months and again at discharge. A quarterly report is submitted which tracks the number of initial assessments, workforce development, training about psychosis and community outreach to educate others about this program.

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:

The purpose of this program is to enhance the PREP program. It is a stepped care model and

Mental Health Office Directives

allows clients to be screened and then tracked during the first onset of psychotic symptoms as young as age 13. Clients will be monitored for the first onset of psychosis so that PREP can be determined when to start. Young people and their families will receive specialized support and monitoring during this critical time.

Outcomes Framework:

See Outcomes in FEP section above.

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:

Cassie Helferich, LCSW, Program Manager / chelferich@wasatch.org

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

Michael King, LCSW

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

Training includes the following: Providers at WBH have training in Child Parent Psychotherapy as well as the Save Babies Court Team approach. Other training includes the Early Denver Model, Trauma Focused CBT, Advanced Trauma & Loss Training, Sandplay Training, and Structured Sensory Interventions.

Mental Health Office Directives

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

Service Delivery Framework:.

N/A

Outcomes Framework:

N/A

Intellectual and Developmental Disabilities (IDD)

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

Chris Westover, cwestover@wasatch.org, Program Manager at Westpark Family Clinic

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.

<https://www.wasatch.org/idd-trained/>

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

Mental Health Office Directives

- ☐ 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:

The School Based Services program is designed to intervene early in the course of mental illness to minimize the trauma to children and their families, while at the same time, treated in the least restrictive environment in an effort to improve quality of life. A psychiatrist for psychiatric evaluation and medication management may see children ages 3 to 18 years of age. Licensed therapists provide assessment, individual therapy, group therapy, and family therapy. School Based Services has experienced therapists who work with the broad range of disorders that occur in children and youth. School Based Services is a training site for social work interns. To obtain services through the School Based Services Onsite Program, the child/youth can be referred by school personnel, parents, or other interested parties. Therapists are assigned to schools where they provide an array of mental health services to the child and his/her family. The On-site program is contract specific. This past year we were able to successfully be in over 130 different schools in Utah County throughout the year and we anticipate continuing due to the contracts with school districts and the Early Intervention Funds provided by the legislature.

CYFAST (Child, Youth & Family Assessment Stabilization Team) is a specialized group offering crisis support under the Crisis and Intensive Services Division. Through CYFAST, early intervention services—including short-term support and resources—are available to the Utah County community, regardless of funding. Community members can access CYFAST services by contacting their local agency or calling the Crisis and Intensive Services Division directly. Services for sub-acute crisis prevention and follow-up (mobile stabilization)—where "sub-acute crisis" refers to situations that are serious but do not require hospitalization—may include respite care, peer support services (EIM not used for FPSS), and individual or family therapy. Respite care may involve temporary relief for caregivers, peer support services connect individuals with trained mentors who have lived experience, and therapy sessions address emotional and behavioral challenges. Short-term early intervention during a crisis is essential for minimizing long-term negative impacts and supporting recovery. Community partners and agencies may refer individuals and families, collaborating directly with CYFAST to ensure coordinated care and timely assistance. Immediate, short-term intervention helps those affected manage stress, stabilize their

Mental Health Office Directives

situation, and prevent escalation. This collaborative, rapid approach fosters resilience and connects individuals with ongoing resources for continued support.

Additionally, WBH has an ongoing contract with Provo City School District to help provide risk assessments for the district's students. Support may include coaching caregivers on de-escalation and coping strategies, connecting the family to community resources, community-based crisis supports (e.g., crisis lines/988, mobile crisis services, crisis stabilization programs, and respite), and outside providers, coordinating appointments, and offering in-home support through WBH when appropriate. Early intervention services are typically offered over the course of several weeks, with ongoing check-ins to help ensure the youth and family are connected to the right resources and have the support needed to maintain stability.

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

Erin Averkamp LCSW, eaverkamp@wasatch.org, Program Manager

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.

[Nursing Home and Assisted Living Outreach Services](#)

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.

Wendy Hendley

Mental Health Office Directives

Kayelyn Robinson
Rosa Reyes
Phil Sorenson
Diana Akan
Lisa O'Donnal
Mel Guest
Kirstin Peterson
Esther Tai
Jennifer Lambert
Lauren Sadler
Erika Green
Alisa Erickson
Rosario Perez
Rhonda Harris
Iesha Bailey
Alexa Lamborne (School Based)
Samantha Robinson (Promise)
Linda Fifita (School Based)
Kami Dayley

****NOTE:** some of these individuals are listed on the Utah Maternal Mental Health Network website. We are encouraging others to register.

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:

Alyson Pallas, apallas@wasatch.org, Peer Support Specialist at Westpark Family Clinic

***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:

Mental Health Office Directives

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

After intake, unfunded clients are scheduled to meet with a case manager. The case manager will help the client determine if he or she is eligible for Medicaid. If so, the case manager will support the client through the application process. If not, the case manager can help the client explore other options for insurance (for example, through employment or the Marketplace),

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

If a client is unfunded, he or she will complete the Income Verification form and provide proof of income with pay stubs, current copy of Federal Tax return, Social Security with income listed, or DWS work history log. The form will help calculate if the individual qualifies for the grant and what his or her sliding scale fee will be per session. Initially, the client is authorized to receive an evaluation and 5 therapy sessions OR and evaluation, 3 therapy sessions, a medication evaluation and 1 med management follow up appt. Additional appts may be authorized by the Program Manager as needed. During this time, the client will also be scheduled with a case manager to explore options for ongoing funding and treatment.

3) Service continuum accessible to unfunded clients.

Unfunded clients are eligible to receive an intake assessment, individual therapy, medication management and case management related to applying for Medicaid or accessing other insurance.

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.

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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.

WBH's Early Intervention Framework focuses on identifying and engaging individuals with substance use concerns who are not yet ready to fully participate in treatment services. While WBH does not hold the state contract for Early Intervention/Prevention in Utah County, we coordinate closely with county providers and refer individuals, including those receiving DUI-related assessments, to Prime for Life programs and other approved early intervention services.

Internally, WBH supports early intervention through targeted readiness-based services. Individuals seeking SUD services who are not ready to engage in ongoing treatment are offered the Early Recovery Skills group. This group utilizes Motivational Interviewing, psychoeducation, and other evidence-informed approaches to enhance motivation, increase awareness of substance use impacts, and support movement toward behavior change.

Peer support specialists facilitate these groups, providing lived experience and engagement strategies to build trust and encourage participation. All individuals identified as not ready for treatment during the assessment process are offered these services and ongoing support to increase readiness for change and transition into appropriate levels of care when clinically indicated.

Substance Use - Adults

Outcomes Framework:

The service delivery framework utilizes ASAM criteria to determine the most appropriate level of care based on individual needs. Standardized tools including the SASSI, RANT, LSI-R-SV, DLA, and TCUD are used not only for screening but also to establish baseline functioning and risk. These measures support an outcomes-driven approach by allowing providers to monitor changes in substance use, risk factors, and daily functioning over time. The Columbia Suicide Risk Rating Scale is also administered at assessment if indicated or in ongoing treatment if indicated.

Evidence-based practices, including Motivational Enhancement Therapy and Motivational Interviewing, are implemented at assessment and throughout treatment to support client engagement, enhance readiness for change, and improve treatment outcomes. Peer support services are integrated across all levels of care, particularly in Early Intervention, to improve engagement and sustain recovery.

WBH utilizes MHSIPs, SASSI, ASAM, LSI-R-SV, and RANT for all individuals receiving substance use evaluations to guide placement and track progress. For individuals with DUI charges whose assessment results indicate early intervention needs, referral to Prime for Life classes provides structured education aimed at reducing recidivism and improving decision-making related to substance use. Outcome measures from these interventions inform ongoing care planning and system-level evaluation.

The following is our Referral to PRIME FOR LIFE with Utah Co and other agencies are as follows:

WHAT IS PRIME FOR LIFE?

Prime for Life is an evidence based, risk reduction drug and alcohol education program it is not substance abuse treatment. Prime for Life simply presents straight-forward, research-based information in a relaxed environment. It is a 16-hour class.

Many states, including Utah, require Prime for Life education following charges related to DUI, DWI, careless driving, reckless driving, public intoxication, contributing to the delinquency of a minor, minors in possession of alcohol and some drug charges. Prime for Life education is also used for minors using or in possession of alcohol/drugs ("Not A Drop Law" violation) to retain their driver's license.

CERTIFIED PRI PROVIDERS IN UTAH COUNTY

AMERICAN FORK

Life Stone Group *

Utahduicourse.com

\$200.00 3-day class

Suncrest Counseling

1062 E 220 S Bamberger Dr.

801-642-2193

Also available in Spanish

\$275.00

PROVO

Utah DUI Class *

Utahduiclass.com

801-474-9669

\$220.00

Finish class in one weekend

SPANISH FORK

Addiction & Psychological Services

826 N 100 E Suite 2B

801-794-2350

\$350.00 English

Also available in Spanish

1st and 3rd weekends each month.

OREM

A.V.Y. Counseling Services *

165 N 1330 W, Suite A-1

801-960-3040

www.avycs.com

\$250.00

Also available in Spanish

(420 class) THC class 8 hours \$200

Abundant Life Institute

950 S Orem BLVD #241

801-836-0477

Also available in Spanish

\$250.00

Addiction & Psychological Services

224 N Orem Blvd

801-222-0603

\$350

Also available in Spanish

Weekends

Capstone Counseling Center *

555 S State St, #205

801-341-0411

\$225 (can make payments)

Finish class in one weekend

* Indicates classes are scheduled frequently

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?

Service Delivery Framework:

Foothill Residential Treatment provides **ASAM III.2-D Clinically Managed Residential Detoxification (social detox)**, which involves a structured, non-medical process for individuals who do not require intensive medical intervention. This level of care is appropriate for individuals with mild to moderate withdrawal risk. Standardized tools at assessment including the SASSI, RANT, LSI-R-SV, DLA, and TCUD are used not only for screening but also to establish baseline functioning and risk. These measures support an outcomes-driven approach by allowing providers to monitor changes in substance use, risk factors, and daily functioning over time. The Columbia Suicide Risk Rating Scale is also administered at assessment if indicated or in ongoing treatment if indicated.

Foothill has the capacity for **34 residential beds and 10 detox beds**, including one dedicated detox bed for emergency room referrals. Services are provided directly by WBH staff and include:

- General health assessment
- Infectious disease screening

Substance Use - Adults

- Monitoring of vital signs
- Nursing care and medication management
- Screening and education on Medication-Assisted Treatment (MAT), including naloxone and methadone
- Referral and coordination for ongoing MAT services
- Peer support services
- Tobacco cessation screening and support
- Case management
- Discharge planning and referrals to ongoing care

Residential Treatment and Stabilization Services

Foothill provides a structured residential environment designed to stabilize individuals with moderate substance use disorder symptoms. Services include:

- Comprehensive behavioral health and recovery needs assessment
- Individualized treatment planning
- Evidence-based therapies, including:
 - Motivational Interviewing (MI)
 - Cognitive Behavioral Therapy (CBT)
 - Dialectical Behavioral Therapy (DBT)
- Group therapy, individual therapy, and skills-based interventions
- Relapse prevention planning
- Nursing services and medication management
- Peer support integration
- Case management and resource coordination

Assessment tools include **ASAM Criteria and DLA-20**, with reassessments conducted **every two weeks or as needed** to ensure appropriate level of care.

The **average length of stay is approximately 90 days**, though this varies based on clinical need.

WBH also incorporates **contingency management and positive reinforcement strategies** to support engagement and promote recovery-oriented behaviors.

Care Coordination and Discharge Planning

All clients are assigned a case manager to assist with:

- Medicaid enrollment
- Food assistance

Substance Use - Adults

- Medical and dental care access
- Housing applications
- Legal system coordination
- Recovery residence placement

Discharge planning begins at admission, with all clients linked to **appropriate outpatient or step-down services** upon completion.

