**GOVERNANCE & OVERSIGHT NARRATIVE**

**Local Authority:** Summit County and Healthy U Behavioral

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

### 1) Access & Eligibility for Mental Health and/or Substance Abuse Clients

<table>
<thead>
<tr>
<th>Who is eligible to receive mental health services within your catchment area? What services (are there different services available depending on funding)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>All residents of Summit County have access to the University of Utah Health Plans Healthy U Behavioral Network (HUB Network), regardless of their ability to pay or level of coverage for behavioral health services. Residents with insurance, capacity for self-pay, employer direct pay, Epic Promis for resort employees and their roommates, or access to other means are able to receive care within the HUB Network. <em>(This includes visiting tourists, J1s, and seasonal workers.)</em> Due to the increased Network, Wasatch residents who reside closer to services within Park City or Kamas, <em>(Such as Black Rock, Hideout, Mayflower, and Tuhaye)</em> are also able to receive services provided by the HUB Network. Where possible, individuals who qualify for Medicaid dollars are walked through the enrollment process during their intake into the HUB Network, when not in crisis. For individuals who do not qualify for Medicaid or state unfunded dollars and are without any other means of care, individuals are connected to other service providers within the Summit County Behavioral Health Network, of which the HUB Network is a component, along with Intermountain Healthcare, private clinicians, and local non-profits, such as the Christen Center of Park City, Holy Cross Ministries, and Jewish Family Services for care. Services provided within the HUB Network include Evaluations and Treatment Plans, Screening and Assessment Services, Outpatient Services, Substance Use Treatment, Rehabilitation Services, Medication Management, Medication Case Management, Case Management, Criminal Justice Involvement <em>(Jail, JJS, CJC, District Court, and Justice Court)</em>, Transitional Treatment, Crisis Services, School-Based Services, Inpatient and residential services, and Physical Health Integration through UUHP. In addition, the Huntsman Mental Health Institute of Park City is introducing a new youth and adult day-treatment program to begin the Spring 2022. Currently, the Network has 93 providers in Summit and Wasatch counties, of which 12 provide direct care in Spanish. Summit County and HUB have recently reached an agreement to contract with Latino Behavioral Health Services to provide peer support services to Spanish speaking residents within Summit County in crisis or waiting for service due to the increased demand for Spanish language services. Residents of Summit County are able to access additional services in Salt Lake, Davis, Weber, and Utah counties with the expanded HUB Network. With the transition to a network model, wait times for clinical services have dropped from over 90 days to 48 hours and medication management appointments now take place within 72 hours as compared to the previous 120 days.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who is eligible to receive substance abuse services within your catchment area? What services (are there different services available depending on funding)? Identify how you manage wait lists. How do you ensure priority populations get served?</th>
</tr>
</thead>
<tbody>
<tr>
<td>As stated above, all residents of Summit County have access to the HUB Network, regardless of their ability to pay for or level of coverage for behavioral health services. Services include Evaluations and Treatment Plans, Screening and Assessment Services, Outpatient Services, Substance Use Treatment, Rehabilitation Services, Medication Management, Medication Case Management, Case Management, Criminal Justice Involvement <em>(Jail, JJS, CJC, District Court, and Justice Court)</em>,</td>
</tr>
</tbody>
</table>
Transitional Treatment, Crisis Services, School-Based Services, Physical Health Integration through UUHP, Inpatient and residential programs, etc.

With the transition to a network model, previous wait times of over 90 days have been eliminated. Currently, only Spanish Language services have a waitlist. Before the public health emergency, this averaged 12 days. Currently, due to the public health emergency, this has increased to approximately 30 days for none-crisis care. In an attempt to address this increase in wait times, HUB has provided interpretation services to any network provider who requests one; however, native or clinical Spanish speakers are preferred. Additionally, Summit County and HUB have recently reached an agreement to contract with Latino Behavioral Health Services to provide peer support services to Spanish speaking residents within Summit County in crisis or waiting for service due to the increased demand for Spanish language services.

Summit County, along with HUB, the University of Utah Department of Psychiatry, College of Social Work, College of Nursing, and the Katz Amsterdam Foundation, along with local businesses, are in the final stages of development of a recruitment and retention program to increase the number of Spanish speaking clinicians within Summit County. Beginning with HUB providing free test preparation for the Association of Social Work Boards, Spanish speaking individuals who are able gain their licensure are then provided a $10,000 retention grant for the first 5 years of providing services within Summit County by the Katz Amsterdam Foundation (conditions apply). The Summit County Behavioral Health Executive Committee is exploring additional means of retaining Spanish speaking clinicians to be run in conjunction with this program. With 2019 community data showing 28% of the residential population and 42% of the seasonal population requiring services in Spanish, this is a priority recruitment for Summit County.

Preferably, a client will contact HUB and coordinate appointments with them, allowing for new clients to be distributed throughout the HUB Network; thus, removing the need for a waitlist in most cases. Should a clinician have a waitlist, often due to clients reaching out to them directly, it is managed by the clinician, in consultation with HUB. A requirement of being within the Network is that all Medicaid and unfunded clients receive priority for care, with the exception being crisis care. For the majority of Substance Abuse treatments, the Huntsman Mental Health Institute of Park City is utilized as the “backbone” provider with additional network clinicians used as needed.

What are the criteria used to determine who is eligible for a public subsidy?

For non-crisis intake, residents are screened during registration and scheduling. Residents are asked for verification of monthly household income and household size. This information is reviewed against a sliding scale based on the market specific to Summit County/Park City. If found eligible for Medicaid or unfunded dollars, they are put in contact with a HUB case manager who begins the enrollment process and coordinates with the client's clinician for payment. In cases in which a sliding-scale is appropriate, income verification is required or a resident may be referred to one of the local nonprofits to provide free or scholarship funded care. If an individual fails to qualify for Medicaid or unfunded dollars, they are referred to the greater Summit County Network to be connected to either a local non-profit or other scholarships private clinician.

For crisis intake, the resident is assigned a case manager who follows-up within 24 hours of the crisis. Further assistance is provided through care management with Healthy U Behavioral if needed.

How is this amount of public subsidy determined?

HUB has established a funding policy which outlines the service costs for network clinicians along with a sliding scale. Public subsidy dollars are utilized as funding of last resort. Working with an assigned care-manager, residents are required to provide verification of income, family size, housing status and/or insurance status. Care-managers connect with clinicians to identify services needed for the resident, and subsidy amounts are determined based on services needed.
How is information about eligibility and fees communicated to prospective clients?

When a client first calls for an appointment, the provider will inform the client of eligibility requirements, ask about Summit County residency, and inform the client of required documents that he or she needs to bring to the intake. When a client first comes in for an intake, eligibility and fee criteria are communicated to the client in further detail. Providing the client has brought all the required documents, they can be immediately informed of eligibility and, if they qualify, what their financial responsibility is going to be.

Are you a National Health Service Corps (NHSC) provider? YES/NO

In areas designated as a Health Professional Shortage Areas (HPSA) describe programmatic implications, participation in National Health Services Corp (NHSC) and processes to maintain eligibility.

No, Summit County is not approved for continued support with the National Health Service Core provider.

2) Subcontractor Monitoring

The DHS Contract with Mental Health/Substance Abuse Local Authority states: When the Local Authority subcontracts, the Local Authority shall at a minimum:

1) Conduct at least one annual monitoring review of each subcontractor. The Local Authority shall specify in its Area Plan how it will monitor their subcontracts.

Describe how monitoring will be conducted, what items will be monitored and how required documentation will be kept up-to-date for active subcontractors.

Describe how monitoring will be conducted, what items will be monitored and how required documentation will be kept up-to-date for active subcontractors.

Monitoring of the Network:

HUB, in partnership with the Summit County Division of Behavioral Health, has an established audit protocol and audit schedule to ensure providers are meeting applicable recordkeeping requirements which is administered through the parent UUHP. UUHP requires recredentialing every three to five years, depending on the provider type.

UUHP monitors client complaints regarding providers and refers such complaints to its Provider Sanctions Committee for review and follow-up. UUHP has an existing database, called Genie, which tracks provider demographics, credentialing deadlines and associated documents, complaints, and license information. UUHP has a regular monitoring process to ensure all appropriate credentialing-related documentation is current and no new sanctions have been filed or imposed. Specifics outlined in the Summit County/HUB Contract include:

HUB, along with the Summit County Behavioral Health Division, will conduct randomly selected audits and site visits of network clinicians as applicable, and best practices to ensure that Providers are complying with all applicable statutes, laws, rules, and regulations. As outlined in Contract. HUB shall monitor and oversee Providers’ performance and the structure and operation of the Network of Providers. HUB shall institute reasonable controls to identify deficiencies in providing the full range of Covered Services to Enrollees including, without
limitation, gaps in coverage, gaps in any particular Covered Services, barriers to access, unreasonable delays concerning Enrollees’ access to services, unreasonable response times for crisis response including, without limitation, response times concerning Summit County jail inmates. HUBI regularly reviews random sampling of treatment charts and records to assess treatment quality and to correct deficiencies.

Monitoring of HUB:

As outlined in the service contract between Summit County and University of Utah Health Plans - Healthy U. Behavioral, the following monitoring mechanisms are in place:

**Monitoring/Site Visits and Special Reports and Studies:**
County will verify that the Contractor is conducting audits of Providers in accordance with any Department requirements, as applicable, and best practices to ensure that Providers are complying with all applicable statutes, laws, rules, regulations, Contractor written policies, and County requirements as outlined in the Contract. Contractor shall diligently monitor and oversee Providers’ performance and the structure and operation of the Network of Providers. Contractor shall institute reasonable controls to identify deficiencies in providing the full range of Covered Services to Enrollees including, without limitation, gaps in coverage, gaps in any particular Covered Services, barriers to access, unreasonable delays concerning Enrollees’ access to services, unreasonable response times for crisis response including, without limitation, response times concerning Summit County jail inmates. Without limiting the foregoing sentence, Contractor shall regularly review a random sampling of treatment charts and records to assess treatment quality and to correct deficiencies.

**Independent Financial Audit:**
Contractor shall, upon request therefore, make available to the County for their examination and audit, Contractor’s financial records. Without limiting the generality of the foregoing sentence, Contractor acknowledges that, pursuant to Utah Code §§ 51-2a-101 et seq. and 67-3-1, County shall require Contractor to submit to an annual independent, financial audit. Contractor shall cooperate fully with each such audit and timely provide all records and information that the audit requires within the scope of such audit. Contractor acknowledges that each auditor shall be entitled to provide a copy of each such final financial audit to the County, CMS, the Utah Department of Health, and DSAMH, as applicable. Within thirty (30) calendar days of County’s receipt of any such financial audit, County shall provide a copy to Contractor with County’s comments. Contractor shall have thirty (30) calendar days to provide its responses to the respective audit and County’s comments concerning the audit. If no comments are received from the Contractor, the audit shall be deemed final. Contractor shall notify the County of the dates of the entrance and exit conferences with each auditor conducting the respective audits hereunder.

Contractor shall, upon request from the County, make available to the County for their examination any and all audits of Providers, data concerning the performance of the Network of Providers, including, without limitation, Encounter Data and any and all reports and data obtained and/or created by Contractor pursuant to subsection V.D, and any and all other records relevant to its performance of the Services provided to County pursuant to this Agreement.

Contractor shall, upon request from the County, therefore, make available to the County for their examination any and all items regarding the use and expenditure of Medicaid funds.
received for the purpose of providing mental health and substance abuse disorder services.

Contractor shall submit and cooperate with all DSAMH service level and performance audits as outlined in DSAMH Annual Division Directives, as applicable, or otherwise required by the County. Contractor shall submit to and cooperate with at least one site visit per year and shall complete and submit to the County any corrective action plans identified in such an audit. The purpose of the audit and site visit shall be to ensure that the Contractor is in compliance with all DSAMH Annual Division Directives, as applicable.

County may conduct one or more Provider site visits per year of HUB and/or their “backbone” provider, UNI-Park City. To the extent that County finds any deficiencies with any Provider, County will provide Contractor with written notice of such deficiencies and Contractor shall promptly begin corrective action.

County may inspect, review and audit any books and records of Contractor and its Providers that pertain to determining the ability of Contractor to bear the risk of potential financial losses or pertain to services performed or determinations of amounts payable under this Agreement. Contractor shall make available to the County, Department, DSAMH, and Federal government agencies any of Contractor's records which may be reasonably requested to conduct the inspection, review or audit. Inspection and audit methods include, but are not limited to, inspection of facilities, review of medical records and other Enrollee data, review of written policies and procedures and other documents, or other means needed by the County, the Department, DSAMH, or Federal government to conduct inspections and audits.

Contractor shall submit to an annual audit conducted in accordance with the University of Utah’s schedule to be conducted by the Office of the Utah State Auditor in accordance with prescribed guidelines in Utah Code § 62A-15-713. Contractor hereby acknowledges that funds or monies it receives are Public Funds as defined in Utah Code §§ 17-43-203 and 303.

Notwithstanding any of the above, the County shall have the right to request an audit of the Contractor at any time. The County shall give the Contractor ten (10) days advance written notice prior to conducting an audit.

**Required Reports:**

Contractor shall provide the following Reports to the extent permitted by law by the established dates for review by the Summit County Mental Wellness Executive Council, a governing body of the Summit County Council:

<table>
<thead>
<tr>
<th>#</th>
<th>Name of Report</th>
<th>Frequency</th>
<th>Period Reported On</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Penetration Report</td>
<td>Monthly</td>
<td>Fiscal Year to Date</td>
<td>3rd Thursday of each month</td>
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<tr>
<td></td>
<td>Report Title</td>
<td>Frequency</td>
<td>Period</td>
<td>Date of issuance</td>
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<tr>
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</tr>
<tr>
<td>2</td>
<td>Provider Claim Inventory</td>
<td>Monthly</td>
<td>Fiscal Year to Date</td>
<td>3rd Thursday of each month</td>
</tr>
<tr>
<td>3</td>
<td>Contract Utilization Report</td>
<td>Monthly</td>
<td>Fiscal Year to Date</td>
<td>3rd Thursday of each month</td>
</tr>
<tr>
<td>4</td>
<td>Claim Denial Reasons</td>
<td>Monthly</td>
<td>Fiscal Year to Date</td>
<td>3rd Thursday of each month</td>
</tr>
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<td>5</td>
<td>Service Utilization by Provider</td>
<td>Monthly</td>
<td>Fiscal Year to Date</td>
<td>3rd Thursday of each month</td>
</tr>
<tr>
<td>6</td>
<td>Service Utilization by Rate Code</td>
<td>Monthly</td>
<td>Fiscal Year to Date</td>
<td>3rd Thursday of each month</td>
</tr>
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<td>7</td>
<td>Services Provided Report by Population:</td>
<td>Monthly</td>
<td>Fiscal Year to Date</td>
<td>3rd Thursday of each month</td>
</tr>
<tr>
<td></td>
<td>a.) Medicaid</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b.) Unfunded</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>c.) Insurance</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>d.) Self-Pay</td>
<td></td>
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<tr>
<td></td>
<td>e.) Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Unduplicated Client Count:</td>
<td>Monthly</td>
<td>Fiscal Year to Date</td>
<td>3rd Thursday of each month</td>
</tr>
<tr>
<td></td>
<td>a.) Medicaid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b.) Unfunded</td>
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<td></td>
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<td>c.) Insurance</td>
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<td></td>
<td>d.) Self-Pay</td>
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<tr>
<td></td>
<td>e.) Spanish Language</td>
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<td></td>
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</tr>
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<td>9</td>
<td>Monthly Inpatient Utilization Management Report</td>
<td>Monthly</td>
<td>Fiscal Year to Date</td>
<td>1st Wednesday of each month</td>
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<tr>
<td>10</td>
<td>Monthly Residential Utilization Management Report</td>
<td>Monthly</td>
<td>Fiscal Year to Date</td>
<td>3rd Thursday of each month</td>
</tr>
<tr>
<td>11</td>
<td>MCOT, Receiving Center, Wellness &amp; Recovery Center</td>
<td>Monthly</td>
<td>Fiscal Year to Date</td>
<td>3rd Thursday of each month</td>
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<tr>
<td>No.</td>
<td>Report Name</td>
<td>Frequency</td>
<td>Periods Covered</td>
<td>Submission Due Date</td>
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<tr>
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</tr>
<tr>
<td>12</td>
<td>Crisis Outcomes Report</td>
<td>Quarterly</td>
<td>Quarterly &amp; Fiscal Year to Date</td>
<td>Quarterly submitted by the 3rd Thursday of each month following the end of the quarter. Previously reported quarters will be re-reported with updated information.</td>
</tr>
<tr>
<td>13</td>
<td>Wait Time Report</td>
<td>Semi-Annually</td>
<td>Quarterly &amp; Fiscal Year to Date</td>
<td>Quarterly submitted by the 3rd Thursday of each month following the end of the quarter. Previously reported quarters will be re-reported with updated information.</td>
</tr>
<tr>
<td>14</td>
<td>Grievance Report</td>
<td>Semi-Annually</td>
<td>Fiscal Year to Date</td>
<td>Third Thursday of January and July</td>
</tr>
</tbody>
</table>
**FORM A - MENTAL HEALTH BUDGET NARRATIVE**

**Local Authority:** Summit County & Healthy U. Behavioral

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

1) **Adult Inpatient**

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
<th>$21,625</th>
<th>Form A1 - FY22 Projected clients Served:</th>
<th>4</th>
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</thead>
<tbody>
<tr>
<td>Form A1 - Amount budgeted in FY21 Area Plan</td>
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<td>Form A1 - Projected Clients Served in FY21 Area Plan</td>
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<tr>
<td>Form A1 - Actual FY20 Expenditures Reported by Locals</td>
<td>$30,610</td>
<td></td>
<td>4</td>
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</table>

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

University of Utah Health Plans (UUHP) does not directly provide services, rather it relies upon a network of providers in Summit County and neighboring counties administered by its behavioral health arm, Healthy U. Behavioral (HUB). University Neuropsychiatric Institute (UNI) has opened a clinic in Park City, which is the main referral source for Adult Inpatient admissions. The case management team at UNI-Park City works with UUHP to place adults who require inpatient treatment in appropriate facilities and follow their progress through aftercare and follow up appointments.

Summit County, through both the Health U. Behavioral (HUB) Network and County Network, has worked to establish diversion and alternative paths for inpatient admissions, which provides for a more direct path to and allows for the Park City Hospital and Summit County Jail to serves as referrers of last resort. HUB Network providers can provide direct inpatient referrals to HMHI-SL HMHI-PC, serving as the point of assessment for non-network providers.

Currently UUHP has the following Psychiatric Hospitals associated as participating facilities:
- Provo Canyon Behavioral Hospital
- Huntsman Mental Health Institute

In the event that it is necessary, single case agreements will also be utilized to serve client needs.

**Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).**

NA

FY21 allocations and clients served were based on estimates received from Valley Behavioral Health. FY22 reflects updated costs and service levels post-transition to HUB.

**Describe any significant programmatic changes from the previous year.**
NA FY21 allocations and clients served were based on estimates received from Valley Behavioral Health. FY22 reflects updated costs and service levels post-transition to HUB.

2) Children/Youth Inpatient

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Form A1 - Amount budgeted in FY21 Area Plan</td>
<td>$20,000</td>
<td>Form A1 - Projected Clients Served in FY21 Area Plan</td>
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<tr>
<td>Form A1 - Actual FY20 Expenditures Reported by Locals</td>
<td>$38,262</td>
<td>Form A1 - Actual FY20 Clients Serviced as Reported by Locals</td>
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</tbody>
</table>

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

Huntsman Mental Health Institute of Park City (HMHI PC) is the main referral source for Child/Youth Inpatient admissions. The case management team at HMHI P.C works with UUHP to place adults who require inpatient treatment in appropriate facilities and follow their progress through aftercare and follow up appointments.

Currently UUHP has the following Psychiatric Hospitals associated as participating facilities:
- Provo Canyon Behavioral Hospital
- Huntsman Mental Health Institute

In the event that it is necessary, single case agreements will also be utilized to serve client needs.

Describe your efforts to support the transition from this level of care back to the community.

Case Management from HMHI PC follows children/youth inpatient admissions and assists with coordinating discharge planning. Because most of the referrals to inpatient level of care have come from HMHI PC this will often mean resuming services with established clinicians as well as coordinating with community supports. School therapists have also made referrals to inpatient level of care through HMHI PC and so in-school services can be part of the discharge plan for continued services. During the upcoming school year (2021-2022) Summit County and UUHP are planning to increase the availability of peer support for children and youth, in Spanish and English, which will also aid with transition to the lowest appropriate level of care.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

Describe any significant programmatic changes from the previous year.

NA
### 3) Adult Residential Care

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
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<td>Form A1 - Projected Clients Served in FY21 Area Plan</td>
<td>2</td>
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<tr>
<td>Form A1 - Actual FY20 Expenditures Reported by Locals</td>
<td>$0</td>
<td>Form A1 - Actual FY20 Clients Serviced as Reported by Locals</td>
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Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

HMHI PC is the main referral source for Adult Residential Care. The case management team at HMHI PC works with the UUHP Utilization Management (UM) team to place adults who require residential care (Acute psychiatric, dual diagnosis, CD, detox, discharge planning, other prescribed inpatient treatments.) in appropriate facilities and follow their progress through follow up appointments, referrals and accommodations.

Currently UUHP has the following Residential Mental Health Facilities associated as participating facilities:

- Volunteers of America
- Provo Canyon Behavioral Hospital
- Provo Canyon School
- Foothill Residential Treatment Center

In the event that it is necessary, single case agreements will also be utilized to serve client needs.

**How is access to this level of care determined? How is the effectiveness and accessibility of residential care evaluated?**

HMHI is the main referral source for adult residential care. The case management team at the clinic works with clients to find appropriate placements, when it is clinically indicated. The Case Management team also works with the inpatient providers to make sure that inpatient criteria is met.

Appropriateness for residential care is determined through clinician recommendations and case staffing. Effectiveness of care is determined through amelioration or worsening of symptoms and further recommendations are made through scheduled staffing or emergency staffing based on need.

The accessibility of care is determined by whether there are openings for our members. The effectiveness is determined by readmission rates. Case Management works with facilities to create a discharge plan so that clients can successfully transition to a lower level of care. Additionally Summit County and UUHP are planning to expand the Peer support offerings in Summit County and hope that in FY22 there will be added peer support resources to help with transition to lower levels of care.

**Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).**

FY21 allocations and clients served were based on estimates received from Valley Behavioral Health. FY22 reflects updated costs and service levels post-transition to HUB.
Describe any significant programmatic changes from the previous year.

FY21 allocations and clients served were based on estimates received from Valley Behavioral Health. FY22 reflects updated costs and service levels post-transition to HUB.

4) Children/Youth Residential Care

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
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<th>Form A1 - FY22 Projected clients Served:</th>
<th>2</th>
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<td>Form A1 - Amount budgeted in FY21 Area Plan</td>
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<td>Form A1 - Projected Clients Served in FY21 Area Plan</td>
<td>1</td>
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<tr>
<td>Form A1 - Actual FY20 Expenditures Reported by Locals</td>
<td>$0</td>
<td>Form A1 - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>0</td>
</tr>
</tbody>
</table>

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Please identify any significant service gaps related to residential services for youth.

HMHI PC is the main referral source for Child/Youth Residential Care. The case management team at HMHI PC and the UM team at UUHP work to place children and youth who require residential care in appropriate facilities and follow their progress through follow up appointments. Services include Acute Psychiatric, Detox, Long Term Residential with Age-Appropriate Schooling.

Currently UUHP has the following Residential Mental Health Facilities associated as participating facilities:
- Provo Canyon Behavioral Hospital
- Provo Canyon School
- Provo Canyon School-Springville

In the event that it is necessary, single case agreements will also be utilized to serve client needs.

How is access to this level of care determined? Please describe your efforts to support the transition from this level of care back to the community.

Case Management from HMHI PC follows children/youth residential care admissions and assists with coordinating discharge planning. Because most of the referrals to inpatient level of care have come from HMHI PC this will often mean resuming services with established clinicians as well as coordinating with community supports and involving family preferences and supports. School therapists have also made referrals to residential level of care through HMHI PC and so in-school services can be part of the discharge plan for continued services. During the upcoming school year (2021-2022) Summit County and UUHP are planning to increase the availability of peer support for children and youth, in Spanish and English, which will also aid with transition to the lowest appropriate level of care.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA
Describe any significant programmatic changes from the previous year.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td></td>
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</tbody>
</table>

5) Adult Outpatient Care

<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td>Form A1 - Amount budgeted in FY21 Area Plan</td>
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<td>Form A1 - Projected Clients Served in FY21 Area Plan</td>
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<td>$227,423</td>
<td>Form A1 - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>227</td>
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</table>

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

Currently, the Network consists of 93 clinicians serving within Summit & Wasatch counties and an additional 2,545 within the valley. General Services provided within Summit County include: Individual and group Counseling, Geriatric Psychiatry, Marriage and Family Therapy, School-Based Services, Medication Assisted Treatments, Medication Management, Neuropsychological Assessment, General Psychiatric Treatment, Child and Adolescent Psychiatric Treatment, General Psychology, Child and Adolescent Psychology, and Spanish Language Services.

In addition to Network Providers, HMHI PC serves as the “backbone” provider for adult outpatient services. The services offered at HMHI PC include: Individual Therapy, Group Therapy, Psychiatric Evaluation, Crisis Care, and Psychiatric Medicaid Management.

Clients within the Network are able to access care Monday-Friday from 8am to 5pm at HMHI (Open later for Groups) with additional network providers providing extended hours till 8pm Monday-Friday and reduced hours on Saturday and Sunday.

During the time of social distancing related protocols for COVID-19 tele-health therapy services are offered through HMHI PC as well as through network providers.

Describe community based services for high acuity patients including Assertive Community Treatment (ACT), Assertive Community Outreach Treatment (ACOT), and/or Intensive Case Management (ICM) services. Identify your proposed fidelity monitoring and outcome measures.

Currently community-based services are provided for all clients, including high acuity clients, through our network providers. Currently the ACT and ACOT services are being developed as part of the transition plan to the new PMHP. The County Council outlined a priority development list in which a phased implementation was established. Assertive Community Treatment and Assertive Community Outreach Treatment is within phase 4 as this is a new program for Summit County and not previously provided under the old contract. We are currently in the 3rd phase of implementation and transition. Summit County is current in phase 3 of a four phase transition and that transition is prioritized by the County council. Discussions around ACT and ACOT have been put on the table for future discussion.
Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

FY21 allocations and clients served were based on estimates received from Valley Behavioral Health. FY22 reflects updated costs and service levels post-transition to HUB.

Describe any significant programmatic changes from the previous year.

HMHI is expanding access to outpatient services by hiring additional clinical staff members.

Describe the programmatic approach for serving individuals in the least restrictive level of care who are civilly committed or court-ordered to Assisted Outpatient Treatment. Include the process to track the individuals, including progress in treatment.

Outpatient care forms the backbone of serving Summit County clients in the least restrictive level of care possible. The HMHIPC clinic serves the majority of Medicaid and DSAMH funded clients. Clients receive case management services in order to assist with maintaining at the lowest level of care given the member’s acuity. The UUHP care management team tracks the civil commitments from Summit County and assists the inpatient facilities with discharge planning, which often includes services at the HMHIPC clinic where they can be followed by the case management team and connected to community supports. Progress in treatment is tracked on an individual basis during multidisciplinary clinical team meetings and clinical coordinating meetings between UUHP and HMHIPC.

6) Children/Youth Outpatient Care

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
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<tbody>
<tr>
<td>Form A1 - Amount budgeted in FY21 Area Plan</td>
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<td>Form A1 - Projected Clients Served in FY21 Area Plan</td>
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<td>Form A1 - Actual FY20 Expenditures Reported by Locals</td>
<td>$289,538</td>
<td>Form A1 - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>289</td>
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</table>

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Please highlight approaches to engage family systems.

Services within the Network are divided amongst Network Providers, independent School-Based Contractors, and HMHIPC. Services provided within the Network: Individual Therapy, Group Therapy, Family Therapy, School-Based Services, Medication Assisted Treatments, Psychiatric Evaluation, Medication Management, Neuropsychological Assessment, Treatment Related Classes, Child and Adolescent Psychiatric Treatment, Child and Adolescent Psychology, and Spanish Language Services.

Individual Therapy: Individual therapy is offered on an outpatient basis for Summit County Children and Youth. Individual therapy can be accessed through the network of providers and is also offered in each of the Summit County schools. Over 300 students have been delivered individual therapy during the 2020-2021 school year in the school districts in Summit County. Additionally, children and youth may receive therapy services from any of the network providers, including clinicians at HMHIPC. Occasionally students wishing to receive services outside of school for academic or extracurricular
reasons are connected to outside services. Sometimes students due to level or acuity, comorbid conditions, or family situation may be best served outside of school, in this case the children are referred to the case management team at HMHI PC and then they are referred to appropriate services.

**Group Therapy:** Group therapy is available through the network providers and is also offered through the school system. Currently only Park City High School has requested group therapy and it was discontinued due to low enrollment and the COVID related service disruptions. The clients were referred to individual therapy.

**Outpatient Classes:** Outpatient classes in partnership with network providers may be offered.

Describe community based services/approaches for high acuity youth and families. Describe the programmatic approach to serving individuals in the least restrictive level of care. Identify your proposed fidelity monitoring and outcome measures.

The school based therapy program in Summit County plays a large role in service delivery and early intervention for the children and youth of Summit County. As noted below the school based therapy program is going to be run through HMHI PC starting during the school year 2021-2022. This will allow for a greater integration between the schools and the array of services (psychological, case management, psychiatric) offered through HMHI PC. The connection between the schools and HMHI PC is important because the first warning signs of need for behavioral health services are often identified by the staff at the schools and so it is the best place for early intervention with the goal of reducing the severity of ongoing behavioral health issues for the client throughout their lifetime. In this way the Summit County approach to serving the children and youth in the least restrictive setting begins in the schools. We are working to extend into the home setting, through peer support services in both Spanish and English, support to identified clients in order again, to minimize the acuity and trajectory of behavioral health issues. If the client needs increased support we can provide psychological testing or even psychiatric services before we look at placement in a more restrictive setting.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

Describe any significant programmatic changes from the previous year.

During the summer of FY22, school-based programs will be transitioning from HUB to HMHI-Park City. This is being done to better serve the youth and to streamline services. Additionally, HMHI-Park City is in the development of a youth day treatment program to be offered out of their Park City location beginning Spring of 2022.

7) **Adult 24-Hour Crisis Care**

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
<th>Contracted - DSAMH to WBH</th>
<th>Form A1 - FY22 Projected clients Served:</th>
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<tbody>
<tr>
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<td>Form A1 - Projected Clients Served in FY21 Area Plan</td>
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<td>Form A1 - Actual FY20</td>
<td>$7,068</td>
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</table>
## Expenditures Reported by Locals

<table>
<thead>
<tr>
<th>Clients Serviced as Reported by Locals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Describe access to crisis services during daytime work hours, afterhours, weekends and holidays. Describe how crisis services are utilized as a diversion from higher levels of care (inpatient, residential, etc.) and criminal justice system. Identify what crisis services are provided and where services are provided and what gaps need to still be addressed to offer a full continuum of care. Identify plans for meeting any statutory or administrative rule governing crisis services. For each service, identify whether you will provide services directly or through a contracted provider. Describe how you coordinate with state and local partners for services to include the Utah Crisis Line, JJS and other DHS systems of care, for the provision of services to at risk youth, children, and their families.</strong></td>
</tr>
</tbody>
</table>

Adult Crisis Services are provided by the overall community network which includes HMHI-Park City, Intermountain Healthcare, Peace House, and Network Providers overseen by HUB. Services within the overall community network are coordinated collectively through the Summit County Division of Behavioral Health and HUB. Individuals which require crisis services are reported to both the Summit County Division of Behavioral Health and HUB for appropriate follow-up and recovery care. HUB/UNI Park City received a monthly report and quarterly calls for coordination with the statewide crisis line.

**HMHI-Park City:** Adult Day Crisis services are provided by both walk-in crisis care and crisis appointment scheduling Monday-Friday, 8am-5pm. Additionally, UNI-Park City responds to all crisis calls within the Summit County Jail 24/7. (Spanish Provider Available)

**Intermountain Healthcare-Hospital:** Adult Crisis services are provided 24 hour a day in the emergency department in coordination with UNI-Salt Lake City via tele-health to determine if transport to inpatient care is required or if hospital behavioral staff are able to stabilize. Prior to discharge, an action/safety plan is developed including setting up a follow-up appointment with either Intermountain Healthcare or a HUB Network Providers. (Spanish Provider Available)

**Intermountain Healthcare-Round Valley Clinic:** Adult Crisis services are provided Monday-Saturday, 9am-8pm for both walk-in crisis care and crisis appointment scheduling. (Spanish Provider Available)

**Peace House:** Adult Female crisis services are available 24/7. Special consideration required for residential stay. (Spanish Provider Available)

**Network Providers:** The majority of providers provide 24/7 on-call services for clients in crisis and coordinate with either UNI-Park City or the HUB Clinical Director on post care. (Spanish Provider Available)

**MCOT:** Effective, January of 2021, Summit County and Wastache County have entered into an interlocal agreement to contract with Wasatch Behavioral Health to operate a joint MCOT based out of Park City. Per the agreement, Psychiatric services are provided by Summit County along with 911 Dispatching and law enforcement coordination. Currently, there is one team providing coverage 6 days a week during the day.

**Describe your evaluation procedures for crisis intervention services that objectively measure access and measurable outcomes for persons with both mental health and substance use disorders using data. Technical assistance with data specifications is available if needed, please describe any areas for help that is required.**

Adults who are civilly committed have their care coordinated through HMHI-Park City case managers. Those in court ordered services go through HMHI-Park City clinic for services, they are not coordinated through UUHP per the PMHP contract with the local authority.
Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

With the addition of MCOT and a return to normal tourist visitations, MCOT utilization is expected to increase in Summit County in relation to the increase in lodging numbers. As seen in the past, calls for crisis services have doubled during high tourist events such as Sundance and World Cup Competitions. During Sundance, it is estimated that the population of Summit County balloons from 40,000 to over 150,000 individuals.

Latino Behavioral Health is in the final stages of contracting with HUB to perform crisis services in Spanish. This will be a new and dedicated service for Summit County.

Describe any significant programmatic changes from the previous year.

See above.

8) Children/Youth 24-Hour Crisis Care

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
<th>Contracted - DSAMH to WBH</th>
<th>Form A1 - FY22 Projected clients Served:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>40</td>
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<td>23</td>
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</table>

Describe access to crisis services during daytime work hours, afterhours, weekends and holidays. Describe how crisis services are utilized as a diversion from higher levels of care (inpatient, residential, etc.) and criminal justice system. Identify what crisis services are provided, where services are provided, and what gaps need to still be addressed to offer a full continuum of care. Include if you provide SMR services. For each service, identify whether you will provide services directly or through a contracted provider. Describe how you coordinate with state and local partners, to include JJS and other DHS systems of care, for the provision of services to at risk youth, children, and their families.

Child and Youth Crisis services are provided by the overall community network which includes HMHI-Park City, Intermountain Healthcare, Local Education Authorities, MCOT, and Network Providers overseen by HUB. Services within the overall community network are coordinated collectively through the Summit County Division of Behavioral Health and HUB. Individuals which require crisis services are reported to both the Summit County Division of Behavioral Health and HUB for appropriate follow-up and recovery care.

**HMHI-Park City:** Child and Youth Crisis services are provided by both walk-in crisis care and crisis appointment scheduling Monday-Friday, 8am-5pm. (Spanish Provider Available)

**Intermountain Healthcare-Hospital:** Child and Youth Crisis services are provided 24 hour a day in the emergency department in coordination with HMHI-Salt Lake City via tele-health to determine if transport to inpatient care is required or if hospital behavioral staff are able to stabilize. Prior to discharge, an action/safety plan is developed including setting up a follow-up appointment with either Intermountain Healthcare or a HUB Network Provider. The Summit County Division of Behavioral Health is notified of
individuals seen in the emergency department and coordinates follow-up as needed from school-based services. (Spanish Provider Available)

**Intermountain Healthcare-Round Valley Clinic:** Child and Youth Crisis services are provided Monday-Saturday, 9am-8pm for both walk-in crisis care and crisis appointment scheduling. (Spanish Provider Available)

**Local Education Authorities:** School counselors work closely with assigned school-based service providers to address crises during school hours. Monthly meetings between LEA’s councilors, Principles, Superintendents, HUB, and School-Based Providers allows for early identification of possible concerns and corresponding intervention to reduce the risk of needing a future crisis intervention. Meetings currently take place within all school districts. (Spanish Provider Available)

**Network Providers:** The majority of providers provide 24/7 on-call services for clients in crisis and coordinate with either HMHI-Park City or the HUB Clinical Director on post care. (Spanish Provider Available)

**MCOT:** Effective, January of 2021, Summit County and Wastach County have entered into an interlocal agreement to contract with Wasatch Behavioral Health to operate a joint MCOT based out of Park City. Per the agreement, Psychiatric services are provided by Summit County along with 911 Dispatching and law enforcement coordination. Currently, there is one team providing coverage 6 days a week during the day.

**Latino Behavioral Health:** Summit County and HUB have entered into an agreement with LBH out of Salt Lake City to provide Spanish language crisis care as needed through an oncall clinician who is able to coordinate with local law enforcement and MCOT. It is the goal of Summit County to have at least one member of each MCOT be a native and/or clinical Spanish speaker.

Describe your evaluation procedures for children and youth crisis intervention services that objectively measure access and measurable outcomes for persons with both mental health and substance use disorders using data. Technical assistance with data specifications is available if needed, please describe any areas for help that is required.

Access is currently measured by if a client is identified who needs a service or a client requests a service and it cannot be provided. If that were to happen then HMHI PC and UUHP would staff the case and determine how to provide the service(s) to the client. HMHPIC has daily crisis walk-in appointments available and the MCOT team can be accessed through the crisis line. The MCOT team will create a follow up plan depending on the needs of client when they are called. Those receiving services are tracked using TEDs data, YOQ/OQ assessments, and MSHIP surveys.

There are many ways to children and youth to crisis intervention services--therapists in the schools make referrals, parents can engage the crisis line/MCOT team and HMHI PC can serve/assess and make referrals as well.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

With the addition of MCOT and a return to normal tourist visitations, MCOT utilization is expected to increase in Summit County in relations to the increase in lodging numbers. As seen in the past, calls for crisis services have doubled during high tourist events such as Sundance and World Cup Competitions. During Sundane, it is estimated that the population of Summit County balloons from 40,000 to over 150,000 individuals.

Latino Behavioral Health is in the final stages of contracting with HUB to perform crisis services in Spanish. This will be a new and dedicated service for Summit County.
Describe any significant programmatic changes from the previous year.

See above.

9) Adult Psychotropic Medication Management

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
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<td>76</td>
</tr>
</tbody>
</table>

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Please list any specific work related to medication management during transition from or between providers/settings.

Medication management is provided by the overall community network which includes HMHI-Park City, Intermountain Healthcare, and Network Providers overseen by HUB.

**HMHI-Park City:** Serving as the backbone provider, the majority of medication management is provided by HMHI-Park City. HMHI-Park City is staffed by a Psychiatrist, Dr. Stoddard, APRN, Corey Cutler, who perform adult mediation management services. Dr. Weeks provides medication management to the Summit County Jail as needed. The HUB network HMHI, in partnership with the University of Utah College of Psychiatry is currently recruiting for a Spanish speaking psychiatrist to begin in the Fall of 2021.

Work also includes many providers in Salt Lake who will manage psychotropic medications. **Intermountain Round Valley Clinic:** Provided through an ongoing donation, medication management is provided at the Clinic, free of charge, for those in need or are on SelectHealth insurance.

**Network Providers:** Additional APRNs and MDs provider medication management through the Network within Summit and surrounding counties, allowing for expanded access to psychotropic medication management.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

Nelson

Describe any significant programmatic changes from the previous year.

HMHI, in partnership with the University of Utah College of Psychiatry is currently recruiting for a Spanish speaking psychiatrist and APRN to begin expanding Spanish medication management Fall of 2021.
**10) Children/Youth Psychotropic Medication Management**

<table>
<thead>
<tr>
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<td>16</td>
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</table>

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Please list any specific work related to medication management during transition from or between providers/settings.

Medication management is provided by the overall community network which includes HMHI-Park City, Intermountain Healthcare, and Network Providers overseen by HUB.

**HMHI-Park City**: Serving as the backbone provider, the majority of medication management is provided by HMHI-Park City. UNI-Park City is staffed by Psychiatrist Dr. Weeks for Children and Youth, and APRN, Corey Cutler, who perform adult medication management services. The HUB network also includes many providers in Salt Lake who will manage psychotropics. HMHI, in partnership with the University of Utah College of Psychiatry is currently recruiting for a Spanish speaking psychiatrist to begin in the Fall of 2021.

**Intermountain Round Valley Clinic**: Provided through an ongoing donation, medication management is provided at the Clinic, free of charge, for those in need or are on SelectHealth insurance.

**Network Providers**: Additional APRNs and MDs provide medication management through the Network within Summit and surrounding counties, allowing for expanded access to psychotropic medication management.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

Describe any significant programmatic changes from the previous year.

With the transition of school-based services from HUB to HMHI-Park City, access to increased psychiatric care will be provided.

**11) Adult Psychoeducation Services & Psychosocial Rehabilitation**

<table>
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<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
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<th>Form A1 - FY22 Projected clients Served:</th>
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<tbody>
<tr>
<td>Form A1 - Amount</td>
<td>$10,000</td>
<td>Form A1 - Projected Clients</td>
<td>90</td>
</tr>
</tbody>
</table>
Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

Psychoeducational Services and Psychosocial Rehabilitation services are provided through the Summit County Clubhouse which is in its second year of operations. Currently, all SCC services are being conducted via Zoom due to both the current public health emergency and renovations taking place at their newly acquired facility. Individuals in need of these services are additionally referred to community providers as needed, often being referred through the HMHI-Park City Case Management team or the UUHP UM team.

Describe how clients are identified for Psychoeducation and/or Psychosocial Rehabilitation services. How is the effectiveness of the services measured?

The Summit County Clubhouse is a local 501c3 which provides psychoeducational and psychosocial rehabilitation to individuals referred from local providers who have a history of mental health and substance abuse disorder. Upon referral, the prospective member is invited to SCC for a tour and to see if the program is something they would like to be involved in. Effectiveness is measured in decreased hospital stays, decreased engagement with law enforcement, increased employment, engagement in positive social activities, and daily participation with the program.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

FY21 allocations and clients served were based on estimates received from Valley Behavioral Health. FY22 reflects updated costs and service levels post-transition to HUB.

Describe any significant programmatic changes from the previous year.

The clubhouse is now billing Medicaid and they are moving to their permanent home.

<table>
<thead>
<tr>
<th>12) Children/Youth Psychoeducation Services &amp; Psychosocial Rehabilitation</th>
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</thead>
<tbody>
<tr>
<td><strong>Form A1 - FY22 Amount Budgeted:</strong></td>
</tr>
<tr>
<td><strong>Form A1 - Amount budgeted in FY21 Area Plan</strong></td>
</tr>
<tr>
<td><strong>Form A1 - Actual FY20 Expenditures Reported by Locals</strong></td>
</tr>
</tbody>
</table>
Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

Summit County Division of Behavioral Health provides Psychoeducational Rehabilitation for children and families in the community in conjunction with the local LEAs through parenting classes (Guiding Good Choices & Primed For Life in English and Spanish) and school based organizations (Hope Squads in all three high schools, and Peer Leadership Programs in each middle school.) HUB serves to coordinate with therapists and case managers, prevention team, Respite providers and FRFs work to help youth improve coping skills, friendships, social functioning and parenting effectiveness. Individual, family and group classes help children and their families obtain skills to better function within the community.

Describe how clients are identified for Psychoeducation and/or Psychosocial Rehabilitation services. How is the effectiveness of the services measured?

Effectiveness is measured by decreased hospital stays, decreased engagement with law enforcement and school authorities, increased employment outcomes, increased social activities and daily participation in the program.

The goal in Summit County is that there are many pathways for entry for children and youth services. When a child participates in the school therapy program they will receive the YOQ which will help indicate the need for Psychoeducation Services and Psychosocial Rehabilitation Services. When a Child or Youth is referred from a school counselor or the Spanish Language Coordinator then they may also be evaluated or after a brief case staffing they may be determined to be eligible for services. Referrals will be made to the afterschool program, run by LBH, through the parents or the schools.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

Describe any significant programmatic changes from the previous year.

UUHP and Summit County are working with Latino Behavioral Health to provide an afterschool program starting in school year 2021-2022.

<table>
<thead>
<tr>
<th>13) Adult Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Form A1 - FY22 Amount Budgeted:</strong></td>
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<tr>
<td><strong>Form A1 - Amount budgeted in FY21 Area Plan</strong></td>
</tr>
<tr>
<td><strong>Form A1 - Actual FY20 Expenditures Reported by Locals</strong></td>
</tr>
</tbody>
</table>

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Please include how you ensure each case management provider is certified to provide these services.
Case management services are provided through HUB. Case management is an important part of the service continuum. The purpose of case management is to assist individuals with serious mental illness to access needed resources and coordinate care with other providers in order to be successful and improve their quality of life in the least restrictive setting possible. Case management works with mental illness but also assists with psychosocial problems such as housing, transportation, application/attainment of benefits, attainment of food, activities of daily living, medical appointments, education, employment, and other activities. In most cases, case managers work in conjunction with UUHP care managers, who oversee the full integration of behavioral health care with the clients physical health care.