Collaborative Services (Contracted/Partnered Care)

WBH partners with **Intermountain Healthcare (Utah Valley Hospital)** through a PICC line program serving individuals who inject drugs and require intravenous antibiotics.

Through this collaboration:

- Patients are stabilized in the hospital setting
- Discharged to WBH or affiliated treatment facilities
- Provided with housing, case management, counseling, and transportation to medical appointments

This program supports safe recovery while reducing acute care utilization.

Outcomes Framework:

Foothill Residential utilizes a comprehensive outcomes framework to monitor client progress and inform ongoing treatment. Standardized tools—including ASAM III criteria, Outcome Questionnaire (OQ), SURE, MHSIPS, C-SSRS, and DLA-20—are used to establish baseline functioning and to assess changes in substance use, mental health symptoms, safety risk, and daily living skills over time.

Individualized treatment plans, developed collaboratively with each client, include measurable goals and objectives that are regularly reviewed and updated based on assessment data and client progress. Urinalysis (UA) testing is also used as an objective measure to support monitoring of substance use and recovery progress.

Data gathered from these tools informs clinical decision-making, including treatment

Substance Use - Adults

interventions, level of care adjustments, and discharge planning, ensuring services remain responsive to each client's evolving needs and support improved treatment outcomes.

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?

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

WBH provides residential substance use disorder (SUD) services through **Foothill Residential Treatment**, operating within an **ASAM-guided, evidence-based service delivery framework**. Services are delivered directly by WBH staff in a **24-hour structured setting**, consistent with ASAM criteria for residential care.

Access and Level of Care Determination

Access to Foothill Residential is based on a **comprehensive assessment using ASAM criteria**, supported by DLA-20 evaluations. Level of care determinations are made at admission and **reviewed every two weeks** to ensure appropriate placement and continued medical necessity.

Foothill has capacity for:

Substance Use - Adults

- **34 residential beds**
- **10 detox beds**
- **1 dedicated emergency room detox bed**

Comprehensive Assessment and Individualized Treatment Planning

At admission, clients receive:

- Behavioral health and recovery support needs assessment
- General health and infectious disease screening
- ASAM and DLA-20 assessments

Individualized treatment plans are developed in collaboration with the client and include **measurable goals and objectives** focused on stabilization, recovery skill development, and relapse prevention. Treatment plans are **regularly updated based on clinical progress and reassessment data**.

Evidence-Based Treatment and Therapeutic Interventions

Foothill Residential delivers **evidence-based and best practice interventions** consistent with state expectations, including:

- Motivational Interviewing (MI)
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavioral Therapy (DBT)
- Contingency Management

Services include:

- Individual, group, and skills-based therapy
- Medication Assisted Treatment (MAT) and medication management
- Nursing services and vital sign monitoring
- Peer support services
- Tobacco cessation interventions
- Case management and care coordination

Interventions are designed to:

- Stabilize substance use symptoms
- Reduce risk factors
- Build relapse prevention skills

Substance Use - Adults

- Strengthen recovery supports and address barriers

Monitoring, Engagement, and Outcomes

Client progress is continuously monitored through:

- **Biweekly ASAM reassessments (or as needed)**
- Ongoing clinical evaluation and documentation
- Engagement in treatment and recovery-oriented behaviors

Foothill incorporates **contingency management and positive reinforcement strategies** to improve engagement, increase retention, and support behavior change.

The **average length of stay is approximately 90 days**, with flexibility based on clinical need and ASAM criteria.

Care Coordination and Discharge Planning

WBH ensures **continuity of care** through early and ongoing discharge planning. Each client is assigned a case manager to coordinate:

- Medicaid and benefits access
- Medical and dental services
- Housing and recovery residence placement
- Legal system coordination
- Connection to community-based supports

All clients are **linked to appropriate outpatient or step-down services** upon discharge to support sustained recovery.

Continuum of Care and Contracted Services

WBH maintains a **continuum of care** through contracts with:

- **Odyssey House**
- **House of Hope**

These providers offer **residential services** for adults when:

- Dual relationships or access limitations exist
- A placement for a mother or father with a young child is needed.

Substance Use - Adults

Referrals are completed **case-by-case with prior authorization**, ensuring access to the **full continuum of residential services**. Youth residential needs are addressed through contracted providers due to the absence of in-county services.

Outcomes Framework:

Foothill Residential utilizes a comprehensive outcomes framework to monitor client progress and inform ongoing treatment. Standardized tools—including ASAM III criteria, Outcome Questionnaire (OQ), SURE, MHSIPS, C-SSRS, and DLA-20—are used to establish baseline functioning and to assess changes in substance use, mental health symptoms, safety risk, and daily living skills over time.

Individualized treatment plans, developed collaboratively with each client, include measurable goals and objectives that are regularly reviewed and updated based on assessment data and client progress. Urinalysis (UA) testing is also used as an objective measure to support monitoring of substance use and recovery progress.

Data gathered from these tools informs clinical decision-making, including treatment interventions, level of care adjustments, and discharge planning, ensuring services remain responsive to each client's evolving needs and support improved treatment outcomes.

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:

WBH provides Intensive Outpatient Services within an **ASAM-guided, evidence-based service delivery framework** designed to treat individuals with substance use and co-occurring mental health disorders impacting daily functioning. Services are delivered directly by WBH; there are **no contracted outpatient SUD providers**.

Substance Use - Adults

Access and Level of Care Determination

Clients enter services through referrals from community partners (courts, DCFS, AP&P, healthcare providers) or self-referral.

Level of care is determined using **ASAM Criteria**, supported by standardized screening tools including:

- SASSI
- RANT
- LSI-R-SV
- TCUD
- OQ
- CRRSS (as needed when indicated)

Placement into IOP is based on **clinical need and functional impairment**, with services designed to reduce symptoms, improve functioning, and prevent escalation to higher levels of care.

Comprehensive Assessment and Individualized Treatment Planning

All clients receive:

- Comprehensive behavioral health assessment
- Functional assessment using **DLA-20**
- Ongoing clinical evaluation

Clients participate in **individualized treatment planning**, including measurable goals and objectives, which are **reviewed and updated regularly** based on progress and engagement.

Core Service Components

IOP services are structured and individualized, including:

- Group therapy
- Individual therapy
- Case management
- Recovery support services

Services are delivered using **evidence-based and best practice modalities**, including:

- Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT)

Substance Use - Adults

- Dialectical Behavior Therapy (DBT)
- Contingency Management and Behavioral Contracting
- Brief Intervention Treatment
- Relapse Prevention Therapy
- Medication Assisted Treatment (MAT)
- Family Therapy and couples therapy
- Seeking Safety and trauma-informed approaches
- Moral Reconnection Therapy (MRT) and Creating Change
- Helping Men Recover / Helping Women Recover
- Eye Movement Desensitization and Reprocessing (EMDR)
- Tobacco cessation interventions

Services are designed to:

- Reduce substance use and psychiatric symptoms
- Improve functioning and daily living skills
- Increase engagement in recovery supports
- Prevent relapse and deterioration

Monitoring, Engagement, and Outcomes

WBH maintains a **data-driven outcomes framework** to evaluate client progress and program effectiveness.

Standardized outcome tools include:

- **Outcome Questionnaire (OQ)**
- **MHSIP**
- **SURE (Substance Use Recovery Evaluator)**

Outcome data is **reviewed regularly (each session as indicated)** and used to:

- Monitor changes in symptoms and functioning
- Inform treatment adjustments
- Support level-of-care decisions

The **DLA-20** is used to track functional improvement and guide transition planning.

Operational and Quality Assurance Practices

WBH ensures fidelity to evidence-based practices through:

Substance Use - Adults

- **Standardized clinical protocols**
- **Peer audit reviews** for quality assurance and training
- Ongoing **clinical supervision and performance evaluation**

These processes support **consistent service delivery, adherence to EBPs, and continuous quality improvement.**

Care Coordination, Family Engagement, and Support Services

All clients are assigned a case manager to coordinate:

- Medical and behavioral health services
- Social supports and resource linkage
- Benefits and community services

WBH emphasizes **family engagement**, offering:

- Family therapy and couples counseling
- Child-Parent Psychotherapy (CPP) for eligible populations

These services strengthen support systems and improve outcomes.

Transition Planning and Continuum of Care

Transition planning is **integrated throughout treatment** to ensure continuity of care.

Using **DLA-20 and ongoing clinical assessment**, WBH supports:

- Movement between levels of care
- Successful program completion
- Linkage to outpatient, recovery, and community supports

The goal is to promote:

- Sustained recovery
- Client independence
- Long-term stability

Community Integration and Outreach

WBH maintains active collaboration with:

- Courts

Substance Use - Adults

- DCFS
- Adult Probation & Parole
- Local health departments and coalitions

These partnerships ensure:

- Coordinated referrals
- System alignment
- Increased community awareness and access to care

Outcomes Framework:

Wasatch Behavioral Health (WBH) utilizes a **comprehensive, data-driven outcomes framework** to monitor client progress, evaluate treatment effectiveness, and inform ongoing clinical decision-making within Intensive Outpatient Services.

Standardized outcome measurement tools include:

- **MHSIP (Mental Health Statistics Improvement Program)**
- **Outcome Questionnaire (OQ)**
- **SURE (Substance Use Recovery Evaluator)**
- **C-SRRS (Columbia Suicide Risk Rating Scale) as needed when indicated**

These tools are used to **establish baseline functioning** and are administered **throughout treatment to monitor changes in mental health symptoms, substance use, and recovery progress over time**. Outcome data is **reviewed regularly, including during treatment sessions as clinically indicated**, to guide service delivery.

The **DLA-20 (Daily Living Activities Assessment)** is utilized to assess functional needs, measure improvement in daily living skills, and support determination of when identified needs have been met.

Individualized treatment plans, developed in collaboration with the client, include **measurable goals and objectives** that are continuously reviewed and updated based on outcome data and clinical progress.

ASAM Criteria is used throughout treatment to:

- Reassess level of care needs

Substance Use - Adults

- Determine progress toward treatment goals
- Guide decisions regarding continued stay, step-down, or discharge

WBH also incorporates **randomized urinalysis (UA) testing**, with frequency adjusted based on clinical need, to provide objective measures of substance use and support monitoring of recovery progress.

Data collected through these tools is used to:

- Monitor individual client progress over time
- Inform adjustments to treatment interventions and service intensity
- Support appropriate level-of-care transitions
- Guide discharge planning and ensure readiness for continued recovery

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:

WBH provides General Outpatient Services within an **ASAM-guided, evidence-based service delivery framework** designed to treat individuals with substance use and co-occurring mental health disorders impacting daily functioning. Services are delivered directly by WBH; there are **no contracted outpatient SUD providers**.

Access and Level of Care Determination

Clients enter services through referrals from community partners (courts, DCFS, AP&P, healthcare providers) or self-referral.

Level of care is determined using **ASAM Criteria**, supported by standardized screening tools including:

- SASSI
- RANT

Substance Use - Adults

- LSI-R-SV
- TCUD
- OQ
- CRRSS (as needed when indicated)

Placement into IOP is based on **clinical need and functional impairment**, with services designed to reduce symptoms, improve functioning, and prevent escalation to higher levels of care.

Comprehensive Assessment and Individualized Treatment Planning

All clients receive:

- Comprehensive behavioral health assessment
- Functional assessment using **DLA-20**
- Ongoing clinical evaluation

Clients participate in **individualized treatment planning**, including measurable goals and objectives, which are **reviewed and updated regularly** based on progress and engagement.

Core Service Components

IOP services are structured and individualized, including:

- Group therapy
- Individual therapy
- Case management
- Recovery support services

Services are delivered using **evidence-based and best practice modalities**, including:

- Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET)
- Cognitive Behavioral Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Contingency Management and Behavioral Contracting
- Brief Intervention Treatment
- Relapse Prevention Therapy
- Medication Assisted Treatment (MAT)
- Family Therapy and couples therapy
- Seeking Safety and trauma-informed approaches
- Moral Reconciliation Therapy (MRT) and Creating Change
- Helping Men Recover / Helping Women Recover

Substance Use - Adults

- Eye Movement Desensitization and Reprocessing (EMDR)
- Tobacco cessation interventions

Services are designed to:

- Reduce substance use and psychiatric symptoms
- Improve functioning and daily living skills
- Increase engagement in recovery supports
- Prevent relapse and deterioration

Monitoring, Engagement, and Outcomes

WBH maintains a **data-driven outcomes framework** to evaluate client progress and program effectiveness.

Standardized outcome tools include:

- **Outcome Questionnaire (OQ)**
- **MHSIP**
- **SURE (Substance Use Recovery Evaluator)**

Outcome data is **reviewed regularly (each session as indicated)** and used to:

- Monitor changes in symptoms and functioning
- Inform treatment adjustments
- Support level-of-care decisions

The **DLA-20** is used to track functional improvement and guide transition planning.

Operational and Quality Assurance Practices

WBH ensures fidelity to evidence-based practices through:

- **Standardized clinical protocols**
- **Peer audit reviews** for quality assurance and training
- Ongoing **clinical supervision and performance evaluation**

These processes support **consistent service delivery, adherence to EBPs, and continuous quality improvement.**

Care Coordination, Family Engagement, and Support Services

Substance Use - Adults

All clients are assigned a case manager to coordinate:

- Medical and behavioral health services
- Social supports and resource linkage
- Benefits and community services

WBH emphasizes **family engagement**, offering:

- Family therapy and couples counseling
- Child-Parent Psychotherapy (CPP) for eligible populations

These services strengthen support systems and improve outcomes.

Transition Planning and Continuum of Care

Transition planning is **integrated throughout treatment** to ensure continuity of care.

Using **DLA-20 and ongoing clinical assessment**, WBH supports:

- Movement between levels of care
- Successful program completion
- Linkage to outpatient, recovery, and community supports

The goal is to promote:

- Sustained recovery
- Client independence
- Long-term stability

Community Integration and Outreach

WBH maintains active collaboration with:

- Courts
- DCFS
- Adult Probation & Parole
- Local health departments and coalitions

These partnerships ensure:

- Coordinated referrals
- System alignment

Substance Use - Adults

- Increased community awareness and access to care

Outcomes Framework:

Individualized treatment plans, developed in collaboration with the client, include **measurable goals and objectives** that are continuously reviewed and updated based on outcome data and clinical progress.

ASAM Criteria is used throughout treatment to:

- Reassess level of care needs
- Determine progress toward treatment goals
- Guide decisions regarding continued stay, step-down, or discharge

Additional tools that assist with outcome measures include the following:

- Outcome Questionnaire (OQ),
- SURE,
- MHSIPS,
- C-SSRS,
- DLA-20

Each of these are used to establish baseline functioning and to assess changes in substance use, mental health symptoms, safety risk, and daily living skills over time.

Data gathered from these tools informs clinical decision-making, including treatment interventions, level of care adjustments, and discharge planning, ensuring services remain responsive to each client's evolving needs and support improved treatment outcomes.

WBH also incorporates **randomized urinalysis (UA) testing**, with frequency adjusted based on clinical need, to provide objective measures of substance use and support monitoring of recovery progress.

Data collected through these tools is used to:

- Monitor individual client progress over time
- Inform adjustments to treatment interventions and service intensity
- Support appropriate level-of-care transitions
- Guide discharge planning and ensure readiness for continued recovery

Substance Use - Adults

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.*

Treatment for Opioid Use Disorder (OTP/Methadone) Service Delivery Framework

Wasatch Behavioral Health (WBH) runs the **Center for Opioid Recovery (COR)**, which provides **Medication for Opioid Use Disorder (MOUD/MAT)** through a **comprehensive, integrated, and evidence-based service delivery framework**. Services are delivered through a combination of **direct care and contracted medical providers**, ensuring accessibility and continuity of care.

Service Delivery Method

- **Direct Services:** Behavioral health treatment, case management, peer support, and care coordination provided by WBH staff
- **Contracted Medical Providers:** MAT prescribing services provided by **Dr. Joel Bush, MD** and **Dr. William Dunaway, MD**
- Services are available at **WBH outpatient clinics (Orem)** and **Foothill Residential Treatment**
- Additionally we are coordinating through our OTP to provide methadone to individuals in the jail.

Substance Use - Adults

Access and Level of Care Determination

Clients access OTP/MOUD services through **referrals, walk-in intake, or internal transitions from other levels of care.**

All individuals receive a **comprehensive clinical and medical assessment** conducted by a **board-certified addictionologist**, including:

- Substance use history
- Medical and psychiatric evaluation
- Readiness for treatment
- Risk and withdrawal assessment

ASAM Criteria are used, when applicable, to support **level-of-care determination and service matching.**

Integrated Medical and Clinical Treatment Approach

WBH utilizes an **integrated care model**, combining **CARF** and **FDA-approved medications with evidence-based behavioral health interventions** to treat opioid and other substance use disorders.

Medication Services (MOUD/MAT)

WBH provides a full array of medications, including:

- **Methadone (OTP program)**
- Buprenorphine (Suboxone, Subutex, Sublocade, Brixadi)
- Naltrexone / Vivitrol

Medications are used to:

- Normalize brain chemistry
- Reduce cravings and withdrawal symptoms
- Block euphoric effects of opioids and alcohol
- Support stabilization and long-term recovery

Core Treatment Services

Substance Use - Adults

Clients participate in a **comprehensive continuum of care**, including:

- Individual counseling and therapy
- Group therapy and recovery support
- Case management
- Peer support services
- Primary healthcare coordination
- Health education and disease prevention
- Crisis and situational counseling

Services are **client-centered and individualized**, addressing:

- Substance use behaviors
- Co-occurring mental health conditions
- Social determinants of health
- Recovery and relapse prevention

Evidence-Based Practices and Clinical Interventions

WBH incorporates **evidence-based and best practice interventions**, including:

- Motivational Interviewing (MI)
- Cognitive Behavioral Therapy (CBT)
- Relapse Prevention strategies
- Trauma-informed care approaches

Treatment integrates both:

- **Pharmacological interventions** (MOUD)
- **Behavioral therapies**, addressing psychological, emotional, and social needs

Staffing and Multidisciplinary Team

Services are delivered by a **multidisciplinary team**, including:

- Board-certified physicians (addictionologists)
- Nursing staff
- Licensed clinical therapists
- Substance use counselors
- Case managers

Substance Use - Adults

- Peer support specialists

All staff operate within professional **codes of ethics**, with strict adherence to **confidentiality and best practice standards**.

Monitoring, Engagement, and Quality Assurance

WBH maintains **ongoing monitoring and quality improvement processes**, including:

- Regular medical and clinical follow-up
- Ongoing treatment plan review and updates
- Monitoring of medication adherence and response
- Use of individualized outcome measures

Services are **continuously evaluated to ensure quality, effectiveness, and cost-efficiency**, with adjustments made based on client progress and needs.

Client Engagement, Education, and Recovery Support

The program emphasizes:

- **Client responsibility and engagement in recovery**
- Education on substance use disorders and treatment
- Development of healthy lifestyles and coping strategies
- **Family involvement and support**, when appropriate

Clients are supported in building **long-term recovery skills** and reintegration into the community.

Continuum of Care and Transition Planning

WBH ensures **continuity across levels of care**, including:

- Transition from residential or inpatient care into OTP services
- Coordination with outpatient and community-based supports
- Ongoing recovery maintenance and relapse prevention

Services are designed to support:

- Long-term stabilization
- Reduced overdose risk

Substance Use - Adults

- Improved health and functioning
- Reintegration as productive community members

In addition to WBH's **Center for Opioid Recovery (COR)**, WBH contracts with **True North** to expand access to Medication-Assisted Treatment (MAT) and related opioid use disorder services. This collaboration ensures individuals have timely access to a full continuum of care, including medication management, counseling, and recovery support services, based on clinical need and individual preference.

Outcomes Framework:

Individualized treatment plans, developed in collaboration with the client, include **measurable goals and objectives** that are continuously reviewed and updated based on outcome data and clinical progress.

ASAM Criteria is used throughout treatment to:

- Reassess level of care needs
- Determine progress toward treatment goals
- Guide decisions regarding continued stay, step-down, or discharge

Additional tools that assist with outcome measures include the following:

- Outcome Questionnaire (OQ),
- SURE,
- MHSIPS,
- C-SSRS,
- DLA-20

Each of these are used to establish baseline functioning and to assess changes in substance use, mental health symptoms, safety risk, and daily living skills over time.

Data gathered from these tools informs clinical decision-making, including treatment interventions, level of care adjustments, and discharge planning, ensuring services remain responsive to each client's evolving needs and support improved treatment outcomes.

WBH also incorporates **randomized urinalysis (UA) testing**, with frequency adjusted based on

Substance Use - Adults

clinical need, to provide objective measures of substance use and support monitoring of recovery progress.

Data collected through these tools is used to:

- Monitor individual client progress over time
- Inform adjustments to treatment interventions and service intensity
- Support appropriate level-of-care transitions
- Guide discharge planning and ensure readiness for continued recovery

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?

Yes, last reviewed 12/11/2025

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.*

Medication-Assisted Treatment (MAT) is an evidence-based, integrated service designed to treat individuals with opioid and alcohol use disorders. Services are initiated through a comprehensive, person-centered assessment conducted by a board-certified addictionologist, which evaluates substance use history, medical and psychiatric needs, and readiness for treatment.

Based on this assessment, an individualized treatment plan is developed that combines **FDA-approved medications** with **evidence-based behavioral therapies**. This integrated approach supports both the physiological and psychological aspects of substance use disorders and aligns with best practices for reducing substance use, preventing relapse, and decreasing overdose risk.

MAT services emphasize a **recovery-oriented and harm-reduction framework**, supporting individuals in stabilizing symptoms, improving functioning, and progressing toward long-term

Substance Use - Adults

recovery goals.

Description of the Service

Medication-Assisted Treatment (MAT) provides ongoing pharmacological and therapeutic interventions to support recovery from substance use disorders and reduce the risk of overdose and related harms. MAT medications work to normalize brain chemistry, reduce cravings, block euphoric effects of substances, and support physiological stabilization without producing the harmful effects associated with substance misuse.

Services are delivered by a **multidisciplinary team** of licensed professionals, including physicians, nurses, clinical social workers, substance use disorder counselors, case managers, and peer support specialists. This team collaborates to ensure **coordinated, whole-person care**, addressing medical, behavioral, and social determinants of health.

Key components of MAT service delivery include:

- Comprehensive assessment and diagnosis
- Individualized treatment planning and regular plan review
- Medication management and ongoing monitoring
- Evidence-based counseling and behavioral therapies
- Care coordination and case management
- Peer support and recovery support services
- Overdose prevention education and interventions

MAT services prioritize **engagement, retention in treatment, and continuity of care**, with ongoing monitoring of progress and adjustments to treatment as clinically indicated. The program supports improved health outcomes, including reduced substance use, increased stability, and enhanced functioning in daily life.

Outcomes Framework:

Individualized treatment plans, developed in collaboration with the client, include **measurable goals and objectives** that are continuously reviewed and updated based on outcome data and clinical progress.

ASAM Criteria is used throughout treatment to:

Substance Use - Adults

- Reassess level of care needs
- Determine progress toward treatment goals
- Guide decisions regarding continued stay, step-down, or discharge

Additional tools that assist with outcome measures include the following:

- Outcome Questionnaire (OQ),
- SURE,
- MHSIPS,
- C-SSRS,
- DLA-20

Each of these are used to establish baseline functioning and to assess changes in substance use, mental health symptoms, safety risk, and daily living skills over time.

Data gathered from these tools informs clinical decision-making, including treatment interventions, level of care adjustments, and discharge planning, ensuring services remain responsive to each client's evolving needs and support improved treatment outcomes.

WBH also incorporates **randomized urinalysis (UA) testing**, with frequency adjusted based on clinical need, to provide objective measures of substance use and support monitoring of recovery progress.