All Case Managers are reviewed for current licensing and are registered for a service that monitors adverse actions or debarments with regards to ability to bill Medicaid. If an adverse action appears on the record of a network provider, their file will be reviewed for action by UUHP provider relations.

Please describe how eligibility is determined for case management services. How is the effectiveness of the services measured?

Eligibility for case management services is determined by clinicians at HMHI PC through DLA 20 and SDOH screening tools as well as a complete biopsychosocial assessment. Areas assessed which tend to determine overall clients success in treatment are: Access to medical care • Access to nutritious foods • Access to clean water and functioning utilities • Early childhood social and physical environment, including child care • Education and health literacy • Ethnicity and cultural orientation • Familial and other social support • Gender • Housing and transportation resources • Linguistic and other communication capabilities • Neighborhood safety and recreational facilities • Occupation and job security • Other social stressors, such as exposure to violence and other adverse factors in the home environment • Sexual identification • Social status (degree of integration vs. isolation) • Socioeconomic status • Spiritual/religious values. Clinicians make recommendations to case management services as part of a treatment plan. Effectiveness is measured in follow up case management services by reassessing with the same screening tools and finding improved outcomes.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

FY21 allocations and clients served were based on estimates received from Valley Behavioral Health. FY22 reflects updated costs and service levels post-transition to HUB.

Describe any significant programmatic changes from the previous year.

NA

FY21 allocations and clients served were based on estimates received from Valley Behavioral Health. FY22 reflects updated costs and service levels post-transition to HUB.

14) Children/Youth Case Management

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
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<th>Form A1 - FY22 Projected clients Served:</th>
<th>200</th>
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</thead>
<tbody>
<tr>
<td>Form A1 - Amount budgeted in FY21 Area Plan</td>
<td>$11,700</td>
<td>Form A1 - Projected Clients Served in FY21 Area Plan</td>
<td>100</td>
</tr>
<tr>
<td>Form A1 - Actual FY20 Expenditures Reported by Locals</td>
<td>$10,703</td>
<td>Form A1 - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>14</td>
</tr>
</tbody>
</table>
Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Please include how you ensure each case management provider is certified to provide these services.

Child and Youth Case management services are provided through UNI-Park City. Case management is an important part of the service continuum. The purpose of case management is to assist individuals with serious mental illness to access needed resources and coordinate care with other providers in order to be successful and improve their quality of life in the least restrictive setting possible. Case management works with mental illness but also assists with psychosocial problems such as housing, transportation, application/attainment of benefits, attainment of food, activities of daily living, medical appointments, education, employment, and other activities.

UNI, as part of its compliance process, checks certifications when someone is a new hire and then rechecks continuously throughout employment. Certification must be kept current by all staff in order to work in a capacity that requires licensure.

Please describe how eligibility is determined for case management services. How is the effectiveness of the service measured?

Eligibility for case management services is determined by clinicians at HMHI PC through DLA 20 and SDOH screening tools as well as a complete biopsychosocial assessment. Areas assessed which tend to determine overall clients success in treatment are: Access to medical care • Access to nutritious foods • Access to clean water and functioning utilities • Early childhood social and physical environment, including child care • Education and health literacy • Ethnicity and cultural orientation • Familial and other social support • Gender • Housing and transportation resources • Linguistic and other communication capabilities • Neighborhood safety and recreational facilities • Occupation and job security • Other social stressors, such as exposure to violence and other adverse factors in the home environment • Sexual identification • Social status (degree of integration vs. isolation) • Socioeconomic status • Spiritual/religious values. Clinicians make recommendations to case management services as part of a treatment plan. Effectiveness is measured in follow up case management services by reassessing with the same screening tools and finding improved outcomes.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

Summit County anticipates that with HMHIPC taking over the school based therapy program there will be an increase in case management referrals and services provided to children and youth.

Describe any significant programmatic changes from the previous year.

NA

15) Adult Community Supports (housing services)

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
<th>$0</th>
<th>Form A1 - FY22 Projected clients Served:</th>
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<td>Form A1 - Amount budgeted in FY21 Area Plan</td>
<td>$0</td>
<td>Form A1 - Projected Clients Served in FY21 Area Plan</td>
<td>6</td>
</tr>
<tr>
<td>Form A1 - Actual FY20</td>
<td>$0</td>
<td>Form A1 - Actual FY20</td>
<td>0</td>
</tr>
</tbody>
</table>
Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

The Division of Behavioral Health has a community partnership with Mountainlands Community Housing Trust in Park City to provide affordable housing options to qualified residents of Summit County. VBH-SC case manager, FPSS, and therapist assist clients in applying and working toward low-income and independent housing as appropriate. All placements are done through coordination with case managers and Mountainlands Community Housing Trust. Evaluations are done on an ad hoc basis, to prioritize the clinical need for placement in each program. Program has not been used for several years, as such, should a resident be in need of this service, funding will be redirected as needed.

Indicate what assessment tools are used to determine criteria, level of care and outcomes for placement in treatment-based and/or supportive housing?

Appropriateness for referral for housing services (if available through community resources) is determined by clinicians at HMHI PC through DLA 20 and SDOH screening tools as well as a complete biopsychosocial assessment. Outcomes are determined by the case manager following the client in supportive housing and the client’s ability to reintegrate after supportive housing. Referrals made to Mountainlands are based on a lottery system so that the housing options are awarded randomly.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

Describe any significant programmatic changes from the previous year.

NA

### 16) Children/Youth Community Supports (respite services)

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
<th>$0</th>
<th>Form A1 - FY22 Projected clients Served:</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form A1 - Amount budgeted in FY21 Area Plan</td>
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<td>Form A1 - Actual FY20 Expenditures Reported by Locals</td>
<td>$0</td>
<td>Form A1 - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>0</td>
</tr>
</tbody>
</table>

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Please identify how this fits within your continuum of care.
Respite services are provided by Jewish Family Services as needed and covered by both community donations upon recommendation by HUB as part of the greater community network, and bill on a fee for services basis to Medicaid. JFS does not receive any DSAMH funding for respite services currently.

**Please describe how you determine eligibility for respite services. How is the effectiveness of the service measured?**

Case management services performed at HMHI PC will make referrals to respite as needed.

**Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).**

NA

**Describe any significant programmatic changes from the previous year.**

NA

### 17) Adult Peer Support Services

<table>
<thead>
<tr>
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</thead>
<tbody>
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</tr>
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<td>Form A1 - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>10</td>
</tr>
</tbody>
</table>

**Describe the activities you propose to undertake and identify where services are provided.** For each service, identify whether you will provide services directly or through a contracted provider. Describe your policies and procedures for peer support.

Peer Support services include a broad range of supporting services including Social Security, Dept. of Workforce Services, housing, and job search. When Peer Support Specialists work closely with case managers and therapists, clients have the best chance for full recovery. Psychosocial Rehabilitation Services can also be provided by Peer Support Specialists to aid clients in building new skills or forgotten skills. PSS offers services in house, in the jail, and throughout the community. Peer Support Specialists works closely with the courts including Drug Court for additional support with high risk - high need clients.

UNI-Park City provides the majority of Peer Support Services for behavioral health and has a full time Peer Support Specialist who also serves as a peer support. The services provided through UNI peer support are coordinated with psychological services provided through UNI-PC. HUB employs a Family Resource Facilitator (FRF) who works with the Spanish Speaking community. Marcella, the HUB FRF, helps families that are struggling with mental health issues and does an especially good job of helping families navigate systems that can be difficult for Latinx families, including coordination of care.

**Describe how clients are identified for Peer Support Specialist services. How is the effectiveness of the services measured?**
Adult clients are referred to peer support through the HMHI PC clinic, where they are identified through the multidisciplinary treatment team meetings. Clients also often receive PSS services while they are incarcerated. The services are measured as part of the patient's progress on their treatment plan, their subjective decision to continue to participate in PSS, and tools such as the OQ assessments and MSHIP surveys.

Describe your policies and procedures for peer support. Do Certified Peer Support Specialists participate in clinical staffings?

CPSS participate in weekly staff meetings for case conceptualization and best care practices. CPSS follow guidelines for CPSS services through DSAMH division directives and HMHI policies.

How is adult peer support supervision provided? Who provides the supervision? What training do supervisors receive?

There is different supervision for different types of peer support. The FPSS program provides training and supervision. The peer support specialist is supervised through the UNI-Park City Clinic. YPR and Fit to Recover are part of larger organizations which they report to. UUHP’s expectations for peer support organizations is that they follow the guidelines established by DSAMH regarding certification, practice, and supervision. We rely upon the standards established by DSAMH regarding peer support services.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served and number of services provided (15% or greater change).

Summit County is planning on expanding the number of providers who are eligible to provide peer support services to residents so it is likely that the service utilization will also increase.

FY21 allocations and clients served were based on estimates received from Valley Behavioral Health. FY22 reflects updated costs and service levels post-transition to HUB.

Describe any significant programmatic changes from the previous year.

Summit County is planning on increasing the peer support services offered in FY22. The goal will be to have LBH or some other interested providers provide more peer support for adult mental health.

FY21 allocations and clients served were based on estimates received from Valley Behavioral Health. FY22 reflects updated costs and service levels post-transition to HUB.

18) Children/Youth Peer Support Services

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
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</thead>
<tbody>
<tr>
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<td>$24,059</td>
<td>Form A1 - Projected Clients Served in FY21 Area Plan</td>
<td>80</td>
</tr>
<tr>
<td>Form A1 - Actual FY20 Expenditures Reported by Locals</td>
<td>$2,792</td>
<td>Form A1 - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>2</td>
</tr>
</tbody>
</table>
Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. **Describe how Family Peer Support Specialists will partner with other Department of Human Services child serving agencies, including DCFS, DJJS, DSPD, and HFW.**

Children and Youth Peer Support Services are provided by a Family Resource Facilitator (FRF). The FRF is contracted through Allies with Families and acts as an advocate for families and their children. The FRF is trained in Wraparound to fidelity and executes wraparound plans. These services are available to the community and do not require that they be opened as UUHP clients. The FRF participates as necessary with the staffing meetings and coordination of care.

Describe your policies and procedures for peer support. Do Certified Peer Support Specialists participate in clinical staffings?

CPSS participate in weekly staff meetings for case conceptualization and best care practices. CPSS follow guidelines for CPSS services through DSAMH division directives and HMHI policies.

Please identify how youth and family eligibility for this service is determined.

Clients are identified for PSS after initial biopsychosocial screening and assessment as part of their treatment plan at the HMHI PC clinic.

Clients may also be referred to PSS through UUHP if a client is not being seen through the HMHI PC clinic. In the past, clients could also be referred to PSS through the school services, however those will be provided in FY22 through HMHIPC.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served and number of services provided (15% or greater change).

Summit County is planning on expanding the number of providers who are eligible to provide peer support services to residents so it is likely that the service utilization will also increase.

How is Family Peer Support supervision provided? Who provides the supervision? What training do supervisors receive? What training does clinical staff receive on engaging Certified Family Peer Support services in the continuum of care?

FRF supervision is provided through Allies with Families where the training is also provided.

Describe any significant programmatic changes from the previous year.

Summit County is planning on increasing peer support services offered to children and youth, through an afterschool program run by Latino Behavioral Health. This program will likely also include individual peer support by providers certified through DSAMH.

### 19) Adult Consultation & Education Services

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form A1 - Amount budgeted in FY21 Area Plan</td>
<td>1</td>
</tr>
</tbody>
</table>
Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

HUB provides consultation and education services in a variety of ways. UNI-Park City staff and Network Providers are asked to present at various community events including community wide issues conferences, school groups, health fairs and other settings. Staff provide information on how to access services and information on how to access services and information on prevention of behavioral health problems. The Summit County Division of Behavioral Health has regular spots on both Park City TV and KPCW in which various network providers are highlighted in accordance with the behavioral health topic being discussed.

Additionally, the Summit County Mental Wellness Alliance, CONNECT Summit County, the Summit County Health Department, Park City Municipal, partner non-profits, HUB, school districts, and Summit County share Facebook and Twitter posts related to behavioral health care programs and services. Social media posts are developed in both English and Spanish.

Additional information and education on services provided is conducted by the non-profit CONNECT via their navigation services and provider database. https://summit.ut.networkofcare.org/mh/

Twice a year, the Latinx Behavioral Health Committee hosts a Behavioral Health Fair for all services within Summit County provided in Spanish. Event includes panel discussion and QPR training.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

No change anticipated.

Describe any significant programmatic changes from the previous year.

Currently there are no changes anticipated.

### 20) Children/Youth Consultation & Education Services

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
<th>$0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form A1 - Amount budgeted in FY21 Area Plan</td>
<td>1</td>
</tr>
<tr>
<td>Form A1 - Actual FY20 Expenditures Reported by Locals</td>
<td>$0</td>
</tr>
</tbody>
</table>

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.
HUB provides consultation and education services in a variety of ways. UNI-Park City staff and Network Providers are asked to present at various community events including community wide issues conferences, school group, health fairs and other settings. Staff provide information on how to access services and information on how to access services and information on prevention of behavioral health problems. The Summit County Division of Behavioral Health has regular spots on both Park City TV and KPCW in which various network providers are highlighted in accordance to the behavioral health topic being discussed. Hub has been utilizing written media, in addition to KPCW and Park City TV, to provide information to children and youth. Additional focus has been on “swag” for school districts, provided by the Division of Behavioral Health, such as book bags, water bottles, and t-shirts with information about SafeUT, QPR, and school-based services. HUB and local school districts have worked to increase awareness about school-based services through trainings for faculty and general information sent to parents.

HUB participates in the Children’s Justice Center’s monthly meetings where we were able to consult on the active CJC cases.

Additionally, the Summit County Mental Wellness Alliance, CONNECT Summit County, the Summit County Health Department, Park City Municipal, partner non-profits, HUB, school districts, and Summit County share Facebook and Twitter posts related to behavioral health care programs and services. Social media posts are developed in both English and Spanish.

Additional information and education on services provided is conducted by the non-profit CONNECT via their navigation services and provider database. [https://summit.ut.networkofcare.org/mh/](https://summit.ut.networkofcare.org/mh/)

### Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

### Describe any significant programmatic changes from the previous year.

NA

#### 21) Services to Incarcerated Persons

| Form A1 - FY22 Amount Budgeted: | $76,154 | Form A1 - FY22 Projected clients Served: | 300 |
| Form A1 - Amount budgeted in FY21 Area Plan | $88,096 | Form A1 - Projected Clients Served in FY21 Area Plan | 300 |
| Form A1 - Actual FY20 Expenditures Reported by Locals | $6,650 | Form A1 - Actual FY20 Clients Serviced as Reported by Locals | 17 |

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider, and how you will coordinate with the jail to ensure service delivery is adequate.

HUB in collaboration with the Summit County Division of Behavioral Health, Summit County Attorney’s Office, and the Summit County Sheriff Department has created a new program around behavioral health services for incarcerated persons. The program includes weekly consultation with a psychiatrist,
social worker evaluations, and active case management. The goal is to manage mental illness better as individuals are incarcerated and to lower the risk of recidivism and risk to the community after individuals are no longer incarcerated.

HUB is currently working with the Summit County Division of Behavioral Health, Summit County Attorney’s Office, and the Summit County Sheriff Department to explore the possibility of providing MAT within the Summit County Jail.

**Describe how clients are identified for services while incarcerated. How is the effectiveness of the services measured?**

Clients are assessed while incarcerated by request of jail staff, courts and representing attorneys. Clinical staff from HMHI PC will perform assessments in person or via Telehealth in the jail, make treatment recommendations and report to courts and referral sources accordingly. Clients may be released to treatment through the courts. Treatment may include inpatient and outpatient referrals. The MCOT, new this year, provides these same types of services for the jail and utilizes a similar process of assessment and possible transfer to treatment services. Effectiveness is measured by adherence and completion of recommended treatment reported by the HMHI team and translated to the courts via court letter to the judge. In addition, effectiveness is measured by follow up therapy when released from incarceration. HMHI will facilitate that transition in advance of a release date. HMHI PC employs a therapist dedicated to groups and individual therapy in the jail 6-10 hours per week.

**Describe the process used to engage clients who are transitioning out of incarceration.**

Clients transitioning from incarceration are transferred into treatment programs, either through HMHI PC outpatient services or inpatient treatment. Clients are engaged through assessment, treatment planning, goal setting and the use of supports, PSS, case management services and referral to additional community supports. The services are initiated by the MCOT team and HMHI PC.

**Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).**

NA

**Describe any significant programmatic changes from the previous year.**

MCOT services provided to the jail and community are new in 2021.

<table>
<thead>
<tr>
<th>22) Adult Outplacement</th>
<th>Form A1 - FY22 Amount Budgeted:</th>
<th>Form A1 - FY22 Projected clients Served:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$4,500</td>
<td>4</td>
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<table>
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</thead>
<tbody>
<tr>
<td>$4,500</td>
<td>4</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Form A1 - Actual FY20 Expenditures Reported by Locals</th>
<th>Form A1 - Actual FY20 Clients Serviced as Reported by Locals</th>
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</thead>
<tbody>
<tr>
<td>$18,591</td>
<td>4</td>
</tr>
</tbody>
</table>
Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

UUHP will utilize outplacement funds to provide services to individuals transitioning from the Utah State hospital back to the community. These funds are utilized for services, supplies, and needed supports not covered by Medicaid to facilitate a successful community placement. They may be utilized to facilitate a successful community placement. They could be spent to provide housing, non-covered treatment costs or other community resources that may be needed for success in transition to a lower level of care.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

Describe any significant programmatic changes from the previous year.

NA

23) Children/Youth Outplacement

| Form A1 - FY22 Amount Budgeted: | $0 | Form A1 - FY22 Projected clients Served: | 0 |
| Form A1 - Amount budgeted in FY21 Area Plan | $0 | Form A1 - Projected Clients Served in FY21 Area Plan | 1 |
| Form A1 - Actual FY20 Expenditures Reported by Locals | $0 | Form A1 - Actual FY20 Clients Serviced as Reported by Locals |

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

HUB utilizes County outplacement funds to provide services to individuals transitioning from the Utah State hospital back to the community. These funds are utilized to purchase services, supplies, and needed supports not covered by Medicaid to facilitate a successful community placement. They may be utilized to facilitate a successful community placement. They could be spent to provide housing, non-covered treatment costs or other community resources that may be needed for success in transition to a lower level of care.

Describe any significant programmatic changes from the previous year.

NA

24) Unfunded Adult Clients

| Form A1 - FY22 Amount | $10,000 | Form A1 - FY22 Projected | 250 |
### Form A1 - Amount Budgeted in FY21 Area Plan

<table>
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<tbody>
<tr>
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</tr>
</tbody>
</table>

### Form A1 - Actual FY20 Expenditures Reported by Locals

<table>
<thead>
<tr>
<th>Budgeted:</th>
<th>clients Served:</th>
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<tbody>
<tr>
<td>Form A1 - Actual FY20 Expenditures Reported by Locals</td>
<td>$9,055</td>
</tr>
</tbody>
</table>

### Describe the activities you propose to undertake and identify specific populations where services are and are not provided. For each service, identify whether you will provide services directly or through a contracted provider.

HUB provides services to individuals residing in Summit County who are uninsured or underinsured. We require verification of income and then fees are set according to a sliding fee scale. Services include psychiatric evaluation, medication management, individual and group therapy and case management and skills services.

For residents dealing with concerns related to immigration, Jewish Family Services, Christen Center of Park City, and Holy Cross Ministries provide services in Spanish for uninsured or underinsured residents in need to care as part of the overall Community Network.

### Describe efforts to help unfunded adults become funded and address barriers to maintaining funding coverage. Please report the number of individuals who came in unfunded who you helped secure coverage (public or private).

When individuals apply for free or reduced cost services they are encouraged by the intake team to apply for Medicaid if there is reason to believe that they will be successful in their application. Intake coordinators ask “is there a reason to believe you would not be eligible for Medicaid,” this is asked in place of a referral. This has been found to be more effective for enrolling Spanish speaking clients. We do not track the number of individuals referred to Take Care Utah or who are advised to enroll in private insurance plans other than those that are participating in drug court. The referrals are simply made through the clinic as the resident is seeking services.

### Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

FY21 allocations and clients served were based on estimates received from Valley Behavioral Health. FY22 reflects updated costs and service levels post-transition to HUB.

### Describe any significant programmatic changes from the previous year.

FY21 allocations and clients served were based on estimates received from Valley Behavioral Health. FY22 reflects updated costs and service levels post-transition to HUB.

### Form A1 - FY22 Amount Budgeted: 25) Unfunded Children/Youth Clients

<table>
<thead>
<tr>
<th>Budgeted:</th>
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<tbody>
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<tr>
<td>Form A1 - Amount</td>
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</tr>
<tr>
<td>budgeted in FY21 Area Plan</td>
<td>Served in FY21 Area Plan</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------</td>
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<tr>
<td>Form A1 - Actual FY20 Expenditures Reported by Locals</td>
<td>$5,030</td>
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</table>

Describe the activities you propose to undertake and identify specific populations where services are and are not provided. For each service, identify whether you will provide services directly or through a contracted provider.

HUB provides services to individuals residing in Summit County who are uninsured or underinsured. We require verification of income and then fees are set according to a sliding fee scale. Services include psychiatric evaluation, medication management, individual and group therapy and case management and skills services.

Unfunded Children and Youth are eligible for the school-based counseling program which is run through HUB and uses independent contractor therapists to provide services in every school in Summit County. (For the first. Time.) Individual and group therapy is offered through the school-based counseling program.

For families dealing with concerns related to immigration, Jewish Family Services, Christen Center of Park City, and Holy Cross Ministries provide services in Spanish for uninsured or underinsured residents in need to care as part of the overall Community Network.

Describe efforts to help unfunded youth and families become funded and address barriers to maintaining funding coverage. Please report the number of individuals who came in unfunded who you helped secure coverage (public or private).

When individuals or families apply for free or reduced cost services they are encouraged by the intake team to apply for Medicaid if there is reason to believe that they will be successful in their application.

Vail Epic Care program provides BH services for employees as well as people living with employees, including non family members.

Barriers: Summit County, in partnership with HUB and local non-profits, have established a means to allow families to maintain behavioral health treatment through utilization of specific donor gifts to non-profits and the general Summit County Community Wellness Fund overseen by the Park City Community which is available to families in need, thus ensuring continuation of behavioral health services. We do not track the number of individuals referred to Take Care Utah or who are advised to enroll in private insurance plans other than those that are participating in drug court. The referrals are simply made through the clinic as the resident is seeking services.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

Describe any significant programmatic changes from the previous year.

NA
### 26) Other non-mandated Services

<table>
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<th>Form A1 - FY22 Projected clients Served:</th>
<th>0</th>
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</thead>
<tbody>
<tr>
<td>Form A1 - Amount budgeted in FY21 Area Plan</td>
<td>$0</td>
<td>Form A1 - Projected Clients Served in FY21 Area Plan</td>
<td>0</td>
</tr>
<tr>
<td>Form A1 - Actual FY20 Expenditures Reported by Locals</td>
<td>$0</td>
<td>Form A1 - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>0</td>
</tr>
</tbody>
</table>

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

HUB and the Division of Behavioral Health have expanded court ordered services issued at the Justice Court level. Services are provided by HMHI-PC through a separate service contract with Summit County and are coordinated through the Summit County Recovery Foundation and HUB. Services provided are the same as conducted at the District Court level.

**Recovery Support Services:** For Local Authorities intending to use Mental Health Block Grant funding for Mental Health Recovery Support Services - Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. For a list of RSS services, please refer to the following link: [https://dsamh.utah.gov/pdf/ATR/FY21 RSS Manual.pdf](https://dsamh.utah.gov/pdf/ATR/FY21 RSS Manual.pdf)

Block Grant funding is not used to provide Recovery Support Services.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

Describe any significant programmatic changes from the previous year.

NA

### 27) First Episode Psychosis Services

<table>
<thead>
<tr>
<th>Form A1 - FY22 Amount Budgeted:</th>
<th>$0</th>
<th>Form A1 - FY22 Projected clients Served:</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form A1 - Amount budgeted in FY21 Area Plan</td>
<td>0</td>
<td>Form A1 - Projected Clients Served in FY21 Area Plan</td>
<td>0</td>
</tr>
<tr>
<td>Form A1 - Actual FY20 Expenditures Reported by Locals</td>
<td>0</td>
<td>Form A1 - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>0</td>
</tr>
</tbody>
</table>
Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider.

UUHP is currently developing this program for implementation in consultation with the University of Utah College of Psychiatry and HMHI-SL.

Describe how clients are identified for FEP services. How is the effectiveness of the services measured?

UUHP is currently developing this program for implementation in consultation with the University of Utah College of Psychiatry and HMHI-SL.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

Describe any significant programmatic changes from the previous year.

NA

### 28) Client Employment

Increasing evidence exists to support the claim that competitive, integrated and meaningful employment is an essential part of the recovery process and is a key factor in supporting mental wellness. In the following spaces, please describe your efforts to increase client employment in accordance with Employment First 62A-15-105.2

**Competitive, integrated and meaningful employment in the community (include both adults and transition aged youth).**

Assigned Case managers help with employment placement services. It should be noted that given the highly seasonal jobs environment, it is now common for individuals to be without work for upwards of 5 months during "shoulder seasons" in which the resorts, galleries, restaurants and outfitters are closed. (September, October, November, April, May)

Clients, upon recommendation, have access to year-round employment due to support from Home Depot, Park City Municipal, Summit County, and Squatters Roadhouse

**The referral process for employment services and how clients who are referred to receive employment services are identified.**

Case Managers at HMH PC, following the screening process reported in Form A questions 13 and 14 (case mgmt screening/assessment tools), work with clients and the Department of Workforce services as well as our community partner, The Summit County Clubhouse, to support employment services for clients.

Collaborative employment efforts involving other community partners.
HUB works in collaboration with Vocational Rehabilitation and Department of Workforce Services to access supports and services for clients that desire gainful employment but have barriers due to mental health or substance use issues work with case managers and are often referred to Vocational Rehab. The Division of Behavioral Health works with local resorts and ancillary businesses to establish relationships for referred employment. Summit County CONNECT, Jewish Family Service, Clubhouse, Christian Center of Park City, and the Health Department also provide access to employment opportunities.

Employment of people with lived experience as staff through the Local Authority or subcontractors.

Much of employment throughout the University system cannot track lived experience due to employment law and HR regulations. However some community partners such as Summit County Connect and Summit County Clubhouse do hire partly based on lived experience criteria. Currently there are 3 individuals working in CPSS roles who have lived experience as part of their work requirements.

Evidence-Based Supported Employment.

Not applicable with the network model.- DSAMH will provide TA.

29) Quality & Access Improvements

Identify process improvement activities including implementation and training of:

Implementation

UUHP works closely with an External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), to conduct on-site and desk reviews to ensure the integrity of the Performance Measure Validation (PMV), alignment of policies and procedures with the state contract and federal regulations, and the Performance Improvement Project (PIP). This year will be the first of the multi-year PIP process. The focus of the PIP will be the number of clients who receive outpatient services within 7 and 30 days of an inpatient psychiatric stay.

Training and Supervision of Evidence Based Practices. Describe the process you use to ensure fidelity.

The following modalities are utilized within the Network:

- Trauma Focused Cognitive Behavioral Therapy
- Life Skills Training
- Cognitive Behavioral Therapy
- Motivational Interviewing
- Medication Management
- OQ/YOQ
- School-based Treatment
- EMDR
- Seeking Safety
- UNI-Park City will be participating in the Zero Suicide initiative, along with the County’s partnership with the National Health Service – Scotland on implementing Choose Life (Renamed Hope Elevated for Summit County).

All Network Providers participate in continuing education to maintain licensure and to develop new
skills. HMHI sponsors and hosts many conferences and trainings in specific modalities each year. Additionally, supervision is offered through the clinic where regular staffing meetings are held.

**Outcome Based Practices. Identify the metrics used by your agency to evaluate client outcomes and quality of care.**

The PIP is focused on improving the HEDIS (Healthcare Effectiveness Data and Information Set) FUH (Follow-Up after Hospitalization) Measure. This measure is vital because it tracks those that have been released from inpatient psychiatric stays and whether they have received outpatient services within 7 and 30 days of discharge. Receiving outpatient services, in a timely manner, after discharge from an inpatient psychiatric stay is shown to reduce cost through lower readmission rates and also increase wellbeing by having a successful transition for individuals back into the community.

**Increased service capacity**

While the overall Network is performing at 32% capacity as designed, we are still seeing wait times of over 15 days for Spanish Language services. (During the current COVID-19 Public Health Emergency, this has grown to over 60 day.) Even with the network increased to 12 Spanish Language providers, it is estimated that Summit County is in need of 24-30 total Spanish language providers to bring wait times down to the targeted 48-hour window.

Summit County, along with HUB, the University of Utah Department of Psychiatry, College of Social Work, and College of Nursing, along with local businesses, are working together to increase the number of Spanish speaking clinicians within Summit County. With 2019 community data showing 28% of the residential population and 42% of the seasonal population requiring services in Spanish, this is a priority recruitment for Summit County.

**Increased Access for Medicaid & Non-Medicaid Funded Individuals**

The network model operated by HUB has expanded choice and access to Medicaid Members and Non-Medicaid funded individuals. The school-based counseling program has seen over 200 students in Summit County receive therapy services so far in the 2019-2020 school year. Despite the school-based therapy program moving to remote therapy new referrals are still coming in from the schools.

One unforeseen complication with choosing HUB has been the restriction on their ability to market and advertise services as an ACO. As such, this has fallen to the County and community partners (CONNECT, People’s Health Clinic, Jewish Family Services, etc.) to increase awareness about Medicaid and Unfunded services provided through the HUB Network. By holding community behavioral health fairs, targeting eligible individuals, and rolling out a general information campaign Fall of 2020, the County’s goal is to increase Medicaid enrollment by 40%.

**Efforts to respond to community input/need. Describe your participation with key community partners (e.g.: Multi-Agency Coordinating Committees, Regional Advisory Councils, High Fidelity Wraparound teams, Local Interagency Councils, Local Recovery Community, Local Homeless Coordinating Committees, Peer Advocacy Groups, County Attorney, Law Enforcement, Local Education Agencies, Courts, Regional Healthcare Coalitions, and other partnership groups relevant in individual communities) shall occur consistently.**

HUB meets monthly with the Summit County Behavioral Health Executive Committee, which serves as the Local Authority as appointed by the Summit County Council, on issues related to behavioral health. Membership includes local elected leadership, Intermountain Healthcare, Latinx community, non-profits, network providers, Summit County Sheriff’s Office, Summit County Attorney’s Office, and the Summit County Health Department. This Committee reviews metrics established within the contract to
identify areas to be improved upon and provide support.

HUB also serves on several Summit County Mental Wellness Alliance committees such as:
- Latinx Behavioral Affairs Committee
- Marketing & Public Relations Committee
- Fundraising Committee
- Community Behavioral Health Assessment Committee
- Superintendents Committee for Behavioral Health (School Districts)
- Aging and Advocacy Coalition
- First Responder Committee (Expanded JRI Committee)
- Hope Elevated (Suicide Prevention Committee)

Participation with these committees provides for direct feedback from community partners related to behavioral health.

Twice a year, the Division of Behavioral Health, along with CONNECT, conducts a Network Provider meeting to ensure terms of the HUB contract are being met and that providers are receiving the support and resources needed to provide the highest level of care for residents. Issues brought up are discussed with solutions being developed and improvement plans implemented with HUB.

Clients are also able to give feedback through the MHSIP survey.

During FY2022, Summit County, along with HUB, is conducting its annual Behavioral Health Community Assessment, last done in 2016. The goal of this assessment is to gage what improvements to behavioral health services and understanding have taken place within the community and to identify new gaps and areas of improvement. Conducted as both a targeted study conducted by PRC via telephone interviews, a community online assessment, and multiple community focus groups, the results of the assessment will be compiled into the annual report and used to guide the development and update to the Summit County Behavioral Health Strategic Plan (Formerly the Summit County Mental Wellness Strategic Plan) and approved by the Summit County Council. Traditionally, this would have taken place last year but was held for one year due to both the transition from VBH to HUB and the public health emergency.

**Describe Coalition Development efforts**

Summit County has developed a strong community coalition community partners in developing the Summit County Behavioral Health Strategic Plan (Formerly the Summit County Mental Wellness Strategic Plan) and corresponding Summit County Mental Wellness Alliance which remains the primary behavioral health community organization.

**Describe how mental health needs for people in Nursing Facilities are being met in your area**

Beehive Homes of Prk City is a private assisted living and memory care facility which has its own contracted behavioral health services.

**Describe your agency plan to maintain telehealth services in your area as agencies return to in-person service provision. Include programming involved. How will you measure the quality of services provided by telehealth?**

UUHP’s contracted providers are utilizing telehealth services almost entirely at the moment. We have a strong network for school-based services using telehealth at this time, along with our outpatient services.
The Division of Behavioral Health has issued guidance to all clinicians in Summit County that they continue to utilize telehealth as much as prudent, with specific guidance till September per COVID-19 precautions.

Describe how you are addressing maternal mental health in your community. Describe how you are addressing early childhood (0-5 years) mental health needs within your community. Describe how you are coordinating between maternal and early childhood mental health services.

In partnership with the Summit-Wasatch County Early Intervention program (UDOH) run out of the Summit County Health Department, EI clients have both telehealth and in-home access to a contracted psychologist and LCSW. This program is funded jointly by the Summit County Health Department and the Katz-Amsterdam Foundation. Where possible, Medicaid is billed. In cases where Medicaid is unable to be billed for these services, community donations support a scholarship fund to continue these services until such time as State funding is approved by the legislature. Early Intervention includes pre-natal mental health services to support maternal mental health. For program participants located within Wasatch County, Wasatch Behavioral Health serves as the agency of referral.

Describe (or attach) your policies for improving cultural responsiveness across agency staff and in services.

HUB has a cultural competency plan that has the following steps/goals. (There is a full plan that can be found on the pulse internal website that outlines the review timeframes and positions responsible for compliance/performance.)

The high-level steps are:
1) Increase staff awareness and cultural competence.
2) Increase staff awareness and cultural competence regarding spiritual beliefs and traditions.
3) Provide ongoing staff training.
4) Solicit feedback from clients on services provided.
5) Demonstrate cultural sensitivity to clients.
6) Encourage callers to access community cultural/diversity support systems.
7) Recruit and retain a diverse workforce.

Increasing the number of Spanish speaking providers is a priority for both the Summit County and Park City Councils. With an estimated 50% of Summit County residents projected to be speaking Spanish as their preferred language by 2025, the need to recruit and retain medically trained Spanish speaking clinicians is critical. In an effort to help monitor and improve services for this population, the Latinx Behavioral Affairs Committee was established from trusted members of the Latinx community to address issues of service and stigma. Through their actions, a steady growth in the utilization of Spanish speaking clinicians has been seen. While we have increased the number of spanish speaking clinicians, this has led to an increase in wait times for the 12 providers. Efforts are underway with multiple education and business partners to develop incentives to recruit and retain Spanish speaking clinicians in Summit County.

Identify a staff member responsible to collaborate with DSAMH to develop an “Eliminating Health Disparity Strategic Plan” with long term five-year goals and short term action plans. The short term action plans will be based on the needs assessment recommendations.

Aaron Newman ANewman@summitcounty.org

Other Quality and Access Improvements (not included above)
30) Integrated Care

Describe your partnerships with local Health Departments, accountable care organizations (ACOs), federally qualified health centers (FQHCs) and other physical health providers.

HUB is an ACO so many Medicaid members have a de facto integrated Medicaid plan with UUHP as their physical Medicaid ACO. UUHP also has a good relationship with the other three ACOs. We are working on the integrated pilot program along the Wasatch Front, and taking those lessons learned to improve in Summit County. Also, we are taking our relationships with the surrounding counties to collaborate further and work on ways to improve access and services.

HUB and the Division of Behavioral Health, which is a part of the Summit County Health Department, have a strong working relationship. Through weekly meetings with the Director of Behavioral Health and participation in Mental Wellness Alliance committees, HUB is a well-regarded partner for our community. We are truly grateful to have them here.

Describe your efforts to integrate care and ensure that children, youth and adults have their physical, mental and substance use disorder needs met, including screening and treatment and recovery support.

HUB oversees both Mental Health and Substance Use Disorder treatments within the Network. It also includes Care Managers who work with individuals on coordinating physical and behavioral health services to best integrate care and prevent redundancy or holes in care. HUB has the advantage of being an ACO, so we have a large nursing care management team that excels in behavioral and physical care management.

Describe your efforts to incorporate wellness into treatment plans for children, youth and adults.

The HMHI PC clinic offers engagement in programs like Fit to Recover (recovery based wellness), trauma informed yoga through the PC Yoga Collective and Tall Mountain Wellness, care management services through the University of Utah Health network and case management and PSS services used to consistently assess client need over the course of their engagement in treatment.

What education does your staff receive regarding health and wellness for client care (including youth-in-transition and adults)? Describe how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy).

Whenever any HUB member has a significant physical health problem, they are referred to our care management team for referrals and education regarding wellness programs and physical health concerns. This allows for a smooth continuum of care between behavioral and physical health care.

Describe your plan to reduce tobacco and nicotine use in SFY 2022, and how you will maintain a nicotine free environment as a direct service or subcontracting agency. For ongoing engagement, it is recommended to use an evidence-based nicotine dependence tool such as the Fagerstrom scale. SUD Target= reduce tobacco and nicotine use by 4.8%.

UUHP Providers do not allow the use of tobacco products within 25 feet of the facilities, and individuals who wish to stop using tobacco products are referred to the National Jewish Health quit line for one on one coaching, support services, and nicotine replacement therapy. We coordinate prevention work with the Summit County Health Department.
Describe your efforts to provide integrated care for individuals with co-occurring mental health and autism and other intellectual/developmental disorders.

UUHP provides mental health services for children and coordinates with the waiver services, and for adults we provide the mental health services and refer to the Summit County Clubhouse for additional support services.

31) Children/Youth Mental Health Early Intervention

Describe the Family Peer Support activities you propose to undertake and identify where services are provided. Describe how you partner with LEAs and other Department of Human Services child serving agencies, including DCFS, DJJS, DSPD, and HFW. For each service, identify whether you will provide services directly or through a contracted provider. For those not using MHEI funding for this service, please indicate “N/A” in the box below.

UUHP contracts with Allies with Families to provide a Family Resource Facilitator (FRF) with wraparound services. Our FRF is providing 20 hours per week to the community. Services are provided in family homes or community settings. UUHP also participates in the Multidisciplinary Task Force and collaborates with DCFS and CJC, DSPD, and other social services.

Include expected increases or decreases from the previous year and explain any variance over 15%.

Summit County is planning to increase the availability of peer support offerings in Summit County. Latino Behavioral Health is planning on starting an afterschool program during the 2021-2022 school year.

Describe any significant programmatic changes from the previous year.

Summit County is planning to increase the availability of peer support offerings in Summit County. Latino Behavioral Health is planning on starting an afterschool program during the 2021-2022 school year.

Do you agree to abide by the Mental Health Early Intervention Family Resource Facilitation Agreement? YES/NO

Yes.

32) Children/Youth Mental Health Early Intervention

Describe the Mobile Crisis Team activities you propose to undertake and identify where services are provided. Please note the hours of operation. For each service, identify whether you will provide services directly or through a contracted provider. For those not using MHEI funding for this service, please indicate “N/A” in the box below.

Summit County, in collaboration with Wasatch County, have entered into an interlocal agreement for the operations of a regional MCOT. Contracted through Wasatch Behavioral Health, the team is housed at the Summit County Richin’s Building in Kimball Junction as it was determined to be the most central location for responding in under an hour to all populated areas of both Summit and Wasatch Counties.………

Child and Youth Crisis services are provided by the overall community network which includes UNI-
Park City, Intermountain Healthcare, Local Education Authorities, and Network Providers overseen by HUB. Services within the overall community network are coordinated collectively through the Summit County Division of Behavioral Health and HUB. Individuals which require crisis services are reported to both the Summit County Division of Behavioral Health and HUB for appropriate follow-up and recovery care.

**HMHI-Park City**: Child and Youth Crisis services are provided by both walk-in crisis care and crisis appointment scheduling Monday-Friday, 8am-5pm. (Spanish Provider Available)

**Intermountain Healthcare-Hospital**: Child and Youth Crisis services are provided 24 hour a day in the emergency department in coordination with UNI-Salt Lake City via tele-health to determine if transport to inpatient care is required or if hospital behavioral staff are able to stabilize. Prior to discharge, an action/safety plan is developed including setting up a follow-up appointment with either Intermountain Healthcare or a HUB Network Provider. The Summit County Division of Behavioral Health is notified of individuals seen in the emergency department and coordinates follow-up as needed from school-based services. (Spanish Provider Available)

**Intermountain Healthcare-Round Valley Clinic**: Child and Youth Crisis services are provided Monday-Saturday, 9am-8pm for both walk-in crisis care and crisis appointment scheduling. (Spanish Provider Available)

**Local Education Authorities**: School counselors work closely with assigned school-based service providers to address crises during school hours. Monthly meetings between LEA’s counselors, Principals, Superintendents, HUB, and School-Based Providers allows for early identification of possible concerns and corresponding intervention to reduce the risk of needing a future crisis intervention. Meetings currently take place within all school districts. (Spanish Provider Available)

**Network Providers**: The majority of providers provide 24/7 on-call services for clients in crisis and coordinate with either UNI-Park City or the HUB Clinical Director on post care. (Spanish Provider Available)

Include expected increases or decreases from the previous year and explain any variance over 15%.

NA–MCOT spend it attributed to Wasatch

Describe any significant programmatic changes from the previous year.

MCOT team will be in operation from the start of FY22.

Describe outcomes that you will gather and report on. Include expected increases or decreases from the previous year and explain any variance over 15%.

UUHP will report on the crisis services that it manages through its contracted providers.

33) Children/Youth Mental Health Early Intervention

Describe the School-Based Behavioral Health activities you propose to undertake and how you intend to support family involvement in treatment. For each service, identify whether you will provide services directly or through a contracted provider. Please include: any partnerships
related to **2019 HB373** funding and any telehealth related services provided in school settings. For those not using MHEI funding for this service, please indicate “N/A” in the box below.

Currently, all school-based services are provided through independent contractors who are licensed therapists and work in the schools. **Beginning in the coming Fall, HMHI - Park City will be transitioning to oversee the school-based clinician.** By being independent, contracted clinicians, clinicians are available at each school and operate on a salaried payment model and are available to faculty and staff for advice as needed in addition to providing treatment and assessments. We continue to see increased utilization due to consistent access. In order to participate in the school-based therapy program students must have a signed consent form from their parents or guardians. Families are always invited to participate in therapy and are given updates by the therapist working with the students. Group therapy is also offered, however the only school that has utilized group therapy has been Park City High School. **Currently, HB 373 funding is being used by LEAs to provide additional nursing care and has yet to be utilized to expand behavioral health.** That said, LEAs continue to receive community donations to maintain the expansion of behavioral health services provided by HUB in Eastern Summit County. This includes the funding of three LCSWs and one psychologist.

During the current Public Health Emergency, school-based services have continued via telehealth.

<table>
<thead>
<tr>
<th>Include expected increases or decreases from the previous year and explain any variance over 15%</th>
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<tbody>
<tr>
<td>NA</td>
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</tbody>
</table>

**Describe any significant programmatic changes from the previous year and include a list of the schools where you plan to provide services.** *(Please email Leah Colburn [lacolburn@utah.gov](mailto:lacolburn@utah.gov) a list of your current school locations.)*

<table>
<thead>
<tr>
<th>Therapists have been stationed at each school each week. This reliable schedule and more direct relationship with schools has led to an increase in referrals to therapy. The schools that have had a therapist at their school are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>· North Summit High School</td>
</tr>
<tr>
<td>· North Summit Middle School</td>
</tr>
<tr>
<td>· North Summit Elementary</td>
</tr>
<tr>
<td>· Jeremy Ranch Elementary</td>
</tr>
<tr>
<td>· Parley's Park Elementary</td>
</tr>
<tr>
<td>· Treasure Mountain Junior High</td>
</tr>
<tr>
<td>· McPolin Elementary</td>
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<tr>
<td>· Trailside Elementary</td>
</tr>
<tr>
<td>· Winter Sports School</td>
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<tr>
<td>· Ecker Hill Middle School</td>
</tr>
<tr>
<td>· Park City High School</td>
</tr>
<tr>
<td>· Park City Learning Academy</td>
</tr>
<tr>
<td>· Weilenmann School of Discovery</td>
</tr>
<tr>
<td>· South Summit Middle School</td>
</tr>
<tr>
<td>· South Summit Elementary</td>
</tr>
<tr>
<td>· South Summit High School</td>
</tr>
<tr>
<td>· South Summit Middle School</td>
</tr>
<tr>
<td>· Silver Summit Elementary</td>
</tr>
<tr>
<td>· Silver Summit High School</td>
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</tbody>
</table>
Since school was suspended during the 2019-2020 school year all school-based services have been delivered via video conference or via telephone. New referrals continue to be made.

Please describe how you plan to collect data including MHEI required data points and YOQ outcomes in your school programs. Please identify who the MHEI Quarterly Reporting should be sent to including their email.

The first year of implementation we will be evaluating utilization data and we will work with the school districts to see if there is relevant school centered data that could be useful in evaluating the program such as absenteeism rates or possibly disciplinary rates. We will also utilize the MHSIP to provide feedback to the program.