Data collected through these tools is used to:

- Monitor individual client progress over time
- Inform adjustments to treatment interventions and service intensity
- Support appropriate level-of-care transitions
- Guide discharge planning and ensure readiness for continued recovery

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:

Substance Use - Adults

PROMISE PROGRAM:

WBH provides women-specific substance use disorder treatment through the Promise Program, which delivers trauma-informed, family-centered, and evidence-based services to women and their children. Programs continue to offer on-site childcare so mothers can participate in treatment without the burden of childcare interfering. The Promise Program also provides transportation to and from treatment to support consistent engagement. As an additional strategy to increase access, childcare eligibility has been expanded to include children up to age 10.

All services are delivered using trauma-informed care principles, and this approach is integrated across programming. Clinical staff have received extensive training in trauma-informed care, including Seeking Safety, as well as enhanced Motivational Interviewing training (24-hour). Treatment services include a range of evidence-based modalities such as Motivational Interviewing and Motivational Enhancement Therapy, Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Contingency Management, Medication-Assisted Treatment, Relapse Prevention, Brief Intervention, Family Therapy, EMDR, and gender-responsive curricula including Helping Women Recover. ASAM Criteria are utilized for level-of-care determinations, and DLA assessments support ongoing evaluation of functioning. The program has also increased the use of EMDR to further support trauma treatment.

The Promise Program includes a strong focus on parenting and family relationships. Services include a curriculum-based parenting group (Nurturing Families), as well as a weekly parenting support group where mothers can discuss stressors, share challenges, and connect with other women parenting children. In addition, some clients receive individualized, one-on-one parenting support from a childcare specialist. Therapeutic daycare supports both child development and parent-child bonding during treatment.

Additional services support whole-person recovery, including Healthy Steps to Freedom, an evidence-based program addressing body image, nutrition, and health factors associated with relapse among women, as well as trauma-informed yoga to support emotional regulation and wellness.

WBH will continue to provide all services through a trauma-informed framework, with increased focus on addressing perinatal and postnatal mood disorders as part of ongoing program development.

Substance Use - Adults

HOUSE OF HOPE CONTRACT

WBH also contracts with House of Hope in Provo to provide long-term residential treatment for women and their children. These services include therapeutic childcare and coordinated clinical services for children, allowing mothers and children to participate in treatment together and strengthen relationships while working toward shared goals.

Outcomes Framework:

Individualized treatment plans, developed in collaboration with the client, include **measurable goals and objectives** that are continuously reviewed and updated based on outcome data and clinical progress.

ASAM Criteria is used throughout treatment to:

- Reassess level of care needs
- Determine progress toward treatment goals
- Guide decisions regarding continued stay, step-down, or discharge

Additional tools that assist with outcome measures include the following:

- Outcome Questionnaire (OQ),
- SURE,
- MHSIPS,
- C-SSRS,
- DLA-20

Each of these are used to establish baseline functioning and to assess changes in substance use, mental health symptoms, safety risk, and daily living skills over time.

Data gathered from these tools informs clinical decision-making, including treatment interventions, level of care adjustments, and discharge planning, ensuring services remain responsive to each client's evolving needs and support improved treatment outcomes.

WBH also incorporates **randomized urinalysis (UA) testing**, with frequency adjusted based on clinical need, to provide objective measures of substance use and support monitoring of recovery progress.

Data collected through these tools is used to:

Substance Use - Adults

- Monitor individual client progress over time
- Inform adjustments to treatment interventions and service intensity
- Support appropriate level-of-care transitions
- Guide discharge planning and ensure readiness for continued recovery

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
- ☐ 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:

WBH provides priority access and comprehensive services for pregnant and parenting women with substance use disorders. Pregnant women are admitted to treatment within 48 hours, and when immediate admission is not available within 24 hours, a comprehensive referral for interim services is provided to ensure timely access to care.

Block Grant funds are utilized to support pregnant women, parenting women, and women working toward reunification with their children. Services include coordination of primary medical care, including referrals for prenatal care, as well as primary pediatric care for children of individuals in treatment, including access to immunizations.

Substance Use - Adults

WBH also provides therapeutic interventions for children in the custody of individuals receiving SUD treatment, addressing developmental needs as well as issues related to trauma, including sexual and physical abuse and neglect. Case management and transportation services are available for both clients and their children to support engagement, continuity of care, and access to necessary services.

Wasatch Behavioral Health (WBH) has a part-time clinician dedicated to providing **Child-Parent Psychotherapy (CPP)** for children of the men and women served in treatment. CPP is an evidence-based, trauma-focused intervention for young children (typically ages 0–5) and their caregivers that focuses on strengthening the parent-child relationship as a primary means of healing. This model is particularly effective for families impacted by substance use, trauma, attachment disruption, and related stressors.

CPP is implemented as a dyadic treatment, with the caregiver and child participating together in sessions. Through guided interaction, play, and therapeutic support, the clinician helps caregivers better understand their child's behaviors in the context of trauma and development, while building skills to respond in ways that promote safety, attachment, and emotional regulation. Services focus on improving caregiver-child relationships, supporting healthy child development, and addressing the impacts of trauma, including exposure to substance use, abuse, neglect, or instability.

This service enhances WBH's family-centered approach by providing targeted therapeutic support for children while strengthening the caregiving relationship, promoting resilience, and supporting long-term recovery outcomes for both parents and children.

Outcomes Framework:

Individualized treatment plans, developed in collaboration with the client, include **measurable goals and objectives** that are continuously reviewed and updated based on outcome data and clinical progress.

Additional tools that assist with outcome measures include the following:

- Youth Outcome Questionnaire (OQ),
- MHSIPS,
- C-SSRS,
- DLA-20

Substance Use - Adults

Each of these are used to establish baseline functioning and to assess changes in substance use, mental health symptoms, safety risk, and daily living skills over time.

Data gathered from these tools informs clinical decision-making, including treatment interventions, level of care adjustments, and discharge planning, ensuring services remain responsive to each client's evolving needs and support improved treatment outcomes.

Data collected through these tools is used to:

- Monitor individual client progress over time
- Inform adjustments to treatment interventions and service intensity
- Support appropriate level-of-care transitions
- Guide discharge planning and ensure readiness for continued 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?

- ☐ Directly
- ☒ Contracted provider (Please include a list or a link of contracted provider)
- House of Hope website link: [House of Hope – Hope Starts Here](#)

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

Substance Use - Adults

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:

WBH contracts with House of Hope to provide residential options for women with children. House of Hope provides comprehensive services for children of individuals engaged in substance use disorder treatment. Through this partnership, children receive formal assessment and ongoing individual and group services from a Licensed Mental Health Therapist, addressing developmental, emotional, and trauma-related needs. Within the Promise Program, each child participating in childcare services receives an initial developmental assessment, and individualized goals are developed in collaboration with the mother and Childcare Specialist to guide interventions during care. Childcare staff are trained to recognize developmental concerns and coordinate referrals to appropriate community providers when needed.

Childcare services are structured to support age-appropriate development, with programming tailored to meet the needs of both younger and older children. In addition to child-focused services, mothers are supported through individualized parenting assistance provided by Childcare Specialists, strengthening parenting skills and reinforcing the parent-child relationship. WBH and House of Hope maintain strong collaboration with the Division of Child and Family Services (DCFS), including participation of DCFS staff in program meetings and representation at DCFS Drug Court staffing. This coordinated approach supports integrated care, promotes child safety and well-being, and strengthens family stability throughout the treatment process.

Outcomes Framework:

Individualized treatment plans, developed in collaboration with the client, include **measurable goals and objectives** that are continuously reviewed and updated based on outcome data and clinical progress.

Additional tools that assist with outcome measures include the following:

- Youth Outcome Questionnaire (OQ),
- MHSIPS,
- C-SSRS,

Substance Use - Adults

- DLA-20

Each of these are used to establish baseline functioning and to assess changes in substance use, mental health symptoms, safety risk, and daily living skills over time.

Data gathered from these tools informs clinical decision-making, including treatment interventions, level of care adjustments, and discharge planning, ensuring services remain responsive to each client's evolving needs and support improved treatment outcomes.

Data collected through these tools is used to:

- Monitor individual client progress over time
- Inform adjustments to treatment interventions and service intensity
- Support appropriate level-of-care transitions
- Guide discharge planning and ensure readiness for continued recovery

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)?

WBH identifies and prioritizes persons who inject drugs (PWID) for admission through established screening, referral, and care coordination processes. At the time of admission and initial assessment, all clients are asked about injection drug use. Individuals who report injecting drugs are flagged for priority admission and are expedited into the appropriate level of care based on clinical need and ASAM criteria.

WBH works to ensure timely access to treatment for PWID, with admission occurring within 14 days of the request whenever program capacity allows. In situations where immediate admission is not available, WBH ensures that individuals receive **interim services** until treatment becomes available, and admission is completed within 120 days of the initial request. Interim services include ongoing engagement, referral coordination, and linkage to medically appropriate supports to reduce risk and maintain contact with the individual.

WBH also strengthens identification and rapid engagement of PWID through ongoing collaboration with Intermountain Health. This includes coordination of post-acute care for

Substance Use - Adults

individuals with IV PICC lines related to injection-associated infections, as well as partnerships with hospital emergency departments to identify individuals with substance use disorders and facilitate direct connection to WBH Medication-Assisted Treatment (MAT) services. These partnerships support early identification, rapid referral, and continuity of care for individuals who inject drugs, improving access and minimizing delays in treatment entry.

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

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

- ☒ Screening and testing.

Who is responsible for providing screening and testing for TB

WBH provides screening for tuberculosis (TB) as part of the intake and ongoing health assessment process for individuals receiving residential services. All residential clients are screened for TB risk factors, symptoms, and history, and when indicated, are referred for TB testing.

TB testing is conducted in coordination with community medical providers and local public health departments, which are responsible for administering and interpreting TB tests (e.g., TB skin test or blood test) and providing follow-up care as needed. WBH staff support this process through screening, referral, care coordination, and ensuring linkage to appropriate medical evaluation and treatment for individuals who may be infected with or exposed to TB.

- ☒ Education services.

Who is responsible for providing education for TB

Wasatch Behavioral Health (WBH) nursing staff are responsible for providing initial education regarding tuberculosis (TB) to individuals receiving services. WBH coordinates with the local Health Department as needed to ensure accurate, up-to-date information is provided and to support follow-up care, consultation, and additional community-based resources.

- ☒ Counseling services.

Who is responsible for providing counseling in respect to TB

Substance Use - Adults

Wasatch Behavioral Health (WBH) clinical staff are responsible for providing counseling related to tuberculosis (TB) for individuals receiving services. This includes supporting clients in understanding the impact of TB on their health, addressing concerns or barriers related to testing and treatment, and reinforcing the importance of treatment adherence. WBH coordinates with the local Health Department as needed to ensure appropriate guidance, follow-up, and continuity of care for individuals requiring additional medical or public health support.

- ☒ 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.

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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

Substance Use - Youth

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

Service Delivery Framework:

WBH provides Substance Use Disorder (SUD) Early Intervention services for youth using the evidence-based **7 Challenges Brief and Full**, implemented with fidelity. This model is designed specifically for adolescents and young adults and integrates substance use treatment with co-occurring mental health support. Services focus on helping youth examine their substance use, build motivation for change, develop decision-making skills, and address underlying emotional and behavioral concerns.

Early intervention services for youth include screening, assessment, and developmentally appropriate group and individual interventions. The 7 Challenges brief framework supports youth in identifying personal goals, understanding the impact of substance use, and building coping strategies to reduce risk and promote healthy behaviors. Family involvement is incorporated as appropriate to support engagement and strengthen the youth's support system.

These services are coordinated within a broader continuum of care, allowing youth to access additional supports as needed, including mental health treatment, case management, and referral to higher levels of SUD care when indicated. WBH's approach emphasizes early identification, engagement, and intervention to reduce progression of substance use and support positive long-term outcomes for youth.

Outcomes Framework:

WBH monitors outcomes for youth receiving Substance Use Disorder (SUD) services through the use of the **Youth Outcome Questionnaire (YOQ)**, along with ongoing clinical review, application of **ASAM Criteria**, and individualized treatment planning. The YOQ is administered at regular intervals to assess changes in emotional and behavioral functioning and to provide measurable data on treatment progress over time.

The **ASAM Criteria** are utilized to determine appropriate level of care at admission and throughout treatment, ensuring that services are matched to the severity and complexity of each youth's needs. ASAM dimensions are reviewed regularly to guide clinical decision-making, including continued stay, transfer, or discharge planning.

In addition to the YOQ, **urinalysis (UAs)** are utilized as clinically indicated to monitor substance

Substance Use - Youth

use and support accountability and recovery. **Daily Living Activities (DLA) assessments** are completed to evaluate functioning across life domains, including self-care, social relationships, and role performance, and are used to inform treatment planning and measure improvement over time. The **Columbia-Suicide Severity Rating Scale (C-SSRS)** is administered as indicated to assess suicide risk and ensure appropriate interventions and safety planning are in place.

Outcome data from these tools are reviewed regularly by clinical staff and incorporated into treatment planning to ensure services remain responsive to the needs of each youth. Improvements in YOQ scores, reductions in substance use as evidenced by UAs, progress in DLA functioning, and changes across ASAM dimensions are used to guide clinical decision-making and evaluate overall treatment effectiveness.

In addition, clinicians incorporate session feedback, family involvement, and ongoing assessment to evaluate engagement in treatment, reduction in substance use behaviors, and improved functioning at home, school, and in the community. Outcome monitoring is integrated into supervision and program review processes to support fidelity to evidence-based practices, including the 7 Challenges model, and to promote continuous quality improvement.

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?

- ☐ 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?

Substance Use - Youth

Wasatch Behavioral Health (WBH) ensures access to residential levels of care for youth based on clinical need as determined by the ASAM Criteria. WBH contracts with **Odyssey House** to provide **ASAM Level 3.5 residential treatment services** for youth when indicated. In addition, WBH coordinates internally with its youth mental health residential programs, including **ASPIRE and Vantage Point**, to support youth who require a residential level of care and have co-occurring mental health and substance use disorders. This coordinated approach allows for appropriate placement, continuity of care, and integrated treatment for youth with complex clinical needs.

Service Delivery Framework:

WBH provides Substance Use Disorder (SUD) Early Intervention services for youth using the evidence-based **7 Challenges Brief and Full**, implemented with fidelity. This model is designed specifically for adolescents and young adults and integrates substance use treatment with co-occurring mental health support. Services focus on helping youth examine their substance use, build motivation for change, develop decision-making skills, and address underlying emotional and behavioral concerns.

Early intervention services for youth include screening, assessment, and developmentally appropriate group and individual interventions. The 7 Challenges brief framework supports youth in identifying personal goals, understanding the impact of substance use, and building coping strategies to reduce risk and promote healthy behaviors. Family involvement is incorporated as appropriate to support engagement and strengthen the youth's support system.

These services are coordinated within a broader continuum of care, allowing youth to access additional support(s) as needed, including mental health treatment, case management, and referral to higher levels of SUD care when indicated. WBH's approach emphasizes early identification, engagement, and intervention to reduce progression of substance use and support positive long-term outcomes for youth.

Outcomes Framework:

Outcomes for youth receiving SUD services are monitored through their individualized recovery plan, ongoing clinical review, application of ASAM Criteria, and standardized assessment tools.

Substance Use - Youth

The **Youth Outcome Questionnaire (YOQ)** is administered at regular intervals to measure changes in emotional and behavioral functioning over the course of treatment.

The **ASAM Criteria** are used at admission and throughout treatment to determine appropriate level of care and to guide continued stay, transfer, and discharge decisions. Random **Urinalysis (UAs)** are utilized as indicated to monitor substance use and support accountability. **Daily Living Activities (DLA) assessments** are completed to evaluate functioning across key life domains and to measure progress over time. The **Columbia-Suicide Severity Rating Scale (C-SSRS)** is administered as clinically indicated to assess risk and inform safety planning.

These outcome measures are reviewed regularly by clinical staff and incorporated into individualized treatment planning. Progress is evaluated based on improvements in YOQ scores, reduction in substance use, increased functioning as measured by DLA, and stabilization across ASAM dimensions. Additional indicators include engagement in treatment, improved family relationships, and improved functioning in home, school, and community settings.

Outcome data is integrated into supervision and program review to support clinical decision-making, ensure fidelity to evidence-based practices, including the 7 Challenges model, and promote continuous quality improvement.

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:

Services are delivered through a coordinated, multidisciplinary approach that includes individual therapy, group therapy, family involvement, case management, and psychiatric/medication services as indicated. Treatment is guided by ASAM Criteria to ensure appropriate level of care placement and ongoing review of clinical needs.

Youth have access to a continuum of care, including outpatient and intensive services, with referral to residential treatment when indicated. WBH contracts with Odyssey House to provide ASAM Level 3.5 residential services for youth. In addition, coordination occurs with WBH youth residential mental health programs, including ASPIRE and Vantage Point, to support youth with

Substance Use - Youth

co-occurring mental health and substance use disorders requiring a higher level of care.

Services incorporate evidence-based practices, including the 7 Challenges model, and emphasize family engagement, skill development, and relapse prevention. Case management and care coordination support access to community resources, including education, medical care, and social services. Transportation is provided as needed to support engagement and continuity of care.

use and support accountability and recovery. **Daily Living Activities (DLA) assessments** are completed to evaluate functioning across life domains, including self-care, social relationships, and role performance, and are used to inform treatment planning and measure improvement over time. The **Columbia-Suicide Severity Rating Scale (C-SSRS)** is administered as indicated to assess suicide risk and ensure appropriate interventions and safety planning are in place.

Outcome data from these tools are reviewed regularly by clinical staff and incorporated into treatment planning to ensure services remain responsive to the needs of each youth. Improvements in YOQ scores, reductions in substance use as evidenced by UAs, progress in DLA functioning, and changes across ASAM dimensions are used to guide clinical decision-making and evaluate overall treatment effectiveness.

In addition, clinicians incorporate session feedback, family involvement, and ongoing assessment to evaluate engagement in treatment, reduction in substance use behaviors, and improved functioning at home, school, and in the community. Outcome monitoring is integrated into supervision and program review processes to support fidelity to evidence-based practices, including the 7 Challenges model, and to promote continuous quality improvement.

Outcomes Framework:

Outcomes for youth receiving SUD services are monitored through their individualized recovery plan, ongoing clinical review, application of ASAM Criteria, and standardized assessment tools. The **Youth Outcome Questionnaire (YOQ)** is administered at regular intervals to measure changes in emotional and behavioral functioning over the course of treatment.

The **ASAM Criteria** are used at admission and throughout treatment to determine appropriate level of care and to guide continued stay, transfer, and discharge decisions. Random **Urinalysis (UAs)** are utilized as indicated to monitor substance use and support accountability. **Daily Living**

Substance Use - Youth

Activities (DLA) assessments are completed to evaluate functioning across key life domains and to measure progress over time. The **Columbia-Suicide Severity Rating Scale (C-SSRS)** is administered as clinically indicated to assess risk and inform safety planning.

These outcome measures are reviewed regularly by clinical staff and incorporated into individualized treatment planning. Progress is evaluated based on improvements in YOQ scores, reduction in substance use, increased functioning as measured by DLA, and stabilization across ASAM dimensions. Additional indicators include engagement in treatment, improved family relationships, and improved functioning in home, school, and community settings.

Outcome data is integrated into supervision and program review to support clinical decision-making, ensure fidelity to evidence-based practices, including the 7 Challenges model, and promote continuous quality improvement.

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)

Service Delivery Framework:

Youth outpatient SUD services are delivered through a coordinated, multidisciplinary approach that includes individual therapy, group therapy, family involvement, case management, and psychiatric/medication services as indicated. Services are guided by the ASAM Criteria to ensure appropriate level of care placement and ongoing review of clinical needs.

Treatment incorporates evidence-based practices, including the 7 Challenges model, and focuses on increasing motivation for change, reducing substance use, developing coping and decision-making skills, and addressing co-occurring mental health needs. Services are developmentally appropriate and individualized based on assessment and ongoing clinical review.

Family involvement is a central component of youth outpatient services and is incorporated as appropriate to support engagement, improve communication, and strengthen the youth's support system. Case management and care coordination assist youth and families in accessing community resources, including educational supports, medical services, and other needed

Substance Use - Youth

services.

Youth have access to a continuum of care, with transition to more intensive levels of service when indicated, including intensive outpatient or residential treatment. WBH coordinates care internally and with community providers to ensure continuity of care and appropriate service placement. Transportation is available as needed to support access and ongoing engagement in treatment.

Outcomes Framework:

Outcomes for youth receiving outpatient SUD services are monitored through their individualized treatment plan, ongoing clinical review, application of ASAM Criteria, and use of standardized assessment tools. The **Youth Outcome Questionnaire (YOQ)** is administered at regular intervals to assess changes in emotional and behavioral functioning over the course of treatment.

The **ASAM Criteria** are utilized at admission and throughout treatment to determine appropriate level of care and to guide continued stay, transfer, and discharge decisions. Random **Urinalysis (UAs)** are utilized as clinically indicated to monitor substance use and support recovery. **Daily Living Activities (DLA) assessments** are completed to evaluate functioning across domains and to measure progress over time. The **Columbia-Suicide Severity Rating Scale (C-SSRS)** is administered as indicated to assess risk and inform safety planning.

Outcome measures are reviewed regularly by clinical staff and incorporated into individualized treatment planning to ensure services remain responsive to each youth's needs. Progress is evaluated based on improvements in YOQ scores, reduction or cessation of substance use, increased functioning as measured by DLA, and stabilization across ASAM dimensions. Additional indicators include engagement in treatment, improved family functioning, and improved performance in home, school, and community settings.

Outcome data is integrated into clinical supervision and program review processes to support decision-making, ensure fidelity to evidence-based practices, including the 7 Challenges model, and promote continuous quality improvement.

Access and Quality of Youth Treatment Services

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

Substance Use - Youth

services?

WBH continues to enhance coordination, access, and quality of youth substance use disorder (SUD) services through flexible programming, community partnerships, and ongoing workforce development. WBH has implemented flexibility in service delivery by offering both Intensive Outpatient (IOP) and General Outpatient (GOP) services based on individual client need, allowing for more responsive and clinically appropriate care.

WBH maintains active collaboration with community partners, including **Slate Canyon Youth Detention Center**, where staff provide both group and individual SUD treatment services to support early intervention and continuity of care for involved youth. In addition, WBH works closely with local schools and is expanding support for school-based mental health therapists to provide SUD services. School-based clinicians have been trained in the **Seven Challenges Brief model**, increasing early identification and access to evidence-based intervention within the school setting.

To further strengthen family engagement and support systems, WBH is planning to develop **multi-family group services** focused on supporting parents and caregivers of youth with substance use concerns. This effort is intended to enhance education, build family support networks, and improve outcomes through increased family involvement.

Through these strategies, WBH continues to strengthen coordination across systems, expand access points for youth, and improve the quality and effectiveness of SUD services.

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

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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?

☒ Directly

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

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

February 2025

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?

WBH ensures that all drug testing is conducted in accordance with applicable federal and SAMHSA-recommended guidelines through the use of internal laboratory services and established quality standards. WBH operates a **CLIA-certified laboratory**, which is in full compliance with Clinical Laboratory Improvement Amendments (CLIA) regulations. This ensures that all testing procedures meet required standards for accuracy, reliability, and quality control.

All drug testing is conducted either directly through WBH's certified lab or through approved processes that adhere to these same regulatory standards. Laboratory protocols, staff training, quality assurance procedures, and documentation practices are maintained in alignment with CLIA requirements and SAMHSA best practice guidelines. This framework supports the integrity of testing, appropriate handling of specimens, and accurate reporting of results as part of ongoing clinical care.

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?