34) Suicide Prevention, Intervention & Postvention

Describe all current activities in place in suicide prevention, including evaluation of the activities and their effectiveness on a program and community level. Please include a link or attach your localized suicide prevention plan for the agency or broader local community.

Prevention: Suicide prevention programs are run through the Summit County Health Department Office of Health Education in conjunction with the Division of Behavioral Health and the Summit County Mental Wellness Alliance. Due to COVID-19, all 2019-2020 Priorities have been continued to 2021-2022. County funding for Suicide Prevention is expected to be restored in January, 2022.

The action plan provides a summary of the actions that the Hope Elevated committee of the Summit County Mental Wellness Alliance are currently pursuing for the 2022-2023 year. This plan is updated each Spring. Due to the Public Health Emergency, this conversation has not taken place, but is expected to this fall.

During the public health emergency, the following suicide prevention programs were able to take place virtually:

- **QPR** – Summit County Health Department has partnered with community members and groups to provide Suicide Prevention trainings. We have reached 100 students in South Summit School District. We continue to offer QPR trainings virtually and have a few scheduled in May.

- **Working Minds** – our Summit County Health Department has 2 staff trained in Working Minds Suicide Prevention training and assisted the State Suicide Prevention Coalition in providing a training to 10 people.

- **Live ON** – Summit county received a $10,000 to promote the Live On Campaign from the Utah Suicide Prevention Coalition. The Health Department has partnered with Boncom to create radio advertisements, social media advertisements, billboards, print media and partner with the Oakley Rodeo to provide education and information about Live ON’s suicide prevention resources. We hope to reach individuals ages 20+ in working populations with these messages.

2021-2020 Priorities:

- Conduct and publish a needs assessment so we can improve our understanding of the data relating to suicide, identify any trends and understand what interventions work in terms of suicide prevention. The needs assessment will be completed by February 2022 and will inform the Summit County Behavioral Health Strategic Plan (Formerly the Summit County Mental Wellness Strategic Plan), including a new suicide prevention plan.

- Continue to deliver training in the suite of programs which address mental health and wellbeing.
and suicide awareness and prevention with community partners such as CONNECT, school districts, HUB, Holy Cross Ministries, the Latinx Affairs Committee, etc. Examples include QPR (English & Spanish), Mental Health First Aid, SafeUT, U of U Health Suicide training for providers, film screenings, and STORM.

- Promote a broader awareness around the importance of listening and talking both in relation to mental wellbeing and suicide prevention by using social media to support campaigns such as Mental Health Awareness Monty (CONNECT) and Suicide Prevention Week (LEAs) which attract a local press and social media presence.

- Ensure all programs and materials are alliable in both English and Spanish. Continue the targeted and culturally based approach in connecting and educating the Spanish speaking community.

- Expand HOPE Squads from high schools to junior and middle schools.

**Intervention:** Network providers have been trained in U of U Health Suicide recognition and utilize the Stanly Brown Safety Plan as needed. The Division of Behavioral Health is notified in most cases of suicide attempts seen by the Park City Hospital and network partners. This information is shared with HUB which assigns a Network Providers, generally UNI-Park City for follow-up.

With the addition of an MCOT, Summit County still prefers to dispatch members of the Summit County Sheriff’s Office Probation Department to respond to all suicide related calls to 911. (This is due to the plain clothes and unmarked vehicle used.) All members of the SCSO are trained in CIT, QPR, and provided additional behavioral education opportunities yearly. Individuals transported to the Summit County Jail due to reasons on immediate physical harm, are placed in a specific suicide watch cell and seen by the HMHI-Park City on-call staff.

**Postvention:** Follow-up with adults released from the Park City Hospital are conducted within 24 hours and released by a Network Provider, generally HMHI-Park City. For children and youth, this is conducted by the corresponding school-based provider. If a safety plan has not been established due to being seen in the ED, staff will work with the individual to establish a Brown Safety Plan.

School Counseling in the event of a death by suicide: The Summit County School-based counseling program has plans in place to shift counseling resources, including calling in network providers, towards a school in the even of an emergency, including a death by suicide. This protocol has been used once in the previous school year when a preschool teacher was involved in a pedestrian accident and a therapist was tasked to the preschool for two days, counseling staff members and making referrals as necessary.

Community based postvention follows the programs as outlined in the “After A Suicide...” response plan estabilibled by the Scottish Association for Mental Health, which is included within the folder.

**Describe all currently suicide intervention/treatment services and activities including the use of evidence based tools and strategies. Describe your policies and procedures for suicide screening, risk assessment, and safety planning as well as suicide specific treatment and follow up/care transition services. Describe how clients are identified for suicide specific services. How is the effectiveness of the services measured?**

Plan is implemented in HMHI-Park City. Efforts are being made to ensure other contracted providers also have plans in place. This is a focus for the coming year. The HMHI PC clinic provides thorough screening assessment to all patients with the C-SSRS included. Treatment is provided based on screening and assessment. All patients complete a Stanley Brown safety plan. In addition, clinicians
are trained in CALM (Counseling on Legal Means). With this training clinicians ask further crucial screening questions to identify risk and increase safety in regard to access to means. Patients are hospitalized when a higher level of care is indicated and HMHI will track patients while inpatient and follow through with treatment upon release. Resources from the community are provided to support safety. All patients at HMHI PC are provided crisis resources noted in each progress note when they are seen at the clinic. Effectiveness is measured by reduced hospitalizations and treatment outcomes and continued assessment and screening to evaluate progress and reduced and zero report of SI. Efforts are made to increase supports and access to treatment for each high acuity patient through case management services and monitoring, medication management and clinical staff who provide individualized treatment plans per patient.

**Describe all current strategies in place in suicide postvention including any grief supports. Please describe your current postvention response plan, or include a link, or attach your localized suicide postvention plan for the agency and/or broader local community.**

Grief support and community postvention utilized by the Summit County Health Department, local school districts, and the Summit County Mental Health Corps. is outlined in the attached plans entitled “after Suicide Toolkit for Schools” and the SAMH guide, “After A Suicide”.

**Describe your plan for coordination with Local Health Departments and local school districts to identify roles and support implementation of a community postvention plan in alignment with the state Community Postvention Toolkit.**

UUHP has strong collaboration with the Summit County Health Department and its Division of Behavioral Health in implementing processes to handle postvention plans. HUB is working to train Network Providers in the utilization of the state Community Postvention Toolkit as with the exception of UNI-Park City, none of the providers have been exposed to it prior to contracting with HUB.

**For Local Authorities participating in the Garrett Lee Smith State Youth Suicide Prevention and Early Intervention Grant Program summarize your implementation plans for implementing skill based programming, gatekeeper training, community or school based screening activities, and crisis follow up services after inpatient or emergency department visits. (note: this can be done in the box below, or by linking/attaching your most current report).**

For those not participating in this grant program, please indicate “N/A” in the box below.

NA

**For Local Authorities participating in the Comprehensive Suicide Prevention grants describe your implementation plans for primary prevention programs, suicide intervention supports including gatekeeper training, and community postvention planning. (note: this can be done in the box below, or by linking/attaching your most current report).**

If any of the following project deliverables are currently available, please link them here or attach them to your submission.

1. **By year 2, funding recipients shall submit a written comprehensive suicide prevention plan that is in alignment with the Utah Suicide Prevention State Plan and by year 2, funding recipients shall submit a written postvention response plan and communication protocol for their organization.**

2. **By year 3 funding recipients shall submit a written community postvention response**
**35) Justice Treatment Services (Justice Involved)**

<table>
<thead>
<tr>
<th><strong>What is the continuum of services you offer for justice involved clients and how do you address reducing criminal risk factors?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Services include PFL, SOP, IOP, Drug Court, MAT, UA testing, Peer Support, Individual therapy and case management. Criminal risk factors are reduced through treatment planning, successful completion of recommended programs and negative UA results.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Describe how clients are identified as justice involved clients</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals are traditionally identified through their justice involvement, but may also be identified by their attorneys or clinicians who are aware of pending judicial involvement. Additional referrals may be received from the jail or &quot;known flyers&quot; with a behavioral health history of involvement with local law enforcement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>How do you measure effectiveness and outcomes for justice involved clients?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative UA results are an immediate indicator of the effectiveness of justice involved treatment services. Successful completion of the treatment recommendations is also a way to measure the effectiveness for Justice Treatment Services. HMHI PC serves primarily SU related justice involved clients. HMHI PC also serves DV related cases for which effectiveness is measured by completion of DV MRT and associated treatment recommendations.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Identify training and/or technical assistance needs.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>We would like more clinicians trained in DV and MRT. One MRT clinician is departing for private practice.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Identify a quality improvement goal to better serve justice involved clients.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Summit County is in the midst of a CPC evaluation of services. The outcome of the evaluation will include a quality improvement goal. The evaluation will be complete by the Summer of 2021.</td>
</tr>
</tbody>
</table>
Identify the efforts that are being taken to work as a community stakeholder partner with local jails, AP&P offices, Justice Certified agencies, and others that were identified in your original implementation committee plan.

HMHI PC provides individual therapy, assessment and crisis treatment services in the jail weekly. HMHI coordinates with probation and AP&P, justice and district court judges to track compliance with treatment recommendations and UA testing results weekly.

Identify efforts being taken to work as a community stakeholder for children and youth who are justice involved with local DCFS, DJJS, Juvenile Courts, and other agencies.

Due to the low volume of youth engaged with the above agencies, direct contract from the above agencies is made with HMHI-PC. Through expanded usage of school-based services, early identification and intervention within schools is able to take place.

36) Disaster Preparedness and Recovery Plan

Please attach or input your disaster preparedness and recovery plan for programs that provide prevention, treatment and recovery support for mental illness and substance use programs.

Given the network model utilized in Summit County, not every Network Provider will have a plan. HUB, UNI-Park City, and Summit County will serve as the stabilization agencies to continue services. The current Summit County DPRP is over 3,500 pages, and unable to be included in this document, but is available for review through the Health Department’s Office of Emergency Management at 650 Round Valley Way, Park City, UT.

Behavioral health, along with physical health, is interwoven within the plan. There is no specific section for behavioral or physical health; rather, the response is dictated by the type of crisis. For example, action for a Terrorist Attack (During high visitor season) or Radiological Leak differs from Mass Fatality Support and Pandemic. The county plan is scheduled for review in 2022. At that time, a new digital copy is expected to be in place. The plan is utilized, as evidenced during the recent Pandemic. Relevant sections are distributed via paper copies by the Emergency Manager to assigned staff for a coordinated response, and daily EOC coordination takes place seven days a week.

For HUB and UNI-Park City, the overall University of Utah DPRP can be found here: https://pulse.utah.edu/site/uni/Documents/UNI%20Emergency%20Management%20Procedures.pdf#search=UNI%20disaster%20preparedness

37) Speciality Services

If you receive funding for a speciality service outlined in the Division Directives (Operation Rio Grande, SafetyNet, PATH, Behavioral Health Home, Autism Preschools), please list your approach to services, how individuals are identified for the services and how you will measure the effectiveness of the services. If not applicable enter NA.

NA
Local Authority: Summit County & Healthy U. Behavioral

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

<table>
<thead>
<tr>
<th>1) Early Intervention</th>
<th>Form B - FY22 Amount Budgeted:</th>
<th>$92,000</th>
<th>Form B - FY22 Projected clients Served:</th>
<th>200</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Form B - Amount Budgeted in FY21 Area Plan</td>
<td>$61,719</td>
<td>Form B - Projected Clients Served in FY21 Area Plan</td>
<td>136</td>
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<tr>
<td></td>
<td>Form B - Actual FY20 Expenditures Reported by Locals</td>
<td>0</td>
<td>Form B - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>15</td>
</tr>
</tbody>
</table>

Describe local authority efforts to provide for individuals convicted of driving under the influence, a screening; an assessment; an educational series; and substance abuse treatment as required in Utah Code § 17-43-201(5)(m).

The Summit County Health Department offers Prime For Life once every two months in English and Spanish for residents over the age of 18. Any participants under the age of 18 are referred to the online course. All PFL participants must complete the SASSI screening tool and a biopsychosocial (SU/MH) assessment before participating in the class. Any participants scoring High Probability of Having a Substance Use Disorder will be referred for a complete Substance Use Assessment, along with those court ordered to complete a substance use evaluation. Those meeting the criteria for treatment after an assessment, will be referred to a therapist.

Identify evidenced-based strategies designed to intervene with youth and adults who are misusing alcohol and other drugs.

The HMHI PC clinic uses biopsychosocial (SU/MH) assessment including the SASSI, URICA, ASAM, OQ/YOQ are EB screening tools used to determine necessary interventions for youth and adults. For individuals who request services, and are assessed as appropriate for early intervention are referred to ADI (Alcohol & Drug Intervention) or a limited course of outpatient substance use treatment that focuses on psychoeducation. For the limited outpatient services, evidence-based psychoeducation is primarily provided through the Change Company interactive journaling series.

Describe work to identify individuals with substance disorder in your community, implement brief motivational interventions and/or supportive monitoring in healthcare, schools and other settings

For additional information related to school prevention programs, please see Form C. For information related to identification, please see Form A.

SUD intervention takes place at HMHI-PC through referral of network providers to access MAT. Treatment includes motivation interviewing skills in efforts to engage individuals in both health care and
behavioral health services. Summit county contracts with Wasatch Behavioral to provide MCOT and crisis services in the community which facilitates treatment assessment and referral. Individuals involved in DUI and other PRI services are also encouraged and referred as needed. Summit County and UUHP interact with all three school districts in the area and provide services to all three school districts. Schools refer students for therapy and early intervention services.

Describe efforts to conduct outreach and engagement efforts designed to reach individuals who are actively using alcohol and other drugs.

**Courts:** Clients who are court mandated to have a SU/MH assessment are referred to the HMHI PC clinic. Treatment recommendations are determined and sent to the court. Patients receive treatment at HMHI PC and are tracked through the courts and case management services to completion.

**Education:** Community education and identification efforts are provided to local community groups and businesses by the Summit County Behavioral Health Prevention Team, Summit County Health Promotions Team, and partner non-profits such as CONNECT. The largest of these includes annual training of Sundance Volunteers and local ski resort employees for the winter season.

**School:** The school based therapy program in Summit County is robust and all of the students who are referred to counseling services are assessed and given a treatment plan. This assessment includes a risk of substance abuse which if present will be addressed in the treatment plan. Many students, particularly as they are in higher grades, are referred to school based services for substance abuse in tandem with behavioral health issues.

Describe effort to assist individuals with enrollment in public or private health insurance directly or through collaboration with community partners (healthcare navigators or the Department of Workforce Services) to increase the number of people who have public or private health insurance.

Summit County residents are provided two options to help in navigating behavioral healthcare in Summit County.

**HUB:** Network providers operating within the HUB Network are not limited to taking Medicaid, DSAMH, or UUHP funds. Many have additional paneling and are able to be referred within the Network.

**CONNECT:** A local non-profit, CONNECT Summit County has established a peer navigator service free to residents of Summit County. Through use of their service database, individuals and navigators are able to search for specific types of services and see what insurance a provider takes. If an individual is unable to pay for services and is not on Medicaid or DSAMH funding, the navigators are able to coordinate with non-profit providers for scholarship opportunities. The database can be found here: https://summit.ut.networkofcare.org/mh/ A copy of their Resource Guide has been placed within the Summit Folder.

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

The Summit County Health Department provides distribution and training for any agency, school, business, or individual wishing to receive free Naloxone kits. Prior to COVID, trainings were held monthly and are expected to resume this fall. Successful training is required before any Nalone kit is released. Trainings are overseen by the Director of Nursing Services.
Describe any significant programmatic changes from the previous year.

NA

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

<table>
<thead>
<tr>
<th>Form B - FY22 Amount Budgeted:</th>
<th>$20,000</th>
<th>Form B - FY22 Projected clients Served:</th>
<th>6</th>
</tr>
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<tr>
<td>Form B - Amount Budgeted in FY21 Area Plan</td>
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<td>Form B - Projected Clients Served in FY21 Area Plan</td>
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<td>Form B - Actual FY20 Expenditures Reported by Locals</td>
<td>$0</td>
<td>Form B - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

UUHP has a contractual agreement with Volunteers of America to provide non-medical detoxification services for Summit County patients. Medical detoxification services are available through the Huntsman Mental Health Institute (HMHI) in Salt Lake City, and direct admission is available through the HMHI-Park City BHC. HMHI inpatient detoxification program ensures safe withdrawal and the beginning of the recovery process. Patients are detoxified under the care of a psychiatrist, nurses, social workers, and psychologists who provide medication, monitoring, and support during the withdrawal period. Additional treatment includes group therapies and activities throughout the day to address the disease of addiction. To ensure continued success when the patient leaves the hospital HMHI creates discharge plan outlines with the patient and family for appropriate follow-up coordination of care into the UUHP contracted provider network.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

Describe any significant programmatic changes from the previous year.

NA

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

Medical detoxification services will be provided at HMHI Inpatient in SLC and other detoxification services will be provided at Volunteers of America in SLC.
### 3) Residential Treatment Services: (ASAM III.7, III.5, III.3, III.1)

| Form B - FY22 Amount Budgeted: | $89,000 | Form B - FY22 Projected clients Served: | 4 |
| Form B - Amount Budgeted in FY21 Area Plan | $47,181 | Form B - Projected Clients Served in FY21 Area Plan | 4 |
| Form B - Actual FY20 Expenditures Reported by Locals | $30,000 | Form B - Actual FY20 Clients Serviced as Reported by Locals | 2 |

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

UUHP uses contracted providers, Odyssey House, First Step House, Salt Lake Behavioral Health, House of Hope and others, for residential services. Consideration is given to funding sources and services available for placement. There are no residential treatment facilities in Summit county. While in residential treatment case managers and care managers coordinate and arrange after care through network providers. Services consist of evaluation and treatment planning, individual and group therapy, skill development, case management, recovery support services, social detoxification, smoking cessation and, when indicated, medication management and MAT. Clients receive assistance in transitioning to lower levels of care as indicated by the ASAM placement tool.

Please refer to the Healthy U Behavioral Health Network Provider link for a full list of network providers available at https://healthyubehavioral.com/

**Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).**

NA

**Describe any significant programmatic changes from the previous year.**

NA

### 4) Opioid Treatment Program (OTP-Methadone)

| Form B - FY22 Amount Budgeted: | 0 | Form B - FY22 Projected clients Served: | 0 |
| Form B - Amount Budgeted in FY21 Area Plan | $53,000 | Form B - Projected Clients Served in FY21 Area Plan | 4 |
| Form B - Actual FY20 Expenditures Reported by Locals | $0 | Form B - Actual FY20 Clients Serviced as Reported by Locals | 0 |
Describe the activities you propose and identify where services will be provided. Identify whether you will provide services directly or through a contracted provider. Please list all contracted providers and summarize the services they will provide for the local authority.

Currently, methadone services are not provided in Summit County. Resources are provided through Project Reality in SLC. Project Reality serves adults with opioid use disorder diagnoses for recovery and wellness and offers buprenorphine, methadone, and naltrexone combined with physical and mental health services.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

Describe any significant programmatic changes from the previous year.

NA

<table>
<thead>
<tr>
<th>5) Office-based Opioid Treatment -(Vivitrol, Naltrexone, Buprenorphine)</th>
<th>VaRonica Little</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form B - FY22 Amount Budgeted:</td>
<td>$124,000</td>
</tr>
<tr>
<td>Form B - FY22 Projected clients Served:</td>
<td>30</td>
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<tr>
<td>Form B - Amount Budgeted in FY21 Area Plan</td>
<td>$86,854</td>
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<tr>
<td>Form B - Projected Clients Served in FY21 Area Plan</td>
<td>30</td>
</tr>
<tr>
<td>Form B - Actual FY20 Expenditures Reported by Locals</td>
<td>$0</td>
</tr>
<tr>
<td>Form B - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>0</td>
</tr>
</tbody>
</table>

Describe activities you propose to ensure access to Buprenorphine and Naltrexone (including vivitrol) and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider.

HUB provides these services through the Provider Network primarily through HMHI-Park City to prescribe Buprenorphine, Vivitrol and Naltrexone on-site by a prescriber. Services include medication evaluation and management for MAT services with supplemental treatment services and recovery supports to include group therapy, individual therapy, case management, PSS, and urine-drug screening. Services are determined by assessment and screening with individualized treatment plans. MAT services are offered by network providers, for inpatient and outpatient services, like Odyssey House and First Step House who contract with Project Reality for OTP.

The University of Utah School of Psychiatry and HMHI, have created a program to help people struggling with opioid addiction known as BRIDGE. If a patient is experiencing opioid dependency or suffering from withdrawal symptoms, they can receive immediate treatment. Patients are given an initial buprenorphine dose as well as a prescription for the initial month of medication. After receiving the medication they need, they’re referred to an outpatient clinic that will continue treatment by developing a custom tailored long term care program. There is no cost to the patient. The program is state funded by a grant that aims to fight the opioid epidemic in Utah. The goal is to get the patient's addiction stabilized and their head clear so they can focus on the other struggles in their life.
Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

Describe any significant programmatic changes from the previous year.

NA

<table>
<thead>
<tr>
<th>6) Outpatient (Non-methadone – ASAM I)</th>
<th>Shanel Long</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form B - FY22 Amount Budgeted:</td>
<td>$328,262</td>
</tr>
<tr>
<td>Form B - FY22 Projected clients Served:</td>
<td>723</td>
</tr>
<tr>
<td>Form B - Amount Budgeted in FY21 Area Plan</td>
<td>$485,323</td>
</tr>
<tr>
<td>Form B - Projected Clients Served in FY21 Area Plan</td>
<td>640</td>
</tr>
<tr>
<td>Form B - Actual FY20 Expenditures Reported by Locals</td>
<td>$357,151</td>
</tr>
<tr>
<td>Form B - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>135</td>
</tr>
</tbody>
</table>

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

Standard Outpatient services are provided at ASAM 1.0 through the Provider Network with HMHI-Park City providing the backbone operations for SUD treatment in Summit County. Standard Outpatient group therapy is offered Wednesdays, weekly, from 4pm-5pm at HMHI-Park City, with additional groups provided through CONNECT Summit County. Services also include individual therapy, case management, peer support specialist and other recovery support services, urine drug screening and medication management when applicable. Services are determined through assessment and screening with individualized treatment recommendations/plans. Services are provided to men, women and adolescents who are voluntarily seeking treatment and to those referred for treatment from the judicial system. ASAM placement criteria are utilized to determine appropriate treatment levels. Other groups available include process groups, psychoeducation, MRT, family interventions, gender specific treatment and skills-based groups. UUHP is partnered with the National Jewish Health online programs to offer smoking cessation groups.

A portion of outpatient services are offered through contracted network providers outside of the county when appropriate. These outpatient services are provided to increase treatment access and timeliness and to ensure an effective integration into the community as a transition from more intensive treatment to less intensive outpatient services.

**Youth Outpatient Services:** Outpatient youth services are offered in conjunction with school-based services and through the Provider Network. School-based providers work with HUB to ensure warm hand off's when youth transition into new services. In Kamas and Coalville, Youth services are
supported by HMHI-Park City in the South Summit School District and North Summit School District through Expansive Horizons Counseling and HMHI-Park City.

Please refer to the Healthy U Behavioral Health Network Provider link for a full list of network providers available at https://healthyubehavioral.com/

<table>
<thead>
<tr>
<th>Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Describe any significant programmatic changes from the previous year.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
</tr>
</tbody>
</table>

### 7) Intensive Outpatient (ASAM II.5 or II.1)  
Christine Simonette

<table>
<thead>
<tr>
<th>Form B - FY22 Amount Budgeted:</th>
<th>$153,046</th>
<th>Form B - FY22 Projected clients Served:</th>
<th>100</th>
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<td>80</td>
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<tr>
<td>Form B - Actual FY20 Expenditures Reported by Locals</td>
<td>$249,345</td>
<td>Form B - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>71</td>
</tr>
</tbody>
</table>

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

Intensive Outpatient services are provided at ASAM 2.1, through the Provider Network, primarily through the HMHI-Park City in Summit County. Intensive Outpatient (IOP) group therapy is offered five days a week at HMHI-Park City from 8-10 am or 5-7 pm depending on the day. Groups are located at 1820 Sidewinder Drive Ste.100, PC, UT 84040. Services are provided to men, women and adolescents who are voluntarily seeking treatment and to those referred for treatment from the judicial system. ASAM placement criteria are utilized to determine appropriate treatment levels. Other groups available include process groups, psychoeducation, MRT, family interventions, gender specific treatment and skills based groups. HUB is partnered with the National Jewish Health online programs to offer smoking cessation groups. Services are determined through assessment and screening with individualized treatment recommendations/plans.

Recovery WORKS is an intensive outpatient program designed to offer structure and support for adults who are dealing with issues related to substance use disorders. Patients work in a group therapy setting four nights a week for eight weeks. To ensure success after completion of treatment, continued weekly lifetime aftercare support is available for participants. The treatment team includes a board-certified addiction psychiatrist, licensed clinical social workers, licensed substance abuse counselors, and expressive therapists.

Elements of the program include:

- Comprehensive Substance Use Disorder Treatment addressing individual, family, relationship and environmental challenges
Utilization of Cognitive Behavioral Therapy (CBT), Motivational Enhancement (formerly MI), Acceptance and Commitment Therapy (ACT), and other empirical techniques within the most up-to-date, recovery treatment framework.

Collaboration with our addiction psychiatry and addiction medicine doctors and senior residents/fellows and therapists in our Recovery Clinic who incorporate the latest in recovery medications and recovery aides.

Therapeutic and educational support for program participants, and their friends and family members

Cognitive behavior treatment (CBT), and

Experiential therapy, which includes art and music therapy and ROPES challenge course activities, are integrated into the program weekly

The Recovery Clinic is for adults seeking treatment for substance use disorders and dual diagnosis treatment. Staffing includes board-certified psychiatrists, Licensed Clinical Social Workers and Mental Health Counselors who specialize in individual addiction treatment. As a teaching academy, the University Recovery Clinic is also staffed with senior residents and addiction trained fellows.

Services include:

- Medication Addiction Treatment Group (MAT Group)
- MAT is to be used with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders
- Education and practical skills for achieving recovery
- Process group to discuss recent struggles and/or upcoming challenges
- Consultation and evaluation
- Group and individual therapy
- Medication management
- Suboxone maintenance therapy
- Outpatient detoxification, if medically appropriate

ASAM 2.5 LOC is serviced through the UUHP network providers in SLC, day treatment providers (Odyssey House, Steps Recovery)

Youth Outpatient Services:

Outpatient youth services are offered through school-based services and through the contracted network providers. UUHP school-based providers work with the network providers to ensure warm hand-offs when youth transition into higher levels of care. In Kamas and Coalville, youth services are supported by HMHI Kamas BHC, HMHI Coalville BHC, and Expansive Horizons Counseling as well as school-based services for each area, South and North Summit. ASAM LOC 2.5, Day treatment is provided for adolescents through Odyssey House and TeenScope (a treatment program for teens ages 12–18 that helps teens and their parents) programs in SLC.

Please refer to the Healthy U Behavioral Health Network Provider link for a full list of network providers available at https://healthyubehavioral.com/

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

NA

Describe any significant programmatic changes from the previous year.

NA
8) Recovery Support Services

<table>
<thead>
<tr>
<th>Form B - FY22 Amount Budgeted:</th>
<th>$10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Form B - FY22 Projected clients Served:</td>
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</tr>
<tr>
<td>Form B - Actual FY20 Clients Serviced as Reported by Locals</td>
<td>0</td>
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Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider. For a list of RSS services, please refer to the following link:

Recovery support services target current patients, non-treatment seeking individuals and post treatment patients through assistance in creating and implementing recovery lifestyle plans/after care. Recovery support services are available to patients along with community referrals; HUB doesn’t require that an individual be in treatment to access RSS.

Examples of services offered to patients include; Fit To Recover (four pillars: Nutrition, Community Service, Creative Arts, and Fitness through group cooking classes, artistic endeavors, service outreach, and sports & exercise), Peer Support Specialist through HMHI-PARK CITY, Alcoholics Anonymous, Narcotics Anonymous, trauma informed yoga instruction through Tall Mountain Wellness PC, case management (Many of our clients face challenges with housing, employment, access to health care along with a variety of other needs. We have provided emergency temporary housing assistance and funding for medical services and medications) through HMHI-PARK CITY, psychoeducation and life skills groups offered through HMHI PC (both men and women specific groups-Prime for Life, Building Resilience and Seeking Safety) as well as other contracted providers in the network. Clients can be linked with educational opportunities and can obtain their GED or Adult High School Diploma.

Our Drug Court program emphasizes leadership roles in the higher phases of the program. Individuals are mentors to others in the program. Further programming is being developed to enhance alumni support through PSS regular check ins, up to 90 days post active treatment. Additionally, community resources are invaluable. Providers initiated collaboration with USARA to enhance peer mentoring in the county. PSS and CASE MANAGER currently contact patients who complete treatment, post discharge to offer RSS if needed. Case management offers transition out support services used to assess unmet basic needs to overcome barriers that interfere with long term recovery like funding, housing and job placement services.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

FY21 allocations and clients served were based on estimates received from Valley Behavioral Health. FY22 reflects updated cost efficiencies and service levels post-transition to HUB.
Describe any significant programmatic changes from the previous year.

NA

| Form B - FY22 Amount Budgeted: | $16,000 | Form B - FY22 Projected clients Served: | 60 |
| Form B - Amount Budgeted in FY21 Area Plan | $71,000 | Form B - Projected Clients Served in FY21 Area Plan | 60 |
| Form B - Actual FY20 Expenditures Reported by Locals | | Form B - Actual FY20 Clients Serviced as Reported by Locals | |

Describe the activities you propose to undertake and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Describe your policies and procedures for peer support.

Clients have access through the Provider Network to PSS for SUD patients by Certified Peer Support Specialist. The majority of PSS is provided through HMHI-Park City and CONNECT. Additionally, HMHI-Park City provides PSS groups and individual sessions within the Summit County Jail. PSS also runs groups in HMHI-Park City for all SUD programming, including Drug Court. Case managers are trained in CRAFT and extend group offerings throughout the year as well as connect with USARA to include offerings through their agency. Please see the above section on Recovery Support Services for full detail of peer supports offered.

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

Clients are identified for PSS after initial biopsychosocial screening and assessment as part of their treatment plan at the HMHI PC clinic.

Clients may also be referred to PSS through UUHP if a client is not being seen through the HMHIPC clinic. In the past, clients could also be referred to PSS through the school services, however those will be provided in FY22 through HMHIPC.

Describe your policies and procedures for peer support. Do Certified Peer Support Specialists participate in clinical staffings?

CPSS participate in weekly staff meetings for case conceptualization and best care practices. CPSS follow guidelines for CPSS services through DSAMH division directives and HMHI policies.

How is adult peer support supervision provided? Who provides the supervision? What training do supervisors receive?

The supervisor of HMHI-Park City’s PSS is a master's level clinician who meets with the PSS weekly for staffing and supervision.
10) Quality & Access Improvements

Describe how you will increase access to treatment services. Is there a waiting list for certain levels of care? What services are available to individuals who may be on a wait list?

The change from a staff model, with limited clinicians available, to a network model has greatly expanded access. HMHI-Park City is the backbone network provider and remains a resource for both Medicaid members and those receiving services from DSAMH funding. The network has expanded both the geographical and specialty options for residents.

Quality efforts have focused on expanding access and allowing residents a greater choice in how they receive services. UUHP also works with an External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), to conduct on-site and desk reviews to ensure the integrity of the Performance Measure Validation (PMV), alignment of policies and procedures with the state contract and federal regulations, and the Performance Improvement Project (PIP).

HUB utilizes DHS and County funding which makes services affordable to Summit County residents. HUB offers interpreter services through the Provider Network, primarily through HMHI, for Spanish speaking patients and other language needs. Currently there are 12 Spanish Speaking network providers in Summit County. HUB contracts with the Summit County jail and HMHI-Park City is the contracted treatment provider. This partnership allows for increased services in the jail including medication evaluation and management, crisis support, assessment and group psychoeducation and MRT courses. Additionally, follow-up care is coordinated with the HMHI-Park City. Doctors, clinicians, case managers and the peer specialist work to make transitions seamless for individuals.

UUHP care managers are new in Summit County, providing Care Management nurses to help people with their health care and community service needs. Care management is conscious of cultural and linguistic preferences of members and their supports. The Care Management program offers individual attention to help meet health care goals. Services include education, advocacy, and coordination of needed services. This program is no-cost for HUB members and unfunded residents who want care management nursing services.

We do not have a waiting list for services as the UUHP network model provides increased access to treatment in the county for SUD and MH services and therefore directs treatment to providers by specialty and location, rather than funneling all patients through the same channels.

Describe efforts to respond to community input/need. Describe your participation with key community partners (e.g.: Multi-Agency Coordinating Committees, Regional Advisory Councils, High Fidelity Wraparound teams, Local Interagency Councils, Local Recovery Community, Local Homeless Coordinating Committees, Peer Advocacy Groups, County Attorney, Law Enforcement, Local Education Agencies, Courts, Regional Healthcare Coalitions, and other partnership groups relevant in individual communities) shall occur consistently.
HUB works closely with community agencies including that Summit County Health Department, Connect (local MH non-profit), Vail Resorts wellness management, Summit County Recovery Foundation, Peace House, CJC, Summit County Justice Department, probation and local law enforcement, North Summit School District, South Summit School District, and the Summit County School District. These relationships provide an important way to promote services. In addition, the HUB website refers patients to the network providers and has additional information about services available. HUB outreach workers and those employees working in the community offer education to outside agencies. Recovery Support Specialists network with other recovery supports to broaden the array of opportunities for clients.

Every four years, Summit County conducts a community wide assessment specific to behavioral health which includes focus groups, telephone interviews, a community survey, and specific population surveys (Spanish community, educators, law enforcement, seniors, etc.). The results of this assessment are compiled into a public report and the results are utilized in updating the Summit County Behavioral Health Strategic Plan, which is approved by the Summit County. Traditionally, this would have been done in 2020, but was postponed due to wanting to allow HUB a full year of services and then COVID. The community assessment began telephone interviews in April with the community surveys being send out in June and focus groups in September.

What evidence-based practices do you provide? Describe the process you use to ensure fidelity?

HUB offers and supports professional training to ensure competency and fidelity. Many providers in the network have certifications in EBPs. The following is a list of some of the EBPs provided in the network:

1. Motivational Interviewing
2. CBT for Substance Abuse and Co-Occurring Disorders (Hazelden Curriculum)
3. MRT and DV-MRT
4. DBT
5. PTSD Treatments: Seeking Safety & Beyond Trauma & Building Resilience
6. Matrix Model for IOP
7. Substance Abuse and Criminal Behavior
8. Change Companies Curriculum
9. Thinking Errors
10. Anger Management
11. Behavioral Therapy
12. Family Therapy/ Multi-Family Group Therapy/CRAFT
13. Criminal Risk Assessment and Treatment
14. EMDR
15. Trauma Recovery Empowerment Model (TREM)
16. Men’s Trauma Recovery and Empowerment Model (M-TREM)

Staff meetings occur weekly between HUB and the HMHI-Park City Clinic to incorporate opportunities to discuss cases, in addition to one on one clinical supervision. Case consultation meetings are held monthly through HMHI. Clinical staff participate in consultation groups that meet to review case progress with senior clinicians through HMHI-Salt Lake, providing opportunities for learning and growth, burn out reduction and increased clinical support. HMHI-Park City staff training and staff meetings enhance coordination of care within the network and greater utilization of community resources.

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

Priorities for overall improvements in relations to services and programs in Summit County is guided by the Summit County Mental Wellness Strategic Plan, which is a data driven community developed plan designed to address gaps in service and monitor the quality of services provided in Summit County.
Based on this plan, Summit County transitioned to a full network model, which has served as a community win. For FY22, Summit County, in partnership with HUB and a variety of community partners is conducting the annual community assessment.

Every four years, Summit County conducts a community wide assessment specific to behavioral health which includes focus groups, telephone interviews, a community survey, and specific population surveys (Spanish community, educators, law enforcement, seniors, etc.). The results of this assessment are compiled into a public report and the results are utilized in updating the Summit County Behavioral Health Strategic Plan, which is approved by the Summit County. Traditionally, this would have been done in 2020, but was postponed due to wanting to allow HUB a full year of services and then COVID. The community assessment began telephone interviews in April with the community surveys being sent out in June and focus groups in September.

A copy of the most recent dashboard has been uploaded into Google.

**Identify the metrics used by your agency to evaluate substance use disorder client outcomes and quality.

Network Providers, uses the following metrics to evaluate outcomes and quality;

- OQ/YOQ measures at intake and at 30 day intervals
- Medication Assisted Treatment (MAT)
- Abstinence (via UA)
- Patient retention
- Improved housing and employment
- Rapid Accessing treatment after treatment completion or relapse
- Outpatient / Intensive Outpatient: Client outcomes at the time of completion of services in a discharge summary:
  - Goal / Objective attainment.
  - Patient progress and continuing care plan
  - PSS follow up measures and check in reports
  - Discharge Referrals to Recovery Support activities, identified and reviewed
  - Annual questionnaires and surveys
  - DLA-20 used as an outcome measure. Given at admission, every 90 days, and at discharge.
  - Youth SUD Services: Treatment completion/client retention
  - Abstinence/decreased rates of substance use
  - Engagement in school and other prosocial supports and activities
  - Legal involvement/Recidivism

- Additionally, the youth/adolescent program, through HMHI-PARK CITY, is working with the University of Utah’s Social Research Institute to identify how to increase support in the county.
  - Utilizes the DLA to guide and evaluate recovery planning. CASE MANAGERS use the DLA to identify client needs, assess areas where improved functioning is needed, and identify areas of strength that can be used to build recovery capital and develop a recovery plan. Progress is evaluated through ratings on objectives, as well as overall change scores.

**Describe your agency plan to maintain telehealth services in your area as agencies return to in-person service provision. Include programming involved. How will you measure the quality of services provided by telehealth?

UUHP intends to continue to provide telehealth options where appropriate and where preferred as a way to access services for all clients. This will is true even as in-person services have resumed. The choice to use telehealth will be made based on client preference and the availability of services.
Describe the activities you propose and identify where services will be provided. For each service, identify whether you will provide services directly or through a contracted provider, and how you will coordinate with the jail to ensure service delivery is adequate.

HUB, through HMHI-Park City, contracts with the Summit County Jail to provide MH/SUD treatment directly in the jail. With JRI and other funding, HMHI-Park City provides crisis services, case management, PSS, medication evaluation, individual and group services weekly. There are seven gender specific groups offered per week including MRT, trauma informed yoga, and life skills. The clinical manager of HMHI-Park City along with a team of providers was assembled to focus on the needs of the jail. The MDT meets on a monthly basis. These meetings address service delivery and workflow and complete any necessary patient staffing. HMHI-Park City clinical program manager is available by mobile phone to the jail staff and is contacted when needed. HMHI-Park City provides 3 hours of Psychiatry, 6 hours of clinical care and 4 hours of case management per week at minimum for this population.

Justify any expected increase or decrease in funding and/or any expected increase or decrease in the number of individuals served (15% or greater change).

Summit County has decided to provide more ongoing individual therapy with inmates as a way to lower the amount of crisis work that is required at the jail but also as a way to increase the potential willingness for inmates to participate in behavioral health services post incarceration and lower recidivism. The County has increased its funding support for judiciary involved individuals.

Describe any significant programmatic changes from the previous year.

Summit County through HMHI PC is increasing the amount of regular therapy services available to inmates as a way to provide better stabilization and decrease the amount of acute crisis services.

Describe current and planned activities to assist individuals who may be experiencing withdrawal (including distribution of Naloxone) while incarcerated or any efforts to use Medication-assisted treatment within a county jail or Prison. Identify all FDA approved medications currently provided within the jail(s).

HUB offers, through the network, MRT, Anger Management, life skills, wellness classes and crisis therapy to individuals who are incarcerated. Attendees may include individuals who are experiencing withdrawal and can be supported through these interventions. The Summit County jail currently does not provide medication-assisted treatment for any inmates. However, the HMHI-Park City prescriber (Dr. Weeks, HUB Medical Director) is available to consult the jail medical staff when necessary. MAT services through the HMHI-Park City are available upon release and the team coordinates care for clients after their release to ensure ongoing treatment, follow-up care.

MAT for detox is one of the items that is being discussed with the jail, but there is no change in policy at this time.

The SAPT block grant regulations limit SAPT expenditures for the purpose of providing treatment services in penal or correctional institutions of the State. Please identify whether your County plans to expend SAPT block grant dollars in penal or correctional institutions of the State.

No (Please see question about SAPT)
Describe your partnerships with local Health Departments, accountable care organizations (ACOs), federally qualified health centers (FQHCs) and other physical health providers.

HUB is an ACO so many Medicaid members have a de facto integrated Medicaid plan with UUHP as their physical Medicaid ACO. UUHP also has a good relationship with the other three ACOs. We are working on the integrated pilot program along the Wasatch Front, and taking those lessons learned to improve in Summit County. Also, we are taking our relationships with the surrounding counties to collaborate further and work on ways to improve access and services.

HUB and the Division of Behavioral Health, which is a part of the Summit County Health Department, have a strong working relationship. Through weekly meetings with the Director of Behavioral Health and participation in Mental Wellness Alliance committees, HUB is a well-regarded partner for our community. We are truly grateful to have them here.

Describe efforts to integrate clinical care to ensure individuals physical, mental health and substance use disorder needs are met.

HUB Network Providers service both mental health and substance use patients and provide access to the entire University care system. Resources are available through the network to assist clients with the skills, knowledge and strategies for a healthy lifestyle in recovery and whole person-centered care. Providers assess emotional, physical, behavioral health and other needs and plan services with clients to obtain interventions and assistance with community partners, network providers, university resources or other outside agencies. Partnerships with UUHP add the support of care management services which assists treatment providers by supporting elements of physical wellness through nurses who evaluate patients and link them to resources in the network both in Summit County and in SLC.

HUB oversees both Mental Health and Substance Use Disorder treatments within the Network. It also includes Care Managers who work with individuals on coordinating physical and behavioral health services to best integrate care and prevent redundancy or holes in care. HUB has the advantage of being an ACO, so we have a large nursing care management team that excels in behavioral and physical care management.

Describe your efforts to incorporate wellness into treatment plans and how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy, Nicotine).

Network Providers ask health and wellness questions as part of the initial evaluation. Referrals are made to the HUB and the Summit County Health Department for services as needed. HUB Network Providers coordinate with medical staff and local primary care physicians and care managers to access and follow up with medical care. Referrals occur to and from the University Health Redstone Clinic in Kimball Junction.

For clients with co-occurring MH/SUD conditions who receive psychiatric care, coordination with primary care physicians is conducted by documentation of visits with psychiatric medication providers to the primary care physician as needed. Regular monitoring of BMI, and vital signs are conducted for all consumers receiving medication management. Metabolic lab work monitoring (lipid panel, glucose) is conducted for those on antipsychotics, and when abnormalities are discovered, the patient is notified, as well as the consumer’s primary care physician. If needed, care managers and case managers may assist clients in following through with visits with their primary care physician to address medical concerns. For those at risk of blood borne illnesses (hepatitis C, HIV), education is given about the risk, as well as they are recommended to be seen at their PCP or health department for screening and
treatment if needed. For patients not seeing a prescriber in the network, therapists address healthcare
issues as part of our regular assessment process. Clients are routinely assessed for their HIV, TB,
Hepatitis, MAT status and willingness to engage in seeking treatments. Health care issues are referred
either to the client’s primary care physician or People’s Health Clinic or the Health Department.
Therapists follow the status of their client’s health care behaviors during treatment, and at evaluation /
treatment plan updates.

HUB contracts with National Jewish Health for online nicotine cessation at all levels of care. Smoking
Cessation posters are in group rooms and around facilities. Quit-line, brochures and information
booklets are provided to clients. DBH will continue to work with clients to engage them in nicotine
prevention and elimination efforts. DBH will continue to address tobacco use by identifying this element
in the initial assessment. DBH will continue to enhance resources and referrals for those who want to
stop / decrease their use. Those interested in using prescription medications and nicotine replacement
treatment to aid them are offered as part of their treatment.

Describe your plan to reduce tobacco and nicotine use in SFY 2021, and how you will maintain a
tobacco free environment at direct service agencies and subcontracting agencies. SUD Target=
reduce nicotine use to 4.8 in 2021 in TEDs.

HMHI-PC refers clients to the National Jewish Health quitline which offers targeted counseling as well
as nicotine replacement therapy (NRT). The clinic is also a smoke free environment and a client who
uses nicotine will have that added to their treatment plan.

<table>
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<tr>
<th>13) Women’s Treatment (WTA and WTX)</th>
<th>Rebecca King</th>
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<tr>
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Describe the evidence-based services provided for women including gender-specific substance
use disorder treatment and other therapeutic interventions that address issues of trauma,
relationships, sexual and physical abuse, vocational skills, networking, and parenting.

Services for women are provided by the Provider Network and on-site at HMHI-Park City and the
Peace House. These services include individual treatment, group therapy and case management
services. Women are also screened for other factors including pregnancy and are provided immediate
access to services and connected with appropriate community resources. HUB is contracted with the
House of Hope for residential services. A gender specific, Seeking Safety Trauma and a DBT group is
established for women and is run one evening per week. Case management services are also provided
and assist with housing needs, access to medical care, obtaining appropriate benefits among other
activities.

Describe the therapeutic interventions for children of clients in treatment that addresses their
developmental needs, their potential for substance use disorders, and their issues of sexual
and physical abuse and neglect. Describe collaborative efforts with DCFS for women with children at risk of, or in state custody.
As part of the assessment process, children are evaluated and treated. Services can be provided on-site with specific Network Providers and/or therapists. These providers work closely with DCFS, the Juvenile Court, and community partners like Peace House to support children at risk and their mothers. Providers in the network, like HMHI-PARK CITY, collaborate with the Children's Justice Center (CJC), MDT, to support youth and families. Providers participate in the System of Care model which identifies and provides services to dysfunctional family systems and seeks to meet needs by connecting and coordinating family involvement with several community and network supports with the goal of rehabilitation.

UUHP contracted providers who focus on youth and women prioritize care for families. Families involved with DCFS may have children in state custody or are at risk of losing custody. For women in residential treatment and with other extenuating circumstances, contracted providers work with DCFS caseworkers to support and facilitate visitation schedules. At HMHI-PARK CITY, clinical management stays connected to DCFS to develop relationships and communication about families in services and in addition works closely with treatment courts to facilitate case information and services for women and children in this process.

Describe the case management, child care and transportation services available for women to ensure they have access to the services you provide.

UUHP provides these services through the contracted network provider model. Case management services are provided to both children and parents in homes, schools, and in the HMHI-Park City. Additionally, a Family Resource Facilitator (FRF) is available to work with families in the network. The FRF coordinates care by attending staff meetings at HMHI-PARK CITY weekly. Transportation is limited to some patients in the Summit County area. The case manager and FRF are available to travel to patients homes to provide services.

Patients in services have access to a Recovery Support (RSS) through case management and peer support. Coordination for child care through community resources and natural supports, connecting patients to community and vocational resources and working with the Peace House, in DV situations, in specific circumstances to coordinate services. To assist clients with transportation issues, Recovery Support Services assess for need and offer training in public transportation use, providing temporary bus passes, utilizing natural and community supports, and occasionally providing transportation to treatment appointments.

Describe any significant programmatic changes from the previous year.

The amount of money provided for WTA appears to have decreased significantly for this year. We will make up for it in other funding.

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

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

NA
Please describe the proposed use of the WTX funds

NA

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

NA

Submit a comprehensive budget that identifies all projected revenue and expense for this program by email to: bkelsey@utah.gov

NA

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<tr>
<th>14) Adolescent (Youth) Treatment</th>
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Describe services provided for adolescents and families. Please identify the ASAM levels of care available for youth.

UUHP has contracted providers in the network to support outpatient level services to youth with substance use disorders. In Summit County, the HMHI-Park City offers limited standard outpatient services on site. Teen SUD groups are not available at this time at HMHI-PARK CITY. The goal is to provide Teen MRT and other SUD groups this year as the clinic develops. Teen group therapy is available through contracted providers, school-based services. Youth placement for treatment is determined by ASAM levels of care and screening and assessment through contracted network providers. For court mandated youth SUD assessment and urine drug testing, HMHI-PARK CITY will support assessments and provide or refer treatment into the network. The SASSI, URICA, YOQ (for parent and child) and ACE assessments are used to measure treatment needs. Providers use assessment that evaluates co-occurring mental health and substance use disorders. Treatment is provided based on individual and developmentally appropriate needs. Families are encouraged to participate in treatment. All clinicians are Master level therapists and receive training in mental health and substance use disorder treatment. In addition, clinicians have opportunities throughout the year for additional trainings. Staff complete required CEUs for their licensure. Clinicians have been trained in Seeking Safety, an evidence-based treatment for substance use and PTSD. Staff have also been involved in ongoing training on trauma-informed care. Therapists have weekly individual supervision and staffing. Co-occurring assessments and treatment are standard. Providers are trained in TF-CBT and trauma-informed care. Patients may participate in mental health therapy groups and can be referred for med management. Patients are referred and assessed for developmental delays. Recovery support services, through CASE MANAGER, have been implemented in youth substance abuse, with a significant focus on outreach to both engage clients in treatment and retain them once they are in.
Providers are trained in MI to engage clients. Motivational incentives are used to retain clients. Outreach is used to contact clients who have disengaged. Adolescent clients are involved in developing their treatment plans. Youth are referred for day treatment and residential program to contracted providers like Odyssey House, HMHI TeenScope and various other programs. Program evaluation is done quarterly using TEDS data collected at admission vs discharge. Point-in-time evaluations are completed annually via the MHSIP.

HMHI-PARK CITY program is currently working with the University of Utah’s Social Research Institute for a needs assessment/program evaluation of youth/adolescent and young adult SUD treatment in Summit County. SRI is assisting with identification of and measurement of outcomes including parent/youth satisfaction and parental attitudes/beliefs. The SRI will help identify services gaps and a plan of improvement.

**Describe efforts to engage, educate, screen, recruit, and engage youth. Identify gaps in the youth treatment referral system within your community and how you plan to address the gaps.**

UUHP, HUB provider search, University Redstone Health Center, youth mental health clinicians, juvenile probation and court, school-based program, and parents/other family members provide primary referrals for youth SUD treatment needs in the county. Youth are referred for assessment to providers in the UUHP contracted network and recommendations are made for treatment. Providers work with community partners and contracted resources to meet the needs of youth in the county. The HMHI-PARK CITY works with the CJ and juvenile probation officers, school-based therapists and providers to identify youth at risk with substances but do not have any related legal charges. When youth are identified, contracted providers work together to initiate services and encourage treatment. CASE MANAGER and PSS will outreach families to discuss concerns and offer an evaluation.

**Describe collaborative efforts with mental health services and other state child serving agencies (DCFS, DJJS, SOC, DSPD, Juvenile Court) and any significant programmatic changes from the previous year.**

As part of the assessment process children are evaluated and treated. Services can be provided on-site with specific UUHP network providers and/or therapists see children/youth and adolescents in school-based settings. These providers work closely with DCFS, the Juvenile Court and community partners like Peace House to support children at risk and their mothers. Providers in the network, like HMHI-PARK CITY, collaborate with the Children’s Justice Center (CJC), MDT, to support youth and families. Providers participate in the System of Care model which identifies and provides services to dysfunctional family systems and seeks to meet needs by connecting and coordinating family involvement with several community and network supports with the goal of rehabilitation.

UUHP contracted providers who focus on youth and women prioritize care for families. Families involved with DCFS may have children in state custody or are at risk of losing custody. For women in residential treatment and with other extenuating circumstances, contracted providers work with DCFS caseworkers to support and facilitate visitation schedules. At HMHI-PARK CITY, clinical management stays connected to DCFS to develop relationships and communication about families in services and in addition works closely with treatment courts to facilitate case information and services for women and children in this process.

Significant coordination occurs between program staff and the juvenile court including weekly staffing meetings (with the appropriate releases of information in place). If clients are involved with DCFS, frequent coordination also occurs between the appropriate parties, which may include the biological family, the foster family, the caseworker, and the guardian ad litem.
Describe Specialty Court treatment services. Identify the services you will provide directly or
through a contracted provider for each type of court (Adult, Family, Juvenile Specialty Courts, DUI). How will you engage and assist individuals with Medicaid enrollment throughout their episode of care.

Summit County offers the 3rd District Adult Felony Drug Court. Services are designated to the UUHP contracted treatment provider for Drug Court, HMHI-PARK CITY. Services provided include; Screening and assessment, individual therapy, group Intensive Outpatient therapy, RSS through case management and PSS directly. In addition, urine drug screening is located at the HMHI-PARK CITY through the Averhealth forensic lab. Patients call the test line daily and tests are assigned randomly with a unique PIN ID. Results are provided the next day in most cases. Residential treatment programs and detoxification services are arranged through contracted providers (VOA, HMHI, Odyssey House, First Step House, House of Hope, etc..) when indicated. Case managers and HMHI-PARK CITY staff work with UUHP to determine funding support, DHS and Medicaid, and work with participants for eligibility and enrollment.

Describe the MAT services available to Specialty Court participants. Will services be provided directly or by a contracted provider (list contracted providers).

MAT is available to Drug Court participants and prescriptions and treatment are provided through the HMHI-PARK CITY, contracted DC provider through UUHP. HMHI-PARK CITY has a medical staff including a psychiatrist and APRN who prescribe medications directly. Funding is also available to assist in purchasing needed medications. Medications are not distributed at the HMHI-Park City, but medications are monitored and assessed on site. All specialty court clients are able to participate in all forms of FDA approved MAT medications, except methadone is provided through Project Reality if needed. Urine drug screening occurs onsite through Averhealth forensic lab and results are returned the next day in most cases. The MAT protocol requires patients to be in treatment with MAT medications and are given specific information regarding policies when services begin.

Describe your drug testing services for each type of court including testing on weekends and holidays for each court. Identify whether these services will be provided services directly or through a contracted provider. (Adult, Family, Juvenile Specialty Courts, etc).

Urine Drug Screening is done in accordance with DSAMH directives. UUHP uses contracted provider HMHI PC onsite Averhealth forensic lab for urine drug screening. A random schedule for testing is created weekly through Aver health and monitored closely by staff at HMHI-PARK CITY.

List all drug court fees assessed to the client in addition to treatment sliding scale fees for each type of court (Adult, Family, Juvenile Specialty Courts, etc).

DC patients pay fees based on ability and payment plan eligibility. DC members use DHS funds or Medicaid for all clinical services, including UA tests.

Describe any significant programmatic changes from the previous year (Adult, Family, Juvenile Specialty Courts, etc).

NA

<table>
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<tr>
<th>16) Justice Services</th>
<th>Thomas Dunford</th>
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<tr>
<td><strong>Form B - FY22 Amount Budgeted:</strong></td>
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Describe screening to identify criminal risk factors.

The Risk and Needs Triage (RANT) tool is evidence-based and yields an immediate and easily understandable report that classifies offenders into one of four risk/needs quadrants, each with different implications for selecting suitable correctional decisions by judges, probation and parole officers, attorneys, and other decision-makers. The RANT is administered by HMHI-PARK CITY case managers by order of the court. The 19-item instrument is completed in less than fifteen minutes and reports enable real-time placement. This assessment tool is used most often to identify prospective Summit County Drug Court Participant's (high risk /high need). According to the RANT, individuals who score high risk/high need are best suited for intensive supervision and clinical services. Those scoring low risk/high need may be best suited for a lower level of criminal justice supervision, but more intensive clinical services. A high risk/low need score may require more intensive supervision and less intensive clinical services. A low risk/low need score may be best suited to a less intensive supervision, less intensive clinical prevention-based intervention. RANT risk/need domains measured include: Age of onset of criminal activity and substance use, deviant peer affiliations, prior failure in drug/alcohol rehabilitation and diversion programs, prior felony or serious misdemeanors, unstable living arrangements, unemployment, physical addiction to drugs/alcohol, and chronic medical and mental health conditions.

Identify the continuum of services for individuals involved in the justice system. Identify strategies used with low risk offenders. Identify strategies used with high risk offenders.

UUHP contracts with HMHI-PARK CITY and the Summit County District court to administer the RANT screening instrument to coordinate other information from law enforcement or jail services. The SASSI and URICA is also utilized for substance use disorders screening prior to intake appointments. Services include case management, skills development, individual, family and group therapy, and psychiatric evaluation and medication management. UUHP network providers do not provide specific sex offender treatment but provides mental health and substance use disorder treatment to those with prior convictions for sex offenses or violent crimes as appropriate in an outpatient setting: Treatment modalities include:

- MRT
- CBT
- Motivational Interviewing
- Seeking Safety
- MAT

Patients seeking services complete clinical assessment incorporating the assessment requirements from Rule and treatment planning pertaining to Criminal risk factors such as Moral Reconation Therapy and other evidenced based manuals and literature that address criminal risk, substance use and mental illness. Patients are also evaluated using the CSSR-S and Stanley Brown Safety Plan for suicide risk assessment and safety planning.

Recovery Support Services, PSS and CASE MANAGER, aim to reduce criminal risk factors and recidivism through supporting clients in meaningful recovery engagement. Recovery support provides services help clients remove barriers to their recovery by connecting them with individually engaging recovery activities, vocational support, stable housing search, and accessing possible assistance programs. Recovery support also focuses on keeping clients engaged in recovery through outreach to clients deemed high risk and follow-up contact with clients who successfully complete treatment.

Identify a quality improvement goal to better serve individuals involved in the criminal justice system. Your goal may be based on the recommendations provided by the University of Utah Criminal Justice Center in SFY 2020.
Currently the HMHI clinic and UUHP are working with Utah Criminal Justice Center, CPC, to evaluate JRI services. The evaluation supports quality improvement goals. Goals will be set and the evaluation complete by Summer 2021. Improvements will be focused on direct services, fidelity to EBPs, training, staffing and programming.

Identify coalitions, planning groups or councils (or other efforts) at the county level working to improve coordination and outcomes for adults involved in the justice system.

In addition to the community JRI committee, the Summit County Mental Wellness Alliance and Health Department host a community Law Enforcement and Judicial Affairs Coalition comprised of key stakeholders representing the Health Department, Public Defenders, County Attorney’s Office, SCSO, PCPD, Summit County Council, Park City Council, Summit County Recovery Foundation, HMHI, and HUB.

Identify efforts as a community stakeholder for children and youth involved with the juvenile justice system, local DCFS, DJJS, Juvenile Courts, and other agencies.

HMHI coordinates with the Summit County Children’s Justice Center multidisciplinary team (MDT) weekly to provide crisis services, assessments, individual and group therapy. The MDT consists of law enforcement, CJC staff, Treatment (HMHI PC), contracted community providers, medical staff, DCFS and The County Attorney's office. The CJC has a new home, specifically designed (The Zebra House) for providing a safe and warm environment where interviews and direct services are conducted with children and families. HMHI PC coordinates with DCFS to provide treatment services, including crisis appts. (individual and family therapy) on a regular basis.

Provide data and outcomes used to evaluate Justice Services.

MSSHIPS, TEDs Data, arrests, successful completion of treatment and RANT assessment is completed upon admission to determine eligibility for services. OQ evaluations are used for ongoing assessment of clients.

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

Describe all current activities in place in suicide prevention, including evaluation of the activities and their effectiveness on a program and community level. Please include a link or attach your localized suicide prevention plan for the agency.

See Form A

Describe all currently suicide intervention/treatment services and activities including the use of evidence based tools and strategies. Describe your policies and procedures for suicide screening, risk assessment, and safety planning as well as suicide specific treatment and follow
Describe all current strategies in place in suicide postvention including any grief supports. Please describe your current postvention response plan, or include a link or attach your localized suicide postvention plan for the agency and/or broader local community.

See Form A

Describe your plan for coordination with Local Health Departments and local school districts to identify roles and support implementation of a community postvention plan in alignment with the state Community Postvention Toolkit.

See Form A

For Local Authorities participating in the Garrett Lee Smith State Youth Suicide Prevention and Early Intervention Grant Program summarize your implementation plans for implementing skill based programming, gatekeeper training, community or school based screening activities, and crisis follow up services after inpatient or emergency department visits. (note: this can be done in the box below, or by linking/attaching your most current report).

For those not participating in this grant program, please indicate “N/A” in the box below.

See Form A

For Local Authorities participating in the Comprehensive Suicide Prevention grants describe your implementation plans for primary prevention programs, suicide intervention supports including gatekeeper training, and community postvention planning. (note: this can be done in the box below, or by linking/attaching your most current report).

If any of the following project deliverables are currently available, please link them here or attach them to your submission.

1. By year 2, funding recipients shall submit a written comprehensive suicide prevention plan that is in alignment with the Utah Suicide Prevention State Plan and by year 2, funding recipients shall submit a written postvention response plan and communication protocol for their organization.
2. By year 3 funding recipients shall submit a written community postvention response plan.

For those not participating in this project, please indicate, “N/A” below.

See form A

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

See form A
FORM C - SUBSTANCE USE PREVENTION NARRATIVE

With the intention of helping every community in Utah to establish sustainable Community Centered Evidence Based Prevention efforts, fill in the following table per the instructions below.

Not every community will be at optimal readiness nor hold highest priority. This chart is designed to help you articulate current prevention activities and successes as well as current barriers and challenges. Please work with your Regional Director if you have questions about how to best report on your communities. For instructions on how to complete this table, please see the Community Coalition Status Tool [here](#).

List every community in your area defined by one of the following:
1. serving one of the 99 Small Areas within Utah
2. serving the communities that feed into a common high school
3. any other definition of community with DSAMH approval.

*All “zero” or “no priority” communities may be listed in one row

<table>
<thead>
<tr>
<th>CCEBP Community</th>
<th>CCEBP Community Coalition Status (see tool here)</th>
<th>Priority</th>
<th>Notes/Justification of Priority</th>
<th>List of Programs Provided (if applicable)</th>
<th>Evidence Based Operating System (e.g. CTC, CADCA Coalition Academy, PROSPER)</th>
<th>Links to community strategic plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Park City</td>
<td>G.</td>
<td>High</td>
<td>CTC established and functioning at a high level within many community sectors involved. Prevention Coordinator part of the executive board.</td>
<td>PFL, PFL Spanish, PFL teen, STEP parenting class Spanish and English, Botvin Prescription drug, PE, presentation s in schools and community events and presentation s.</td>
<td>Coordinator has been trained in CADCA Academy and is working w/ CTC Coach.</td>
<td>See CTC strategic plan at the end of document.</td>
</tr>
<tr>
<td>South</td>
<td>A5.</td>
<td>Medium</td>
<td>We have been</td>
<td>PFL, PFL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summit</td>
<td>Working with the area for many years and based on conversations with the superintendent, health educators, school counselors and community members they don’t feel the community is ready to develop a coalition.</td>
<td>Spanish, PFL teen, STEP parenting class. Spanish and English, Botvin Prescription drug, PE, presentations in schools and community events and presentations.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
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<td>-------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Summit A5.</td>
<td>We have been working with the area for many years and based on conversations with the superintendent, health educators, school counselors and community members they don’t feel the community is ready to develop a coalition.</td>
<td>PFL, PFL Spanish, PFL teen, STEP parenting class. Spanish and English, Botvin Prescription drug, PE, presentations in schools and community events and presentations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Area Narrative**

For each community identified in the table above, please outline strategic steps the Local Authority is planning to do to improve Community Centered Evidence Based Prevention. A minimum response is at least two sentences per community identified.

Example:
Community: Hurricane
Because Hurricane is identified at Status D2 and High Priority, Southwest Behavioral Health will do...to see these changes in the community.

Park City:
CTC is well accepted in the community with the majority of the sectors represented. The prevention coordinator is a member of the executive team. Summit County Health Department Prevention Team will work on confirmation and expansion. Efforts are in place, community members feel comfortable utilizing services and they support expansion. Local data will be obtained and analyzed when available. Current EB services will be evaluated to measure effectiveness.

North Summit:
Summit County Health Department Prevention Team has been working on building capacity, community readiness and to activate leaders in the planning process. The team will continue to engage key leaders in the community to prepare for a coalition in the future.

South Summit:
Summit County Health Department Prevention Team has been working on building capacity, community readiness and to activate leaders in the planning process. The team will continue to engage key leaders in the community to prepare for a coalition in the future.

**Communities That Care Strategic Plan**

Our VISION is a world of connection, vitality and wellbeing where kids and families thrive.

Our MISSION is to collaboratively improve the lives of youth and families by fostering a culture of health through prevention.

Our VALUES:

- **Compassion:** We come from a place of love and care. We seek to understand and empathize.
- **Integrity:** We practice our values. Our solutions are interrelated.
- **Commitment:** We don’t just talk, we act.
- **Equity:** Inclusive voices create better outcomes
- **Collaboration:** The solutions are within our community.
Strategic Objectives:

1. **Convene** the youth serving organizations of Summit County to collaborate and partner in assessment, planning, implementation of the strategic plan.
2. **Educate** youth serving organizations on best practices, based in prevention science.
3. **Collaborate** with our coalition members and other youth focused community organizations to elevate and expand their programs and services.
4. Advance **equity and inclusion** within our organization and coalition
5. **Build capacity** for prevention work in Summit County.

Priority Risk and Protective Factors: Selected by the Coalition in January 2020

<table>
<thead>
<tr>
<th>Protective Factor</th>
<th>Strategy</th>
<th>Domains of Focused Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rewards for positive social involvement</td>
<td>Fostering Community Connectedness</td>
<td>Community and Family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Factors</th>
<th>Strategy</th>
<th>Domains of Focused Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perceived risk of substance use</td>
<td>Education Awareness</td>
<td>Family and Community</td>
</tr>
<tr>
<td></td>
<td>Skill building</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Culture Change</td>
<td></td>
</tr>
<tr>
<td>Parental Attitudes</td>
<td>Education Awareness</td>
<td>Family and Community</td>
</tr>
<tr>
<td></td>
<td>Skill building</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Culture Change</td>
<td></td>
</tr>
</tbody>
</table>
### Goals:

<table>
<thead>
<tr>
<th>Problem behavior</th>
<th>Lifetime alcohol use – all grades</th>
<th>Outcome statement: We will reduce lifetime alcohol use across all grades by 25% from 20.8% to 15.6% by 2021 as measured by the SHARP survey.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 Baseline</td>
<td>20.8%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problem behavior</th>
<th>Lifetime e-cigarette use – all grades</th>
<th>Outcome statement: We will reduce lifetime e-cigarette use across all grades by 10% from 6.6% to 6% by 2021 as measured by the SHARP survey.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 Baseline</td>
<td>6.6%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Problem behavior</th>
<th>Youth drinking at home with parent permission</th>
<th>Outcome statement: We will reduce youth drinking at home by 15% from 67.7% (of youth reporting alcohol use) to 57.55% (of youth reporting alcohol use) by 2021 as measured by the SHARP survey.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 Baseline</td>
<td>67.7%</td>
<td></td>
</tr>
</tbody>
</table>
### Problem behavior

<table>
<thead>
<tr>
<th>Contemplated suicide – all grades</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 Baseline</td>
</tr>
<tr>
<td>13%</td>
</tr>
</tbody>
</table>

**Outcome statement:** We will reduce youth contemplating suicide across all grades by 10% from 13% to 11.7% by 2021 as measured by the SHARP survey.

### Problem behavior

<table>
<thead>
<tr>
<th>Lifetime marijuana use – all grades</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017 Baseline</td>
</tr>
<tr>
<td>12.1%</td>
</tr>
</tbody>
</table>

**Outcome statement:** We will reduce lifetime marijuana use across all grades by 17% from 12.1% to 10% by 2021 as measured by the SHARP survey.

### Risk Factor

<table>
<thead>
<tr>
<th>Perceived risk of substance use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
</tr>
<tr>
<td>2017 Baseline</td>
</tr>
<tr>
<td>Individual/peer</td>
</tr>
<tr>
<td>40.8%</td>
</tr>
</tbody>
</table>

**Outcome statement:** We will reduce the perceived risk of substance use by 15%, from the baseline of 40.8% to 34.7% by 2021 as measured by the SHARP survey.

### Risk Factor

<table>
<thead>
<tr>
<th>Parental attitudes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
</tr>
<tr>
<td>2017 Baseline</td>
</tr>
<tr>
<td>Family</td>
</tr>
</tbody>
</table>
### Parental attitudes favorable to antisocial behavior

<table>
<thead>
<tr>
<th>Parental attitudes favorable to antisocial behavior</th>
<th>38.9%</th>
</tr>
</thead>
</table>

### Parental attitudes favorable to substance use

<table>
<thead>
<tr>
<th>Parental attitudes favorable to substance use</th>
<th>17%</th>
</tr>
</thead>
</table>

**Outcome statement:** We will reduce parental attitudes favorable to substance use by 12% from 17% to 15%, and we will reduce parental attitudes favorable to antisocial behavior by 15% from 38.9% to 35% by 2021 as measured by the SHARP survey.

### Risk Factor

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Depressive Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>2017 Baseline</td>
</tr>
</tbody>
</table>

### Individual/peer

| Individual/peer             | 27.8%               |

**Outcome statement:** We will reduce depressive symptoms by 15% from 27.8% to 23.63% by 2021 as measured by the SHARP survey.

### Protective Factor

<table>
<thead>
<tr>
<th>Protective Factor</th>
<th>Rewards for Pro-Social Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain</td>
<td>2017 Baseline</td>
</tr>
</tbody>
</table>

### Family

| Family                             | 84.2%                               |

### Community

| Community                          | 49.4%                               |

### Average of all domains

| Average of all domains             | 70%                                |
Outcome statement: We will increase rewards for prosocial involvement in Summit County in the community and family domains by increasing our average 20%, from the baseline average of 70% to an average of 84% by 2021 as measured by the SHARP survey.

Objectives:

<table>
<thead>
<tr>
<th>Priority risk factor</th>
<th>Mental health, targeting depressive symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant outcome statement</td>
<td></td>
</tr>
</tbody>
</table>

Outcome statement: We will significantly increase awareness that depressive symptoms may take various forms and attitudes such as stigma within the family as measured by pre/post tests.

Outcome statement: We will significantly increase positive parental modeling for parents/families as measured by pre/post tests.

<table>
<thead>
<tr>
<th>Priority risk factor</th>
<th>Parental attitudes favorable to substance use and anti-social behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant outcome statement</td>
<td></td>
</tr>
</tbody>
</table>

Outcome statement: We will significantly increase parents’ skills in articulating clear standards of behavior regarding “no substance use” for youth as measured by the SHARP data and pre/post surveys.

Outcome statement: We will significantly decrease parental attitudes for substance for kids as measured by the SHARP survey.

<table>
<thead>
<tr>
<th>Priority risk factor</th>
<th>Perceived risk of substance use</th>
</tr>
</thead>
</table>

Participant outcome statement

Outcome statement: We will significantly increase knowledge surrounding substance abuse and associated risk factors for 6th graders as measured by SHARP.

Outcome statement: We will significantly increase parents’ ability to talk with children regarding basic knowledge and risks of substance use for kids as measured by pre/post surveys.

---

Strategic Plan 2020-2021

<table>
<thead>
<tr>
<th>Due Date</th>
<th>Tactics</th>
<th>Strategic Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2020</td>
<td>Collaborating Around Risk and Protection</td>
<td>Educate</td>
</tr>
<tr>
<td>June 2020</td>
<td>Rewilding Mental Health webinar</td>
<td>Educate</td>
</tr>
<tr>
<td>July 2020</td>
<td>Rewilding Childhood webinar</td>
<td>Educate</td>
</tr>
<tr>
<td>September 2020</td>
<td>Resiliency training</td>
<td>Educate</td>
</tr>
<tr>
<td>October 2020</td>
<td>One Trusted Adult Training</td>
<td>Educate</td>
</tr>
<tr>
<td>October 2020</td>
<td>Katz data as a tool</td>
<td>Educate</td>
</tr>
<tr>
<td>Date</td>
<td>Activity Description</td>
<td>Action</td>
</tr>
<tr>
<td>-------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>December 2020</td>
<td>Develop strategy and tactics for community connectedness: Tribe Outside, Acts of Care</td>
<td>Convene</td>
</tr>
<tr>
<td>January 2021</td>
<td>Perceived risk of substance use awareness campaign in English and Spanish on KPCW</td>
<td>Educate</td>
</tr>
<tr>
<td>January 2021</td>
<td>Increase coalition membership by 10 people in youth, business, civic engagement and parent domains</td>
<td>Build Capacity</td>
</tr>
<tr>
<td>January 2021</td>
<td>Increase participation of youth in our coalition by 5 individuals</td>
<td>Convene and Collaborate</td>
</tr>
<tr>
<td>March 2021</td>
<td>Guiding Good Choices – hold 4 classes depending upon availability of online course materials</td>
<td>Educate</td>
</tr>
<tr>
<td>March 2021</td>
<td>Youth Mental Health Toolkit</td>
<td></td>
</tr>
<tr>
<td>March 2021</td>
<td>Social Development Strategy training</td>
<td>Educate</td>
</tr>
<tr>
<td>October 2021</td>
<td>SHARP data assessment</td>
<td>Collaborate</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Partner around community events</td>
<td>Convene</td>
</tr>
<tr>
<td>Ongoing</td>
<td>- Student Success Panel</td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>- Social Media Risk Panel</td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>- Nature Bathing</td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>- Suicide Prevention – COOK Foundation</td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>Participate in learning cohort with PCCF Translation of video blog</td>
<td>Advance equity and inclusion</td>
</tr>
<tr>
<td>Ongoing</td>
<td>Wide representation in coalition</td>
<td></td>
</tr>
<tr>
<td>Ongoing</td>
<td>Diversity on exec. committee</td>
<td></td>
</tr>
</tbody>
</table>
Create a Logic Model for each program or strategy funded by Block Grant Dollars, PFS, SOR, SPF Rx or State General Funds.

1. Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prime for Life English</td>
<td>Client payments:$4,200 Block Grant Funds:$500</td>
<td>Yes</td>
</tr>
<tr>
<td>Agency</td>
<td>Tier Level:</td>
<td></td>
</tr>
<tr>
<td>Summit County Health Department</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal</th>
<th>Factors</th>
<th>Focus Population: U/S/I</th>
<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Indicated</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Short</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Long</td>
</tr>
</tbody>
</table>
### Logic

- **Reduce adult binge drinking.**
- **Parental Attitudes Favorable to ATOD.**
- 40 Summit County residents that speak English who are 18 yrs. old or older, who are arrested for alcohol or drug related charges and are referred by the court, themselves or their therapists.
- **Offered every other month at U of U, 4 hours per class, 4 classes per session for a total of 16 hours.**
- **Parental Attitudes in all grades Favorable to ATOD will decrease from 17.4% in 2019 to 16.4% by 2023.**
- **Adult binge drinking will decrease from 16.3% in 2018 to 13% by 2028.**

### Measures & Sources

|--------------------|-----------------------------|-------------------|----------------------------------|---------------------|---------------------------------|-----------------------------|

### 2. Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prime for Life Spanish</td>
<td>Client payment:$1,000 Block Grant Fund:$200</td>
<td>Yes</td>
</tr>
<tr>
<td>Agency</td>
<td>Tier Level:</td>
<td></td>
</tr>
<tr>
<td>Summit County Health Department</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prime for Life Teen</td>
<td>Block Grant Funds:$1,000</td>
<td>Yes</td>
</tr>
<tr>
<td>Agency</td>
<td>Summit County Health Department</td>
<td>Tier Level: 4</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Logic</th>
<th>Goal</th>
<th>Focus Population: U/S/I</th>
<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reduce underage drinking.</td>
<td>20 Summit County residents who are younger than 18 yrs., are arrested for alcohol or drug charges and/or are referred by the court, school counselors and parents.</td>
<td>Offered at a Summit County High School as needed, 4 hours per class, 4 classes per session for a total of 16 hours.</td>
<td>Decrease perceived risk of drug use in all grades will decrease from 41.2% in 2019 to 39% in 2023. Underage drinking will be reduced in 10th grade from 16.4% in 2019 to 13% in 2029.</td>
</tr>
</tbody>
</table>


4. Logic Model
<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systematic Training for Effective Parenting English</td>
<td>PFS Funds:$7,000</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agency</th>
<th>Tier Level:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Summit County Health Department</td>
<td>4</td>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Selective</td>
<td>Short</td>
<td>Long</td>
</tr>
</tbody>
</table>

**Logic**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Factors</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Selective</td>
<td>Short</td>
<td>Long</td>
</tr>
</tbody>
</table>

Reduce underage drinking.

Parental Attitudes Favorable to ATOD.

50 English speaking parents of children that live in Summit County from all ethnic and socio-economic backgrounds.

This is a 7 session parenting program, 1 ½ hr. each session. We offer it ongoing year round at the Summit County Library.

Parental Attitudes in all grades Favorable to ATOD will decrease from 17.4% in 2019 to 16.4% by 2023.

Underage drinking will be reduced in 10th grade from 16.4% in 2019 to 13% in 2029.

**Measures & Sources**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Factors</th>
<th>Focus Population: U/S/I</th>
<th>Strategies</th>
<th>Outcomes</th>
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SHARP Survey 2019.

SHARP Survey 2019.

Attendance records. Program logs.

Attendance records.

2023 SHARP Survey. Pre Post test.

2029 SHARP Survey.
## 5. Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
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<tbody>
<tr>
<td>Systematic Training for Effective Parenting Spanish</td>
<td>PFS Funds: $7,000</td>
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<table>
<thead>
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<th>Agency</th>
<th>Tier Level:</th>
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<tbody>
<tr>
<td>Summit County Health Department</td>
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<table>
<thead>
<tr>
<th>Logic</th>
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<th>Outcomes</th>
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<td></td>
<td></td>
<td>Selective</td>
<td>U/S/I</td>
<td>Short</td>
<td>Long</td>
</tr>
<tr>
<td>Logic</td>
<td>Reduce 30 alcohol use rate for all grades</td>
<td>Parental Attitudes Favorable to ATOD.</td>
<td>25 Spanish speaking parents of children that live in Summit County from all ethnic and socio-economic backgrounds.</td>
<td>This is a 7 session parenting program, 1 ½ hr. each session. We offer it ongoing year round at the Summit County Library.</td>
<td>Parental Attitudes in all grades Favorable to ATOD will decrease from 17.4% in 2019 to 16.4% by 2023.</td>
</tr>
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6. Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
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<tr>
<td>Parents Empowered</td>
<td>Block Grant Funds:$6,000</td>
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<thead>
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<th>Strategies</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Universal</td>
<td>Articles, PSA’s, and/or ads will be placed in different Summit County locations at various times of the year. Parents Empowered kits and collateral items will be distributed at various Summit County community events, schools, classes and worksites.</td>
<td>Parental Attitudes in all grades Favorable to ATOD will decrease from 17.4% in 2019 to 16.4% by 2023.</td>
</tr>
</tbody>
</table>

| Logic                       | Reduce 30 day alcohol use rage among all grades | Parental Attitudes Favorable to ATOD. | 4000 parents of children that live in Summit County from all ethnic and socio-economic backgrounds. | 2023 SHARP Survey. |

| Measures & Sources          | Attendance records. | Attendance records. | 2029 SHARP Survey. |
### 7. Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
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<tr>
<td>Community Events and Presentations</td>
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<td></td>
<td>SOR Funds: $1,500</td>
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<td>Agency</td>
<td>Tier Level:</td>
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<th>Outcomes</th>
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### Logic Model

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<tr>
<td>SHARP Survey 2019</td>
<td>Attendance records.</td>
<td>Yes</td>
</tr>
<tr>
<td>Presentations in Schools</td>
<td>Block Grant Funds: $1,500</td>
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<tr>
<td>--------------------------</td>
<td>--------------------------</td>
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<tr>
<td>Agency</td>
<td>Summit County Health Department</td>
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<table>
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<th>Goal</th>
<th>Factors</th>
<th>Focus Population: U/S/I</th>
<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>Reduce 30 day alcohol use rates in all grades.</td>
<td>Any Summit County resident attending school, both male and female from all ethnic and socio-economic backgrounds. 16 Presentations per year, given upon request. 650 attendees.</td>
<td>Presentations will be offered in Summit County schools with a variety of topics, such as: underage drinking and marijuana use. Presentations will be done when asked by teachers and/or counselors in Summit County during the school year.</td>
<td>Decrease perceived risk of drug use in all grades will decrease from 41.2% in 2019 to 39% in 2023. Decrease 30 day alcohol use for all grades from 13.1% in 2019 to 11% in 2029.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measures &amp; Sources</th>
<th>2023 SHARP Survey.</th>
<th>2029 SHARP Survey.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>2023 SHARP Survey.</td>
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<tr>
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9. Logic Model

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<th>Program Name</th>
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<tr>
<td>EASY</td>
<td>Block Grant Funds:$200</td>
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<table>
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<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>Reduce underage drinking,</td>
<td>Perceived risk of drug use (including alcohol).</td>
<td>15 youth up to 21 year’s old living in Summit County from all ethnic and socio-economic backgrounds.</td>
<td>Increase in the number of EASY compliance checks from last year in Summit County.</td>
</tr>
</tbody>
</table>

|-------------------|---------------------------------------------------|---------------------------------------------------|--------------------------|--------------------------|-------------------|-------------------|
### 10. Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communities that Care</td>
<td>Block Grant Funds: $10,000 PFS Funds: $5,000</td>
<td>Yes</td>
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<td>Tier Level:</td>
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<th>Focus Population: U/S/I</th>
<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>Reduce Substance use.</td>
<td>2200 Summit County residents from all ethnic and socio-economic backgrounds, 50 members of the CTC coalition from all ethnic and socio-economic backgrounds.</td>
<td>Summit County Health Department Prevention Team will attend CTC meetings, various trainings and sub-committees. The team will be involved in the CTC process. SCHD</td>
<td>Parental Attitudes in all grades Favorable to ATOD will decrease from 17.4% in 2019 to 16.4% by 2023. Decrease 30 day alcohol use for all grades from 13.1% in 2019 to 11% in 2029.</td>
</tr>
</tbody>
</table>
Prevention director will meet with the CTC coordinator every other month.


11. Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
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</thead>
<tbody>
<tr>
<td>Botvin Prescription drug abuse prevention module</td>
<td>Discretionary Funds: $2,500</td>
<td>Yes</td>
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<tr>
<td>Agency</td>
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<th>Outcomes</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Selective</td>
<td>Short</td>
<td>Long</td>
</tr>
</tbody>
</table>

- **SHARP Survey 2019.**
- **Attendance records.**
- **CTC milestone and benchmark tracking.**
- **2023 SHARP survey. School District data.**
- **2029 SHARP Survey. School District data.**
- **Selective**
- **Short**
- **Long**
Logic

Reduce prescription drug use.

Parental Attitudes Favorable to ATOD.

Any Summit County resident attending school, both male and female from all ethnic and socio-economic backgrounds. 6 Presentations per year, given upon request. 180 attendees.

Presentations are 1 ½ hr. long. Presentations will be offered in Summit County schools. Presentations will be given upon request by teachers and/or counselors in Summit County during the school year.

Parental Attitudes in all grades Favorable to ATOD will decrease from 17.4% in 2019 to 16.4% by 2023.

All grades 30 day prescription drug use will decrease from 13.1% in 2019 to 11% by 2029.

Measures & Sources


Attendance records. Program logs.

Attendance records.

SHARP Survey 2023. SHARP Survey 2029.

12. Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eat Dinner as a Family</td>
<td>SOR Funds: $1,000</td>
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<tr>
<td>Agency</td>
<td>Summit County Health Department</td>
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</tr>
<tr>
<td>------------------------------</td>
<td>---------------------------------</td>
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<tr>
<td>Tier Level:</td>
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<table>
<thead>
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<th>Goal</th>
<th>Focus Population: U/S/I</th>
<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>Universal</td>
<td>Short</td>
<td>Long</td>
</tr>
<tr>
<td>Reduce substance use.</td>
<td>Parental Attitudes Favorable to ATOD.</td>
<td>100 parents and kids that live in Summit County from all ethnic and socio-economic backgrounds.</td>
<td>Dinner and a presentation will be provided at the afterschool program in a Summit County school for parents and children that participate in the program.1 event per year.</td>
</tr>
</tbody>
</table>


Create a Logic Model for each program or strategy funded by Block Grant Dollars, PFS, SOR, SPF Rx or State General Funds.
1. Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prime for Life English</td>
<td>Client payments:$4,200</td>
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<td></td>
<td>Block Grant Funds:$500</td>
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<td>Agency</td>
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<td>Summit County Health</td>
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<td>Department</td>
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<table>
<thead>
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<th>Goal</th>
<th>Factors</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>Reduce adult binge drinking.</td>
<td>40 Summit County residents that speak English who are 18 yrs. old or older, who are arrested for alcohol or drug related charges and are referred by the court, themselves or their therapists.</td>
</tr>
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<table>
<thead>
<tr>
<th>Strategies</th>
<th>Outcomes</th>
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</thead>
<tbody>
<tr>
<td>Indicated</td>
<td>Parental Attitudes in all grades Favorable to ATOD will decrease from 17.4% in 2019 to 16.4% by 2023.</td>
<td></td>
</tr>
<tr>
<td>Short</td>
<td>Adult binge drinking will decrease from 16.3% in 2018 to 13% by 2028.</td>
<td></td>
</tr>
<tr>
<td>Long</td>
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<table>
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<td>Program logs.</td>
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<td>Attendance records.</td>
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<td>IBIS indicator report 2028.</td>
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## 2. Logic Model

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<tr>
<td>Prime for Life Spanish</td>
<td>Client payment:$1,000 Block Grant Fund:$200</td>
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<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>Reduce adult binge drinking</td>
<td>5 Summit County residents that speak Spanish who are 18 yrs. old or older, who are arrested for alcohol or drug related charges and are referred by the court, themselves or their therapists.</td>
<td>Offered at U of U as needed, 4 hours per class, 4 classes per session for a total of 16 hours.</td>
<td>Parental Attitudes in all grades Favorable to ATOD will decrease from 17.4% in 2019 to 16.4% by 2023. Adult binge drinking will decrease from 16.3% in 2018 to 13% by 2028.</td>
</tr>
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3. Logic Model

<table>
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<tr>
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<tbody>
<tr>
<td>Prime for Life Teen</td>
<td>Block Grant Funds:$1,000</td>
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<td>Summit County Health Dept.</td>
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<th>Focus Population: U/S/I</th>
<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>Reduce underage drinking.</td>
<td>Perceived risk of drug use.</td>
<td>Offered at a Summit County High School as needed, 4 hours per class, 4 classes per session for a total of 16 hours.</td>
<td>Decrease perceived risk of drug use in all grades will decrease from 41.2% in 2019 to 39% in 2023. Underage drinking will be reduced in 10th grade from 16.4% in 2019 to 13% in 2029.</td>
</tr>
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4. Logic Model

<table>
<thead>
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<th>Program Name</th>
<th>Cost of Program</th>
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<tbody>
<tr>
<td>Systematic Training for Effective Parenting English</td>
<td>PFS Funds:$7,000</td>
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<td></td>
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<td>Short</td>
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### Logic Model

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<tbody>
<tr>
<td>Systematic Training for Effective Parenting Spanish</td>
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## Logic Model

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<td>Parents Empowered</td>
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<td>Factors</td>
<td>Focus Population: U/S/I</td>
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<tr>
<td>------</td>
<td>---------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Logic</td>
<td>Reduce 30 day alcohol use rage among all grades</td>
<td>Parental Attitudes Favorable to ATOD.</td>
</tr>
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### 7. Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Events and Presentations</td>
<td>Block Grant Funds: $1,500 SOR Funds: $1,500</td>
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<td>Agency</td>
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<td>Summit County Health Department</td>
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<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>Reduce 30 day alcohol use rate among all grades.</td>
<td>Any Summit County resident, all ages, both male and female from all ethnic and socioeconomic backgrounds. 10 Presentations per year, given upon request. 300 attendees.</td>
<td>Presentations will be offered in group or community settings as community education with a variety of topics, such as: underage drinking and healthy lifestyle. Presentations will be provided when asked by community partners in different Summit County locations.</td>
<td>Parental Attitudes in all grades Favorable to ATOD will decrease from 17.4% in 2019 to 16.4% by 2023. Decrease 30 day alcohol use for all grades from 13.1% in 2019 to 11% in 2029.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Measures &amp; Sources</th>
<th>2023 SHARP Survey.</th>
<th>2029 SHARP Survey.</th>
</tr>
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</table>
8. Logic Model

<table>
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<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentations in Schools</td>
<td>Block Grant Funds:$1,500</td>
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<tr>
<th>Logic</th>
<th>Factors</th>
<th>Focus Population: U/S/I</th>
<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Universal</td>
<td>Presentations will be offered in Summit County schools with a variety of topics, such as: underage drinking and marijuana use.</td>
<td>Decrease perceived risk of drug use for all grades from 13.1% in 2019 to 39% in 2023.</td>
</tr>
<tr>
<td>Goal</td>
<td></td>
<td>Universal</td>
<td>Presentations will be offered in Summit County schools with a variety of topics, such as: underage drinking and marijuana use.</td>
<td>Decrease 30 day alcohol use for all grades from 13.1% in 2019 to 11% in 2029.</td>
</tr>
<tr>
<td>Factors</td>
<td></td>
<td>Universal</td>
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</tr>
<tr>
<td>Focus Population: U/S/I</td>
<td></td>
<td>Universal</td>
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</tr>
<tr>
<td>Strategies</td>
<td></td>
<td>Universal</td>
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</tr>
<tr>
<td>Outcomes</td>
<td></td>
<td>Universal</td>
<td>Presentations will be offered in Summit County schools with a variety of topics, such as: underage drinking and marijuana use.</td>
<td>Decrease 30 day alcohol use for all grades from 13.1% in 2019 to 11% in 2029.</td>
</tr>
</tbody>
</table>

Program Name: Presentations in Schools

- **Goal:** Reduce 30 day alcohol use rates in all grades.
- **Factors:** Perceived risk of drug use.
- **Focus Population:** Any Summit County resident attending school, both male and female from all ethnic and socio-economic backgrounds. 16 Presentations per year, given upon request. 650 attendees.
- **Strategies:** Presentations will be offered in Summit County schools with a variety of topics, such as: underage drinking and marijuana use.
- **Outcomes:** Decrease perceived risk of drug use in all grades will decrease from 41.2% in 2019 to 39% in 2023. Decrease 30 day alcohol use for all grades from 13.1% in 2019 to 11% in 2029.
will be done when asked by teachers and/or counselors in Summit County during the school year.

|--------------------|--------------------|--------------------|------------------|------------------|-------------------|-------------------|

9. Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>EASY</td>
<td>Block Grant Funds:$200</td>
<td>Yes</td>
</tr>
<tr>
<td>Agency</td>
<td>Tier Level:</td>
<td></td>
</tr>
<tr>
<td>Summit County Health Department</td>
<td>1</td>
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</tbody>
</table>
10. Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communities that Care</td>
<td>Block Grant Funds:$10,000 PFS Funds: $5,000</td>
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<p>| Agency                | Tier Level:                           |                           |</p>
<table>
<thead>
<tr>
<th>Logic</th>
<th>Goal</th>
<th>Factors</th>
<th>Focus Population: U/S/I</th>
<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reduce Substance use.</td>
<td>Parental Attitudes Favorable to ATOD.</td>
<td>2200 Summit County residents from all ethnic and socio-economic backgrounds, 50 members of the CTC coalition from all ethnic and socio-economic backgrounds.</td>
<td>Summit County Health Department Prevention Team will attend CTC meetings, various trainings and sub-committees. The team will be involved in the CTC process. SCHD Prevention director will meet with the CTC coordinator every other month.</td>
<td>Parental Attitudes in all grades Favorable to ATOD will decrease from 17.4% in 2019 to 16.4% by 2023. Decrease 30 day alcohol use for all grades from 13.1% in 2019 to 11% in 2029.</td>
</tr>
<tr>
<td>&amp; Sources</td>
<td></td>
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</table>

11. Logic Model
<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
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</thead>
<tbody>
<tr>
<td>Botvin Prescription drug abuse prevention module</td>
<td>Discretionary Funds:$2,500</td>
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</table>

<table>
<thead>
<tr>
<th>Agency</th>
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<tbody>
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<td>Summit County Health Department</td>
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</table>

<table>
<thead>
<tr>
<th>Goal</th>
<th>Factors</th>
<th>Focus Population: U/S/I</th>
<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>Reduce prescription drug use.</td>
<td>Parental Attitudes Favorable to ATOD.</td>
<td>Any Summit County resident attending school, both male and female from all ethnic and socio-economic backgrounds. 6 Presentations per year, given upon request. 180 attendees.</td>
<td>Presentations are 1 ½ hr. long. Presentations will be offered in Summit County schools. Presentations will be given upon request by teachers and/or counselors in Summit County during the school year.</td>
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</table>

<table>
<thead>
<tr>
<th>Measures &amp; Sources</th>
<th>Short</th>
<th>Long</th>
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</table>
12. Logic Model

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Cost of Program</th>
<th>Evidence Based: Yes or No</th>
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</thead>
<tbody>
<tr>
<td>Eat Dinner as a Family</td>
<td>SOR Funds: $1,000</td>
<td>Yes</td>
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<tr>
<td>Agency</td>
<td>Tier Level:</td>
<td></td>
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<tr>
<td>Summit County Health Dept.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal</th>
<th>Factors</th>
<th>Focus Population: U/S/I</th>
<th>Strategies</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Logic</td>
<td>Reduce substance use.</td>
<td>100 parents and kids that live in Summit County from all ethnic and socio-economic backgrounds.</td>
<td>Dinner and a presentation will be provided at the afterschool program in a Summit County school for parents and children that participate in the program.1 event per year.</td>
<td>Parental Attitudes in all grades Favorable to ATOD will decrease from 17.4% in 2019 to 16.4% by 2023. Decrease 30 day alcohol use for all grades from 13.1% in 2019 to 11% in 2029.</td>
</tr>
<tr>
<td>FY2022 Mental Health Revenue</td>
<td>State General Fund</td>
<td>County Funds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>-------------------</td>
<td>-------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total FY 2022</td>
<td>$137,679</td>
<td>$100,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Care (171 &amp; 173)</td>
<td>$12,528</td>
<td>$130,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Care (22-24 and 30-50)</td>
<td>$17,082</td>
<td>$960,284</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Non-Mandated MH Services</td>
<td>$78,035</td>
<td>$0</td>
<td></td>
<td></td>
</tr>
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**Total FY 2022 Mental Health Expenditures**

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</tbody>
</table>

**FY2022 Mental Health Revenue by Source**

<table>
<thead>
<tr>
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<th>County Funds</th>
</tr>
</thead>
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</table>

**FY2022 Mental Health Expenditures Budget**

<table>
<thead>
<tr>
<th>FY2022 Mental Health Expenditures</th>
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<th>County Funds</th>
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<td>$137,679</td>
<td>$100,000</td>
</tr>
</tbody>
</table>
### FY22 Proposed Cost & Clients Served by Population

<table>
<thead>
<tr>
<th>MH Budgets</th>
<th>Clients Served</th>
<th>FY2022 Expended Cost/Client Served</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Care Budget</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>4</td>
<td>$546</td>
</tr>
<tr>
<td>Child/Youth</td>
<td>2</td>
<td>$8,332</td>
</tr>
<tr>
<td><strong>Residential Care Budget</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>2</td>
<td>$12,499</td>
</tr>
<tr>
<td>Child/Youth</td>
<td>2</td>
<td>$12,499</td>
</tr>
<tr>
<td><strong>Outpatient Care Budget</strong></td>
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</tr>
<tr>
<td>Adult</td>
<td>575</td>
<td>$775</td>
</tr>
<tr>
<td>Child/Youth</td>
<td>900</td>
<td>$745</td>
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<tr>
<td><strong>24-Hour Crisis Care Budget</strong></td>
<td></td>
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</tr>
<tr>
<td>Adult</td>
<td>200</td>
<td>MCOT Contract 0</td>
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<tr>
<td>Child/Youth</td>
<td>40</td>
<td>MCOT Contract 0</td>
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<tr>
<td><strong>Psychotropic Medication Management Budget</strong></td>
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</tr>
<tr>
<td>Adult</td>
<td>400</td>
<td>$241</td>
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<tr>
<td>Child/Youth</td>
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<td>$321</td>
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<tr>
<td><strong>Psychosocial and Psychosocial Rehabilitation Budget</strong></td>
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<tr>
<td>Adult</td>
<td>90</td>
<td>$177</td>
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<tr>
<td>Child/Youth</td>
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<td>$704</td>
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<tr>
<td><strong>Case Management Budget</strong></td>
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<tr>
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<td>$34</td>
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<tr>
<td>Child/Youth</td>
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<td>$204</td>
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<td><strong>Community Supports Budget (including Respite)</strong></td>
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<tr>
<td>Adult</td>
<td>6</td>
<td>SURF 0</td>
</tr>
<tr>
<td>Child/Youth</td>
<td>1</td>
<td>JFS 0</td>
</tr>
<tr>
<td><strong>Peer Support Services Budget</strong></td>
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</tr>
<tr>
<td>Adult</td>
<td>250</td>
<td>LBH/HMHII 67</td>
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<tr>
<td>Child/Youth</td>
<td>150</td>
<td>LBH/HMHII 167</td>
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<tr>
<td><strong>Consultation &amp; Education Services Budget</strong></td>
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</tr>
<tr>
<td>Adult</td>
<td>0</td>
<td>KAF Funded</td>
</tr>
<tr>
<td>Child/Youth</td>
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<td></td>
</tr>
<tr>
<td><strong>Services to Incarcerated Persons Budget</strong></td>
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<tr>
<td>Adult</td>
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<td>$254</td>
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<td><strong>Outplacement Budget</strong></td>
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<td>Adult</td>
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<td>$1125</td>
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<td><strong>Other Non-standardized Services Budget</strong></td>
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</tr>
<tr>
<td>Adult</td>
<td>1</td>
<td>$0</td>
</tr>
<tr>
<td>Child/Youth</td>
<td>1</td>
<td>$0</td>
</tr>
</tbody>
</table>

#### Summary

- **Totals**: $720,844 Total Adult
- **Child/Youth**: $565,284

From the budgets and clients served data reported above, please breakout the following information regarding unfunded (duplicated from above):

- **Unfunded ($2.7 million)**
  - Adult: $10,000
  - Child/Youth: $10,000

- **MH Budgets**
  - Inpatient Care Budget: $45,000
    - Adult: 4
    - Child/Youth: 2
FY22 Mental Health Early Intervention Plan & Budget

<table>
<thead>
<tr>
<th>State General Fund</th>
<th>County Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2022 Mental Health Revenue</td>
<td></td>
</tr>
<tr>
<td>State General Fund</td>
<td>County Funds</td>
</tr>
<tr>
<td>Not Used for Medicaid Match</td>
<td>Used for Medicaid Match</td>
</tr>
<tr>
<td>$43,043</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

**FY2022 Mental Health Expenditures Budget**

<table>
<thead>
<tr>
<th>State General Fund</th>
<th>County Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY2022 Mental Health Expenditures Budget</td>
<td></td>
</tr>
<tr>
<td>State General Fund</td>
<td>County Funds</td>
</tr>
<tr>
<td>Not Used for Medicaid Match</td>
<td>Used for Medicaid Match</td>
</tr>
<tr>
<td>MCOT 24-Hour Crisis Care-CLINICAL</td>
<td></td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>MCOT 24-Hour Crisis Care-ADMIN</td>
<td></td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>FRF-CLINICAL</td>
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</tr>
<tr>
<td>$20,000</td>
<td>$0</td>
</tr>
<tr>
<td>FRF-ADMIN</td>
<td></td>
</tr>
<tr>
<td>$5,000</td>
<td>$0</td>
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<tr>
<td>School Based Behavioral Health-CLINICAL</td>
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</tr>
<tr>
<td>$15,000</td>
<td>$100,000</td>
</tr>
<tr>
<td>School Based Behavioral Health-ADMIN</td>
<td></td>
</tr>
<tr>
<td>$3,043</td>
<td>$0</td>
</tr>
<tr>
<td>FY2022 Mental Health Expenditures Budget</td>
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<tr>
<td>$43,043</td>
<td>$0</td>
</tr>
</tbody>
</table>

* Data reported on this worksheet is a breakdown of data reported on Form A.
## FY22 Substance Use Disorder Treatment Area Plan Budget

### FY2022 Substance Use Disorder Treatment Revenue

<table>
<thead>
<tr>
<th>Type</th>
<th>State Funds NOT used for Medicaid Match</th>
<th>State Funds used for Medicaid Match</th>
<th>County Funds NOT used for Medicaid Match</th>
<th>County Funds used for Medicaid Match</th>
<th>Federal Medicaid</th>
<th>SAPT Treatment Revenue</th>
<th>SAPT Women’s Treatment Set aside</th>
<th>Other State/Federal</th>
<th>3rd Party Collections (eg, co-pays, private pay, fees)</th>
<th>Client Collections (eg, co-pays, private pay, fees)</th>
<th>Other Revenue (grants, donations, reserves etc)</th>
<th>TOTAL FY2022 Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Court</td>
<td>$39,391</td>
<td>$0</td>
<td>$40,000</td>
<td>$0</td>
<td>$0</td>
<td>$79,391</td>
<td>$17,620</td>
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<td>$0</td>
<td>$0</td>
<td>$873,137</td>
</tr>
<tr>
<td>JRI</td>
<td>$45,579</td>
<td>$0</td>
<td>$0</td>
<td>$9,116</td>
<td>$0</td>
<td>$54,695</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$709,051</td>
</tr>
<tr>
<td>Local Treatment Services</td>
<td>$115,292</td>
<td>$0</td>
<td>$0</td>
<td>$44,314</td>
<td>$285,000</td>
<td>$183,267</td>
<td>$43,482</td>
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</tr>
<tr>
<td>Total FY2022 Substance Use Disorder Revenue</td>
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<td>$0</td>
<td>$40,000</td>
<td>$53,430</td>
<td>$285,000</td>
<td>$183,267</td>
<td>$43,482</td>
<td>$31,696</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$873,137</td>
</tr>
</tbody>
</table>

*We do not track network providers third party billing.*

### FY2022 Substance Use Disorder Expenditures Budget by Level of Care

<table>
<thead>
<tr>
<th>Type</th>
<th>State Funds NOT used for Medicaid Match</th>
<th>State Funds used for Medicaid Match</th>
<th>County Funds NOT used for Medicaid Match</th>
<th>County Funds used for Medicaid Match</th>
<th>Federal Medicaid</th>
<th>SAPT Treatment Revenue</th>
<th>SAPT Women’s Treatment Set aside</th>
<th>Other State/Federal</th>
<th>3rd Party Collections (eg, co-pays, private pay, fees)</th>
<th>Client Collections (eg, co-pays, private pay, fees)</th>
<th>Other Revenue (grants, donations, reserves etc)</th>
<th>TOTAL FY2022 Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and Assessment Only</td>
<td>$25,000</td>
<td>$0</td>
<td>$10,000</td>
<td>$10,000</td>
<td>$5,000</td>
<td>$50,000</td>
<td>$6,696</td>
<td>$396</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$138</td>
</tr>
<tr>
<td>Detoxification: ASAM IV-D or III.7-D (ASAM III.2-D)</td>
<td>$20,862</td>
<td>$0</td>
<td>$20,000</td>
<td>$0</td>
<td>$0</td>
<td>$40,862</td>
<td>$6,696</td>
<td>$396</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$138</td>
</tr>
<tr>
<td>Residential Services (ASAM II.7, III.5, III.1 III.1 I or III.3)</td>
<td>$24,280</td>
<td>$65,000</td>
<td>$5,000</td>
<td>$25,000</td>
<td>$0</td>
<td>$94,280</td>
<td>$4,000</td>
<td>$396</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$138</td>
</tr>
<tr>
<td>Outpatient: Contracts with Opioid Treatment Providers (Methodone: ASAM I)</td>
<td>$0</td>
<td>$25,000</td>
<td>$20,000</td>
<td>$0</td>
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<td>$4,000</td>
<td>$396</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$138</td>
</tr>
<tr>
<td>Office based Opioid Treatment (Buprenorphine, Vixtril, Naltrexone and prescriber costs) Non-Methodone</td>
<td>$12,500</td>
<td>$60,000</td>
<td>$15,000</td>
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<td>$0</td>
<td>$0</td>
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<tr>
<td>Outpatient: Non-Methodone (ASAM I)</td>
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<td>$53,430</td>
<td>$510,000</td>
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<td>$383,430</td>
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<td>$396</td>
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<tr>
<td>Intensive Outpatient (ASAM II or III)</td>
<td>$20,000</td>
<td>$40,000</td>
<td>$6,696</td>
<td>$0</td>
<td>$0</td>
<td>$66,696</td>
<td>$0</td>
<td>$396</td>
<td>$0</td>
<td>$0</td>
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<td>$138</td>
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<tr>
<td>Recovery Support (includes housing, peer support, case management and other non-clinical)</td>
<td>$17,620</td>
<td>$53,430</td>
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<td>$0</td>
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<tr>
<td>FY2022 Substance Use Disorder Expenditure Budget</td>
<td>$200,262</td>
<td>$0</td>
<td>$53,430</td>
<td>$285,000</td>
<td>$183,267</td>
<td>$43,482</td>
<td>$31,696</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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### FY2022 Substance Use Disorder Expenditures Budget By Population

<table>
<thead>
<tr>
<th>Type</th>
<th>State Funds NOT used for Medicaid Match</th>
<th>State Funds used for Medicaid Match</th>
<th>County Funds NOT used for Medicaid Match</th>
<th>County Funds used for Medicaid Match</th>
<th>Federal Medicaid</th>
<th>SAPT Treatment Revenue</th>
<th>SAPT Women’s Treatment Set aside</th>
<th>Other State/Federal</th>
<th>3rd Party Collections (eg, co-pays, private pay, fees)</th>
<th>Client Collections (eg, co-pays, private pay, fees)</th>
<th>Other Revenue (grants, donations, reserves etc)</th>
<th>TOTAL FY2022 Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant Women and Women with Dependent Children, (Please include pregnant women under age of 18)</td>
<td>$0</td>
<td>$0</td>
<td>$1,000</td>
<td>$37,050</td>
<td>$150,000</td>
<td>$35,000</td>
<td>$8,482</td>
<td>$25,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$459,160</td>
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<tr>
<td>All Other Women (18+)</td>
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<td>$0</td>
<td>$10,000</td>
<td>$44,314</td>
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<td>$183,267</td>
<td>$43,482</td>
<td>$31,696</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$459,160</td>
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<tr>
<td>Men (18+)</td>
<td>$176,000</td>
<td>$50,000</td>
<td>$40,000</td>
<td>$188,100</td>
<td>$25,000</td>
<td>$2,326</td>
<td>$8,482</td>
<td>$25,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$459,160</td>
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<tr>
<td>Youth (12 - 17) (Not including pregnant women or women with dependent children)</td>
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<td>$6,696</td>
<td>$223,050</td>
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<td>Total FY2022 Substance Use Disorder Expenditures Budget by Population Served</td>
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<td>$53,430</td>
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<td>$31,696</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$837,137</td>
</tr>
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</table>
Screening and Assessment Only

ASAM IV-D or III.7-D (ASAM III.2-D)

Residential Services

ASAM III.7, III.5, III.1, III.3, III.1 or III.3

Outpatient: Contracts with Opioid Treatment Providers (Methadone: ASAM I)

Office-based Opioid Treatment (Buprenorphine, Vivitrol, Naloxone and prescriber cost) Non-Methadone

Outpatient: Non-Methadone (ASAM I)

Intensive Outpatient (ASAM II.5 or II.1)

Recovery Support (includes housing, peer support, case management and other non-clinical services)
## FY22 Drug Offender Reform Act & Drug Court Expenditures

<table>
<thead>
<tr>
<th>FY2022 DORA and Drug Court Expenditures Budget by Level of Care</th>
<th>Drug Offender Reform Act (DORA)</th>
<th>Felony Drug Court</th>
<th>Family Drug Court</th>
<th>Juvenile Drug Court</th>
<th>DUI Fee on Fines</th>
<th>TOTAL FY2022 Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening and Assessment Only</td>
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<td>$0</td>
<td>$0</td>
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<tr>
<td>Residential Services (ASAM III.7, III.5, III.1 III.3 1II.1 or III.3)</td>
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<td>$0</td>
<td>$0</td>
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<tr>
<td>Outpatient: Contracts with Opioid Treatment Providers (Methadone: ASAM I)</td>
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<td>$53,513</td>
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<td>$0</td>
<td>$0</td>
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<tr>
<td>Office based Opioid Treatment ([Buprenorphine, Vivitrol, Naloxone and prescriber cost]) Non-Methadone</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Outpatient: Non-Methadone (ASAM I)</td>
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<td>$0</td>
<td>$0</td>
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<td>$0</td>
<td>$0</td>
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<tr>
<td>Intensive Outpatient (ASAM II.5 or II.1)</td>
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<td>$5,000</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$5,000</td>
</tr>
<tr>
<td>Recovery Support (includes housing, peer support, case management and other non-clinical)</td>
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<td>$5,000</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>FY2022 DORA and Drug Court Expenditures Budget</td>
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<td>$79,391</td>
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</table>
### SFY 2022 Opioid Budget

**Local Authority:** Summit Co

**Form B**

<table>
<thead>
<tr>
<th>State Fiscal Year</th>
<th>Projected SOR SFY 2020 Revenue Not Used</th>
<th>State Opioid Response SFY 2022 Revenue</th>
<th>Total SFY 2021 SOR Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022</td>
<td>12500</td>
<td>SOR 2</td>
<td>$12,500.00</td>
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*These funds expire 09.29.2020 as the SOR grant ends*

#### SFY2022 State Opioid Response Budget Expenditure

<table>
<thead>
<tr>
<th>Direct Services</th>
<th>Estimated Cost</th>
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<td>Salary Expenses</td>
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<td>Title 1</td>
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<tr>
<td>Title 2</td>
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</tr>
<tr>
<td>Title 3</td>
<td></td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>$0.00</td>
</tr>
<tr>
<td>Supplies</td>
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</tr>
<tr>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td>Travel</td>
<td></td>
</tr>
<tr>
<td>Conference/Workshops</td>
<td><em>Insert a note providing details</em></td>
</tr>
<tr>
<td>Equipment/Furniture</td>
<td><em>Insert a note describing it</em></td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
</tr>
<tr>
<td>Screening &amp; Assessment</td>
<td>$0.00</td>
</tr>
<tr>
<td>Drug Testing</td>
<td>$0.00</td>
</tr>
<tr>
<td>Office Based Opioid Treatment (Buprenorphine, Vivitrol, Nalaxone)</td>
<td>$12,500.00</td>
</tr>
<tr>
<td>Opioid Treatment Providers (Methadone)</td>
<td>$0.00</td>
</tr>
<tr>
<td>Intensive Outpatient</td>
<td>$0.00</td>
</tr>
<tr>
<td>Residential Services</td>
<td>$0.00</td>
</tr>
<tr>
<td>Outreach/Advertising Activities</td>
<td>$0.00</td>
</tr>
<tr>
<td>Recovery Support (housing, contracted peer support, contracted care)</td>
<td>$0.00</td>
</tr>
<tr>
<td>Contracted Services</td>
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<td>Contracted Service 1</td>
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<td>Contracted Service 2</td>
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<td>Contracted Service 3</td>
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<td>Contracted Service 4</td>
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<tr>
<td>Contracted Service 5</td>
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<tr>
<td>Contracted Service 6</td>
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</tbody>
</table>

**Total Expenditure FY2022:** $12,500.00
## FY22 Substance Abuse Prevention Area Plan & Budget

### Local Authority: Summit

#### Form C

<table>
<thead>
<tr>
<th>FY2022 Substance Abuse Prevention Revenue</th>
<th>State Funds</th>
<th>County Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Funds NOT used for Medicaid Match</td>
<td>$61,378</td>
<td>$0</td>
</tr>
<tr>
<td>State Funds used for Medicaid Match</td>
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<td>$0</td>
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<tr>
<td>County Funds NOT used for Medicaid Match</td>
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<td>County Funds used for Medicaid Match</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Federal Medicaid</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>SAPT Prevention Revenue</td>
<td>$78,543</td>
<td>$28,075</td>
</tr>
<tr>
<td>Partnerships for Success PPS Grant</td>
<td>$8,009</td>
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</tr>
<tr>
<td>Other Federal TANF, Discretionary Grants</td>
<td>$0</td>
<td>$4,200</td>
</tr>
<tr>
<td>Client Collections (eg. co-pays, private pay, fees)</td>
<td>$0</td>
<td>$20,000</td>
</tr>
<tr>
<td>Other Revenue (gifts, donations, reserves etc)</td>
<td>$212,481</td>
<td>$0</td>
</tr>
<tr>
<td>TOTAL FY2022 Revenue</td>
<td>$28,075</td>
<td>$8,009</td>
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</table>

### FY2022 Substance Abuse Prevention Expenditures Budget

<table>
<thead>
<tr>
<th>State Funds</th>
<th>County Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$30,689</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$14,038</td>
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<tr>
<td>Selective Services</td>
<td>$12,276</td>
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<tr>
<td>Indicated Services</td>
<td>$5,615</td>
</tr>
<tr>
<td>TOTAL FY2022 Expenditures</td>
<td>$106,242</td>
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</table>

### SAPT Prevention Set Aside

<table>
<thead>
<tr>
<th>Information Dissemination</th>
<th>Education</th>
<th>Alternatives</th>
<th>Problem Identification &amp; Referral</th>
<th>Community Based Process</th>
<th>Environmental</th>
<th>Total</th>
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<tbody>
<tr>
<td>$12,391</td>
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<td>$28,268</td>
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### Cost Breakdown

<table>
<thead>
<tr>
<th>Salary</th>
<th>Fringe Benefits</th>
<th>Travel</th>
<th>Equipment</th>
<th>Contracted</th>
<th>Other</th>
<th>Indirect</th>
<th>Total FY2022 Expenditures</th>
</tr>
</thead>
<tbody>
<tr>
<td>121800</td>
<td>73130</td>
<td>6000</td>
<td>9000</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$209,930</td>
</tr>
</tbody>
</table>

ERROR
FORM D
LOCAL AUTHORITY APPROVAL OF AREA PLAN

IN WITNESS WHEREOF:

The Summit County Council, serving as the Local Authority, approves and submits the attached Area Plan for State Fiscal Year 2022 in accordance with Utah Code Title 17 Chapter 43.

The Local Authority represents that it has been authorized to approve the attached Area Plan, as evidenced by the attached Resolution or other written verification of the Local Authority’s action in this matter.

The Local Authority acknowledges that if this Area Plan is approved by the Utah Department of Human Services Division of Substance Abuse and Mental Health (DHS/DSAMH) pursuant to the terms of Contract(s) #152261 and #160329, the terms and conditions of the Area Plan as approved shall be incorporated into the above-identified contract by reference.

LOCAL AUTHORITY:

By: ________________________________
(Signature)

PLEASE PRINT:

Name: Glenn Wright
Title: Summit County Council Chair
Date: 5/26/2021
Sliding Fee Scale Policy

Healthy U Behavioral - Summit

The purpose of the sliding fee scale is to assist individuals who are unable to meet the financial requirements of paying for services, to be able to obtain services for mental health and substance use in Summit County. The Healthy U Behavioral Sliding Fee scale takes into account the unique market in Summit County. This market has a higher cost of living in Park City and so a more lenient fee scale was adopted. This scale is used in conjunction with DHS funding for services.
### Healthy U Behavioral
### Sliding Fee Scale FY 2022

<table>
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<th>Monthly Income</th>
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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
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<tbody>
<tr>
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<tr>
<td>$3,500</td>
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<td>$3,900</td>
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<tr>
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Incomes under $2,800 will have no fee & incomes over $10,000 will pay fee for service per office visit.

No copay will be assessed for school based services.
After a Suicide
Introduction

Every day, around two people in Scotland die by suicide. For every one of those people, there are friends, partners, children, relatives, carers and colleagues left behind. This booklet is for all of them.

SAMH first produced After a Suicide in 2004, and it has helped many people since then. Funded by Choose Life, Scotland’s national strategy and action plan to prevent suicide, this new edition has been fully revised and updated. It will help you with the practical issues that need to be faced after a suicide, talk about some of the emotions you might be experiencing and suggest some places where you can get help.

“The fact that there was the After a Suicide booklet was a huge relief to me. It never left my side in the early days. I encouraged my friends and family to read it and it helped them too! Knowing that this booklet was at hand meant that although I didn’t know anyone else in the same situation as me, there were others out there who had gone through and were going through this experience. It made me feel less alone.”

Jacqui

After a Suicide

This booklet is dedicated to the memory of Jennifer Susan Ross, who took her own life on 4th February 2001, at the age of 23, after struggling with mental health problems for 11 years.

SAMH (Scottish Association for Mental Health) is Scotland’s leading mental health charity and is dedicated to mental health and well-being for all.
1. **Practical Issues**

03 The police
04 The Procurator Fiscal
04 Post mortems
05 Releasing the body for burial/cremation
06 Communications with the Procurator Fiscal
06 Fatal Accident Inquiries
07 Registering the death
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### Part 1. Practical issues

Following any death, there will inevitably be practical issues to deal with. This section sets out some of the organisations you might now come into contact with, explains what their roles are and covers some other issues that you might need to know about.

#### The police

When a body is found under circumstances which may indicate suicide, the police will:

- secure any item that has an obvious connection with the death
- record the position and appearance of the body in writing and by taking photographs
- examine any notes or letters that the person has left which indicate a suicidal intention
- make enquiries to establish the person’s state of mind before their death.

The deceased person’s body will be taken to the local mortuary.

Police enquiries can take many different forms and often involve interviewing family, friends and colleagues as potential witnesses. Police officers often have to inform people of the death of a relative and should carry out this duty professionally and sensitively. As a next-of-kin or someone close to the deceased person, you may be asked to formally identify the person. This may be done immediately if you have found the person, or you may have to go to the mortuary later and do this.

A police report to the Procurator Fiscal (see next section for a description of a Procurator Fiscal) should also include information about any cultural or religious issues that may be relevant to the investigation into the death and sensitive liaison with bereaved relatives.
The Procurator Fiscal
The Procurator Fiscal (referred to here as the Fiscal) is a lawyer who works for Scotland's prosecution service. There are eleven Area Procurator Fiscals in Scotland. The Fiscal is responsible for investigating all sudden, suspicious, accidental and unexplained deaths and any death occurring in circumstances which give rise to serious public concern. The Fiscal must enquire into any death where the circumstances point to suicide. The Fiscal has legal responsibility for the deceased person until the death certificate is issued and the deceased person is released to the person arranging the funeral.

The Fiscal will investigate the cause and circumstances and will then decide whether any further investigation is needed. This may involve instructing a post mortem, to be carried out by a forensic pathologist. The Fiscal is responsible for directing the level and type of post mortem examination, subject to advice from investigating police officers, medical experts and other expert advisers.

The purpose of the Fiscal’s investigation is to decide whether there is a need for criminal proceedings or if a Fatal Accident Inquiry should be held (see page 6 for a description of a Fatal Accident Inquiry). This decision may depend on the results of toxicological examinations.

Post mortems
There are different levels of post mortem depending on the circumstances of the death:

- an external examination by a pathologist to determine the cause of death
- a non invasive post mortem examination by one doctor
- an invasive post mortem examination by one doctor
- an invasive post mortem examination by two or more doctors.

In a suspected suicide the post mortem will almost always include toxicology tests to identify any substances the person may have taken. The nearest relative is entitled to request a copy of the post mortem report and this is normally issued through the family’s GP.

After the post mortem, you will be given the first part of the death certificate. However, toxicology reports may take up to six months and the second part of the death certificate, showing the cause of death, will not be issued until toxicology reports are complete.

Post mortems do not usually leave any obvious marks when the person is placed in their coffin. They can usually still be dressed in their own clothes and seen after the post mortem.

If there are any cultural, religious or other objections to a post mortem examination it is important to tell the Fiscal as soon as possible. There may be legal reasons why a post mortem is unavoidable, but where possible the wishes of the next of kin will be respected.

Releasing the body for burial/cremation
The Fiscal is responsible for instructing the release of the deceased person’s body for burial or cremation. The extent of the investigations will determine how long the deceased person’s body needs to be kept before being released. In deaths where there are no grounds for suspecting that homicide has been committed, the Fiscal must ensure that there are arrangements in place for the deceased’s body to be released to the nearest relative as soon as possible.

The Fiscal recognises that a delay in confirming the cause of death can be very distressing for a bereaved family and is also aware that it is a tradition in many cultures to bury or cremate the deceased’s body as quickly as possible.

Once the Fiscal has all the information needed, he/she will send a report to the Crown Office, which is the headquarters of the Procurator Fiscal Service. In most cases, there will be no further proceedings once the case has been reported to Crown Office. However, in a very small number of suicide cases, a decision may be made at Crown Office to hold a Fatal Accident Inquiry.
Communications with the Procurator Fiscal
Regardless of whether there is to be a Fatal Accident Inquiry, the Fiscal should normally contact the nearest relatives at the earliest opportunity and may offer a meeting to discuss matters. The Fiscal will ensure that families are updated on any developments in the investigation. The nearest relatives will be informed about the decision to hold, or not hold, a Fatal Accident Inquiry. If there is to be a Fatal Accident Inquiry, and you, as the nearest relatives, want to raise any issues, you may wish to contact a solicitor for advice. The nearest relatives are entitled to be represented at a Fatal Accident Inquiry, and can lead evidence and question witnesses.

Fatal Accident Inquiries
A Fatal Accident Inquiry (FAI) is a public inquiry into the circumstances of a death. It will be held in the Sheriff Court. Generally speaking, an FAI will only be held in cases that involve issues of public safety or public concern arising from the death. If the death happened when the person was working, or in legal custody (eg in prison or police custody), an FAI must be held.

The purpose of an FAI is to assess the circumstances surrounding the death and to identify any issues of public concern or safety. The Court will identify whether anything might be done to help avoid similar deaths in the future. At the end of an FAI, a Sheriff makes a determination. The determination will set out:

- where and when the death occurred
- the cause of death
- any precautions by which the death might have been avoided
- any defect in systems that caused or contributed to the death.

An FAI cannot make any findings of fault or blame against individuals.

Registering the death
The General Register Office for Scotland keeps records of all births, deaths, marriages, divorces and adoptions. Any death which occurs in Scotland must be registered within eight days by the Registrar of Births, Deaths and Marriages. Deaths can be registered at any registrar's office. You should be able to find out the contact details of the local registrar from the police, undertaker, hospital, doctor, local telephone book, or from the General Register Office’s website at www.gro-scotland.gov.uk. You should phone the registrar before you go, as many registrars require people to make appointments to register deaths. Although a burial can take place before the death has been registered, a cremation can only take place afterwards.

The death can be registered by any of the following people:

- any relative of the deceased person
- any person who was present when the death occurred
- the deceased person's executor or legal representative
- the occupier of the property where the person died
- any other person who knows the information to be registered.

If you are registering the death, you should try to take with you:

- the medical certificate showing cause of death
- the deceased person's birth certificate and, if relevant, marriage certificate
- the deceased person’s NHS medical card
- any documents relating to the receipt of a pension or allowance from government funds.
Don’t worry if you don’t have all of these documents, as the death can still be registered without them. After you have registered the death, the registrar will give you:

• a certificate of registration to give to the person in charge of the burial ground or crematorium
• a Social Security registration or notification of death certificate for use in obtaining or adjusting Social Security benefits
• an abbreviated extract (excluding cause of death and parentage details) of the death entry.

You may wish to buy some extra copies of the extract as they will often be required by banks and other organisations when you notify them of the death. If you want a copy of the full death entry in the register, you will need to pay a small fee.

If the person died abroad, the death will have to be registered according to the rules of the country concerned. A record of the death will be sent to Scotland. You can get a copy of it from the General Register Office at New Register House, Edinburgh, EH1 3YT (tel: 0131 334 0380). You can also use the contact form at www.gro-scotland.gov.uk.

The funeral
Funerals can be expensive and the costs will depend on the requirements. Services can vary greatly, taking account of different cultures, religions and beliefs. It is best to check where the money for the funeral will come from before finalising the arrangements, otherwise you may find that you have to cover the cost. You do not have to use the services of a funeral director but most people find it easier to have someone make all the arrangements on their behalf. You can ask the funeral director to explain the costs, give you a written estimate and explain whether you have to pay the costs before or after the funeral.

The total cost will cover services such as laying out the body, use of the chapel of rest and hearse, and purchasing the coffin. It will also include any expenditure that the funeral director makes on your behalf such as inserting notices in newspapers and obtaining official documents. In some cases, the funeral expenses will be covered entirely by the person’s estate. In other cases, depending on the circumstances, help may be available to cover the costs; see the next section.

Funeral payments from the Social Fund
You may be able to get help towards the cost of a funeral from the Social Fund, depending on your relationship with the person who died and any other money, other than your personal savings, that may be available to help with the costs. You can apply for a Funeral Payment if you or your partner are getting any of the following benefits or tax credits:

• Income Support
• income-based Jobseeker’s Allowance
• income-related Employment and Support Allowance
• Pension Credit
• Housing Benefit
• Council Tax Benefit (or the Council Tax payer where you live gets a Second Adult Rebate because you are on a low income)
• Working Tax Credit which includes a disability or severe disability element
• Child Tax Credit at a rate higher than the family element.

You can claim a Funeral Payment up to three months after the date of the funeral. To apply for a Funeral Payment contact your local Jobcentre Plus office and ask for a Funeral Payment from the Social Fund Form (SF200). If you are waiting for a decision on a qualifying benefit or entitlement you must still claim within the time period above.

You will need to show a copy of the final invoice from the funeral director, showing a breakdown of the total costs. A Funeral Payment includes necessary burial or cremation fees, certain other specified expenses and up to £700 for any other funeral expenses, such as the funeral director’s fees, the coffin or flowers.
For your claim to be successful, it must have been reasonable for you rather than anyone else to take responsibility for the cost of the funeral. If there are any other funds available to pay for the funeral, this may affect your claim.

**Letting others know**

As well as family, friends and carers, there are likely to be other people who should be informed of the death. A solicitor might be able to help you notify banks, creditors or other organisations. The following list might help you in deciding who you need to notify:

- GP and/or hospital
- other health professionals like dentists or opticians
- the person’s employer (you may need to arrange to collect the person’s belongings or notify staff of the funeral date)
- the person’s pension company
- the person’s insurance company
- the person’s bank
- the person’s mortgage provider or housing association
- the Driver and Vehicle Licensing Agency
- the Passport Office
- a car insurance company (if you are insured under the deceased person’s name, your insurance will become invalid)
- gas, electricity and telephone companies
- the Post Office so they can redirect the person’s mail
- email providers, like Gmail or Hotmail (most accounts will be automatically closed if they are not used for a certain period)
- online networks like Facebook or Bebo.

You might find it helpful to register at: www.the-bereavement-register.org.uk. This is a free service which can help to cut down the amount of unsolicited mail that is sent to a deceased person.

**Media interest**

Sometimes the media might take an interest in a death by suicide. Your funeral director or the police might be able to help deal with any media attention. The police might provide you with a Family Liaison Officer who you can speak to about this. It is best to check the identity of anyone who phones or comes to your door before telling them anything. If you are asked to release a picture of the person to the press, consider this carefully before you do so: the picture could subsequently appear in other publications and on the internet, which you may find distressing. You might it useful to consult the National Union of Journalists’ media guidelines on reporting suicide, they are at: www.nuj.org.uk. The Samaritans also have media guidelines at: www.samaritans.org.

**Money and possessions**

If the deceased person has left savings, property and/or debts, then someone will need to deal with these. It is best to try and gather together all of the relevant paperwork such as:

- any will
- bank or building society books or documents
- insurance documents
- benefit order books
- mortgage statements or rent book
- savings certificates
- credit card or loan statements
- utility bills (gas, electricity, telephone).

It is also best to seek advice as soon as possible from a solicitor or Money Advice Centre. Legal costs vary depending on how much work is involved in winding up the estate. Legal Aid may be available for the costs of winding up an estate. You may also be able to get Legal Aid to cover the costs of going to court to be appointed as the executor of the will. You should not dispose of any property until you have sought legal advice. If the person has not left a will, then there are rules about how the estate should be divided among surviving relatives. Funeral expenses take priority over any other debts on the person’s estate.
Benefits and allowances
If you are a widow or widower as a result of the death, then you may be entitled to receive:

• Bereavement payment – a one-off, tax-free lump sum payment of £2000 paid to the husband, wife or civil partner of someone who has died
• Widowed parent’s allowance – a weekly payment made to a parent whose husband, wife or civil partner has died who has a dependent child or young person (aged 16 and under 20) and for whom they receive Child Benefit
• Bereavement allowance – a taxable weekly benefit paid to a widow, widower or civil partner for 52 weeks from the date of death.

There are rules and conditions about eligibility for these. You can get advice on eligibility from your local Jobcentre Plus Office, Citizens Advice Bureau or welfare rights adviser (see ‘Useful contacts and resources’ section) to find out if you are entitled to any payment.

If the deceased person was receiving any benefits, or if you were receiving welfare benefits for them (such as Child Benefit), you will need to notify Jobcentre Plus of the death. You should also notify the Tax Office.

Other investigations and inquiries
There are several different organisations besides the police and Fiscal which might be involved in investigating the circumstances surrounding a suicide. The type of inquiries that may be carried out will depend very much on a person’s circumstances at the time of, and leading up to, their death. As a result, some of this section may not be relevant in your own case.

You may not always be told that an inquiry is taking place, or given copies of reports that are produced.

The NHS
NHS Boards usually carry out some form of review in any case where someone who has been receiving treatment, either as an in-patient or as an out-patient, has died and suicide is the most likely cause. These reviews are usually referred to as critical incident reviews or suicide reviews. The main aim of these reviews is to look at the care and treatment the person was receiving prior to his or her death and to see if any lessons can be learned in order to help reduce the risk of future suicides. These reviews are not fault finding investigations.

At the moment, there is considerable variation in the way that NHS Boards deal with reviews. NHS Quality Improvement Scotland (NHS QIS) scrutinises all reports of reviews and is developing good practice advice for NHS Boards to ensure that lessons learnt can be shared throughout the NHS in Scotland.

The clinical staff involved in the care of someone who has died by suicide will usually speak with the relatives and close carers of the person concerned. It is usually very helpful to the suicide review to have information from relatives who were in close contact with the person who has died.

NHS QIS may refer individual cases to the Mental Welfare Commission if it believes further investigation should be considered.
The Mental Welfare Commission
The Mental Welfare Commission for Scotland (MWC) is an independent organisation set up by Parliament. It works to safeguard the rights and welfare of people with mental disorder. (‘Mental disorder’ covers mental illness, personality disorder, learning disability and dementia.)

The MWC will not routinely look into the care and treatment of people who die by suicide. They can investigate if there appears to be any abuse, neglect or “deficiency of care”. Sometimes, the MWC investigates a death by suicide if they think the care might have been poor. The MWC will not investigate if there is to be an FAI.

Part 2. The Grieving Process

What follows is an attempt to outline some common reactions to losing someone to suicide. You might recognise some of them, or you might find that your reactions are totally different. Everyone grieves differently: there is no correct response.

You may feel low and unable to cope. You might find it very difficult to sleep, eat or feel motivated to do anything. You may even have suicidal thoughts yourself. If you do, it is important that you speak to someone about it. Talk to someone you trust or phone Breathing Space on 0800 83 85 87 or Samaritans on 08457 90 90 90. If you are having serious thoughts about suicide, and you have a plan and the means to carry it out: call 999 right now.

Immediate responses

Nothing can truly prepare you for the news that someone you love or care for has taken their own life. Whether someone else broke the news to you, or you had the uniquely traumatic experience of discovering the body, shock and disbelief are often the immediate responses to suicide. The emotions that you experience can be powerful, frightening and overwhelming.

You may feel that the person’s death has come out of the blue with no warning. Even in cases where someone has previously told you that they were feeling depressed, or had self-harmed or made suicide attempts, their death may still come as a shock.

In other cases, people may feel that they had ‘seen it coming’ but been powerless to prevent it. You might have had a loved one go missing and known in your heart that they would not be coming back. The manner of death may be particularly hard for you to accept. Whatever the circumstances, finding out about a suicide is a deeply painful experience.
The big question – why?
One of the first things that you might ask yourself, or others might ask you, is “Why did they do it?”. Even if the person left a note, it might not give you all the answers. Notes are generally written at a time when the person was extremely distressed and they may not properly express how the person was feeling at the time. It’s very hard to accept, but you will probably never know for sure.

Stigma and shame
You may find yourself wondering what to tell people – should you say that the cause of death was suicide? Some people find it helpful to be open about this, for example at the funeral, but it can be a difficult decision. Sadly, there is still an element of stigma which surrounds suicide and mental health problems. This can lead to misunderstanding and intolerance, which can make things even more difficult for people affected by the death. There are initiatives ongoing in Scotland to try to tackle this issue, such as the ‘see me’ anti-stigma campaign which SAMH manages.

Many people simply do not know much about suicide, although it is a major public health issue. For example, many people are unaware that suicide is a leading cause of death among young people.

Ultimately, only you can decide what to tell people. You may wish to tell only the people closest to you, and others who ‘need to know’. Or you may decide to tell anyone who asks. Bear in mind that sometimes people will speculate about what happened and it is not always possible to keep things hidden.

Although you will probably find that most people will be supportive, you may be disappointed by the way that others react. Some people may be afraid or feel helpless; they might not know what to say to you or be worried that they will upset you, or they might avoid talking about it at all. Try to accept that this might happen and focus on coping with your own feelings without dwelling on what others think or say.

“Before Darryn died, the phone never stopped ringing, but afterwards it was the opposite. People who I thought were friends cut contact and said things that made me feel as if I was being judged as a parent. They didn’t realise that their comments were really, really hurtful. I felt rejected and isolated which made me retreat for a period of time. But online support groups and organisations made me realise that I wasn’t alone and that the feelings I was having were normal.” Caroline

Children affected by suicide
Depending on the circumstances, and the age and maturity of children affected by suicide, it is often best simply to be truthful about what happened and how it is affecting you, without going into too much detail. Avoid using phrases like ‘gone to sleep’ or ‘gone to a better place’, as this can be confusing for them. Children should be encouraged to talk about their feelings and not to bottle things up. Reading stories and drawing can help children express emotions and understand some difficult issues. Children who experience loss and grief can act differently from adults and may communicate their feelings in lots of ways.

Children are likely to need reassurance that they are not to blame in any way for the death, that people still love and care for them, and that it doesn’t mean that other people in their life will die unexpectedly. If it is too difficult for you to support or reassure children while you are grieving, try to get other people to help you. It might be helpful to let the school know what has happened, so that teachers can be supportive.

“I played the game of Jenga with my young daughter to help her understand what happened when her father died. We built a tower of wooden blocks, and slowly, as we recognised a difficulty for her daddy, we pulled a block out and placed it on top of the tower. After these difficulties began to pile up, the tower became unsteady and eventually tumbled. This showed her that there was never just one event that caused her daddy to take his own life, but that there were a number of unresolved issues and pressures which finally became unbearable for him.” Teresa
Your emotions
Experiencing bereavement by suicide will mean dealing with sometimes conflicting emotions, such as:

Guilt
You may feel that you should have seen it coming and that you should have done something to prevent the person’s suicide, or perhaps that something you did or said was partly to blame. This is a very common reaction, but no matter what happened, it is not your fault. People may go to great lengths to hide their thoughts of suicide from their loved ones. Even if you suspected that the person was deeply depressed, it is often extremely difficult to convince people to get help, or to get help on their behalf.

The reality is that you did what you thought was best at the time and that is all that can be expected of you. You cannot take complete responsibility for anyone else’s life. Nor can you know exactly how someone is thinking or feeling.

Perhaps you feel guilty because you may feel partly relieved that the person has gone and that you don’t have to worry about them anymore. This is another common reaction, particularly when you have spent a long time caring for, and worrying about, someone who has been very unwell.