Substance Use - Quality Improvement

Wasatch Behavioral Health (WBH) ensures staff are educated in the identification of overdoses and the administration of naloxone through standardized training and ongoing program support. All staff within Substance Use Disorder (SUD) programs receive training on recognizing the signs and symptoms of opioid overdose, appropriate response protocols, and proper administration of naloxone.

Training includes education on overdose risk factors, assessment of respiratory and responsiveness indicators, and step-by-step instruction on naloxone use. Staff competency is reinforced through initial training and periodic review as part of program expectations.

WBH also supports overdose prevention efforts by making **naloxone kits available** and distributing them to clients and community members as appropriate. This approach ensures both staff and individuals served are equipped to respond effectively in the event of an overdose, promoting safety and reducing risk of fatal outcomes.

Does the LA maintain naloxone in each facility?

WBH maintains **naloxone at all facilities** to ensure immediate access in the event of an opioid overdose. Naloxone is readily available to trained staff, supporting timely response and enhancing client safety across all service locations.

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?

WBH provides naloxone kits, education, and training to individuals with opioid use disorders, as well as their family members and supports, through coordinated community partnerships. WBH works closely with **Utah Naloxone** to supply kits for Receiving Center clients and collaborates with the **Utah County Health Department**, which provides naloxone kits and delivers group training to individuals in outpatient, residential, and Opioid Treatment Program (OTP) services, including the Center for Opioid Recovery (COR). These efforts support overdose prevention, education, and community-wide access to life-saving interventions.

Policy Review (Directives)

Substance Use - Quality Improvement

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

The WBH Expanded Executive Committee (EEC) is the body responsible for the development, review and implementation of all WBH policies. A schedule for review of all policies is managed by the WBH Compliance Coordinator. When a policy is drafted or an existing policy is scheduled for review, the draft is submitted to the Expanded Executive Committee or Clinical Committee, as appropriate, for review and feedback. The draft is then placed on the EEC agenda for approval or remanded back for further modification. Once approved, the Compliance Coordinator uploads the policy to the approved policy manual and updates the dates accordingly.

How often are policies reviewed and updated?

Policies are generally set to be reviewed within 3 years of approval.

Technical Assistance- Quality Improvement

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

- ☐ Yes
☒ No, not at this time.

Please name sections requested and provide description of requested TA

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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)

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

Wasatch Behavioral Health is co-located with Mountainlands Health Clinics at 2 locations: at the Westpark Family Clinic and the Payson Family Clinic. In the Westpark building, a case manager in an office next to Mountainlands is the initial point of contact for Mountainlands if they have a patient who is in need of any services available at Wasatch Behavioral Health. The medical providers talk to the case manager immediately after appts with patients and often introduce the patient to the case manager. The case manager is then able to facilitate connecting the client with the appropriate services, including mental health treatment and substance use treatment. The case manager can also help unfunded clients be scheduled for an evaluation. The case manager can also share other community resources with the client. Additionally, Wasatch Behavioral Health staff are able to refer clients to Mountainlands for medications/refills or other medical care.

In the Payson Family Clinic, Mountainlands are periodically invited to staff meeting to present about their services or medical topics that are of current concern (i.e., measles).

The Wasatch Behavioral Health Medical Director meets regularly with Mountainlands Health Clinic provider.

Adaptations for YOUTH programming

Same process for youth.

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

Adult:

With a signed authorization, Wasatch Behavioral Health staff and Mountainlands clinic staff are able to share records and consult regarding shared clients/patients. Clients completing an assessment at Wasatch Behavioral Health are asked about general health and any medical concerns at the time of intake. When clients come to Wasatch for med management appointments, they are weighed, blood pressure is measured, and they have the option of testing A1C (Westpark building). We also assess for Maternal/Perinatal Mental Health and refer to a prescriber within WBH or to Mountainlands or another medical provider as needed.

Adaptations for YOUTH programming

Similar for youth.

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?

Wasatch Behavioral Health utilizes four platforms currently to ensure compatibility with clients' technology. They include LYSSN's telehealth platform, Zoom, Teams, and Jitsi. These platforms are used both with Substance Use and Mental Health Services throughout WBH.

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

Wasatch Behavioral Health provides the following telehealth services for both mental health and SUD clients: Assessment, individual therapy, medication management, case management,

behavior management, peer support, and MCOT/Crisis. These services are all offered both with Substance Use and Mental Health Services.

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)

Wasatch Behavioral Health (WBH) provides tobacco cessation services directly using the **Dimensions: Tobacco-Free Program**, an evidence-based curriculum. Staff are trained in the Dimensions model, which supports individuals in understanding nicotine dependence, increasing motivation for change, and developing practical skills for reducing and quitting tobacco use. This approach is integrated into treatment services to support overall health and recovery.

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.

Wasatch Behavioral Health (WBH) maintains a **nicotine-free environment** across its facilities, supporting a culture of wellness and reinforcing tobacco cessation efforts as part of comprehensive treatment services.

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.

WBH assesses access to the service continuum through ongoing review of **population demographics, service utilization data, and geographic distribution of services** within its catchment area. WBH analyzes demographic information of both the community at large and individuals currently receiving services, including age, gender, socioeconomic status, insurance coverage, and special populations (e.g., youth, pregnant and parenting women, individuals with co-occurring disorders). This analysis is used to identify gaps in service access and populations that may be underserved or underrepresented in care.

Access is also evaluated by reviewing the **location and distribution of services** across the catchment area to ensure services are available in areas of highest need. WBH provides services across multiple sites, including outpatient clinics, residential programs, school-based settings, and community locations, to improve accessibility. Transportation services and partnerships with community providers further support access for individuals who may face geographic or logistical barriers.

To improve access to care for **Medicaid, unfunded, and underfunded individuals**, WBH utilizes multiple strategies. These include the use of Block Grant funding and other resources to provide services for uninsured or underinsured individuals, as well as flexible service delivery models such as same-day access, telehealth services, and varying levels of care (e.g., GOP, IOP) to meet clients where they are. WBH also engages in community outreach and collaborates with partners such as schools, healthcare providers, and the criminal justice system to identify individuals in need of services and facilitate early engagement.

WBH continues to evaluate service capacity, wait times, and engagement outcomes to identify areas for improvement and guide planning efforts. Ongoing efforts focus on expanding access points, enhancing coordination of care, and reducing barriers to ensure individuals across all

funding categories are able to access timely and appropriate services within the continuum of care.

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).

WBH will continue to strengthen collaboration efforts over the next 1–3 years to improve client engagement, outcomes, and access to care through expanded partnerships and coordinated service delivery across systems.

WBH will maintain and enhance partnerships with **local hospitals and Intermountain Health**, including coordination with emergency departments to identify individuals with substance use disorders and support rapid linkage to treatment, including Medication-Assisted Treatment (MAT) and outpatient services. Collaboration with the **Receiving Center** will continue to ensure timely access to crisis stabilization and connection to ongoing care.

WBH will continue its strong collaboration with the **Utah County Health Department** to support prevention initiatives, naloxone distribution, and community education. Partnerships with **Federally Qualified Health Centers (FQHCs)** and other medical providers will support integrated, whole-person care, including access to primary and prenatal services.

WBH will also maintain and expand partnerships with **county, city, and state agencies**, including the Division of Child and Family Services (DCFS), Drug Court programs, and other justice system partners. This includes ongoing coordination with the **Utah County Jail**, where WBH supports screening, treatment linkage, and continuity of care for individuals involved in the criminal justice system. These efforts promote engagement both during incarceration and upon reentry into the community.

In addition, WBH actively collaborates with **homeless services providers and the Food and Care Coalition**, supporting individuals experiencing homelessness through coordinated outreach, assessment, and linkage to behavioral health and substance use treatment services. These

partnerships are critical to reducing barriers to care and ensuring access for some of the community's most vulnerable populations.

WBH will continue to expand collaboration with **schools and educational systems**, including support for school-based therapists trained in the Seven Challenges model, and ongoing partnerships with **Slate Canyon Youth Detention Center** to provide on-site treatment and improve continuity of care for justice-involved youth.

Additional efforts include strengthening relationships with community providers and residential treatment programs, such as **House of Hope and Odyssey House**, to ensure a seamless continuum of care. WBH also plans to develop **multi-family groups** to increase family engagement and improve outcomes for youth and families impacted by substance use.

Through these collaborative efforts, WBH will continue to expand access points, improve care coordination, reduce service gaps, and enhance the overall quality and effectiveness of services for individuals and families across the community.

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?*

WBH provides integrated mental health and substance use services for justice-involved individuals through programming located within the **Utah County Security Center (jail)**, as well as through coordinated reentry services in the community. Services are designed to address criminogenic risk

factors, support stabilization while incarcerated, and ensure continuity of care upon release.

Within the jail, WBH operates the **On Unit Treatment Program (OUT)**, a structured 90-day program targeting individuals identified as high risk and high need. Participants receive approximately **20 hours of treatment per week**, including group therapy, individual therapy, and case management services delivered daily. Treatment is based on evidence-based approaches including **Cognitive Behavioral Therapy (CBT)**, **Moral Reconation Therapy (MRT)**, and **Relapse Prevention**, with a focus on the **risk, need, responsivity model** and the eight criminogenic risk factors.

Assessment and eligibility for services are guided by validated criminogenic and substance use screening tools, including the **RANT**, **LSI-R-SV**, and **TCUD**, which inform treatment planning and level of service intensity. Individuals identified as appropriate for OUT are engaged in structured programming designed to address criminal thinking, substance use, and behavioral health needs.

WBH provides ongoing **psychiatric and clinical services within the jail**, including one psychiatric prescriber conducting two 8-hour clinics per week and on-call availability for emergencies. A team consisting of one full-time licensed therapist and additional part-time therapists provides crisis assessment, treatment coordination, and discharge planning.

Transition planning and continuity of care are core components of service delivery. WBH staff coordinate referrals to community-based programs, including the **Jail Transition Program (JTP)** and **WATCH**, both located at the **Food and Care Coalition**. These programs provide continued case management, treatment access, and linkage to essential supports such as housing, medical care, employment resources, and emergency services. The same staff working within the jail also support these community programs, enhancing continuity and engagement.

Family engagement is incorporated as appropriate, particularly during transition planning, to support successful reintegration. Outreach and collaboration occur with jail staff, courts, and community partners to ensure coordination of care and appropriate service linkage.

Outcomes Framework:

WBH monitors outcomes for justice-involved individuals through a combination of clinical, criminogenic, and system-level measures. Key performance indicators include **recidivism rates**, **engagement in treatment post-release**, **successful linkage to community services**, and **reduction in acute behavioral health crises** while incarcerated.

Clinical and criminogenic progress is tracked using tools such as the **ASAM**, **LSI-R-SV**, **RANT**, and **TCUD**, along with ongoing clinical assessment and case review. Participation in and completion of

the **OUT Program** is monitored, along with progress in addressing criminogenic thinking, substance use behaviors, and life skills development.

Additional measures include:

- **Continuity of care upon release**, including successful connection to JTP, WATCH, or other community-based services
- **Housing stability, employment engagement, and access to medical and behavioral health services post-release**
- **Length of stay in treatment programs and completion rates**
- **Reduction in behavioral incidents, crisis interventions, and need for higher levels of care while incarcerated**
- **Discharge barriers**, including housing, transportation, and access to follow-up care

Outcome data is reviewed regularly by program leadership and clinical staff to identify trends, gaps, and opportunities for improvement. Findings are used to inform program modifications, enhance coordination between jail and community services, and improve engagement strategies.

WBH utilizes this data-driven approach to support **continuous quality improvement**, strengthen program effectiveness, and reduce recidivism by ensuring individuals receive appropriate treatment, coordinated care, and ongoing support as they transition back into the community.

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

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)

Wasatch Behavioral Health (WBH) provides services to individuals referred or approved by the **Utah Department of Corrections (UDC)** directly. UDC funding is utilized to support **mental**

health, substance use disorder (SUD), and recovery support services for justice-involved individuals as they transition from incarceration to the community.

Services funded through UDC include comprehensive **assessment, individual and group therapy, case management, psychiatric services, and medication management** as indicated. SUD services include evidence-based treatment interventions, relapse prevention, and ongoing recovery support. WBH also provides coordination of care to ensure individuals are connected to appropriate levels of service and community-based supports upon release.

WBH works closely with correctional partners to support **continuity of care**, reduce recidivism, and improve overall functioning. Services are coordinated with existing reentry programs, including the Jail Transition Program (JTP) and WATCH, to support housing stability, employment, and access to medical and behavioral health services.

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.

Recovery Support Services (RSS), including peer support, housing assistance, and other recovery-oriented services, are provided as appropriate; further detail regarding RSS services is outlined in the designated **RSS section**.

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)

WBH provides services to individuals involved in Drug Court **both directly and through contracted providers**.

WBH directly delivers a comprehensive range of services within the Drug Court system. All Drug Court participants receive **case management services through WBH**, including 100% of felony and probation clients. Treatment services are provided through the WBH continuum of care, including **residential, intensive outpatient, general outpatient, recovery support, and**

recovery management services. As a result of TAM and ACO Medicaid eligibility, approximately **75% of felony and probation Drug Court clients receive treatment services through community providers**, while continuing to receive WBH case management and care coordination.

Case management responsibilities are shared across systems to support specialized populations. WBH provides case management for felony Drug Court clients, while services for families are coordinated in collaboration with **DCFS Western Region**, and youth case management is supported by **Juvenile Court probation officers**.

WBH also provides **drug testing services directly** through its CLIA-certified laboratory. Drug testing is conducted as a Medicaid-billable service and is available on a **randomized basis Monday through Saturday**, with additional availability on Sundays and holidays to meet Drug Court requirements. WBH anticipates conducting approximately **25,000 drug tests annually**, the majority of which support Drug Court participants.

CONTRACTED PROVIDERS:

In addition to direct services, WBH utilizes **contracted providers** to ensure access to specialized residential treatment. These include **House of Hope** for women with dependent children, **Odyssey House for youth residential treatment**, and **Odyssey House for longer-term adult residential treatment**. This combination of direct service delivery and contracted partnerships ensures a full continuum of care and supports successful engagement and outcomes for Drug Court participants.

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

- ☒ Family Dependency Court
- ☒ Youth Specialty Court
- ☒ Adult Specialty Court
- ☐ DUI Court
- ☒ Mental Health Court
- ☐ Vet Court
- ☐ Other Courts? Please specify what other courts

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.*

WBH provides services to individuals involved in **Family Dependency Court, Youth Drug Court, Adult Drug Court, and Mental Health Court** through direct service delivery and coordinated care. In addition to standard treatment services, each participant is assigned a **dedicated case manager** who works alongside the individual's clinical treatment team.

The case manager supports clients in navigating the court system and ensures ongoing communication between the court, treatment providers, and other involved systems. This includes coordinating services, monitoring progress, addressing barriers to engagement, and aligning treatment goals with court requirements.

As part of the assessment and treatment planning process, WBH utilizes validated criminogenic risk tools, including the **Risk and Needs Triage (RANT)** and the **Level of Service Inventory-Short Version (LSI-SV)**, to support identification of criminogenic risk and need. These tools inform service intensity, case planning, and ongoing monitoring of progress.

WBH utilizes the same **evidence-based treatment approaches, clinical standards, and outcome measures** for court-involved individuals as are used throughout its broader continuum of care. This ensures consistency in service delivery while addressing the specialized needs of justice-involved individuals. Through this integrated approach, WBH supports engagement in treatment, compliance with court expectations, and improved behavioral health and criminal justice outcomes.

Outcomes Framework:

Outcomes for justice-involved individuals are monitored through a combination of clinical, substance use, and criminogenic measures, along with ongoing review of individual progress and system-level performance.

Clinical outcomes are tracked using standardized assessment tools, including the **Outcome Questionnaire (OQ)** or **Youth Outcome Questionnaire (YOQ)** as appropriate, the **Daily Living Activities (DLA) assessment** to measure functioning across life domains, and the **Columbia-Suicide Severity Rating Scale (C-SSRS)** when indicated to assess and monitor risk.

Substance use outcomes are measured through **urinalysis (UAs)** conducted by WBH's CLIA-certified laboratory. UAs are utilized on a randomized and ongoing basis to monitor abstinence, identify relapse, and support accountability within treatment and court requirements. Reduction in substance use and sustained abstinence are key indicators of progress.

Criminogenic outcomes are assessed using validated tools, including the **Risk and Needs Triage (RANT)** and the **Level of Service Inventory - Short Version (LSI-SV)**. These tools support identification of risk and need, inform treatment planning, and allow for tracking of changes in

criminogenic factors over time. Improvements in criminogenic risk scores, reduction in criminal thinking, and increased prosocial behaviors are used as indicators of progress.

Additional outcome measures include:

- **Recidivism and re-arrest rates**
- **Program engagement, retention, and completion rates**
- **Successful compliance with court requirements**
- **Continuity of care upon transition to community services**
- **Stability in housing, employment, and social functioning**
- **Reduction in behavioral incidents and crisis interventions**

Outcome data is reviewed regularly by clinical and program leadership to identify trends, address gaps, and inform program improvements. This information is used to support **continuous quality improvement**, strengthen service delivery, and improve long-term outcomes for justice-involved individuals.

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

Yearly

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:

WBH provides services to individuals referred by the **Department of Corrections (DOC) for High-Risk Habitual Offenders directly**. Services are delivered through a coordinated continuum of care that addresses criminogenic risk, substance use, and behavioral health needs.

The **On Unit Treatment (OUT) Program** at the Utah County Jail delivers a structured curriculum targeting criminogenic factors for high and medium-risk individuals. Services are guided by the **ASAM Criteria** to determine level of care placement and to support ongoing clinical

decision-making throughout treatment and transition planning.

WBH utilizes multiple justice-informed interventions and supervision strategies, including **Felony Drug Court participation, Medication-Assisted Treatment (MAT), and GPS ankle monitoring** as behavioral prevention and intervention tools. Clinical services incorporate evidence-based practices such as **Moral Reconciliation Therapy (MRT), Motivational Enhancement Therapy, Motivational Interviewing, Cognitive Behavioral Therapy (CBT), Contingency Management, Behavioral Contracting, Brief Intervention Treatment, Medication-Assisted Treatment (MAT), and Eye Movement Desensitization and Reprocessing (EMDR)**. Trauma-informed approaches are integrated throughout services to address the complex needs of this population.

Recovery management services extend beyond incarceration and include **Drug Court alumni groups, Recovery-Oriented Systems of Care (ROSC) activities**, and ongoing peer and community support. WBH is also utilizing the **OUT Program Community Transition Group**, which provides continued support for former OUT participants, Drug Court alumni, and other justice-involved individuals as they transition back into the community.

Through this integrated framework, WBH supports engagement, reduces recidivism risk, and promotes long-term recovery and community stability for high-risk justice-involved individuals.

Outcomes Framework:

Outcomes for individuals referred by the Department of Corrections (DOC), including high-risk habitual offenders, are monitored through a combination of clinical, substance use, criminogenic, and level-of-care measures, along with ongoing review of engagement and system-level outcomes.

Clinical outcomes are tracked using standardized tools, including the **Outcome Questionnaire (OQ), Daily Living Activities (DLA) assessments**, and the **Columbia-Suicide Severity Rating Scale (C-SSRS)** as indicated, to monitor changes in mental health functioning, stability, and risk.

The **ASAM Criteria** are utilized at admission and throughout treatment to determine appropriate level of care and to guide continued stay, transfer, and discharge decisions. Changes across ASAM dimensions are monitored to assess progress in areas such as substance use severity, behavioral health needs, readiness for change, relapse potential, and recovery environment.

Substance use outcomes are measured through **urinalysis (UAs)** conducted by WBH's CLIA-certified laboratory. UAs are administered on a randomized and ongoing basis to monitor substance use, support accountability, and inform treatment planning. Reduction in substance use and sustained abstinence are key indicators of progress.

Criminogenic outcomes are assessed using validated tools, including the **Risk and Needs Triage (RANT)** and the **Level of Service Inventory – Short Version (LSI-SV)**. These tools inform service intensity and are used to track changes in criminogenic risk factors over time. Improvements in criminogenic scores, reduction in criminal thinking patterns, and increased prosocial behaviors are key outcome indicators.

Additional performance indicators include:

- **Recidivism and re-arrest rates**
- **Program engagement, retention, and completion rates** (e.g., OUT Program, Drug Court participation)
- **Compliance with supervision and treatment requirements**, including participation in MAT and monitoring interventions (e.g., GPS where applicable)
- **Successful transition to community-based services**, including engagement in recovery management and alumni programming
- **Stability in housing, employment, and social functioning post-release**
- **Reduction in behavioral incidents and need for crisis or higher levels of care**

Outcome data is reviewed regularly by clinical and program leadership to identify trends, address service gaps, and inform program improvements. This data-driven approach supports **continuous quality improvement**, strengthens coordination between correctional and community-based services, and promotes reduced recidivism, increased treatment engagement, and improved long-term recovery outcomes.

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

Wasatch Behavioral Health (WBH) is requesting technical assistance regarding current Drug Court requirements related to **urinalysis (UA) frequency**, specifically the requirement that all Drug Court participants submit to drug testing two or more times per week. From a clinical perspective, this level of frequency may be contraindicated for treatment progress for some individuals.

WBH recommends that **UA frequency be determined as part of the individualized treatment plan**, guided by clinical assessment, ASAM Criteria, and ongoing team review. A flexible approach allows clients to **step down in testing frequency as they demonstrate progress** and stability in recovery, while also allowing for an increase in monitoring when clinically indicated for additional support.

A fixed requirement of two or more UAs weekly can inadvertently limit opportunities for clients to develop **intrinsic motivation and internalized recovery skills**, as it places continued emphasis on external monitoring rather than self-regulation. Individualized approaches better align with evidence-based practices and recovery-oriented systems of care.

Additionally, there are financial and access considerations, particularly for Medicaid recipients. While Medicaid covers up to **60 drug tests per year**, additional testing may be authorized through a **prior authorization process** once this limit has been reached. However, approval for additional tests must be based on **documented clinical necessity**, and not solely on a client's participation in Drug Court. While this aligns with appropriate clinical practice, it creates challenges when court-mandated testing requirements exceed what is clinically indicated, potentially resulting in barriers to care or administrative burden.

WBH has encountered challenges addressing this issue at the local level and believes this would benefit from **state-level guidance and consistency across the Drug Court system**. A standardized, clinically-informed approach to UA frequency would support both improved treatment outcomes and equitable access to care.

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.

Mental Health and Substance Use Recovery Supports

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

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?*

WBH provides Recovery Support Services (RSS) to both **adult and youth populations** as part of a comprehensive continuum of care designed to support long-term recovery, engagement, and stability in the community. RSS services are individualized and may include peer support, case management, recovery coaching, transportation, housing supports, employment assistance, and linkage to community-based resources.

RSS are integrated into treatment planning and are **clinically driven**, based on individualized assessment, including ASAM Criteria, DLA functioning, and ongoing clinical review. Clinical teams

Mental Health and Substance Use Recovery Supports

identify needs for recovery supports during assessment and throughout treatment, ensuring services are responsive to changes in client needs over time.

WBH utilizes a structured process to ensure that **RSS services are appropriate, necessary, and compliant with funding requirements**, including:

- **Clinical determination of need** documented in the treatment plan
- Alignment with **ASAM dimensions**, particularly recovery environment and relapse risk
- Review and approval of services by supervisory or designated program staff when required
- Verification that requested services are **allowable under the specific funding source** (e.g., Medicaid, Block Grant, UDC funding)
- Ongoing documentation and monitoring to confirm services are being utilized appropriately and effectively

Outcomes Framework:

Outcomes for Substance Use Disorder and Recovery Support Services are monitored through a comprehensive, data-driven approach that integrates standardized assessment tools, clinical review, and individualized care planning.