Anger
The fact that someone has ‘chosen’ to end their life may make you feel very angry. You may ask yourself, “How could they do this to me/us?” You might want someone to direct your feelings towards or to blame. This may be the person you have lost, or it may be others who were involved with them. Coping with anger can be very difficult and you may need the help of others to work through this (see ‘Coping strategies’ section).

Confusion and helplessness
You may feel very confused and unable to concentrate. It can be very hard to make decisions when you are struggling to get through days which may be filled with exhausting and overwhelming emotions. Some people talk of a sense of helplessness – that things are completely out of their control, and that they don’t know how to help others who are also grieving.

Isolation
You might feel that no-one understands what you are going through and that you are on your own. People react differently to loss, even within close families. Some people may cope by talking about their feelings, while others may prefer not to talk about things and feel that what they need is to ‘put it behind them and get on with life’. This may lead to disagreements. It is worth recognising that although some people may not want to talk about their loss initially, this may change as time goes on.

Everyone grieves in different ways and at different times. Triggers that can set off tears and immense feelings of sadness for one person will not necessarily do the same for another. This does not mean they don’t care: it just means that they are grieving differently.

Coping strategies
Not all of these suggestions will work for you, but these are some things that people who have lost someone to suicide have found helpful.

It is essential that you do not feel that you have to cope alone. You might turn to family or friends, or you may find other sources of comfort, such as spiritual beliefs. In some cases, you may find it easier to speak to people outside your family or friends. The last section of this booklet gives details of organisations that provide bereavement counselling or local support groups: your GP can also refer you to a counsellor. Support groups offer you the opportunity to meet other people who have been bereaved and to talk through your feelings in a supportive environment. There are some groups in Scotland specifically for people...
who have been bereaved as a result of suicide: see the ‘Useful contacts and resources’ section.

“When the police came to tell me my son was dead I thought I would die. How can you describe the feeling of loss? The anger, years of trying to get the right help and support then all of a sudden it was too late. I was lucky I had great family and friends who supported and encouraged me through the first months, which was just as well as there wasn’t much support from anywhere else. I do hope things have changed over the years. Doing something, getting together with other people, finding ways of helping others are all great healers. We don’t need to do earth shattering things to make a difference, and that’s how I got over my grief.” Isabel

Many employers offer Employee Assistance Programmes, which can arrange telephone or face-to-face access to counselling: if you are working, it may be worth asking your manager or HR department whether this is available.

Some people might find it helpful to read self-help books or poetry, perhaps written by others who have had a similar experience see ‘Helpful books’ section. Others may find an outlet for their emotions by writing about how they feel or keeping a diary.

Bereavement can affect your health, physically and mentally. It is important to take care of yourself – try to eat a balanced diet, get sleep and rest. You might be tempted to use alcohol or other substances to numb your feelings, but this is not a solution, and may well make things worse.

When you are ready, it can help to commit some time to try and focus on things which help to take your mind off your bereavement, such as hobbies or sporting and leisure activities like swimming, cycling or running. Perhaps you could try something new, like meditation or yoga, which might help you to relax.

Some people find it helpful to set up a web page that can be dedicated to someone. It enables friends/family to have input and can often help with the healing process. One such company is www.gonetoosoon.org but there are many others.

Inevitably, there will be difficult times such as the anniversary of the death, birthdays or family events. It also might help to plan ahead for these times. It might help to talk through your feelings with someone, or do something in remembrance on significant days like visiting a place that has a special memory or planting a shrub or flower. Sometimes, the anticipation of the event can be worse than the actual day itself.

You will undoubtedly hear clichés like ‘time is a great healer’. Although you may not initially accept this, most people find that as they work through their emotions, it becomes easier to adjust to living with their loss. For every person who has died as a result of suicide, there are many others who have somehow survived losing them. Learning to accept that the person has gone doesn’t mean you are forgetting that they played an important role in your life, and that they always will.

“It’s really good to be able to get together with other people and talk about the people you’ve lost and what they meant to you, and to celebrate their lives. It is by having such contacts now that I feel able to get that information out to others who may be in that same place of despair and isolation.” Caroline
Part 3. Useful contacts and resources

Mental health information

If you have any queries or comments about this booklet or would like information or advice about mental health issues, please contact:

SAMH:
By phone: 0800 917 3466
By email: info@samh.org.uk
By post: SAMH, Cumbernaud House, 15 Carlton Court, Glasgow G5 9JP
Website: www.samh.org.uk

For information or advice about depression, contact:

Depression Alliance Scotland:
By phone: 0845 123 23 20
By email: info@dascot.org.uk
By post: Depression Alliance Scotland, 11 Alva Street, Edinburgh EH2 4PH
Website: www.dascot.org.uk

Support

Breathing Space is a free and confidential phone line service for anyone who is experiencing low mood, anxiety or depression, or who is in need of someone to talk to or unusually worried. Contact Breathing Space:
By phone: 0800 83 85 87 (Mon-Thurs 6pm-2am, Fri 6pm-Mon 6am)
Website: www.breathingspacescotland.org.uk

Samaritans provide confidential emotional support 24 hours a day for people who are feeling distressed or need to talk to someone. You can contact them:
By phone: 08457 90 90 90
By email: jo@samaritans.org
By post: Chris, PO Box 90 90, Stirling FK8 2SA
Website: www.samaritans.org.uk

Childline is a free 24 hour helpline. Children and young people can call and talk to a Childline counsellor about any problem, including coping with bereavement. You can contact them:
By phone: 0800 11 11
Website: www.childline.org

Winston’s Wish works with children who have been bereaved. Contact them:
By phone: 08452 03 04 05
By email: info@winstonswish.org.uk
By post: Westmoreland House, 80-86 Bath Road, Cheltenham, Gloucestershire GL53 7JT
Website: www.winstonswish.org.uk

Survivors of Bereavement by Suicide offers emotional and practical support to people bereaved by suicide. You can contact them:
By phone: 0844 561 6855 (9am-9pm)
By post: The Flaminsteed Centre, Albert Street, Ilkeston, Derbyshire DE7 6GU
Website: www.uk-sobs.org.uk

The PAPYRUS helpline, HOPElineUK, offers practical advice and information from mental health professionals to anyone who is concerned that they or someone they know may be at risk of suicide. Contact them:
By phone: 0800 068 4141 (Mon-Fri 10am-5pm, 7pm-10pm; Sat-Sun 2pm-5pm)
Website: www.papyrus-uk.org

The Compassionate Friends is an organisation of bereaved parents and their families offering support to others who have experienced the death of a child. You can contact them:
By phone: 0845 123 2304 (10am-4pm, 6.30pm-10.30pm)
By email: helpline@tcf.org.uk
By post: TCF, 53 North Street, Bristol BS3 1EN
Website: www.tcf.org.uk

Cruse Bereavement Care Scotland offers free bereavement care and support through one-to-one counselling or local support groups. To find out about the availability of services in your area, contact the National Office:
By phone: 0845 600 2227
By email: info@crusescotland.org.uk
By post: Cruse Bereavement Care Scotland, Riverview House, Friarton Road, Perth PH2 8DF
Website: www.crusescotland.org.uk

PETAL (People Experiencing Trauma and Loss) provides practical and emotional support to those affected by murder or suicide. Contact them:
By phone: 01698 324502
Website: www.petalsupport.com

Widowed by Suicide aims to reduce the isolation felt by those who have lost their life partner through suicide.
Email: Jacqui@widowed-by-suicide.org.uk
Website: www.widowed-by-suicide.org.uk

Scottish Government initiatives

Choose Life is a 10-year strategy and action plan aimed at reducing suicide in Scotland by 20% by 2013. It is funded by the Scottish Government and hosted by NHS Health Scotland. All 32 local authorities in Scotland have a suicide prevention action plan and a local co-ordinator to implement it.
Find out more at: www.chooselife.net

The ‘see me’ campaign was launched in October 2002 to challenge stigma and discrimination around mental ill-health in Scotland.
Find out more at: www.seemescotland.org.uk

The Scottish Recovery Network raises awareness of recovery from mental health problems.
Find out more at: www.scottishrecovery.net
3. Useful contacts and resources

Legal advice

If you need a solicitor, you can contact the Law Society:
By phone: 0131 226 7411
By email: lawscot@lawscot.org.uk
By post: 26 Drumsheugh Gardens, Edinburgh EH3 7YR
Website: www.lawscot.org.uk

For advice on welfare benefits, contact:
Citizens Advice Bureau (CAB). You will find your local branch in your phonebook or contact them:
By phone: 0844 848 9600
Website: www.cas.org.uk

Money Advice Scotland can provide details of your local welfare rights projects:
By phone: 0141 572 0237
Website: www.moneyadvicescotland.org.uk

Helpful books


Beyond the Rough Rock: Supporting a Child who has been Bereaved through Suicide. Available from Winston’s Wish www.winstonswish.org.uk

Acknowledgements

This booklet was inspired by families who contacted the SAMH Information Service for advice and information. Their cases highlighted the need for information and support for people bereaved as a result of suicide. SAMH is particularly grateful to Graham and Rona Ross and family, who kindly allowed this booklet to be dedicated to the memory of their daughter Jennifer.

Our special thanks to the family and friends of Garry McMurray Bowers, who made a donation towards the first edition of the booklet in his memory, following his death on 7th January 2004, aged 22.

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Further copies of this booklet can be obtained by contacting the SAMH Information Service on 0800 917 3466 or can be downloaded from the SAMH website at www.samh.org.uk

The information contained in this booklet is believed, but not warranted, to be accurate as at the date of publication. If you have any queries as to how any of this information may apply in your own particular circumstances, seek advice from a solicitor or other appropriate adviser.

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Other advice

You can contact the Mental Welfare Commission for Scotland (MWC):
By phone: 0131 313 8777
User and carer advice line:
0800 389 6809
By email: enquiries@mwcscoot.org.uk
By post: Thistle House, 91 Haymarket Terrace, Edinburgh EH12 5HE
Website: www.mwcscoot.org.uk

You can contact the Care Commission at their national headquarters:
By phone: 01382 207100 or ‘lo-call’ 0845 60 30 890
By email: enquiries@carecommission.com
By post: Care Commission, Compass House, 11 Riverside, Dundee DD1 4NY
Website: www.carecommission.com
If you are feeling overwhelmed by problems or suicidal, don’t hide it. Talk to someone you trust or phone Breathing Space on 0800 83 85 87 or Samaritans on 08457 90 90 90. **If you are having serious thoughts about suicide, and you have a plan and the means to carry it out: call 999 right now.**
After a Suicide: A Toolkit for Schools
Second Edition
Endorsements from Other Organizations

National Association of School Psychologists (NASP)

When a suicide occurs, it can disrupt the foundation of the school and larger community to the core. How school leaders respond can help minimize negative effects and reinforce resilience. In fact, effective postvention efforts serve as the first line for prevention of potential suicide contagion among vulnerable members of the school community. *After a Suicide: A Toolkit for Schools* provides step-by-step guidance, templates, and resources all in one place. It is a vital resource to help school administrators and crisis teams plan for and implement appropriate postvention strategies to facilitate communications, support grieving students and staff, identify at-risk individuals, and more.

National Association of Secondary School Principals (NASSP)

The tragedy of suicide affects many schools each year, and it is essential for principals and other school leaders to have the resources they need to help them cope personally and professionally in the event of a student death. During the high-stress period after a suicide, these professionals must provide effective postvention (activities that reduce risk and promote healing after a suicide death) and facilitate an orderly return to the daily operation of the school. That’s why the National Association of Secondary School Principals (NASSP) collaborates with organizations like the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center. Toolkits like *After a Suicide: A Toolkit for Schools* provide our members with tools and resources designed to help them work with faculty, staff, students, and others to restore the health of the school community. Resources like these are integral in helping principals and other school leaders carry out their mission to serve all students.

American School Counselor Association (ASCA)

A student suicide has a tremendous impact on the entire school as well as the broader community. School administrators, faculty, and staff are called on to provide leadership and strength to students and their families, even though they themselves may be shaken emotionally and unsure of the proper actions to take. They will be grappling with issues such as immediate crisis response, helping students and parents cope, and communicating with the school and wider community, as well as the media. *After a Suicide: A Toolkit for Schools*, developed by the American Foundation for Suicide Prevention and the Suicide Prevention Resource Center, is a valuable guide to help school personnel prepare for the tumultuous and stressful aftermath of a student suicide and to help prevent future tragedies.
This second edition of *After a Suicide: A Toolkit for Schools* was written in 2018 by the American Foundation for Suicide Prevention (AFSP) and the Suicide Prevention Resource Center (SPRC), Education Development Center (EDC).

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After a Suicide: A Toolkit for Schools addresses Objective 10.1 of the National Strategy for Suicide Prevention (2012): Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels.

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The American Foundation for Suicide Prevention (AFSP) is the leading national not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education, and advocacy. AFSP’s mission is to save lives and bring hope to those affected by suicide. afsp.org

The Suicide Prevention Resource Center (SPRC) is the nation’s only federally supported resource center devoted to advancing the National Strategy for Suicide Prevention. It enhances the nation’s mental health infrastructure by providing states, government agencies, private organizations, colleges and universities, and suicide survivor and mental health consumer groups with access to the science and experience that can support their efforts to develop programs, implement interventions, and promote policies to prevent suicide. sprc.org
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Introduction
Introduction

The suicide of a student can leave a school faced with grieving students, distressed parents and school staff, media attention, and a community struggling to understand what happened and why. In this situation, schools need reliable information, practical tools, and pragmatic guidance to help them protect their students, to communicate with the public, and to return to their primary mission of educating students.

In 2011, the American Foundation for Suicide Prevention (AFSP) and the Suicide Prevention Resource Center (SPRC) produced *After a Suicide: A Toolkit for Schools* to assist schools in the aftermath of a suicide in the school community. This second edition includes updated information and new material.

This toolkit reflects consensus recommendations developed in consultation with national experts, including school-based administrators and staff, clinicians, researchers, and crisis response professionals. It provides guidance and tools for postvention, a term used to describe activities that help people cope with the emotional distress resulting from a suicide and prevent additional trauma that could lead to further suicidal behavior and deaths, especially among people who are vulnerable.

This resource was developed primarily for administrators and staff in middle and high schools, but it can also be useful for parents and communities. Although some of the guidance can be used by schools serving other age groups, the developmental differences between students in elementary, middle, and high school, and college must be taken into account when using the toolkit to respond to a death in a school.

*After a Suicide* focuses on how to respond in the immediate aftermath of a suicide death of a student. Ideally, schools should have a crisis response and postvention plan in place before a suicide occurs. That will enable staff to respond in an organized and effective manner. But whether or not a school has such a plan, this toolkit contains information schools can use to initiate a coordinated response. For information on developing protocols for responding to a suicide, see Chapter 3 in *Preventing Suicide: A Toolkit for High Schools*.\(^1\)

The following principles have guided the development of the toolkit:

- Schools should treat all student deaths in the same way. Having one approach for a student who dies of cancer (for example) and another for a student who dies by suicide reinforces the negative association that often surrounds suicide and may be deeply painful to the deceased student’s family and close friends.
- Adolescents are vulnerable to the risk of suicide contagion, that is, when a struggling student experiences the loss of another student to suicide and becomes at greater risk. Therefore, it is important not to inadvertently simplify, glamorize, or romanticize the student or his or her death.
- Adolescents are also resilient. With the proper information, guidance, and support from school staff, students can learn to cope with the suicide of a fellow student, process their grief, and return to healthy functioning.
- Suicide has multiple causes. However, a student who dies by suicide was likely struggling with significant concerns, such as a mental health condition that caused substantial psychological pain even if that pain was not apparent to others. But it is also important to understand that most people with mental health conditions do not attempt suicide.

\(^1\) There are some differences in terminology and roles between *Preventing Suicide: A Toolkit for High Schools* and this toolkit. We provide additional explanation in this toolkit’s section “Crisis Response.”
• Help should be available for any student who may be struggling with mental health issues or suicidal feelings.

• Postvention efforts need to consider the cultural diversity of those affected by a suicide.

After a Suicide: A Toolkit for Schools was designed to help schools respond immediately in the minutes, hours, and days after a suicide as well as in the weeks and months it takes the school community to heal and move forward. Since significant numbers of high school-aged youth die by suicide across the United States every year, every school needs to be prepared to respond to such an event.

Brief Descriptions of the Toolkit Sections

Crisis Response – Steps that should be taken immediately when the school learns that a student has died by suicide

Helping Students Cope – Ways that the school can help reduce the emotional trauma of an unexpected death for all students and reduce suicide risk among vulnerable students

Working with the Community – Approaches to sharing information and coordinating activities with organizations and groups outside the school, including the police department, local government, faith community, and mental health providers

Working with the Media – Helping journalists ensure that the public gets the information it needs without causing undue emotional stress, increasing the risk of contagion to other students, or violating the privacy of the deceased and his or her family

Memorialization – Appropriately remembering and honoring a student who died without contributing to additional emotional trauma or suicide risk among other students

Social Media – How to appropriately use social media to inform the community while working to limit the spread of rumors and social media content that can raise the risk of vulnerable students

Suicide Contagion – Helping vulnerable students who may be in emotional or suicidal crisis as a result of the death of another student, member of the school community, or a celebrity with whom they identify, in order to avoid additional suicidal behavior and deaths

Bringing in Outside Help – Identifying and working with postvention experts from outside the school

Going Forward – Moving past the immediate crisis and implementing a comprehensive suicide prevention plan (if the school does not already have one)

Appendix A: Tools and Templates – Sample guidelines, letters, and procedures to be used in the aftermath of a suicide

Appendix B: Additional Resources – Sources of more information and guidance on preparing for and responding to a suicide in the school community, listed by the section of the toolkit to which they are most relevant
Crisis Response
Crisis Response

When a school receives the news that one of its students has died by suicide, the first step is to make sure this news is true. In this age of social media and smartphones, it is easy for rumors to spread.

- School staff should immediately confirm the death of a student.
- Upon confirmation, the school should immediately implement a coordinated crisis response to achieve the following:
  - Effectively manage the situation
  - Provide opportunities for grief support
  - Maintain an environment focused on normal educational activities
  - Help students cope with their feelings
  - Minimize the risk of suicide contagion

Mobilize a Crisis Response Team

It is most effective for schools to have an identified Crisis Response Team set up and ready to respond to a crisis before one occurs. This team is responsible for implementing the elements of your school’s crisis response plan.

Before a crisis occurs, find out whether your school district has a Crisis Response Team that can provide additional support to your school if needed. Many districts have a Crisis Response Team to handle larger crisis events, with each school having its own Crisis Response Team. This allows schools to pull from the district-wide team if they require additional support staff to meet the needs of their staff and students in the aftermath of a suicide. A district team is also beneficial if the school’s Crisis Response Team is emotionally impacted in a way that makes it difficult for team members to engage in postvention activities effectively, or if they need extra support.

Depending on the size of the school or district, the school Crisis Response Team should have at least 5 or 6 people (but no more than 15), chosen for their skills, credentials, and ability to work compassionately and effectively under pressure with all members of the school community. Ideally the team will be a combination of administrators, counselors, social workers, psychologists, nurses, and school resource officers. It can also be useful to include a member of the school’s information technology staff to help with social media. The team should have the ability to work with all of the cultures represented by the students and their families.

If You Have Used Preventing Suicide: A Toolkit for High Schools

Note: Preventing Suicide: A Toolkit for High Schools uses the term “Suicide Response Team.” In this toolkit on postvention, we use “Crisis Response Team” instead because this term is now more widely known, accepted, and used in school safety plans. Some schools have a Suicide Response Team that is part of a larger Crisis Response Team. Even if you have a Suicide Response Team, consider mobilizing the entire Crisis Response Team after a suicide, since effective postvention requires the expertise, roles, and knowledge of the entire team.
The Crisis Response Team coordinator is usually the principal. The team coordinator:

- Has overall responsibility throughout the crisis
- Is the central point of contact
- Monitors overall postvention activities throughout the school
- Handles communications with the different groups of people within the school (e.g., administration, staff, students, and parents) and the media

Depending on the needs of the school and its Crisis Response Team, the team coordinator may find it helpful to designate a member of the mental health staff to serve as an assistant coordinator for the team. This person assists the coordinator in the following activities:

- Coordinate communication among the staff, students, and community
- Share updates with Crisis Response Team members
- Work with the mental health team to organize safe rooms for students and staff in need of assistance
- Facilitate communication with parents when concerns arise about particular students

If an assistant coordinator is designated, that person can also fill in for the coordinator if he or she is not available. If an assistant coordinator is not designated, a back-up coordinator should be assigned by the coordinator for times when the coordinator is not available.

**Comparison of Roles in This Toolkit and Preventing Suicide: A Toolkit for High Schools**

This toolkit updates the roles listed in *Preventing Suicide: A Toolkit for High Schools*.

<table>
<thead>
<tr>
<th>After a Suicide: A Toolkit for Schools</th>
<th>Preventing Suicide: A Toolkit for High Schools</th>
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<tbody>
<tr>
<td>Crisis Response Team coordinator</td>
<td>Suicide Response Team coordinator</td>
</tr>
<tr>
<td>Assistant coordinator (optional)</td>
<td>N/A</td>
</tr>
<tr>
<td>Back-up coordinator if no assistant coordinator</td>
<td>Back-up coordinator</td>
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**Get the Facts**

A postvention plan should emphasize a single point of contact for information if the school learns of a student death. For example, the school principal would likely be the first person notified when anyone in the school learns of a student death.

Although it may not always be possible to immediately determine all of the details about a death, confirming as much factual information as possible before communicating with students is important. Speculation and rumors can exacerbate the emotional upheaval within the school. Time is also of the essence in confirming factual information.
since social media and other forms of communication may be occurring simultaneously, and it is possible that others, including students, may already have some information about the death.

It can be challenging for a school to determine how to proceed if the cause of death has not been confirmed to be suicide, if there is an ongoing investigation, or if the family does not want the cause of death disclosed. The school’s principal or the superintendent should first check with the family, the coroner, and/or the medical examiner’s office (or, if necessary, local law enforcement) to ascertain the official cause of death.

**If the Cause of Death Is Unconfirmed**

If there is an ongoing investigation, schools should state that the cause of death is still being determined and that additional information will be forthcoming once it has been confirmed. Acknowledge that there may be rumors (which are often inaccurate), and remind students that rumors can be deeply hurtful and unfair to the missing/deceased person and his or her family and friends.

Given how quickly news and rumors spread (including through media coverage, e-mail, texting, and social media), schools may not be able to wait for a final determination before they need to begin communicating with the students. In those cases, schools can say, “At this time, this is what we know…” For a more complete example of how to talk with students about this, see [Sample Death Notification Statement for Students: Option 2 – When the Cause of Death Is Unconfirmed](#).

The school attorney may wish to first research the applicable state law regarding discussing the cause of death before the school issues a statement. In addition, schools should check with local law enforcement before speaking about the death with students who may need to be interviewed by the authorities.

**If the Family Does Not Want the Cause of Death Disclosed**

Although the fact that a student has died may be disclosed immediately, official information about the cause of death should not be disclosed to students until the family has been consulted. The need to share information should be carefully balanced with honoring the family’s request. Therefore, the school may choose to initially release a more general, factual statement without using the student’s name if the family does not give permission (e.g., “We have learned that a ninth-grade student died over the weekend.”).

There may be cases where the death has been declared a suicide, but the family does not want this communicated, perhaps due to prejudice, privacy concerns, or fear of risking contagion or because they simply do not (yet) believe or accept that it was suicide. If this situation occurs, someone from the administration or mental health staff who has a good relationship with the family should be designated to contact them to explain that students are already talking about the death among themselves, and that having adults in the school community talk with students about suicide and its causes can help keep students safe.

Schools have a responsibility to balance the need to be truthful with the school community with the need to be sensitive to the family. If the family refuses to permit disclosure, schools can state, “The family has requested that information about the cause of death not be shared at this time.” But staff can also use the opportunity to talk with students about the phenomenon of suicide, for example:

*We know there has been a lot of talk about whether this was a suicide death. Since the subject of suicide has been raised, we want to take this opportunity to give you accurate information about suicide in general, ways to prevent it, and how to get help if you or someone you know is feeling depressed or may be suicidal.*
Share the News with the School Community

The principal or Crisis Response Team coordinator should use care in sharing the information about the death with staff and parents in the school community. This communication should be done separately from communications with students. Also, what is said publicly may be limited to some degree by the family’s wishes, and it is important to distinguish what might be said in a public meeting (e.g., with parents) versus a meeting of necessary school staff (e.g., teachers who taught the deceased student).

In any communication about suicide, it is important to follow guidelines on safe messaging about suicide. It is particularly important to avoid idealizing the person and glorifying suicide. Talk about the person in a balanced manner. Do not be afraid to include the struggles that were known, especially in individual conversations about the death. If the student’s struggles are not mentioned, it may cause confusion as well as give the impression that suicide is an effective way of addressing one’s distress—especially among the other students.

For more suggestions on how to talk about suicide, see the tool Tips for Talking about Suicide.

Address Cultural Diversity

Postvention efforts need to take into consideration the cultural diversity of everyone affected by a suicide, including the family, school, and community. This diversity may include differences in race, ethnicity, language, religion, sexual orientation, and disability. Culture may significantly affect the way people view and respond to suicide and death.

Key points involving cultural differences include the following:

- Be aware that the extent to which people are able to talk about suicide varies greatly, and in some cultures suicide is still seen as a moral failing.
- Be sensitive to the beliefs and customs regarding the family and community, including rituals, funerals, the appropriate person to contact, etc.
- Be sensitive to how the family or community may need to respond to the death before individuals outside of the family or community intervene to provide support.
- Engage a “cultural broker” to act as a liaison between the family, community, and school if key members of school staff are not from the same racial, ethnic, or religious group as the person who died by suicide.
- Bring in interpreters and translators if there are language differences. If possible, have resource materials in different languages available for parents.

Activities for Responding to a Crisis

Crisis Response Team Coordinator’s Tasks

- Inform the principal (if not already notified or designated as team coordinator) and school superintendent of the death.
- Contact the deceased’s family to:
  - Offer condolences
  - Inquire as to what the school can do to assist
  - Ask them to identify the student’s friends who may need assistance
Discuss what students should be told

Inquire about funeral arrangements

Note: Schools may establish a better rapport with the family if they make this contact in person.

• Call an immediate meeting of the Crisis Response Team to assign responsibilities.

• Establish a plan to immediately notify school staff of the death via the school’s crisis alert system. If possible, this should be an in-person notification, especially for those who worked directly with the deceased student.

• Schedule an initial all-staff meeting as soon as possible—ideally before school starts in the morning (see the tool Sample Guidelines for Initial All-Staff Meeting).

• Arrange for students to be notified of the death in small groups, such as in homerooms. Do not notify students by PA (public address) system or in a large assembly.

• Disseminate a death notification statement for students to homeroom teachers (see the tool Sample Death Notification Statement for Students). It is suggested that in the homeroom of the deceased student, it might be helpful to have a mental health professional (e.g., school psychologist, counselor, social worker) present as well as the teacher.

• Identify social media accounts that may need attention or monitoring, and designate a member of the crisis team to monitor them (for more information, see the Social Media section).

• Draft and disseminate a written death notification statement to parents (see the tool Sample Death Notification Statement for Parents).

• Disseminate the handouts Facts about Suicide in Adolescents, Tips for Talking about Suicide, and Youth Warning Signs and What to Do in a Crisis to teachers and other relevant school staff to give them more information about suicide and how to help their students.

• Speak with the school superintendent and Crisis Response Team assistant coordinator throughout the day.

• Determine whether additional grief counselors, crisis responders, or other resources may be needed from outside the school.

**Team Assistant Coordinator’s Tasks**

The following tasks may be delegated as appropriate to specific staff by the team coordinator if an assistant coordinator is not designated:

• Conduct an initial all-staff meeting.

• Conduct periodic meetings for the Crisis Response Team members.

• Monitor activities throughout the school, making sure teachers, staff, and Crisis Response Team members have adequate support and resources.

• Plan a parents’ meeting, if necessary (see the tool Sample Agenda for Parent Meeting).

• Assign roles and responsibilities to Crisis Response Team members in the areas of safety, support for staff and students, community liaisons, funeral, media relations, and social media.
Other Key Activities

These activities can be implemented by the team coordinator, assistant coordinator, and/or other designated staff, depending on the activity and the specific situation:

Safety

- Keep to regular school hours.
- Ensure that students follow established dismissal procedures.
- Call on school resource officers or facilities managers to assist parents and others who may show up at the school with inquiries and to keep media off school grounds.
- Pay attention to students who are having particular difficulty, including those who are either withdrawing from others or congregating in hallways and bathrooms. Encourage them to talk with counselors or other appropriate school staff.

Support for Staff and Students

- Assign a staff member to follow the deceased student’s schedule to monitor peer reactions and answer questions. It is also important to monitor staff reactions to the death.
- If possible, arrange for several substitute teachers or “floaters” from other schools within the district (or outside consultants) to be on hand in the building in case teachers need to take time out of their classrooms.
- If possible, identify an easily accessible mechanism for students to request support (e.g., be able to request a pass to meet with a counselor or others) throughout the day.
- Arrange for crisis counseling rooms for staff and students.
- Provide tissues and water throughout the building and arrange for food for teachers and crisis counselors who may be giving up lunch periods to respond to students.
- Work with the administration, teachers, and school mental health professionals to identify individuals who may be having particular difficulty, such as family members, close friends, and teammates; those who had difficulties with the deceased; those who may have witnessed the death; and students known to have depression or prior suicidality.
- Work with school-based mental health professionals to develop plans to provide counseling and referrals to those who need it.
- Prepare to track and respond to student and/or family requests for memorialization.

Community Liaisons

- Several team members will be needed, each serving as the primary contact for working with community partners of various types, including:
  - Coroner/medical examiner – To ensure accuracy of information disseminated to school community
  - Police – As necessary, particularly if an investigation about the death occurs, and the police wish to speak with school staff
  - Mayor’s office and local government – To facilitate a community-wide response to the suicide death
• Mental health and medical communities and grief support organizations – To plan for student, staff, and community needs

• Arrange for outside trauma responders, if necessary, and brief them as they arrive on scene.

**Funeral**

• Communicate with the funeral director about logistics for students and staff attending the services, including the need for crisis counselors and/or security to be present at the funeral.

• Encourage the family to hold the funeral off of school grounds and outside of school hours if at all possible.

• Be sensitive to the needs and wishes of different religious, ethnic, and racial groups that may be involved in the funeral.

• When possible, discuss with the family the importance of communicating with clergy/religious leaders, or whoever will be conducting the funeral, to ask if they are comfortable mentioning something about the struggles the student was having. When appropriate, include mental health concerns. While ultimately this is the family and religious leader’s decision, an informed discussion should occur where the family and religious leader are made aware of the benefits of providing this information as a way to promote understanding about suicide as well as to reduce possible contagion.

• Depending on the family’s wishes, help disseminate information about the funeral to students, parents, and staff, including:
  
  o **Location**
  
  o **Time of the funeral (keep school open if the funeral is during school hours)**
  
  o **What to expect (e.g., whether there will be an open casket)**
  
  o **Guidance regarding how to express condolences to the family**
  
  o **Policy for releasing students during school hours to attend (i.e., students will be released only with permission of parent, guardian, or designated adult)**
  
  o **Procedures for staff who want to attend (i.e., excused time away, getting substitute teachers)**

• Work with school mental health professionals and community mental health professionals to arrange for counselors to attend the funeral.

• Encourage parents to accompany their child to the funeral.

**Media Relations**

• Designate a media spokesperson to field media inquiries using the tool [Key Messages for Media Spokesperson](#).

• Prepare a media statement.

• Advise staff that only the media spokesperson is authorized to speak to the media.

• Advise students to avoid interviews with the media.

• Refer media outlets to [Recommendations for Reporting on Suicide](#).
Social Media

- Oversee the school’s use of social media as part of the crisis response.
- See the Social Media section for details on monitoring social media.

Tools for Crisis Response

These tools are in Appendix A: Tools and Templates:

- Sample Guidelines for Initial All-Staff Meeting
- Sample Death Notification Statement for Students
- Sample Death Notification Statement for Parents
- Sample Agenda for Parent Meeting
- Tips for Talking about Suicide
- Facts about Suicide in Adolescents
- Youth Warning Signs and What to Do in a Crisis

For more resources on crisis response, see Appendix B: Additional Resources.
Helping Students Cope
Helping Students Cope

In the aftermath of a suicide, students and others in the school community may feel emotionally overwhelmed. This can make it difficult for the school to return to its primary function of educating students and can also increase the risk of prolonged stress responses and even suicide contagion. A school’s approach to supporting students after a suicide loss is most effective when it provides different levels of support depending on the students’ needs. It is critical that an opportunity to meet in smaller groups be given to students in need of more in-depth support, augmenting the support given to all students.

Key Considerations

Adolescence is a time of increased risk for difficulties with emotional regulation given the intensification of responses that come with puberty and the structural changes in the brain that occur during this developmental period. Most adolescents have mastered basic skills that allow them to handle strong emotions encountered day to day. But these skills may be challenged in the face of a suicide. Young people may not yet have learned how to recognize complex feelings or physical indicators of distress, such as stomach upset, restlessness, or insomnia.

It is therefore important for schools to provide students with appropriate opportunities to express their emotions and identify strategies for managing them, such as in group and individual counseling sessions. Schools can also help students balance the timing and intensity of their emotional expression. Staff can use the information in the tool Tips for Talking about Suicide to help students understand and manage their emotions.

If there are concerns about a student’s emotional or mental health, the parent(s) or guardian(s) should be notified, and a referral should be made to a mental health professional for assessment, diagnosis, and possible treatment. Mental health resources that may be available in addition to school-based mental health professionals (e.g., school psychologists, counselors, social workers) include community mental health agencies, emergency psychiatric screening centers, and children’s mobile response programs. Pediatricians and primary care providers can also be a source of mental health referrals. In addition, it may be useful for school staff to identify and reach out to families of students who are not coming to school.

When implementing these strategies, leadership will most likely be provided by the school psychologist, counselor, social worker, school nurse, and/or possibly a community mental health partner, all of whom may be members of the school’s Crisis Response Team and likely trained in culturally competent counseling strategies. However, all adults in the school community can help by modeling calm, caring, and thoughtful behavior.

Schedule Meetings with Students in Small Groups

Schools will likely need to adjust the regular academic schedule to allow time for helping students address their emotional needs. It is preferable to reach out to students in a deliberate and timely way, rather than allow the emotional environment to escalate, and to do so in homerooms and small group meetings.

All students should be provided with the opportunity to go to a small group meeting where they can express their feelings about the death of their classmate and obtain support. This type of group would be optional for students and should take place outside their classroom in private offices within the school. Ideally, these groups would be facilitated by a school mental health professional or another person experienced in postvention. However, if that is not possible, it is important that the staff who meet with students are comfortable with students’ grief and know the school’s
procedure for addressing a student who is in distress and the importance of referring the student for help. Such small groups also provide a chance for adults to identify youth who appear in need of additional support.

These group meetings can either have a structured agenda and keep to a time limit or be open-ended and focus more on addressing the students’ specific needs. It is important to provide each student with an opportunity to speak. The groups should focus on helping students identify and express their feelings and discuss practical coping strategies (including appropriate ways to memorialize the loss) so that they can return their focus to their regular routines and activities.

In addition to the small groups, it might be helpful to have mental health professionals visit classrooms to:

- Give all students accurate information about suicide
- Prepare students for the kinds of reactions that can be expected after hearing about a peer’s suicide death
- Provide them with safe coping strategies they can use to help them in the coming days and weeks
- Answer questions students may have and dispel any rumors

If the deceased student participated in sports, clubs, or other school activities, the first practice, game, rehearsal, or meeting after the death may be difficult for the other students. These events can provide further opportunities for the adults in the school community to help the students appropriately acknowledge the loss.

**Help Students Identify and Express Their Emotions**

Youth will vary widely in terms of emotional expression. Some may become openly emotional, others may be reluctant to talk at all, and still others may use humor. How they express their emotions may also be influenced by their cultural background. Acknowledge the diversity of experiences and the wide range of feelings and reactions to a crisis that students may have, and emphasize the importance of being respectful of others.

Some students may need help identifying emotions beyond simply sad, angry, or happy, and they may need reassurance that a wide range of feelings and experiences are to be expected. They may also need to be reminded that emotions may be experienced as physical symptoms, including butterflies in the stomach, shortness of breath, insomnia, fatigue, or irritability. To facilitate this discussion, ask students questions, such as:

- What is your biggest concern about the immediate future?
- What would help you feel safer right now?

It may help establish rapport to open a conversation by asking students what their favorite memories are of the student.

**Practical Coping Strategies**

Encourage students to think about specific things they can do when intense emotions, such as worry or sadness, begin to well up, for example:

- Use simple relaxation and distraction skills, such as taking three deep, slow breaths; counting to 10; or picturing themselves in a favorite calm and relaxing place
- Engage in favorite activities or hobbies, such as music, talking with a friend, reading, or going to a movie
• Exercise
• Think about how they have coped with difficulties in the past and remind themselves that they can use those same coping skills now
• Write a list of people they can turn to for support
• Write a list of things they are looking forward to
• Focus on personal goals, such as returning to a shared class or spending time with mutual friends

Often, youth will express guilt about having fun or thinking about other things. They may feel that they somehow need permission to engage in activities that will help them feel better and take their mind off the stressful situation.

Encourage students to think about how they want to remember their friend. Ideas may include writing a personal note to the family, attending the memorial service, creating a memory book, or doing something kind for another person in honor of their friend. Be sure to educate students about the school’s guidelines regarding memorialization. Acknowledging their need to express their feelings while helping them identify appropriate ways to do so can begin the process of returning their focus to their daily lives and responsibilities.

Schools, in partnership with community mental health resources, might also consider creating drop-in centers that provide a safe and comfortable place for youth to be together after school hours. These can be staffed by volunteer counselors and clinicians from the community who can provide grief counseling, as well as identify and refer youth who may need additional mental health or substance abuse services. These centers can also be used during times of particularly heightened emotion, such as graduation or the anniversary of a student’s death.

Reach Out to Parents

Parents may need guidance on how to talk about suicide with their children and how best to support them at this difficult time. They may also need reliable information such as that found in Facts about Suicide in Adolescents, Youth Warning Signs and What to Do in a Crisis, and Tips for Talking about Suicide. Encourage parents to contact school mental health staff if they are concerned about their children or other students.

Anniversary of the Death

The anniversary of the death (and other significant dates, such as the deceased’s birthday) may stir up emotions and can be an upsetting time for some students and staff. It is helpful to anticipate this and provide an opportunity to acknowledge the date, particularly with those students who were especially close to the student who died. These students may also need additional support since mourning can be a long-term process, and an anniversary of a loss can trigger the grief and trauma they experienced at the time of the death.

For more resources on helping students cope, see Appendix B: Additional Resources.
Working with the Community
Working with the Community

Because schools exist within the context of a larger community, it is very important that before a suicide or other death occurs they establish and maintain open lines of communication and working relationships with community partners, such as the coroner/medical examiner, police department, local government office, funeral director, clergy, mental health and health care professionals, and community-based agencies. In many communities, schools and community partners may have established a memorandum of understanding (MOU) to clarify requirements and responsibilities. With these relationships already set up, schools and community partners will be ready to work together in the event of a crisis. If these relationships and MOUs are not in place, reach out to the partners described in this section as soon as possible after a suicide occurs to help clarify roles.

Key Considerations

The school is in a unique position to encourage open and constructive dialogue among important community partners, as well as with the family of the deceased student. Even in those realms where the school may have limited authority (such as the funeral), a collaborative approach allows for the sharing of important information and coordination of strategies. For example, a school may be able to offer relevant information (such as input on the likely turnout at the funeral) and anticipate problems (such as the possibility that students may gather late at night at the place where the deceased died). A coordinated approach can be especially critical when the suicide death receives a great deal of media coverage, and the entire community becomes involved.

Coroner/Medical Examiner

As noted in Get the Facts (in the Crisis Response section), the coroner or medical examiner is the best starting point for confirming that a death has been declared a suicide. So to help make accurate information available and to avoid or stop the spread of rumors as quickly as possible, it is important for the school to maintain a positive working relationship with the local coroner or medical examiner.

Police Department

The police are also likely to be an important source of information about the death, particularly if there is an ongoing investigation (e.g., if it has not yet been determined whether the death was a suicide or homicide). The school needs to be in close communication with the police to determine (a) what they can and cannot say to the school community so as not to interfere with the investigation, and (b) whether there are certain students or staff who must be interviewed by the police before the school can debrief or counsel them in any way. If school staff are to be interviewed, the school may want to consult its legal counsel prior to the interview(s).

There may also be situations in which the school has information that is relevant to the ability of the police to keep students safe. For example, the school may become aware that students have established a memorial off-campus and may even be engaging in dangerous behavior (such as gathering in large groups at the site of the death at night or holding vigils at which alcohol is being consumed) and may need to enlist the cooperation of the police to keep the students safe. The school may also be in a unique position to brief the police (and even the family of the deceased student) about what to expect at the funeral or memorial service in terms of turnout and other safety concerns.
Local Government
A student suicide death may reveal an underlying community-wide problem, such as drug or alcohol use, bullying, gang violence, or a possible suicide cluster. Because schools function within—not separate from—the surrounding community, local government entities, such as the mayor’s office, can be helpful partners in promoting dialogue and presenting a united front in the interest of protecting the community’s young people.

Funeral Director
The school and funeral home are complementary sources of information for the community.

Schools are often in an excellent position to:

- Give the funeral director a heads-up about what to expect at the funeral in terms of the number and types of students likely to attend and the possible need to have additional staff and/or security present
- Provide information about local counseling and other resources to the funeral directors, with the request that the information be made available to attendees at the funeral

Schools can also ask the funeral director to:

- Provide (or recommend) materials that the school could give to students to help them prepare for the funeral
- Talk to the family about the importance of scheduling the service outside of school hours, encouraging students’ parents to attend, and providing counselors to meet with distraught students after the service (and the need for a quiet area in which to do so)

A guide for funeral directors is available here.

Faith Community Leaders
The school can play an important role by encouraging a dialogue with the family and the faith community leaders (or whoever will be officiating at the service) to help them all understand the risk of suicide contagion. For example, the school could explain the importance of not inadvertently romanticizing either the student or the death in the eulogy, and emphasize the connection between suicide and underlying mental health issues. It may be helpful to refer faith community leaders to the publication After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances.

If the school has a religious affiliation, it is important to include clergy who are on staff in any communications and outreach efforts to support the student body and encourage them to be familiar with their faith’s current understanding of the relationship between mental illness and suicide.
Faith communities may also be helpful in supporting community postvention efforts. Vignette A provides an example.

**Vignette A: Faith Leaders Educating Community Members**

A high school whose staff had been trained in postvention lost a student to suicide. The principal invited the family minister, whose youth group the student had been involved in, to the school’s early morning crisis response meeting. The minister learned about the many risk factors that can lead to suicide. He and his wife both became leaders in the community’s postvention response. They hosted an evening gathering at the church to educate all community members about suicide as a public health issue and inform them of the warning signs and resources for help.

This collaborative approach with key community stakeholders helped to give people permission to grieve the loss and learn how to hold onto hope and resilience.

**Mental Health and Health Care**

Most schools have mental health professionals on staff, and it is important that these individuals are linked to other mental health professionals in the community. If there are concerns that a student needs additional supports, school staff should notify the parent(s) or guardian(s) and make a referral to an appropriate mental health professional for assessment, diagnosis, and possible treatment.

Schools should also establish an ongoing relationship with a community mental health center that can see students in the event of a psychiatric emergency. In the aftermath of a suicide death, schools will want to notify the center to ensure seamless referrals if students show signs of distress. Schools will also want to publicize crisis hotline numbers, including the National Suicide Prevention Lifeline: 800-273-TALK (8255). In addition, schools can encourage the local health care community, including primary care doctors and pediatricians, to screen affected youth they see for depression, substance abuse, and other relevant disorders and refer them to a mental health professional as needed.

Schools can also help students, staff, and families find local bereavement support groups through community mental health and health care centers. Another way to find suicide bereavement support groups is through AFSP’s listing of suicide loss survivor groups across the country.

**Outside Postvention Specialists**

Working with students in the aftermath of a suicide death can easily exhaust a school’s crisis team members, which can interfere with their ability to effectively assist the students. Bringing in postvention specialists or trauma responders from other school districts or local mental health or crisis centers to work alongside the school’s crisis team members—and to provide care for the caregivers—can be quite helpful. See the section Bringing in Outside Help for more information.

**Building a Community Coalition**

If a community does not already have a coalition focused on suicide prevention, it may be helpful to create one.
After a Suicide: A Toolkit for Schools

Schools can be an active partner in this process. The coalition should include senior representation from the school, together with representatives from as many of the following as possible:

- Law enforcement
- Government (e.g., the mayor’s office, medical examiner’s office, and public health department)
- Parents who have demonstrated community leadership in addressing drug and alcohol abuse, bullying, or other related issues
- Mental health community (e.g., community mental health centers, psychiatric screening centers, private practitioners, and substance abuse treatment centers)
- Social service agencies
- Faith community leaders
- Funeral directors
- First responders and hospital emergency department personnel
- Media (as coalition members, not to cover it as a news event)
- Students
- Suicide bereavement support group facilitators
- Primary health care providers and clinics

The coalition’s initial goals should include the following tasks:

- Identify a leader or lead agency.
- Identify any particular risk factors within the community, such as widespread drug and alcohol use, bullying, or easy access to means of suicide.
- Mobilize existing mental health and primary care resources to identify and help young people who may be at high risk.
- Mobilize parents to assist in monitoring youth who come to their homes and neighborhoods.
- Reach out to other groups and businesses in the community where youth gather, such as recreation centers, religious organizations, sports leagues, movie theaters, and diners.