The **ASAM Criteria** are used at admission and throughout treatment to determine and adjust level of care, with ongoing monitoring across ASAM dimensions to assess progress in substance use severity, behavioral health, readiness for change, relapse risk, and recovery environment. Changes in ASAM ratings inform continued stay, transfer, and discharge decisions.

Clinical and functional outcomes are measured using the **Outcome Questionnaire (OQ) for adults** and the **Youth Outcome Questionnaire (YOQ) for youth**, administered at regular intervals to evaluate changes in emotional and behavioral functioning. The **Substance Use Recovery Evaluator (SURE)** is utilized to monitor recovery progress, including improvements in self-management, substance use behaviors, and overall quality of life.

Risk and safety are assessed using the **Columbia-Suicide Severity Rating Scale (C-SSRS)** as clinically indicated, ensuring ongoing monitoring of suicide risk and the implementation of appropriate safety interventions.

All services are guided by **Individualized Care Plans**, which incorporate assessment data, client goals, and identified needs. These plans are reviewed and updated regularly to reflect progress,

Mental Health and Substance Use Recovery Supports

adjust interventions, and ensure alignment with clinical presentation and recovery goals.

Additional outcome indicators include:

- **Reduction in substance use**, supported by clinical reporting and urinalysis when indicated
- **Improvement in daily functioning**, as identified through clinical review and care plan updates
- **Engagement, retention, and completion of treatment services**
- **Progress in recovery goals**, as identified through SURE and care plan metrics
- **Reduction in crisis events and need for higher levels of care**

Outcome data is reviewed consistently by clinical teams and leadership through supervision and program evaluation processes. This information is used to:

- Adjust Individualized Care Plans
- Ensure appropriate level of care through ASAM
- Identify trends and gaps in service delivery
- Support continuous quality improvement (CQI)

This integrated framework ensures that outcomes are clinically meaningful, measurable, and directly tied to individualized treatment and recovery goals for both youth and adult populations.

Peer Support Services (PSS)

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

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

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:

Mental Health and Substance Use Recovery Supports

At WBH, Peer Support Specialists (PSS) provide advocacy, engagement, and coordination of community-based resources. Peer Support Specialists assist clients in accessing supports such as **employment, housing, transportation, and social services**, helping to address barriers to recovery and promote stability in the community.

Peer Support Specialists utilize their own lived experience in recovery to foster **engagement, build trust, instill hope, and support motivation for change** among individuals participating in both residential and outpatient treatment programs. Their role is integrated into the treatment team, enhancing client connection and retention in services.

In addition to traditional peer support functions, PSS have expanded their role to include **facilitation of early recovery skills development, orientation to services, and provision of individual peer support sessions**. These services help clients better understand the treatment process, develop practical recovery strategies, and strengthen their ability to engage in ongoing care.

Peer Support Specialists are fully integrated across multiple service settings, including **crisis services, outpatient programs, and residential treatment**, ensuring continuity of support across levels of care. This integration supports timely engagement, improves transitions between services, and enhances the overall effectiveness of the recovery-oriented system of care.

Outcomes Framework:

Outcomes for Peer Support Services are monitored through a combination of clinical, functional, and recovery-oriented measures, integrated with ongoing review of engagement and individualized care planning.

The **ASAM Criteria** are utilized to guide level of care and to monitor progress across dimensions, particularly in areas related to recovery environment, readiness for change, and relapse potential. Peer Support Specialists contribute to this process by providing insight into client engagement, motivation, and barriers identified through peer interaction.

Clinical outcomes are measured using the **Outcome Questionnaire (OQ) for adults** and the **Youth Outcome Questionnaire (YOQ) for youth**, administered at regular intervals to assess changes in emotional and behavioral functioning. The **Substance Use Recovery Evaluator (SURE)** is also utilized to track recovery progress, including improvements in self-efficacy, coping

Mental Health and Substance Use Recovery Supports

skills, and overall recovery capital.

Risk and safety are monitored using the **Columbia-Suicide Severity Rating Scale (C-SSRS)** as indicated, ensuring appropriate identification of risk and implementation of safety interventions.

Peer-specific outcomes focus on:

- **Engagement and retention in treatment and recovery services**
- **Increased connection to community-based supports and recovery resources**
- **Improvement in recovery skills and self-management**, including early recovery skill development
- **Increased hope, motivation, and participation in services**
- **Successful linkage to resources such as housing, employment, and social supports**

Additional measures include reduction in substance use, supported by **urinalysis (UAs)** as clinically indicated, and improvement in functioning as identified through **Daily Living Activities (DLA) assessments** and ongoing clinical review.

All outcomes are tracked and reflected within **Individualized Care Plans**, which are updated regularly to incorporate peer input, client goals, and progress across treatment domains. Peer Support Specialists document services and contribute to the treatment team's understanding of client needs, strengths, and barriers.

Outcome data is reviewed through supervision and program evaluation processes to identify trends, improve engagement strategies, and strengthen integration of peer services within the continuum of care. This approach supports **continuous quality improvement**, ensuring Peer Support Services effectively enhance treatment engagement, support sustained recovery, and improve overall client outcomes.

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

Mental Health and Substance Use Recovery Supports

Please identify the LAs identified Local Homeless Council (LHC) or Continuum of Care (COC) representative for this SUMH office directive:

Name	Monte Memmott CMHC
Email	mmemmott@wasatch.org
Job role/title	Program Manager WATCH, Jail Transition Program, OUT Program

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)

Rock Solid Recovery
Steps Recovery
Rightway Recovery

Service Delivery Framework:

WBH provides access to **sober living and recovery residence services both directly and through contracted providers** to support individuals in maintaining recovery and stability in a structured, substance-free environment.

WBH contracts with several recovery residences throughout Utah County that offer safe, supportive housing for individuals engaged in substance use disorder treatment and recovery. These residences provide structured living environments that reinforce recovery principles, promote accountability, and support continued engagement in treatment and recovery-oriented activities. WBH currently supports approximately **20 clients in recovery residence placements**.

Eligibility for recovery residence placement is determined through clinical assessment, including ASAM Criteria, and is based on individual need for a structured and supportive recovery environment. Priority populations include individuals involved in **Drug Court, the On-Unit Treatment (OUT) Program within the Utah County Jail, and Utah County Probation (UCP)**, as well as those **transitioning from incarceration at the Utah County Jail or from residential treatment programs such as Foothill**.

Recovery residence placements are integrated into the broader treatment plan and include coordination with case management, peer support, and outpatient or residential treatment

Mental Health and Substance Use Recovery Supports

services as indicated. WBH staff work collaboratively with recovery residence providers to monitor progress, ensure accountability, and support successful transitions to more independent living as individuals progress in their recovery.

Mental Health recovery support is provided at various levels of intensity based on client need. WBH offers a full continuum of support from contracted Inpatient services, a crisis receiving center, various residential options including 24 hour care, as well as community based outpatient modalities including case management services

Outcomes Framework:

Outcomes for individuals participating in sober living and recovery residence services are monitored through a combination of clinical, substance use, and functional measures, integrated with ongoing treatment services and individualized care planning.

The **ASAM Criteria** are utilized at admission and throughout participation to assess the appropriateness of a recovery residence placement and to monitor progress across dimensions, particularly recovery environment, relapse potential, and readiness for change. Movement across levels of care is guided by changes in these dimensions.

Clinical outcomes for both mental health and substance use clients are measured using the **Outcome Questionnaire (OQ) for adults** and the **Youth Outcome Questionnaire (YOQ) for youth**, administered at regular intervals to assess emotional and behavioral functioning. The **Substance Use Recovery Evaluator (SURE)** is utilized as applicable to monitor recovery progress and self-reported improvements in recovery capital and quality of life.

Substance use outcomes are tracked through **urinalysis (UAs)** as clinically indicated, particularly for individuals participating in **Intensive Outpatient (IOP) and General Outpatient (GOP) programs**, where many sober living residents are concurrently engaged. Reduction in substance use and sustained abstinence are key indicators of success.

Risk and safety are assessed using the **Columbia-Suicide Severity Rating Scale (C-SSRS)** as indicated, ensuring appropriate monitoring and intervention for individuals at risk.

Additional outcome indicators include:

- **Engagement and retention in IOP, GOP, and recovery support services**
- **Length of stay in sober living and successful completion of placement**

Mental Health and Substance Use Recovery Supports

- **Successful transition to more independent housing**
- **Stability in employment, education, and social functioning**
- **Reduction in relapse episodes and crisis interventions**
- **Compliance with program expectations and recovery plans**

Progress is tracked through **Individualized Care Plans**, which are reviewed and updated regularly to reflect changes in clinical presentation, recovery progress, and housing stability. Coordination between WBH clinical staff and recovery residence providers supports monitoring of progress and identification of barriers.

Outcome data is reviewed through clinical supervision and program evaluation processes to identify trends, inform service adjustments, and support **continuous quality improvement (CQI)**. This integrated approach ensures that sober living services effectively support recovery, promote stability, and enhance long-term outcomes for individuals engaged in treatment.

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)

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.*

WBH provides some IPS at Wasatch House (Clubhouse), but it is not done to fidelity due to it conflicting with Clubhouse Accreditation. Clubhouse works closely with Vocational Rehabilitation for an IPS assessment and provides supported employment using the Clubhouse model.

Outcomes Framework:

Wasatch House regularly tracks the number of members who are employed, included supported employment and transitional employment.

Mental Health and Substance Use Recovery Supports

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).

During the first four months of the calendar year, secretarial staff administer satisfaction questionnaires to clients who have not yet completed one when the client checks in for an appointment. There is a tool built into our EHR to show the staff member checking the client in whether or not the client has already taken a satisfaction questionnaire during the calendar year. Most administrations are completed electronically through the OQ system, though some paper copies (which are then entered manually) are used in situations where the client cannot complete the questionnaire electronically. Once entered into the OQ Analyst software, the satisfaction questionnaire data becomes available in aggregate reports through power BI that have been developed to allow managers to gauge their departments' performance and develop goals for improvement.

Mental Health Outcome Questionnaire

Service Satisfaction and Outcome Data

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.

All new clinical staff are trained on clinical and technical aspects of the OQ/YOQ/SURE/Clinical Support Tools/etc. questionnaires soon after starting their jobs. They receive intermittent follow-up training at the departmental level on an ongoing basis. Several of each clinician's progress notes are audited at least every three months for compliance with the center's OQ protocols, and reports are prepared for managers allowing their employees'/departments' performance to be evaluated individually and in aggregate. Every month, Wasatch Behavioral Health receives a report from OQ Systems allowing the center to determine which clients are at risk for negative outcomes according to their OQ results. These data are combined with information about which clients have already received clinical support tool (CST) administrations, and alerts are sent to program managers and clinicians of clients who, according to this algorithm, would be likely to benefit from a CST administration. Performance on all of these metrics is reviewed in quarterly QAPI meetings and in management team meetings, along with a discussion of what needs to be changed (if anything) in order to meet agency goals. Division directors are responsible for following up with the managers of clinics that are not meeting their goals.

Recovery Support Screenings and Tools

What Recovery Support screening or tools are you utilizing? (i.e., SURE, SUD OQ, etc).

The **ASAM Criteria** are utilized to guide level of care and to monitor progress across dimensions, particularly in areas related to recovery environment, readiness for change, and relapse potential.

Clinical outcomes are measured using the **Outcome Questionnaire (OQ) for adults** and the **Youth Outcome Questionnaire (YOQ) for youth**, administered at regular intervals to assess changes in emotional and behavioral functioning. The **Substance Use Recovery Evaluator (SURE)** is also utilized to track recovery progress, including improvements in self-efficacy, coping skills, and overall recovery capital.

Risk and safety are monitored using the **Columbia-Suicide Severity Rating Scale (C-SSRS)** as indicated, ensuring appropriate identification of risk and implementation of safety interventions.

Service Satisfaction and Outcome Data

If you are not utilizing any Recovery Support screenings or tools can you please provide details on the barriers?

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