The coalition should also identify the gaps in existing resources and how to fill those gaps, such as by:

- Appointing a suicide prevention resource coordinator
- Hiring or contracting for additional counseling staff as needed
- Hiring staff to provide screening programs throughout the school district
- Developing alcohol and drug programs for youth
- Developing teen centers where youth can come together and engage in social and recreational activities with caring adults
• Creating a public awareness campaign or website to:
  o Educate the community about mental health disorders, substance abuse, and other high-risk behaviors
  o Decrease negative associations with mental health disorders and help-seeking
  o Increase help-seeking

  Note: See Framework for Successful Messaging for examples of safe messaging.

• Creating public service campaigns to educate the community about suicide risk factors, warning signs, and local resources for those at risk

• Identifying ways to reach at-risk youth who are not in the education system, such as recent graduates, dropouts, or those in the juvenile justice system

• Identifying and implementing ways to reduce access to lethal means

• Exploring eligibility for additional sources of funding, such as a U.S. Department of Education School Emergency Response to Violence (SERV) grant, awarded to school districts that have experienced a traumatic event and need additional resources to respond

Vignette B is an example of how community partners in a regional network may work together when a suicide occurs.

**Vignette B: Networking throughout a State**

In one state, a system of regional public health networks supports good communication among health care providers, first responders, and behavioral health services. Many providers who are active members in this network received training in postvention that included protocols and strategic planning.

When a young man died by suicide shortly after graduating from high school, staff in the network’s member organizations drew on the protocols they had learned. One of the trainers had ties to the young man’s family and helped them connect immediately with loss survivor support services. As a result, within days, family members were receiving individual support, and later in the month, several family members were attending loss survivor support groups. School personnel who knew he had a girlfriend in another school district contacted the school counselor there to extend resources and supports.

Throughout the week and into the weekend, members of the network circulated an e-mail loop with resources and protocols, identifying who was available as a contact for resources and/or support. They also alerted first responders and the regional mental health emergency services team to the possibility of related incidents and had a spokesperson available for media inquiries. Postvention guidelines and sample notices, as well as resources for loss survivors, were sent to the counselors in the young man’s high school and athletic groups. One of the counselors used the information to make changes in a program that would have memorialized the student in an unsafe way. Another counselor worked with youth to organize a fundraiser to support suicide prevention efforts in their region.

Even without a formal network, such as the one described here, organizations and schools can develop collaborative relationships and receive training so that they are prepared if a suicide occurs.

For more resources on working with the community, see Appendix B: Additional Resources.
Working with the Media

A death by suicide of a school-age student can attract a lot of media attention. And when multiple suicide deaths have occurred, media interest can be particularly intense. It is important for a school to develop safe messages in order to avoid contagion. The school should appoint a media spokesperson to ensure that news is released to the media in a deliberate and consistent manner and to disseminate the document Recommendations for Reporting on Suicide to the media.

The risk of contagion is related to the amount, duration, prominence, and content of media coverage. Therefore, it is extremely important that schools strongly encourage the media to adhere to the recommendations for safe reporting, which were developed by the nation’s leading suicide prevention organizations.

These recommendations include the following:

- Do not glamorize or romanticize the victim or the suicide.
- Do not oversimplify the causes of suicide.
- Do not describe the details of the method.
- Do not include photographs of the death scene or of devastated mourners, which can draw in vulnerable youth who may be desperate for attention and recognition.
- Use preferred language, such as “died by suicide” or “killed himself or herself” rather than a “successful” suicide.
- Include messages of hope and recovery.
- Consult suicide prevention experts.
- Include a list of warning signs, since most (but not all) people who die by suicide show warning signs.
- List the National Suicide Prevention Lifeline number (800-273-8255) and include information on local mental health resources in each article.
- Include up-to-date local and national resources.

Tools for Working with the Media

The following tools are in Appendix A: Tools and Templates:

- Sample Media Statement
- Key Messages for Media Spokesperson

For more resources on working with the media, see Appendix B: Additional Resources.
Memorialization
Memorialization

Students often wish to memorialize a student who has died, reflecting a basic human desire to remember those we have lost. However, it can be challenging for schools to strike a balance between compassionately meeting the needs of grieving students and appropriately memorializing the student who died without risking suicide contagion among other students who may themselves be at risk.

Key Considerations

It is very important that schools develop a policy on memorialization before a suicide death occurs and ensure that the policy is in the school’s suicide prevention procedures. Schools should strive to treat all deaths in the same way. Having one approach for memorializing a student who died of cancer or in a car accident and a different approach for a student who died by suicide reinforces prejudice associated with suicide and may be deeply painful to the student’s family and friends.

Nevertheless, because adolescents are especially vulnerable to the risk of suicide contagion, it is equally important to memorialize the student in a way that does not inadvertently glamorize or romanticize either the student or the death. Focus on how the student lived, rather than how he or she died. If the student had underlying mental health problems, seek opportunities to emphasize the connection between suicide and those problems, such as depression or anxiety, that may not be apparent to others (or that may manifest as behavioral problems or substance abuse).

Wherever possible, schools should meet with the student’s friends and coordinate memorialization with the family in the interest of identifying a meaningful, safe approach to acknowledging the loss. Make sure to be sensitive to the cultural needs of the students and the family.

This section includes several creative suggestions for memorializing students who have died by suicide and a tool to assist with making decisions about school-related memorials.

Funerals and Memorial Services

It is strongly advised not to hold funeral and memorial services on school grounds. The school should instead focus on maintaining its regular schedule, structure, and routine. Using a room or an area of the school for a funeral service can inextricably connect that space to the death, making it difficult for students to return there for regular classes or activities.

It is also strongly advised that the service be held outside of school hours. If the family does hold the service during school hours, it is recommended that the school remain open and that school buses not be used to transport students to and from the service. Students should be permitted to leave school to attend the service only with appropriate parental permission. Regular school protocols should be followed for dismissing students over the age of majority.

If possible, the school should coordinate with the family and funeral director to arrange for mental health professionals to attend the service. In all cases, the principal or another senior administrator should attend the funeral.

Schools should strongly encourage parents whose children express an interest in attending the funeral to attend with them. This provides not only emotional support but also an opportunity for parents to monitor their children’s response, to open a discussion with their children, and to remind them that help is available if they or a friend are in need.
Spontaneous Memorials

It is not unusual for students to create a spontaneous memorial by leaving flowers, cards, poems, pictures, stuffed animals, or other items in a place closely associated with the student, such as his or her locker or classroom seat, or at the site where the student died. Students may even come to school wearing T-shirts or buttons bearing photographs of the deceased student.

The school’s goal should be to balance the students’ need to grieve with the goal of limiting the risk of inadvertently glamorizing the death. If spontaneous memorials are created on school grounds, school staff should monitor them for messages that may be inappropriate (hostile or inflammatory) or that indicate students who may themselves be at risk.

A combination of time limits and straightforward communication regarding the memorials can help to restore equilibrium. Although it may be necessary in some cases to set limits for students, it is important to do so with compassion and sensitivity, offering creative suggestions whenever possible. For example, schools may wish to make poster boards and markers available so that students can gather and write messages. It is advisable to set up the posters in an area that may be avoided by those who don’t wish to participate (i.e., not in the cafeteria or at the front entrance) and have them monitored by school staff.

Memorials may be left in place until after the funeral (or for up to approximately five days), after which the tribute objects may be offered to the family. Find a way to let the school community know that the posters are going to the family so that people do not think they were disrespectfully removed. For example, post a statement near the memorial on the day it will be taken down.

Vignette C: Adapting a Memorial for Dia de Los Muertos

A large comprehensive high school was trying to find a way to honor the cultural heritage of its Latino students on Dia de Los Muertos (Day of the Dead). The students requested that they be allowed to memorialize their loved ones who had died (including some who had died by suicide) by setting up an altar with images of their friends on a public section of campus. The school psychologist (who is also Latina) struggled with how to follow the known guidelines regarding memorialization, while also respecting the students’ wishes, so she consulted with experts in suicide prevention.

The school decided to have a couple of adult advisors meet with the students and hear their points of view in order to connect with what their underlying motivations were: to celebrate their cultural heritage in the face of tragedy. It was proposed that an altar be set up with favorite foods and imagery (sports, activities, music, other hobbies), rather than using pictures of their deceased loved ones. The altar was permitted for three days, October 31 to November 2, which coincided with the Mexican holiday. According to their feedback, the students felt validated and respected, and they also felt connected to the larger campus community.

* The celebration of the Day of the Dead is an integral part of embracing death that is particular to Mexican national identity but is also celebrated by other Latino cultures in the United States. During this event, the popular belief is that the deceased have divine permission to visit friends and relatives on earth and to again enjoy the pleasures of life.
It is recommended that schools discourage requests to create and distribute images of the deceased, such as on T-shirts or buttons. Although these items may be comforting to some students, they may be quite upsetting to others. Repeatedly bringing images of the deceased student into the school can also be disruptive and inadvertently glamorize suicide. The school should prioritize protecting students who might be vulnerable to contagion over what might comfort students who want to remember the deceased student. If students come to school wearing such items, it is recommended that they be allowed to wear the items only for that day, and that staff explain to students the rationale for the school’s policy. Some schools have found a middle ground with students, for example, by allowing them to wear wristbands that portray a positive message (i.e., Faith, Hope, Love) as a way to honor and remember the deceased.

Since the emptiness of the deceased student’s chair can be unsettling and evocative, after approximately five days (or after the funeral), seat assignments may be re-arranged to create a new environment. Teachers should explain in advance that the intention is to strike a balance between compassionately honoring the student who has died, while at the same time returning the focus back to the classroom curriculum. Students may be involved in planning how to respectfully move or remove the desk; for example, they could read a statement that emphasizes their love for their friend and their commitment to work to eradicate suicide in his or her memory.

When a spontaneous memorial occurs off school grounds, the school’s ability to exert influence is limited. It can, nevertheless, encourage a responsible approach among the students by explaining that it is recommended that memorials be time-limited (again, approximately five days, or until after the funeral), at which point the memorial would be disassembled, and the items offered to the family. The school may also suggest that students participate in a (supervised) ceremony to disassemble the memorial, during which music could be played, and students permitted to take part of the memorial home. The rest of the items would then be offered to the family.

Schools should discourage gatherings that are large and unsupervised. When necessary, administrators may consider enlisting the cooperation of local police to monitor off-campus sites for safety. Counselors can also be enlisted to attend these gatherings to offer support, guidance, and supervision.

It is not recommended that flags be flown at half-staff (a decision generally made by local government authorities rather than the school administration, in any event).

**Online Memorial Pages**

Posting on online memorial pages and messaging sites has become common practice in the aftermath of a death. Some schools (with the permission and support of the deceased student’s family) may choose to establish a memorial page on the school website or on a social networking site. It is vital that memorial pages use safe messaging, include resources to obtain information and support, be monitored by an adult, and be time-limited. For more information on what’s involved in safe messaging, see the [Framework for Successful Messaging](#).

It is recommended that online memorial pages remain active only for up to 30 to 60 days after the death of the student. At that time, they should be taken down and replaced with a statement acknowledging the caring and supportive messages that had been posted and encouraging students who wish to further honor their friend to consider other [creative suggestions](#).

Schools should keep a copy of the memorial page after it has been taken down. This could be a print-out of the Facebook page or a series of screenshots, etc. The archive of the memorial page can serve as a reference later if there are concerns about the safety of students who left messages.
If the student’s friends create a memorial page of their own, school staff should communicate with the students to ensure the page includes safe messaging and accurate information. School staff should join any student-initiated memorial pages so that they can monitor and respond as appropriate.

**School Newspapers**

Coverage of the student’s death in the school newspaper may be seen as a kind of memorial. Articles may also be used to educate students about suicide warning signs and available resources. Having some focus on healthy coping, resilience, and recovery is also helpful. Any such coverage should be reviewed by an adult to ensure it conforms to the standards set forth in *Recommendations for Reporting on Suicide*.

**Events**

The student’s classmates may wish to dedicate an event, such as a dance performance, poetry reading, or sporting event, to the memory of their friend. End-of-the-year activities may raise questions of whether to award a posthumous degree or prize or to include a video tribute to the deceased student during graduation. The guiding principle is that all deaths should be treated the same way. Schools may also wish to encourage the student’s friends to consider creative suggestions, as noted below, such as organizing a suicide prevention awareness or fundraising event.

**Vignette D: A Creative Solution for a Difficult Event**

A 17-year-old senior who was playing the lead in a high school musical died by suicide 10 days before opening night. The Drama Department struggled with whether to stage the show as scheduled. The plot of the show featured a possible suicide attempt by one of the main characters. Some cast members felt unable to continue with rehearsals, although most felt that “the show must go on.” The director did not want to unwittingly highlight the real-life tragedy by cancelling the show and also wanted to find a way to increase awareness about mental health issues, encourage help-seeking, and decrease prejudice. The school leadership consulted with suicide prevention experts and also met with the family of the student who died.

The solution was to have the students propose ideas to the director for how to decrease risks if the show were to go on. They made a brief video that was sent out to the school community (parents and students) to describe their reasons for carrying on with the show as scheduled. Intentional messages of hope, help-seeking, and strength in times of difficulty were included in the video, as well as communicated before each show in introductory comments made by the director and in the show’s program, which also included a list of mental health resources. The script was edited to remove most of the direct references to suicide. According to student, parent, and staff reflections, all of the shows were successful, and there were no negative incidents related to this show.

Often, the parents of the deceased student express an interest in holding an assembly or other event to address the student body and describe the intense pain the suicide death has caused to their family in hopes that this will dissuade other students from taking their own lives.
While it is understandable that bereaved parents would wish to prevent another suicide death, schools are strongly advised to explain that both presenting this content and holding assemblies or other large events for students is not an effective approach to suicide prevention and may actually be risky. Students suffering from depression or other mental health issues may hear the messaging very differently from the way it is intended, and they may be even more likely to act on their suicidal thoughts. In addition, students are very reluctant to speak in an assembly and may be more trusting in a small group or classroom. A more helpful option is to encourage parents to work with the school to bring an appropriate educational program to the school, such as *More Than Sad: Teen Depression*, a DVD that educates teens about the signs and symptoms of depression, or others listed on the websites of [SPRC](https://www.sprc.org) and [AFSP](https://www.AFSP.org).

**Yearbooks**

If there is a history of dedicating the yearbook (or a page of the yearbook) to students who have died by other causes, that policy is equally applicable to a student who has died by suicide. Final editorial decisions should be made by an adult to ensure that it conforms to the standards in *Recommendations for Reporting on Suicide*. The staff member in charge of the yearbook should work with the principal and school mental health professionals on these decisions.

The focus should be on mental health and/or suicide prevention. Underneath the student’s picture it might say, “In your memory, we will work to erase the prejudice surrounding mental health problems and suicide.” The page might also include pictures of classmates engaging in a suicide prevention event, such as an AFSP *Out of the Darkness Walk*.

**Graduation**

If there is a tradition of including a tribute to deceased students who would have graduated with the class, students who have died by suicide should likewise be included. Schools may wish to include a brief statement acknowledging and naming those students from the graduating class who have died. Final decisions about what to include in such tributes should be made by the principal and appropriate staff.

**Permanent Memorials and Scholarships**

Some communities wish to establish a permanent memorial: sometimes physical, such as planting a tree or installing a bench or plaque, and sometimes commemorative, such as a scholarship.

While there is no research to suggest that permanent memorials create a risk of contagion, they can be upsetting reminders to bereaved students. Whenever possible, it is recommended they be established off school grounds. The school should bear in mind that once it plants a tree, puts up a plaque, installs a park bench, or establishes a named scholarship for one deceased student, it should be prepared to do so for others, which can become quite difficult to sustain over time.

**Creative Suggestions**

Simply prohibiting any and all memorialization is problematic in its own right. It is deeply hurtful to the student’s family and friends and can generate intense negative reactions.

Schools can play an important role in channeling the energy and passion of the students (and greater community) in a positive direction, balancing the community’s need to grieve with the impact that the proposed activity will likely have on students, particularly on those who might be vulnerable to contagion.
Schools may proactively suggest a meeting with the student’s close friends to talk about the type and timing of any memorialization. This can provide an important opportunity for the students to be heard and for the school to sensitively explain its rationale for permitting certain kinds of activities and not others. Schools may even wish to establish a standing committee composed of students, school administrators, and family members that can be convened on an as-needed basis.

Schools may also suggest specific types of safe memorialization for students, such as the following:

- Hold a day of community service or create a school-based community service program in honor of the deceased.
- Put together a team to participate in an awareness or fundraising event sponsored by one of the national mental health or suicide prevention organizations (e.g., an AFSP Out of the Darkness Walk) or hold a fundraising event to support a local crisis hotline or other suicide prevention program.
- Sponsor a mental health awareness day.
- Purchase books on mental health for the school or local library.
- Work with the administration to develop and implement a curriculum focused on enhancing social and emotional development and help-seeking behaviors.
- Volunteer at a community crisis hotline.
- Raise funds to help the family defray their funeral expenses.
- Make a book or notecards available in the school office for several weeks, in which students can write messages to the family, share memories of the deceased, or offer condolences. The book or notecards can then be presented to the family on behalf of the school community.

**Tool for Making Decisions about Memorials**

The following tool is in **Appendix A: Tools and Templates**:

- Making Decisions about School-Related Memorials

For more resources on memorialization, see **Appendix B: Additional Resources**.
Social Media
Social Media

In the emotionally charged atmosphere that often follows a suicide death, schools may be inclined to try to control or stifle students’ use of social tools such as texting, Facebook, Twitter, YouTube, Instagram, and Snapchat—a task that is virtually impossible. However, by working in partnership with key students to identify and monitor the relevant social networking sites, schools can strategically use social media to disseminate information, share prevention-oriented messaging, offer support to students who may be struggling, and identify and respond to students who could be at risk.

Key Considerations

Following a suicide death, students may immediately turn to social media for a variety of purposes, including:

- Getting and sharing news about the death (both accurate and rumored)
- Expressing their feelings about what has happened
- Giving and receiving emotional support
- Calling for impromptu gatherings (both safe and unsafe)
- Creating online memorials (both moving and risky) and posting messages (both appropriate and hostile) about the deceased

The deceased person’s social media page often becomes a place where friends and family talk about the suicide and the person who died.

Social media provides schools with a powerful set of tools to do the following:

- Disseminate important and accurate information to the school community
- Identify students who may be in need of additional support or further intervention
- Share resources for grief support and mental health care
- Promote safe messages that emphasize suicide prevention
- Minimize the risk of suicide contagion that could occur through glorifying suicide or describing details of the means used

Schools will be able to use social media most effectively and efficiently if they have set up policies and protocols and developed a presence on social media sites before a crisis takes place. Policies can include guidelines about how social media should be used (e.g., for broadcast, interaction, linkage). Protocols can include platform-specific templates that can be filled in and deployed rapidly in a crisis. Schools should determine which social media tools to use based on the culture and needs of their school community. Schools may also want to have a designated staff person serve as a social media manager to assist the school district’s public information officer.
Involve Students

Students themselves are in the best position to assist in the school’s efforts. They can:

- Help identify the particular media favored by the student body
- Engage their peers in honoring their friend’s life appropriately and safely
- Inform school or other trusted adults about online communications that may be worrisome or inappropriate

It will enhance the credibility and effectiveness of social media efforts to have a designated member of the Crisis Response Team who is familiar with social media work in partnership with student leaders.

Students recruited to help should be reassured that school staff are only interested in supporting a healthy response to their peer’s death, not in thwarting communication. They should also be made aware that staff are available to provide support if they see a social media post that indicates someone may be at risk of suicide.

Disseminate Information

Schools may already have a website and/or an online presence on one or more social media sites. These can be used to share information with students, teachers, and parents, for example:

- The funeral or memorial service (schools should check with the student’s family before sharing information about the funeral)
- Where students can go for help or to meet with counselors
- Facts related to mental illness and the warning signs of suicide
- Local mental health resources
- The National Suicide Prevention Lifeline: 800-273-TALK (8255) or www.suicidepreventionlifeline.org for live chat
- Other national suicide prevention organizations, such as AFSP and SPRC
- Schools should emphasize help-seeking and suicide prevention. Students can also be enlisted to post this information on their own social media outlets. More specific guidance for safe message content is in the Framework for Successful Messaging.
Vignette E: Using Social Media to Help Native American Youth

A Native American community on a reservation experienced multiple suicide deaths among its high school youth. The youth shared with each other on social media that they were depressed and that the future seemed hopeless. They expressed sentiments such as, “Because of [name of the person who died by suicide], maybe I should kill myself, too.” These emotions were not showing up in school or elsewhere in public. The students felt comfortable expressing these feelings on social media, where they experienced a sense of community and anonymity.

Because Facebook profiles remained online after individuals died and were used as memorials, there was concern about the potential for students to inadvertently glamorize the suicide deaths on these sites. However, the suicide prevention staff and school counselors used the sites in a positive way to address the contagion. They posted messages encouraging the youth to talk with a supportive adult. A key message was:

*With help, loss of life can be prevented. The best way to honor [name of the person who died] is to seek help if you or someone you know is struggling. If you’re feeling lost, desperate, or alone, please visit the National Suicide Prevention Lifeline, call 1-800-273-TALK, or text TALK to 741741. The call or text is free and confidential, and crisis workers are there 24/7 to assist you.*

They used the word *honor* in the message because in this Native American culture, honoring a person and life is highly valued.

Soon after the positive messages were posted, youth in the community began reaching out more. They expressed their distress more openly on their social media profiles to their friends and peer helpers who then informed trusted adults. The program staff proactively monitored the social media profiles for expressions of distress and depression and initiated contact when warranted. In addition, the staff provided more gatekeeper training to adults to increase the number of adults able to help the youth.

The program and school staff also worked with local faith leaders. One pastor who was trusted by the youth strongly encouraged them to talk with an adult and reinforced the positive messages that were posted on social media.

These efforts created a turning point, and there were no more suicides during that period of time.

Online Memorial Pages

For information on online memorial pages and message boards, see the Memorialization section.
Monitor and Respond

Social media sites, including the deceased’s wall or personal profile pages, should be monitored to whatever extent possible for the following:

- Rumors
- Information about upcoming or impromptu gatherings
- Derogatory messages about the deceased
- Messages that bully or victimize current students
- Comments indicating students who may themselves be at risk

Responses should emphasize safe messaging and dispel rumors, reinforce the connection between mental illness and suicide, and offer resources for mental health care. In some cases, it may be appropriate to go beyond replying online, for example, to notify parents and local law enforcement about the need for security at late-night student gatherings.

It may also be necessary in some cases to take action against so-called “trolls,” who seek out memorial pages on social media sites and post deliberately offensive messages and pictures. Most services (e.g., Facebook, Twitter, Instagram) have a report mechanism or comparable feature that enables users to notify the site of the offensive material and request that it be removed. The administrator of the memorial page may also be able to block particular individuals from accessing the site.

On occasion, schools may become aware of posted messages indicating that another student may be at risk of suicide. Messages of greatest concern are those suggesting hopelessness or referring to plans to join the deceased student. In these instances, it may be necessary to alert the student’s family, refer the student for immediate mental health services, and/or contact the National Suicide Prevention Lifeline to request that a crisis center follow up with the student.

For more resources on social media, see Appendix B: Additional Resources.
Suicide Contagion
Suicide Contagion

Key Considerations

Contagion is the process by which one suicide death may contribute to another. Although contagion is relatively rare (accounting for between 1 and 5 percent of all youth suicide deaths annually), adolescents and teenagers appear to be more susceptible to imitative suicide than adults, largely because they may identify more readily with the behavior and qualities of their peers. It is also important to recognize the impact of highly publicized suicide deaths, such as those of celebrities, which may contribute to contagion.

If there appears to be contagion, schools should consider taking additional steps beyond the basic crisis response outlined in this toolkit to avoid suicidal behavior and deaths. It is advisable for schools to increase efforts to identify other students who may be at heightened risk of suicide, actively collaborate with community partners in a coordinated suicide prevention effort, and possibly bring in outside experts.

Identifying Other Students at Possible Risk for Suicide

In the face of potential contagion, it is important for schools to use mental health professionals and others who have been trained to identify students who may be at heightened risk for suicide due to underlying mental disorders or behavioral problems (e.g., depression, anxiety, conduct disorder, and/or substance abuse) or who have been exposed to the prior suicide either directly (by witnessing the suicide or by close identification or relationship with the deceased) or indirectly (by extensive media coverage).

Of special concern are those students who:

- Have a history of suicide attempts
- Have a history of depression, trauma, or loss
- Are dealing with stressful life events, such as a death or divorce in the family
- Were eyewitnesses to the death
- Are family members or close friends of the deceased (including siblings at other schools as well as teammates, classmates, significant others, and acquaintances of the deceased)
- Received a phone call, text, or other communication from the deceased foretelling the suicide and possibly feel guilty about having missed the warning signs
- Had a last very negative interaction with the deceased
- May have fought with or bullied the deceased

Schools can also seek to identify those in the general student body who may be at heightened risk by using a mental health screening tool. It is advised that schools consult with mental health professionals on appropriate strategies for screening and assessment.
Connecting with Local Mental Health Resources

Schools should work with local primary care and mental health resources (including pediatricians, community mental health centers, and local private practice mental health clinicians) to develop plans to refer at-risk youth. Once these plans are established, they should be reviewed with all the school-based mental health professionals so that any student who is identified as being at high risk can be referred to a local mental health screening center or private practitioner for further evaluation.

Suicide Clusters

The possibility of contagion resulting in multiple suicides in a community (also known as a suicide cluster) is rare. But if a potential cluster is suspected, at a minimum, school-based mental health professionals and/or trained outside professionals should be available to meet with distraught students for grief counseling and help them connect with other resources in the community.

Schools need to collaborate with community partners to effectively manage all aspects of reacting to possible contagion and preventing its spread. Many communities may already have a coalition focused on suicide prevention. It is often helpful for school officials and other designated persons to join these coalitions, particularly if contagion occurs. If a coalition does not exist at the local level, it is strongly recommended that the community build a community coalition as described in the section Working with the Community, or at least convene a coordinating committee that meets on a regular basis to work on these efforts.

Bringing in outside help can also be particularly valuable when contagion occurs or is suspected. See the next section for more detailed information.

If multiple suicides do occur, media coverage will likely be more extensive, and journalists may try to interview students, school administrators, and staff. A designated school spokesperson should proactively reach out to media outlets to ensure that media recommendations are followed.

For more resources on suicide contagion, see Appendix B: Additional Resources.
Bringing in Outside Help
Bringing in Outside Help

School crisis team members should remain mindful of their own limitations and consider bringing in crisis team members from other parts of their school district (if there are any), trained trauma responders from other school districts, and/or staff from local mental health centers to help them as needed. Often, crisis team members are also impacted by a suicide death, and it is important that they respond in a way that protects the school community while not diminishing or ignoring their own reactions to the death.

In especially complicated situations, schools may even consider bringing in local or national experts in school suicide postvention for consultation and assistance (provided that sufficient funding is available). Such steps should generally be taken in consultation with the community committee, and all outside experts must of course be carefully vetted and references and clearances checked.

Following is a list of national organizations that provide crisis response, postvention consultation, and training, and/or that can put schools in touch with appropriate experts:


- The National Institute for Trauma and Loss in Children (TLC) ([TLC](https://www.tlc.org)) provides schools, agencies, and parents with names of TLC-certified trauma practitioners in their area who are available for consultation and referrals. TLC also has certified trauma trainers who can come to a school, organization, or community to provide training on suicide crisis response and postvention as well as other trauma-related topics. Call 877-306-5256 or e-mail info@starr.org.

- The Dougy Center: National Center for Grieving Children & Families provides phone and onsite consultation and onsite training.

- Many states also have resources available. SPRC’s website provides suicide prevention contacts in every state who can assist you in identifying local experts ([www.sprc.org/states](https://www.sprc.org/states)). You can also check with your state’s office of education.
Going Forward
Going Forward

After a school has addressed the needs arising directly from a suicide, it should consider implementing a comprehensive suicide prevention program, if it does not already have one. This is also a good time to develop or review policies and procedures for dealing with all deaths, including deaths by suicide.

There are no specific guidelines regarding how long a school should wait after a death to implement such a program. However, a school should not use a prevention program as a substitute for responding to how students and others in the school community have been impacted by the death. Students and staff will likely be more ready to receive prevention information after grief needs have been appropriately addressed. Some experts suggest waiting several months or a semester before providing prevention education to students, teachers, and other school staff.

A useful resource for developing a school-based suicide prevention plan is *Preventing Suicide: A Toolkit for High Schools*. It offers guidance on implementing key components of a comprehensive plan, including creating protocols on identifying and responding to students at risk of suicide; educating staff, students, and parents; and establishing postvention policies and programs. Another useful tool is *Model School Policy on Suicide Prevention*, which provides model language, explanations, and resources to help schools develop a suicide prevention policy.

The Resources and Programs section of SPRC’s website has information on and links to suicide prevention programs, many of which are designed for schools. Programs with evidence of effectiveness are flagged.

Some schools may also wish to take collective action to address the problem of suicide, such as participating in an awareness or fundraising event to support a national suicide prevention organization or local community mental health center. AFSP has chapters in all 50 states that can help connect individuals to volunteer suicide prevention opportunities in their communities. For more information on national opportunities, see AFSP’s website.
Appendices
Appendix A: Tools and Templates

This appendix contains tools and templates to help carry out different parts of the postvention process.

Sample Guidelines for Initial All-Staff Meeting

The first meeting with school staff is typically conducted by the Crisis Response Team coordinator and should be held as soon as possible, ideally before school starts in the morning.

However, depending on when the death occurs, there may not be enough time to hold the meeting before students begin to hear the news through word of mouth, social media, or other means. If this happens, the Crisis Response Team coordinator should first verify the accuracy of the reports and then notify staff of the death through the school’s predetermined crisis alert system, such as e-mail or calls to classroom phones. Information about the cause of death should be withheld until the family has been consulted.

Goals of Initial Meeting

Allow at least one hour to do the following:

• Introduce the Crisis Response Team members.
• Share accurate factual information about the death, honoring the family’s request for privacy.
• Allow staff an opportunity to express their own reactions and grief; identify anyone who may need additional support and refer them to appropriate resources.
• Have substitute teachers available to replace any teachers who are too upset to teach (a task for the principal).
• Remind staff of the school’s policy or response following a student death and any considerations specifically for a suicide death.
• Provide appropriate staff (e.g., homeroom teachers or advisors) with a scripted Sample Death Notification Statement for Students, and arrange coverage for any staff person who is unable to manage reading the statement.
• Prepare for student reactions and questions by providing staff with the handouts Tips for Talking about Suicide and Facts about Suicide in Adolescents.
• Share with staff how to handle parent inquiries and plans for communicating with parents, including who parents should contact for further information and resources.
• Explain plans for the day, including locations of crisis counseling rooms or other supports.
• Remind all staff of the following:
  o How they respond to the crisis can have a strong impact on their students. They need to project that they are in control and are concerned about their students’ mental health.
  o They can play an important role in identifying changes in students’ behavior. Discuss a plan for handling students who are having difficulty.
• Brief staff about identifying and referring at-risk students as well as the need to keep records of those efforts.
• Let staff know about any outside crisis responders or others who will be assisting.
• Remind staff of student and staff dismissal protocols for the funeral.
• Identify which Crisis Response Team member has been designated as the media spokesperson, and instruct staff to refer all media inquiries to him or her.

End of the First Day

It can also be helpful for the Crisis Response Team coordinator and/or assistant coordinator to have an all-staff meeting at the end of the first day. This meeting provides an opportunity to take the following steps:

• Offer verbal appreciation of the staff.
• Review the day's challenges and successes, including any students of particular concern.
• Debrief, share experiences, express concerns, and ask questions.
• Check in with staff to assess whether any of them need additional support, and refer accordingly.
• Disseminate information regarding the death and/or funeral arrangements.
• Discuss plans for the next day.
• Remind staff of the importance of self-care.
• Remind staff of the importance of documenting crisis response efforts for future planning and understanding.
Sample Death Notification Statement for Students

Share this death notification statement with students in small groups, such as homerooms or advisories, not in assemblies or over loudspeakers. These statements are examples that can be modified by the principal or Crisis Response Team as needed.

Option 1 – When the Death Has Been Ruled a Suicide

I am so sorry to tell you all that one of our students, [NAME], has died. I’m also very sad to tell you that the cause of death was suicide.

Many of you may also feel very sad. Others may feel other emotions such as anger or confusion. It’s okay to feel whatever emotions you might be feeling. When someone takes their own life, it leads to a lot of questions, some of which may never be completely answered.

While we may never know why [NAME] ended [HIS/HER] life, we do know that suicide has many causes. In many cases, a mental health condition is part of it, and these conditions are treatable. It’s really important if you’re not feeling well in any way to reach out for help. Suicide should not be an option.

Rumors may come out about what happened, but please don’t spread them. They may turn out to be untrue and can be deeply hurtful and unfair to [NAME] and [HIS/HER] family and friends. I’m going to do my best to give you the most accurate information as soon as I know it.

Each of us will react to [NAME]'s death in our own way, and we need to be respectful of each other. Some of us may have known [NAME] well, and some of us may not. But either way, we may have strong feelings. You might find it difficult to concentrate on schoolwork for a little while. On the other hand, you might find that focusing on school helps take your mind off what has happened. Either is okay.

I want you to know that your teachers and I are here for you. We also have counselors here to help us all cope with what happened. If you’d like to talk to one of them, just let me or one of your teachers know or look for the counselors in [NOTE SPECIFIC LOCATION] between classes or during lunch.

We are all here for you. We are all in this together, and the school staff will do whatever we can to help you get through this.
Option 2 – When the Cause of Death Is Unconfirmed

I am so sorry to tell you all that one of our students, [NAME], has died. The cause of death has not yet been determined.

We are aware that there has been some talk that this might have been a suicide death. Rumors may begin to come out, but please don’t spread them. They may turn out to be untrue and can be deeply hurtful and unfair to [NAME] and [HIS/HER] family and friends. I’m going to do my best to give you the most accurate information as soon as I know it.

Since the subject has been raised, I do want to take this chance to remind you that suicide, when it does occur, is very complicated. No one single thing causes it. But in many cases, a mental health condition is part of it, and these conditions are treatable. It’s really important if you’re not feeling well in any way to reach out for help. Suicide should not be an option.

Each of us will react to [NAME]’s death in our own way, and we need to be respectful of each other. Right now, I’m feeling very sad, and many of you may feel sad too. Others may feel anger or confusion. It’s okay to feel whatever emotions you might be feeling. Some of us may have known [NAME] well, and some of us may not. But either way, we may have strong feelings. You might find it difficult to concentrate on schoolwork for a little while. On the other hand, you might find that focusing on school helps take your mind off what has happened. Either is okay.

I want you to know that your teachers and I are here for you. We also have counselors here to help us all understand what happened. If you’d like to talk to one of them, just let me or one of your teachers know, or you can seek out the counselors in [NOTE SPECIFIC LOCATION] between classes or during your lunch.

We are all here for you. We are all in this together, and the school staff will do whatever we can to help you get through this.
Option 3 – When the Family Has Requested the Cause of Death Not Be Disclosed

I am so sorry to tell you all that one of our students, [NAME], has died. The family has requested that information about the cause of death not be shared at this time.

We are aware that there has been some talk that this might have been a suicide death. Rumors may begin to come out, but please don’t spread them. They may turn out to be untrue and can be deeply hurtful and unfair to [NAME] and [HIS/HER] family and friends. I’m going to do my best to give you the most accurate information as soon as I know it.

Since the subject has been raised, I do want to take this chance to remind you that suicide, when it does occur, is very complicated. No one single thing causes it. But in many cases, a mental health condition is part of it, and these conditions are treatable. It’s really important if you’re not feeling well in any way to reach out for help. Suicide should not be an option.

Each of us will react to [NAME]’s death in our own way, and we need to be respectful of each other. Right now, I’m feeling very sad, and many of you may feel sad too. Others may feel anger or confusion. It’s okay to feel whatever emotions you might be feeling. Some of us may have known [NAME] well, and some of us may not. But either way, we may have strong feelings. You might find it difficult to concentrate on schoolwork for a little while. On the other hand, you might find that focusing on school helps take your mind off what has happened. Either is okay.

I want you to know that your teachers and I are here for you. We also have counselors here to help us all understand what happened. If you’d like to talk to one of them, just let me or one of your teachers know, or you can seek! out the counselors in [NOTE SPECIFIC LOCATION] between classes or during your lunch.

We are all here for you. We are all in this together, and the school staff will do whatever we can to help you get through this.
Sample Death Notification Statement for Parents

This death notification statement is to be sent by the most efficient and effective method(s) for the school, including e-mail, text, printed copy sent home with students, or regular mail. It can also be posted on the school’s website and social media accounts. If there is a resource about talking to students and children about suicide, it should be shared. It should be translated for parents who may know little or no English. See AFSP’s *Children, Teens and Suicide Loss* for information about how to talk to students about suicide.

Option 1 – When the Death Has Been Ruled a Suicide

I am so sorry to tell you all that one of our students, [NAME], has died. Our thoughts and sympathies are with [HIS/HER] family and friends.

All of the students were given the news of the death by their teacher in [ADVISORY/HOMEROOM] this morning. I have included a copy of the announcement that was read to them.

The cause of death was suicide. Suicide is a very complicated act. Although we may never know why [NAME] ended [HIS/HER] life, we do know that suicide has multiple causes. In many cases, a mental health condition is part of it. But these conditions are treatable. It’s really important if you or your child are not feeling well in any way to reach out for help. Suicide should not be an option. I am including some information that may be helpful to you in discussing suicide with your child.

Members of our Crisis Response Team are available to meet with students individually and in groups today as well as over the coming days and weeks. Please contact the school office if you feel your child is in need of additional assistance. Note that children who are already vulnerable may be at greater risk due to exposure to the suicide of a peer. If you or your child needs help right away, call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), call 911, or take your child to the nearest crisis center or emergency department.

Information about the funeral service will be made available as soon as we have it. If your child wishes to attend, we strongly encourage you to accompany him or her to the service. If the funeral is scheduled during school hours, students who wish to attend will need parental permission to be released from school.

The school will be hosting a meeting for parents and others in the community at [DATE/TIME/LOCATION]. Members of our Crisis Response Team [OR NAME SPECIFIC MENTAL HEALTH PROFESSIONALS] will be present to provide information about common reactions following a suicide and how adults can help youth cope. They will also provide information about suicide and mental illness in adolescents, including risk factors and warning signs of suicide, and will address attendees’ questions and concerns.

If you have any questions or concerns, please do not hesitate to contact me or one of the school mental health professionals. We can be reached by calling [PHONE NUMBER, EXTENSION].

Sincerely,

[PRINCIPAL’S NAME]
Option 2 – When the Cause of Death Is Unconfirmed

I am so sorry to tell you all that one of our students, [NAME], has died. Our thoughts and sympathies are with [HIS/HER] family and friends.

All of the students were given the news of the death by their teacher in [ADVISORY/HOMEROOM] this morning. I have included a copy of the announcement that was read to them.

The cause of death has not yet been determined by the authorities. We are aware there has been some talk that this might have been a suicide death. Rumors may begin to circulate, and we have asked the students not to spread them since they may turn out to be untrue and can be deeply hurtful and unfair to [NAME] and [HIS/HER] family and friends. We will do our best to give you accurate information as it becomes known to us.

Members of our Crisis Response Team are available to meet with students individually and in groups today, as well as over the coming days and weeks. Please contact the school office if you feel your child is in need of additional assistance. If you or your child needs help right away, call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), call 911, or take your child to the nearest crisis center or emergency department.

Information about the funeral service will be made available as soon as we have it. If your child wishes to attend, we strongly encourage you to accompany him or her to the service. If the funeral is scheduled during school hours, students who wish to attend will need parental permission to be released from school.

If you have any questions or concerns, please do not hesitate to contact me or one of the school mental health professionals. We can be reached by calling [PHONE NUMBER, EXTENSION].

Sincerely,

[PRINCIPAL'S NAME]
Option 3 – When the Family Has Requested That the Cause of Death Not Be Disclosed

I am so sorry to tell you all that one of our students, [NAME], has died. Our thoughts and sympathies are with [HIS/HER] family and friends.

All of the students were given the news of the death by their teacher in [ADVISORY/HOMEROOM] this morning. I have included a copy of the announcement that was read to them.

The family has requested that information about the cause of death not be shared at this time. We are aware there have been rumors that this was a suicide death. Since the subject has been raised, we want to take this opportunity to remind our community that suicide, when it does occur, is a very complicated act. No one single thing causes it. But in many cases, a mental health condition is part of it, and these conditions are treatable. It’s really important if you or your child is not feeling well in any way to reach out for help. Suicide should not be an option. I am including some information that may be helpful to you in discussing suicide with your child.

Members of our Crisis Response Team are available to meet with students individually and in groups today, as well as over the coming days and weeks. Please contact the school office if you feel your child is in need of additional assistance. Note that children who are already vulnerable may be at greater risk due to exposure to the death of a peer. If you or your child needs help right away, call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255), call 911, or take your child to the nearest crisis center or emergency department.

Information about the funeral service will be made available as soon as we have it. If your child wishes to attend, we strongly encourage you to accompany him or her to the service. If the funeral is scheduled during school hours, students who wish to attend will need parental permission to be released from school.

If you have any questions or concerns, please do not hesitate to contact me or the school mental health professionals. We can be reached by calling [PHONE NUMBER, EXTENSION].

Sincerely,

[PRINCIPAL’S NAME]
Sample Agenda for Parent Meeting

Meetings with parents can provide a helpful forum for disseminating information and answering questions. The Crisis Response Team coordinator and all other Crisis Response Team members, the superintendent, and the school principal should attend parent meetings. Representatives from community resources, such as mental health providers, county crisis services, and clergy, may also be invited to be present and provide information. This is a good time to acknowledge that suicide can be a difficult subject to talk about and to distribute the handout Tips for Talking about Suicide.

Be sure to consider the racial, ethnic, and religious backgrounds of students and parents:

- Address the language needs of parents who speak little or no English.
- Determine if there is any content or format that would feel uncomfortable or inappropriate for those who might attend the meeting. For example, if parents of the deceased are in attendance, how might discussing this in a group setting impact their experience?

Large, open-microphone meetings are not advised, since they can result in an unwieldy, unproductive session focused on scapegoating and blaming.

The meeting should ideally be broken into two parts. During the first part, presented by school staff, the focus should be on dissemination of general information to parents, without opening the meeting to discussion. During the second part, have parents meet in small groups with trained crisis counselors for questions and discussion.

The following is a sample meeting agenda.

**Part 1 – General Information (45–60 minutes)**

**Crisis Response Team coordinator, school superintendent, or principal:**

-Welcomes all and expresses sympathy
-Introduces the school administration and members of the Crisis Response Team
-Expresses confidence in the staff’s ability to assist the students
-Encourages parent and school collaboration during this difficult time
-Reassures attendees that there will be an opportunity for questions and discussion
-States school’s goal of treating this death as it would any other death, regardless of the cause, while remaining aware that adolescents can be vulnerable to the risk of imitative suicidal behavior
-States the importance of balancing the need to grieve with not inadvertently oversimplifying, glamorizing, or romanticizing suicide

**Principal or Crisis Response Team coordinator:**

- Outlines the purpose and structure of the meeting
- Verifies the death (see Sample Death Notification Statement for Parents)
- Discourages the spread of rumors
- Informs parents about the school’s response activities, including to media requests
- Informs parents about the student release policy for funerals
Crisis Response Team coordinator, assistant coordinator, or other designated crisis team member:

- Discusses how the school will help students cope
- Mentions that more information about bereavement after suicide is available on AFSP’s website
- Shares the handouts Facts about Suicide in Adolescents, Youth Warning Signs and What to Do in a Crisis, and Tips for Talking about Suicide
- Explains risk factors and warning signs
- Reminds parents that help is available for any student who may be struggling with mental health issues or suicidal thoughts or behaviors
- Provides contact information (names, telephone numbers, and e-mail addresses) for mental health resources at the school and in the community, such as:
  - School mental health professionals
  - Community mental health agencies
  - Emergency psychiatric screening centers
  - Children’s mobile response programs
  - National Suicide Prevention Lifeline: 1-800-273-TALK (8255)

Part 2 – Small Group Meetings (1 hour)

- Ideally, each small group should have no more than 8 to 10 parents.
- Each group should be facilitated by at least two trained mental health professionals.
- Support staff should be available to direct parents to meeting rooms, distribute handouts, and make water and tissues available.
- If possible, additional mental health professionals should be available to meet with parents individually as needed.

Some Additional Considerations

- Since some parents may arrive with young children, provide onsite childcare.
- Some students may accompany their parents so provide separate discussion groups for them.
- Media should not be permitted access to the small groups. Arrange for the media spokesperson to meet with any media at a separate location away from parents and children.
- In some cases (e.g., if the death has received a great deal of sensationalized media attention), security may be necessary to assist with traffic flow and media and crowd control.
### Tips for Talking about Suicide

Suicide is a difficult topic for most people to talk about. This tool suggests ways to talk about key issues that may come up when someone dies by suicide.

<table>
<thead>
<tr>
<th>Give accurate information about suicide.</th>
<th>By saying....</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide is a complicated behavior. It is not caused by a single event.</td>
<td>“The cause of [NAME]’s death was suicide. Suicide is not caused by a single event. In many cases, the person has a mental health or substance use disorder and then other life issues occur at the same time leading to overwhelming mental and/or physical pain, distress, and hopelessness.”</td>
</tr>
<tr>
<td>In many cases, mental health conditions, such as depression, bipolar disorder, PTSD, or psychosis, or a substance use disorder are present leading up to a suicide. Mental health conditions affect how people feel and prevent them from thinking clearly. Having a mental health problem is actually common and nothing to be ashamed of. Help is available.</td>
<td>“There are effective treatments to help people with mental health or substance abuse problems or who are having suicidal thoughts.”</td>
</tr>
<tr>
<td>Talking about suicide in a calm, straightforward way does not put the idea into people’s minds.</td>
<td>“Mental health problems are not something to be ashamed of. They are a type of health issue.”</td>
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<table>
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<tr>
<th>Address blaming and scapegoating.</th>
<th>By saying....</th>
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<tbody>
<tr>
<td>It is common to try to answer the question “why?” after a suicide death. Sometimes this turns into blaming others for the death.</td>
<td>“Blaming others or the person who died does not consider the fact that the person was experiencing a lot of distress and pain. Blaming is not fair and can hurt another person deeply.”</td>
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<tr>
<th>Do not focus on the method.</th>
<th>By saying....</th>
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<tbody>
<tr>
<td>Talking in detail about the method can create images that are upsetting and can increase the risk of imitative behavior by vulnerable individuals.</td>
<td>“Let’s talk about how [NAME]’s death has affected you and ways you can handle it.”</td>
</tr>
<tr>
<td>The focus should not be on how someone killed themselves but rather on how to cope with feelings of sadness, loss, anger, etc.</td>
<td>“How can you deal with your loss and grief?”</td>
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<tr>
<th>Address anger.</th>
<th>By saying....</th>
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<tbody>
<tr>
<td>Accept expressions of anger at the deceased and explain that these feelings are normal.</td>
<td>“It is okay to feel angry. These feelings are normal, and it doesn’t mean that you didn’t care about [NAME]. You can be angry at someone’s behavior and still care deeply about that person.”</td>
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<tr>
<td>Address feelings of responsibility.</td>
<td>By saying….</td>
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<td>--------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------</td>
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<tr>
<td>Help students understand that they are not responsible for the suicide of the deceased.</td>
<td>“This death is not your fault. We cannot always see the signs because a suicidal person may hide them.”</td>
</tr>
<tr>
<td>Reassure those who feel responsible or think they could have done something to save the deceased.</td>
<td>“We cannot always predict someone else’s behavior.”</td>
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<tr>
<th>Promote help-seeking.</th>
<th>By saying….</th>
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<tbody>
<tr>
<td>Encourage students to seek help from a trusted adult if they or a friend are feeling depressed.</td>
<td>“Seeking help is a sign of strength, not weakness.”</td>
</tr>
<tr>
<td></td>
<td>“We are always here to help you through any problem, no matter what. Who are the people you would go to if you or a friend were feeling worried or depressed or had thoughts of suicide?”</td>
</tr>
<tr>
<td></td>
<td>“If you are concerned about yourself or a friend, talk with a trusted adult.”</td>
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</table>
Sample Media Statement
To be provided to local media outlets either upon request or proactively.

School staff were informed that a [AGE]-year-old student at [SCHOOL NAME] has died. The cause of death was suicide. Our thoughts and support go out to [his/her] family and friends at this difficult time.

The school will be hosting a meeting for parents and others in the community at [DATE/TIME/LOCATION]. Members of the school’s Crisis Response Team [OR NAME SPECIFIC MENTAL HEALTH PROFESSIONALS] will be present to provide information about common reactions following a suicide, how adults can help youth cope, the emotional needs of adolescents, and the risk factors and warning signs for suicide. They will also address attendees’ questions and concerns. A meeting announcement has been sent to parents, who can contact school administrators or counselors at [PHONE NUMBER, EXTENSION] or [E-MAIL ADDRESS] for more information.

Trained crisis counselors will be available to meet with students and staff starting tomorrow and continuing over the next few weeks as needed.

Following is a list of warning signs and steps to take that were developed specifically for youth.

<table>
<thead>
<tr>
<th>Youth Warning Signs</th>
<th>What to Do</th>
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<tr>
<td>Leaders in the suicide prevention field agree that the following warning signs indicate a young person may be at risk for suicide:</td>
<td>If you notice any of these signs in a student, take these recommended steps right away:</td>
</tr>
<tr>
<td>• Talking about or making plans for suicide</td>
<td>1. Do not leave the student alone and unsupervised. Make sure the student is in a secure environment supervised by caring adults until he or she can be seen by the school mental health contact.</td>
</tr>
<tr>
<td>• Expressing hopelessness about the future</td>
<td>2. Make sure the student is escorted to the school’s mental health professional.</td>
</tr>
<tr>
<td>• Displaying severe/overwhelming emotional pain or distress</td>
<td>3. Provide any additional information to the school’s mental health contact that will assist with the assessment of the student.</td>
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<tr>
<td>• Showing worrisome behavioral cues or marked changes in behavior, particularly in the presence of the warning signs above. Specifically, this includes significant:</td>
<td></td>
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<tr>
<td>○ Withdrawal from or change in social connections or situations</td>
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<tr>
<td>○ Changes in sleep (increased or decreased)</td>
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<td>○ Anger or hostility that seems out of character or out of context</td>
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<td>○ Recent increased agitation or irritability</td>
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**Resources**

Note: The items in brackets are to be added by each school.

**Local Community Mental Health Resource(s)**

[NAME(S)]

**National Suicide Prevention Lifeline**

800-273-TALK (8255) or [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org) for live chat

**Local Hotline Number(s)**

[NAME(S)]

**Recommendations for Reporting on Suicide**

Research has shown that graphic, sensationalized, or romanticized descriptions of suicide deaths in the news media can contribute to suicide contagion (i.e., copycat suicides), particularly among youth. Media are strongly encouraged to refer to the document *Recommendations for Reporting on Suicide*.

**Local Media Contact**

[NAME]

[TITLE]

[SCHOOL]

[PHONE]

[E-MAIL ADDRESS]
Key Messages for Media Spokesperson

This information is for use by the person designated by the school to speak with the media.

School’s Messages

- We are heartbroken over the death of one of our students. Our hearts, thoughts, and prayers go out to [HIS/HER] family and friends and the entire community.
- We will be offering grief counseling for students and staff starting on [DATE] and lasting through [DATE] or as long as needed.
- We will be hosting an informational meeting for parents and the community regarding suicide prevention on [DATE/TIME/LOCATION]. Experts will be on hand to answer questions.
- No TV cameras or reporters will be allowed in the school or on school grounds.

School’s Response to the Media

- The media are strongly encouraged to refer to the document Recommendations for Reporting on Suicide.
- Research has shown that graphic, sensationalized, or romanticized descriptions of suicide deaths in the news media can contribute to suicide contagion (i.e., copycat suicides), particularly among youth.
- Media coverage that details the location and manner of suicide with photos or video increases the risk of contagion.
- Media should also avoid oversimplifying the cause of a suicide (e.g., “student took his own life after breakup with girlfriend”). This gives the audience a simplistic understanding of a complicated issue.
- Remind the public that in a majority of suicide deaths, mental health issues play an important role, underscoring the need to address mental health concerns proactively.
- Media should include links to or information about helpful resources, such as local crisis hotlines and the National Suicide Prevention Lifeline (800-273-TALK (8255).

Information on Suicide

- Suicide is complicated and involves multiple risk factors. It is not simply the result of stress or difficult life circumstances. Many people who die by suicide have a mental health condition, the most common of which is depression.
- Mental health conditions and substance abuse problems are treatable.
- The best way to prevent suicide is through early detection, diagnosis, and treatment of depression and other mental health conditions, including substance abuse problems.
Making Decisions about School-Related Memorials

This tool poses questions to consider about both planned and spontaneous memorials associated with a school, although not necessarily sponsored by the school. Examples include a school event, student-created memorial, and a page in a yearbook.

- Does the school or school district have a policy (or standard procedure) on memorialization for the death of a student (or school staff person), regardless of the cause?
  - If yes, how would implementing what is usually done for other types of deaths be done for a death by suicide? How might those procedures be interpreted with a suicide? For example:
    - If a memorial page in the yearbook is a standard procedure, are there other deaths (from other causes) during the school year that would also have pages or be on the same page? Could a memorial page also have a message to promote help-seeking among students or a similar supportive message?
  - If no, look at districtwide practices or consult with other schools.

- Has the family expressed a desire for or opposition to any public acknowledgment of the death as a suicide?

- How might a memorial on school grounds help facilitate (or impede) grieving of the loss by students and school staff?

- How will the school deal with a spontaneous memorial initiated by students?

- Could a memorial be something other than a physical object, such as a suicide prevention program?

- What other ways are there for students to acknowledge and express their grief following a suicide?

- When would be a good time to memorialize a student’s death?
  - Does the plan for memorialization coincide with other student events (e.g., graduation)?

- How might the memorial procedure affect vulnerable students? Teachers and other staff?
  - Is there a way to memorialize so that a life-affirming message is the focus?

- If the school puts up a *physical* memorial, what will the students and staff who were not at the school during the year of the death be told about the memorial?
Facts about Suicide in Adolescents

Suicide is complicated and involves the interplay of multiple risk factors. It is not simply the result of stress or difficult life circumstances. Many people who die by suicide have a mental health condition. In teens, the behavioral health conditions most closely linked to suicide risk are major depressive disorder, bipolar disorder, generalized anxiety disorder, conduct disorder, eating disorders, and substance abuse problems. Although in some cases these conditions may be precipitated by environmental stressors, they can also occur as a result of changes in brain chemistry, even in the absence of an identifiable or obvious “trigger.”

Other key risk factors for suicide include the following:

- Personality characteristics, such as hopelessness, low self-esteem, impulsivity, risk-taking, and poor problem-solving or coping skills
- Family characteristics, such as family history of suicidal behavior or mental health problems, death of a close family member, and problems in the parent-child relationship
- Childhood abuse, neglect, or trauma
- Stressful life circumstances, such as physical, sexual, and/or psychological abuse; breaking up of a romantic relationship; school problems; bullying by peers; trouble with the law; and suicide of a peer
- Access to lethal means, especially in the home

It is important to remember that the vast majority of teens who experience even very stressful life events do not become suicidal. But in some cases, such experiences can be a catalyst for suicidal behavior in teens who are already struggling with depression or other mental health problems. In others, traumatic experiences (such as prolonged bullying) can precipitate depression, anxiety, abuse of alcohol or drugs, or another mental health condition, which can increase suicide risk. Conversely, existing mental health conditions may also lead to stressful life experiences, which may then exacerbate the underlying illness and in turn increase suicide risk.

Help Is Available

If there are concerns about a student’s emotional or mental health, a referral should be made to an appropriate mental health professional for assessment, diagnosis, and possible treatment. Mental health resources that may be available include the following:

- School-based mental health professionals
- Community mental health providers and clinics
- Emergency psychiatric screening centers
- Children’s mobile response programs

Pediatricians and primary care providers can also be a source of mental health referrals. Many of them are also well-versed in recognizing and treating certain mental health conditions like depression.

Information and referrals regarding treatment for mental and substance use disorders are available at SAMHSA’s National Helpline: 1-800-662-HELP (4357). This is a free, confidential service open 24/7.
Crisis Lines

A crisis line is a service that provides free, confidential support and resources for people in emotional distress. The service is provided by a trained crisis counselor on the phone and in some cases by text and/or chat. You can call or text for help with someone you’re worried about or for yourself. In addition to the resources listed below, some states have their own crisis lines with phone, text, and/or chat services.

**National Suicide Prevention Lifeline**
Call 800-273-TALK (8255)
Chat service and other information: Go to [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org)

**Crisis Text Line**
Text HOME to 741741
Other information: Go to [www.crisistextline.org](http://www.crisistextline.org)

**Trevor Project**
Provides crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) young people ages 13–24
Trevor Lifeline: Call 1-866-488-7386
TrevorText: Text TREVOR to 1-202-304-1200
TrevorChat and other information and resources: Go to [www.trevorproject.org](http://www.trevorproject.org)
Youth Warning Signs and What to Do in a Crisis

When you are concerned that a person may be suicidal, look for changes in behavior or the presence of entirely new behaviors. This is of greatest concern if the new or changed behavior is related to a painful event, loss, or change, such as losing a friend or classmate to suicide. Most people who take their lives exhibit one or more warning signs, either through what they say or what they do.

Take any threat or talk about suicide seriously. Start by telling the person that you are concerned. Don’t be afraid to ask whether she or he is considering suicide or has a plan or method in mind. Research shows that asking someone directly about suicide will not “put the idea in their head.” Rather, the person in distress will often feel relieved that someone cares enough to talk about this issue with them.

Below is a list of warning signs and steps to take specifically for youth. It was developed by a consensus panel of experts in the field. See www.youthsuicidewarningsigns.org.

<table>
<thead>
<tr>
<th>Youth Warning Signs</th>
<th>What to Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leaders in the suicide prevention field agree that the following warning signs indicate a young person may be at risk for suicide:</td>
<td>If you notice any of these signs in a student, take these recommended steps right away:</td>
</tr>
<tr>
<td>• Talking about or making plans for suicide</td>
<td>1. Do not leave the student alone and unsupervised. Make sure the student is in a secure environment supervised by caring adults until he or she can be seen by the school mental health contact.</td>
</tr>
<tr>
<td>• Expressing hopelessness about the future</td>
<td>2. Make sure the student is escorted to the school’s mental health professional.</td>
</tr>
<tr>
<td>• Displaying severe/overwhelming emotional pain or distress</td>
<td>3. Provide any additional information to the school’s mental health contact that will assist with the assessment of the student.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What to Do</th>
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</thead>
<tbody>
<tr>
<td>• Showing worrisome behavioral cues or marked changes in behavior, particularly in the presence of the warning signs above. Specifically, this includes significant:</td>
</tr>
<tr>
<td>○ Withdrawal from or change in social connections or situations</td>
</tr>
<tr>
<td>○ Changes in sleep (increased or decreased)</td>
</tr>
<tr>
<td>○ Anger or hostility that seems out of character or out of context</td>
</tr>
<tr>
<td>○ Recent increased agitation or irritability</td>
</tr>
<tr>
<td>1. Ask if the student is okay or if he or she is having thoughts of suicide.</td>
</tr>
<tr>
<td>2. Express your concern about what you are observing in his or her behavior.</td>
</tr>
<tr>
<td>3. Listen attentively and nonjudgmentally.</td>
</tr>
<tr>
<td>4. Reflect what the student shares and let the student know he or she has been heard.</td>
</tr>
<tr>
<td>5. Tell the student that he or she is not alone.</td>
</tr>
<tr>
<td>6. Let the student know there are treatments available that can help.</td>
</tr>
<tr>
<td>7. If you or the student are concerned, guide him or her to additional professional help, or to call the National Suicide Prevention Lifeline, a 24-hour toll-free phone line for people in suicidal crisis or emotional distress: 1-800-273-TALK (8255).</td>
</tr>
</tbody>
</table>
Appendix B: Additional Resources

Appendix B contains links to materials that provide additional information on the topics covered in the toolkit. Resources are organized by the section of the toolkit to which they are the most relevant.

Crisis Response


To purchase this manual and CD-ROM: http://www.hazelden.org/OA_HTML/ibeCCtpltmDspRte.jsp?item=54103
Helping Students Cope


To purchase this resource: https://stores.kotisdesign.com/afspexternal/resources/children-teens-and-suicide-loss/40691


To purchase this manual and CD-ROM: http://www.hazelden.org/OA_HTML/ibeCCtpItmDspRte.jsp?item=54103

Working with the Community


Working with the Media


Memorialization


Social Media


Suicide Contagion


Appendix C: Additional Reviewers of the First Edition

The following individuals also reviewed the first edition of After a Suicide: A Toolkit for Schools, along with the primary reviewers listed at the beginning of the toolkit. The job titles listed were the ones when the first edition was reviewed.

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**Paula Clayton, MD**, Medical Director, American Foundation for Suicide Prevention, New York, NY

**Cheryl DiCara**, Director, Maine Youth Suicide Prevention Program, Augusta, ME

**Joan Schweizer Hoff, MA**, Program Director, The Dougy Center: The National Center for Grieving Children & Families, Portland, OR

**John Kelly, PhD**, School Psychologist, Commack Public Schools/New York Association of School Psychologists, Commack, NY

**Sue Klebold, MA**, Parent of Dylan Klebold, Littleton, CO

**Richard Lieberman, MA, LEP, NCSP**, Coordinator, Suicide Prevention Unit, Los Angeles Unified School District, Los Angeles, CA

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**Michelle Rath, PhD**, Director of School Counseling, Essex High School, Essex Junction, VT

**Margo Requarth, MA, MFT**, Children’s Bereavement Coordinator, Sutter VNA & Hospice, Santa Rosa, CA

**Donna Schuurman, EdD, FT**, Executive Director, The Dougy Center: The National Center for Grieving Children & Families, Portland, OR

**Nicky Yates**, Online Communications Manager, National Suicide Prevention Lifeline, New York, NY
MENTAL HEALTH RESOURCE GUIDE

A GUIDE TO NAVIGATING MENTAL HEALTH RESOURCES IN SUMMIT COUNTY

UPDATED APRIL 2021
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Non-Traditional & Complementary Approaches to Mental Health
  Holistic Approaches
  Pursuing Hobbies and Interests
  Connecting With Others
  Connecting with Nature

Spanish Speaking Resources

Spanish Speaking Resources
CONNECT Summit County Peer Navigation Services

Finding help when facing a mental health challenge can be difficult and daunting. Our Peer Navigators have experienced these challenges firsthand. They can listen to you from a place of understanding and empathy, having gone through the challenge of finding the right help and support for themselves and/or their family members. Our trained Peer Navigators understand how difficult it can be to ask for help and they are equipped to help you find the resources and support you need in a spirit of compassion, understanding and empathy.

English
Phone: 435.776.HELP(5347)
Email: Resources@CONNECTSummitCounty.org

Spanish
Phone: 435.655.1230
Email: Preguntas@CONNECTSummitCounty.org

www.CONNECTSummitCounty.org/

Get Help: Mental Health Crisis Response Services

- **Call 911** if a person in mental health crisis is behaving violently, has a weapon, has ingested something that is potentially dangerous, is bleeding or incurring property damage. Let dispatch know that this is a mental health emergency and ask for a CIT (Crisis Intervention Trained) Officer to be dispatched.

- **IHC Emergency Room in Park City**: 900 Round Valley Drive, Park City, UT. Located on the first floor of the hospital. There is a separate ER entrance on the opposite side of the hospital’s main entrance (in the back). Open 24/7.

- **Summit County Crisis Hotline** 833.995.1295
- **State Crisis Hotline** 801.587.3000
• **SafeUT App** Text and talk support with trained crisis counselors. To download the app, search “SafeUT” in your smartphone’s app store and download the app. You will be required to accept terms and permissions—something all apps ask you to do. You will also create a passcode once the app is downloaded.

• **Huntsman Mental Health Institute**. Park City Clinic. Walk in or call for a same day crisis appointment. Open Monday through Friday 8 a.m. to 5 p.m. 1820 Sidewinder Drive, Park City. Phone: 435.658.9998

**MCOT Explained**

**MCOT (Mobile Crisis Outreach Team)** is an interdisciplinary team consisting of a licensed clinical professional, a certified peer specialist and a law enforcement officer who are dispatched to the scene of a mental health emergency and are trained to provide crisis intervention on site. Services include: crisis resolution services for anyone experiencing, or at risk of, a mental health crisis, and who requires mental health intervention; rapid response face to face assessment and crisis intervention anywhere in Summit and Wasatch Counties. Consultation and support to individuals of any age, families, and treatment providers; and follow-up services including information and referrals, linkage with appropriate community based mental health services for ongoing treatment. You may request that MCOT be dispatched when you call any crisis line for assistance during a mental health crisis between 9 am and 6 pm Monday through Friday (excluding holidays).

**How to Find a Mental Health Provider**

**Check with your health insurance company** to obtain a list of mental or behavioral health providers in your area.

**Check to see if your employer has an Employee Assistance Program (EAP)** that covers free mental or behavioral health services for employees and their family members.

**Check with your primary care provider** for a referral to a therapist.

**If you have Medicaid**, please contact Healthy U Behavioral Plans to find a therapist and schedule an appointment. Phone: 801.587.2851
Online Provider Search: HealthyUBehavioral.com

If you do not have any health insurance coverage or if your health insurance doesn’t have behavioral health benefits, please call CONNECT Summit County’s Peer Navigation Services to help you locate providers who have sliding fee scales and/or scholarships.

To locate a private provider or learn more about the providers who are covered by your health insurance or EAP, please check CONNECT Summit County’s online mental health resource and provider directory: ConnectSummitCounty.org

Medication Management

If you run out of medication, contact your prescriber or your primary care doctor for a refill.

If you are looking to start medication, you might want to start with your primary care doctor. However, be aware that to continue taking psychiatric medications you will need to be seen by a mental health professional. You may schedule an appointment with a therapist who can refer you for medication management if that is what is mutually decided upon.

Paying for Mental Health Services

- Don’t have insurance? Not sure if you qualify for Medicaid? Contact the Utah Health Policy Project for immediate help with Medicaid or Marketplace options and applications. You may book an appointment online or find the phone number to call a local representative to schedule an appointment. Advocate will meet with you free of charge and help you find the health insurance program that will meet your needs and income. HealthPolicyProject.org

- Have insurance? Find out the details about your health insurance plan’s coverage for mental or behavioral health services, including deductibles and copayment amounts. If you are unable to obtain services because of the cost of the copayments and/or the deductible, please contact our Peer Navigation Services for information on providers who have sliding fee and/or scholarship programs available.
• **Peer Navigation Services** - English: 435.776.HELP (4357)
  Spanish: 435.655.1230

• **If you have or qualify for Medicaid, your behavioral health services are generally covered.**
  Contact Healthy U Behavioral
  Phone: 801.213.4104
  Website: [UHealthPlan.utah.edu](http://UHealthPlan.utah.edu)

• **If you've been the victim of a crime**, check with your County's Victim's Advocate Office for Crime Victims Reparations which usually covers medical and therapy bills related to the recovery of injuries resulting from a criminal act.

• **Are you over 65 or Disabled?** See if you qualify for Medicare coverage by visiting: [Medicare.gov](http://Medicare.gov)

• **Are you a student?** Check with your child's school counseling department to see if they are eligible for school-based mental health services or a referral to a mental health provider in the community. Some colleges have free or low cost counseling services available.

• **Are you a Veteran?** Contact VA Salt Lake City Health Care System.
  801.584.1217.

• **Do you belong to a faith organization?** Some churches provide free counseling services or will help you pay for mental health counseling. Check with your faith organization to see if this is available to you and/or your family.

• **Does your employer have an Employee Assistance Program?** Check to see if your employer provides FREE mental health/counseling appointments for employees and immediate household and/or family members.

### Need Help Paying for Medications?

• [Blinkhealth Prescription Assistance](http://Blinkhealth.com): A digital pharmacy that analyzes your insurance, copay and deductible to find your lowest prescription rates. Spanish language option on patient assistance line.

• [National Alliance on Mental Illness (NAMI) Getting Help Paying for Medications](http://NAMI.org)

• [Needy Meds](http://NeedyMeds.org): This patient assistance program offers reduced cost and free medications. English/Spanish 800.503.6897
- **PhRMA's Medicine Assistance Tool**: A search engine for many of the patient assistance resources that the pharmaceutical industry offers.

- **RX Assist**: Find ways to manage your medication costs.

- **RX Hope**: This organization helps people in need obtain critical medications.

- **USARX**: This tool searches several of the nation’s lowest pharmacy discount sources to find discount cards and coupons.

## Resources for Youth Mental Health

If your child is enrolled in school in Summit County and he or she is experiencing increasing emotional difficulties please send an email to your child’s teacher and ask for a referral to a behavioral health counselor. This is a service your child’s school can provide. Also, these local and state-wide organizations are providing timely support, information and resources for parents, caregivers and families.

- **NAMI Utah offers a FREE six-week class called BASICS** for parents or caregivers of a child/youth who has behavioral health challenges. You will learn how to advocate on behalf of your child, navigate the complex mental health resources, find the support you and your family needs, learn family communication and self-care skills that help mitigate the stress that goes with raising a child with mental health challenges. For more information or to register: [https://namiut.org/our-programs/for-families-caregivers/nami-basics](https://namiut.org/our-programs/for-families-caregivers/nami-basics)

- **NAMI Utah offers a FREE six-week class called PROGRESSION** for teens who are living with a behavioral health challenge. This class provides a safe place to talk about mental health challenges, options for getting help and support, communication skills, helpful tips and tools for managing symptoms and dealing with the stress of being a teen in today’s world. For more information and/or to register: [Progression for Teens](https://namiut.org/our-programs/for-teens/nami-progression)

- **Utah Parent Center** is available to help parents and caregivers find resources and help answer education questions about children with special needs, including mental health. Spanish speaking available. Call (800) 468-1160. [https://utahparentcenter.org/resources/](https://utahparentcenter.org/resources/)

- **Encircle** - Resources for LGBTQ youth and their families.

- **SafeUT App**: Youth may download the free SafeUT App for 24/7 talk, chat or phone calls with licensed clinicians about any topic related to mental health,
including relationship problems, bullying and other topics that can cause emotional or mental distress. Adults may also use the App if they have concerns about a youth.

- **Communities That Care Summit County** has programming and events designed to foster connection, health and well-being in youth and families. Visit their website for more information.

**Online resources for children, teens and families:**

- **Action for Healthy Kids** – Resources for schools and families during the COVID-19 school closures.

- **Anxiety and Depression Association of America**. How to talk to your child/teen about COVID-19.

- **Communities That Care**. Parents can subscribe to the Communities That Care newsletter for ongoing information and resources for youth in Summit County.

- **Evoke Therapy**. Check-out the podcasts by Dr. Brad Reedy for insights and tools for you and your family.

- **Family Resiliency Kit**. Parents can use this interactive tool to increase the resiliency of themselves and their children. Anyone can benefit from these tools.

- **OK2Talk** is a community where teens and young adults struggling with mental health conditions can find a safe place to talk by sharing their personal stories of recovery, tragedy, struggle or hope.

- **Park City School District**. Do you want to know what is happening with online learning at Park City School District? Check-out their resources and information for families.

- **Educational resources and related articles for parents during COVID-19**. PC Reads.

- **Understood.org**. Legal FAQs on COVID-19, School Closings and Special Education.

- **Parent Guidance**. Resources and free courses on parenting challenges.

**Resources for Substance Misuse**
U.S.A.R.A. - Utah Support Advocates Recovery Awareness. USARA 801.590.6556 MyUSARA.com

Utah Division of Substance Abuse and Mental Health. Free, Fast and Confidential Mental Health Screening Tool for yourself or someone else you are concerned about. You’ll get an assessment result right away with resource options for next steps. HealthyMindsUtah.org

LDS Addiction Recovery Services. Individuals can find ongoing addiction recovery programs in the Salt Lake area. Find several options for virtual meetings here.

- **Alcoholics Anonymous.** AA is a Twelve Step group for people seeking help with alcohol and other substances. Many groups are available in Summit County.

- **Narcotics Anonymous.** NA is a Twelve Step group for people seeking help with narcotics addiction issues.

- **Al-Anon Family Groups.** Al-Anon groups are Twelve Step groups for people who are worried about someone with a drinking or drug problem. To find a meeting go to utah-alanon.org-find meeting.

- **Adult Children of Alcoholics.** This is a Twelve Step group for people who have grown up in homes with alcoholics or any type of Dysfunctional family.

- **In the Rooms** is a free online recovery tool that offers 130 weekly online meetings for those recovering from addiction and related issues. They embrace multiple pathways to recovery, including all 12 Step, Non-12 Step, Wellness and Mental Health modalities.

- **LifeRing Secular Recovery.** FREE online recovery support groups and 24/7 chat room for those seeking to maintain sobriety.

- **Recovery Dharma.** Organizes daily meetings accessible via computer, smartphone or dial-in by phone for those in recovery and for those who live with and love those in recovery. These are virtual gathering places to meditate, study Buddhist teachings and support each other on our paths to sobriety and peace.

- **Sasquatch Area of Narcotics Anonymous Support Groups** is offering free online and telephone support groups to help recovering addicts stay clean in Wasatch and Summit Counties.

- **SMART Recovery** is a non-profit that offers assistance to those seeking abstinence from addiction. They are currently offering free online support meetings for those in recovery.

TREATMENT OPTIONS FOR SUBSTANCE USE DISORDER
Huntsman Mental Health Institute. Park City Clinic. Walk in or call for a same day crisis appointment. Open Monday through Friday 8 a.m. to 5 p.m. 1820 Sidewinder Drive, Park City. Phone: 435.658.9998

There are many private treatment centers in Summit County and the surrounding area, which can be found by looking online at “treatment centers near me.”

Peer Support

Peer CONNECTors

- **Peer CONNECTors is a Peer Support volunteer program** offered by CONNECT Summit County. These volunteers are community members who have the lived experience of coping with their own or a loved one’s mental health challenges. They have successfully navigated the behavioral health system, found the services, supports and resources that worked for them and they are now in a place of recovery and ready to help others in the community who are struggling to find what they need.

- **Our Peer CONNECTors have gone through training** in how to offer emotional support while maintaining high standards in ethics, boundaries and confidentiality, as well as how to effectively guide others to their OWN answers. Recognizing that each situation and each person is unique, our Peer CONNECTors can help you identify what your needs are, help you explore your options and allow you to make informed choices. The empathy and understanding provided by our Peer CONNECTors makes reaching out for help a little easier.

- **To request a Peer CONNECTor**, please call 435.776.HELP(4357) or go to connectsummitcounty.org

Peer Led Support Groups and Classes

NAMI Utah offers a variety of FREE support groups and psycho-social educational classes for anyone impacted by mental health conditions, including those with a mental health condition and their family members or loved ones. Programs in English and Spanish educate and support participants, helping them realize they are not alone, recovery is possible, and treatment works. Peer-led programs are taught by certified teachers and facilitators who have personal experience with their own mental health
condition or with a loved one who has a mental health condition. For more information on peer support available through NAMI Utah please visit their website at www.NAMIUt.org

Certified Peer Support Specialists & Certified Family Peer Support Specialists

- **Certified Peer Support Specialists** are individuals who are trained to use their lived experience in recovery from mental illness and/or substance use disorder.

- **Certified Family Peer Support Specialists** are parents of children, youth and young adults with behavioral health challenges. They have the lived experience of caring for and navigating the many systems their children are involved with.

- **Peer support workers** often work with behavioral health clinicians to increase engagement with services and help to deliver services that promote recovery and resiliency. To learn more about peer support in Utah: Peer Support | DSAMH

Grief Support Groups

*Caring Connections* Located at the University of Utah/School of Nursing, Caring Connections conducts several grief support programs. They also have information on other programs available in the Salt Lake City area. Contact for more information at: 801-585-9522.

Many of our Faith Community Groups have Grief support resources. Please see the list of FAITH COMMUNITY RESOURCES on the following pages.

Suicide Support Groups and Resources

- Speedy Foundation.org
- Taylor Hagen Foundation.org
- Griefshare.org
- Survivors of Suicide.com
- Compassionate Friends.org
- SAVE.org
Insight on ways to reach those who may be struggling with suicidal tendencies

**Sitting on the Bench: Thoughts on Suicide Prevention**

**Caregiver/Family Support**

- Jewish Family Services Park City – Programs for Seniors
- NAMI Online Family and Friends – 90-minute seminar
- NAMI Family-To-Family Classes – 8-week course
- NAMI Homefront – 6-week course (for families, caregivers, and friends of military service members and veterans)
- NAMI Online family support group
- NAMI Peer-To-Peer (for adults with mental health conditions 8-week course)

**Support Groups for Spanish Speakers**

**Holy Cross Ministries:**
Afrentando la Vergüenza y Enforzando la Resiliencia - Facing shame and enforcing resilience only Spanish)
For more information call
Para más información llamar o enviar un correo a:
435.658.4739
vfajardo@hcmutah.org

**Encaminandolos hacia buenas decisiones - Guiding Good Choices**
Para padres de niños de 9 a 14 años
For parents of kids ages 9 to 14 years
For more information call
Para más información llamar a: 385.257.2414 o 385.257.2445

**Latino Behavioral Health Services in partnership with Connect Summit County**
Grupo de apoyo para el estrés y la ansiedad - support group for stress and anxiety (only Spanish)
Para personas que estén lidiando con estrés y ansiedad
For people who may be struggling with stress and anxiety
For more information call
Para más información llamar: 435.655.1230
Email: Preguntas@connectsummitcounty.org

Latino Behavioral Health Services
Family Support Group - Grupo de apoyo para familias (only Spanish)
Para personas que son miembros de familia de alguien con una condición mental o emocional
For family members of someone going through a mental condition

United in Recovery/Connections - Unidos en recuperación (only Spanish)
Para personas que tiene condiciones de la salud mental o emocional
For people who are going through a mental health condition

Grupo de apoyo para personas en duelo - Bereavement support group (only Spanish)

Peers in Recovery - (only Spanish)
Support group for people recovering from substance abuse and alcoholism.

Youth support group - Grupo de apoyo de jóvenes (English and Spanish)

Inteligencia emocional - Emotional intelligence (English and Spanish)
For child 6-12 years
For more information visit Para más información visitar: form.jotform.com
Llamar a: 801.935.4447
Email: latinobehavioral@gmail.com

Warm Lines & Online Resources

- **CONNECT Summit County Peer Navigator.** For confidential emotional support and/or help finding local resources from a local trained peer specialist, please call 435.776.HELP (4357).

- **Huntsman Mental Health Institute Warm Line.** Speak to a trained peer specialist daily from 8 a.m. to 11 p.m. for emotional support, resources and referrals. Call 801.587.1055

- **IHC Line- Emotional Support Line.** Callers speak with a trained caregiver who can provide self-care tools, peer support, treatment options, and more. Available 7 days a week, from 10 a.m. to 10 p.m. Call 833.442.2211
● **NAMI Utah Mentor Line.** Speak to trained peers Monday through Friday 9 am to 4 pm. 801.323.9900

● **Utah Strong Project. Covid-19 Stress Response Line.** Call or text 385.386.2289 to talk to a licenced counselor seven days a week from 7 am to 7 pm or email your first name and phone number to UtahStrong@utah.gov. Video chat and counseling are available in Spanish and other languages.

● **National Alliance on Mental Illness.** [NAMI COVID-19 (Coronavirus) Information and Resources Sheet](#) NAMI HelpLine 800.950.6264

● **Free, Fast and Confidential Mental Health Screening Tool** for yourself or someone else you are concerned about. You’ll get an assessment result right away with resource options for next steps. [HealthyMindsUtah.org](#)

● **Utah Coronavirus Information Hotline** 1.800.456.7707 A resource for all of your COVID-19 related questions. Website: [coronavirus.utah.gov](#)

● **Disaster Distress Helpline** 1.800.985.5990. A 24/7 national hotline dedicated to providing immediate crisis counseling for people seeking emotional help in the aftermath of a disaster. Text TalkWithUs to 66746.

● **Suicide Prevention Resources.** [www.liveonutah.org](#)

---

**Resources from Local Nonprofits**

- **Christian Center of Park City** offers counseling and wellness services while providing critically important basic needs services.

- **Communities That Care** coordinates important youth mental health and substance abuse prevention programs and education within Summit County.

- **Holy Cross Ministries** responds to the underserved community’s need for mental health and well-being.

- **Jewish Family Service** assists families in crisis and provides food, financial assistance, care management and employment support.
Peace House provides resources to end domestic violence, which has risen during the COVID-19 pandemic.

People's Health Clinic provides high-quality healthcare to the uninsured residents of Summit County.

Summit County Clubhouse has created a Clubhouse without walls and are conducting three web meetings a week, allowing members to continue to have a safe environment to support each other, creatively continue to focus on the important work of the Clubhouse while at home, provide opportunities for online learning and most importantly be reminded that no one is alone.

Summit County Recovery is dedicated to the recovery efforts of participants in the Summit County Drug Court.

Faith Community Resources

Many of the Communities of Faith in Summit County offer support groups such as Grief Support and support for other life-changing experiences. We have listed some of the churches in Summit County, not in any particular order and not a complete list at this time. Please contact them for more information as groups, classes and events change throughout the year.

Park City Community Church
435-649-8131

Mountain Life Church
435-647-5855

St. Mary's Catholic Church
435-649-9676

St. Luke's Episcopal Church
435-649-4900

Capital Church
435-631-9877

The Church of Jesus Christ of Latter-day Saints
Many locations are located in Summit County, with contact information located online.
Non-Traditional & Complementary Approaches to Mental Health

At CONNECT Summit County we believe it is important to be inclusive and honor everyone’s right to choose the way they approach seeking help for their mental health challenges. We recognize that sometimes individuals seek help outside of the traditional system of therapy and medication while many seek to supplement therapy and/or medication with complementary practices. Here you will find some options for non-traditional and complementary practices that may be helpful to you. We do not recommend or endorse any of the following practices, but we do encourage you to explore your full range of options and make informed choices in your behavioral health treatment planning.

Holistic Approaches

- Acupuncture
- Body Work
- Breathwork
- Energy Healing
- Essential Oils
- Herbal Remedies
- Integrative Practitioners
- Meditation/Mindfulness
- Nutrition
- Qi Gong
- Prayer
- Sleep Hygiene
- Sound Healing
- Spiritual Practice
- Tai Chi
- Yoga

- Coaching for Youth Team Sports
- Community Choir
- Cooking/Culinary Arts
- Dance
- Drawing
- Drums
- Fitness
- Guitar/Strings
- Gardening
- Hiking Group/Club
- Journaling
- Leather Crafts
- Martial Arts
- Music
- Needlework
- Orchestra
- Painting
- Pet Sitting
- Reading
- Scrapbooking
- Sculpture
- Service (JustServe app)
- Sewing/Quilting
- Voice/Singing
- Volunteer Work
- Walking Group/Club
- Woodworking
- Writing
- Youth Mentoring

Connecting with Others

- Art Classes
- Assisted Living Visits
- Baking
- Biking Group/Club
- Book Club/Bible Study
- Cake Decorating
- Child Care
Connecting with Nature

- Adopt a Puppy for a Day
- Bird Watching
- Cross-Country Skiing
- Dog Walking
- Fishing
- Goat Yoga
- Horseback Riding
- Horse Therapy/Horse Yoga
- Ice Fishing
- Ice Skating
- Kayaking
- Mountain Biking
- Outdoor Summer Concerts
- Paddle Boarding
- Snowshoeing
- Swimming
- Trail Walks

Spanish Speaking Resources

CONNECT Summit County Promotor Comunitario
Phone: 435.655.1230
Email: Preguntas@CONNECTSummitCounty.org

Latino Behavioral Health Services
Phone: 801.935.4447
Website: LatinoBehavioral.org
- Peer mentoring
- Support groups
- Therapy
- Educational classes.
- Spanish Speaking Crisis Line 385.495.2188

Jewish Family Services
Phone: 435.731.8455
Website: JFSUtah.org
- Roxana Cordova
- 801.746.4334
- roxana@jfsutah.org

Holy Cross Ministries
Phone: 801.261.3440
Website: HCMUtah.org
- Sr. Veronica Fajardo
- 385.257.2442
- vfajardo@hcmutah.org

Christian Center of Park City
Phone: 435.649.2260
Website: CCofPC.org
● Lindsey Broadbent

People’s Health Clinic
Phone: 435.333.1850
● Physical & Mental Health

Peace House
Phone: 800.647.9161
Website: PeaceHouse.org
Contact: Pepe Grimaldo 435.658.4739 pepe@peacehouse.org
● Domestic Violence
● Sexual Assault

Spanish Speaking Resources

Latino Behavioral Health Services
801.935.4447
LatinoBehavioral.org
● Mentorias de pares
● Grupos de apoyos: Son en línea, se dan de forma gratuita, algunos necesitan registración y otros no.
● Terapia
● Clases educacionales.
● Línea de Crisis en Español 385.495.2188

Jewish Family Services
435.731.8455
JFSUtah.org
O ofrece Consejería/Terapia en español vía telehealth and doxy
● Roxana Cordova
● 801.746.4334
● roxana@jfsutah.org

Holy Cross Ministries
801.261.3440
HCMUtah.org
Ofrecen grupos de apoyo que pueden variar y Consejería/Terapia
● Sr. Veronica Fajardo
Christian Center of Park City
435.649.2260
https://www.ccofpc.org/

Ofrecen Consejería/Terapia en español
• Claire Camp, Psy. D.
• 707.235.8286
• claire@ccofpc.org

People’s Health Clinic
435.333.1850
Servicio de Consejería/Terapia en español

• Physical & Mental Health

Peace House
Casos de violencia doméstica y/o agresión sexual
800.647.9161
PeaceHouse.org
• Pepe Grimaldo 435.658.4739
• pepe@peacehouse.org
ARE YOU STRUGGLING RIGHT NOW?

REACH OUT FOR HELP TODAY.
Call or text 435.776.HELP (4357)
Or email Resources@CONNECTSummitCounty.org.
You’ll be in touch with CONNECT Summit County’s Peer Navigation Services

CONNECT Summit County’s Peer Navigation Services are FREE and CONFIDENTIAL. This is not a crisis line. If you are in crisis, please call (801) 587-3000.

SU OPORTUNIDAD DE AYUDAR A LOS DEMÁS
Para mejorar tu salud mental encuentra el apoyo y los recursos con nuestro Promotor Comunitario, llámanos al (435) 655-1230 o envíanos un correo electrónico a preguntas@connectsummitcounty.org.

Los servicios del promotor comunitario de CONNECT Summit County son GRATIS y CONFIDENCIALES. Esta no es una línea de crisis, si estas en crisis por favor llamar: (385) 495-2188

CONNECT
The People’s Voice for Mental Health in Summit County
Exhibit A-11
Summit County Behavioral

Contracting Payer Agreement: Summit County Behavioral Professional

Plan: Summit County Medicaid and non-Medicaid (Scope of Services listed in Addendum C - Summit County Behavioral Health Scope of Services)

Effective Date: January 1, 2020

A. Summit County Medicaid and non-Medicaid Reimbursement. Summit County Medicaid members, including services provided to non-Medicaid individuals or services funded through Summit County and/or Divisions of Substance Abuse and Mental Health (also referred to as “DHS” or “DSAMH”) for Professional Covered Services shall be based upon the payment methodologies set forth below.

1. Lesser of Reimbursement. Reimbursement for Professional Covered Services shall be reimbursed at lesser of billed charges or 109% of the State of Utah Medicaid Essential (Enhanced) Provider fee schedule. Updates to the fee schedule will occur within thirty (30) days from the date of notification from the State of Utah to University and shall only apply to Provider’s claim that have not been reprocessed by University prior to the implementation of the updated fee schedule.

2. Telemedicine. Services provided via telemedicine with POS 02 or subsequent identifier will be reimbursed at the same rate as face-to-face visits.

3. Incarcerated Persons. Services to Incarcerated Persons shall be billed with POS 09. Service Code 90792 will be billed for all consultations on treatment, medications, and diagnosis for an incarcerated person. CPT 90792 for incarcerated persons will not be subject to benefit limitations for these members.

4. Reduction from Fee Schedule. Rates shown in fee schedule are the highest level of reimbursement for the highest level of education required to perform the service. If a provider with a lower level of education performs the service then the reimbursement will be reduced by 10%.

5. CG modifier. E&M services for pharmacologic management require CG modifier.

6. Health Behavioral Assessment and Intervention (HBAI). HBAI CPTs 96156-96159 and 96164-96171 should be billed to medical ACO regardless of diagnosis code or provider type/specialty.

7. Telepsychiatric Consultations. CPTs 99447-99449 should be billed to medical ACO.

8. Default. University and Provider agree to meet in good faith to establish rates for new and unlisted services specific to DHS/DSAMH and unfunded services. Until such rates may be established, new and unlisted service codes shall be paid at 50% of billed charges.
B. **Drug Court Program Reimbursement.** Services billed for drug court clients shall be billed reimbursed according to the following rates minus any applicable client fees. Services not listed below shall be reimbursed the lesser of billed charges or 109% of the State of Utah Medicaid Essential (Enhanced) Provider fee schedule (or if unlisted per A.8 of this rate exhibit).

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Court Oversight and Management</td>
<td>Per Addendum B, Mandated Substance Use Disorder, 11. Drug Court Program</td>
<td>$100.00 per Drug Court Client per month (invoice)</td>
</tr>
<tr>
<td>Additional Services</td>
<td>Evaluations, group or individual therapy</td>
<td>109% of the State of Utah Medicaid Essential (Enhanced) Provider fee schedule</td>
</tr>
<tr>
<td>Forensic drug testing</td>
<td>Forensic drug testing required by drug court program.</td>
<td>Provider will reimburse drug testing invoice directly.</td>
</tr>
</tbody>
</table>
UNIVERSITY OF UTAH
NEUROPSYCHIATRIC INSTITUTE

EMERGENCY MANAGEMENT PROCEDURES

CODE YELLOW

DECEMBER 2019

These procedures are specific to the University of Utah Neuropsychiatric Institute (UNI). Where the procedures/processes are similar to the University of Utah Healthcare (UHC) procedures, the UHC Emergency Operations Plan is referenced. That plan is available online or in the Command Center Operations box.
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I. Non-Medical Manpower Pool Plan
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K. Alternate Care Site Plan
L. Shelter In Place
M. Influx Of Psychiatric Patients
N. Code Yellow Lockdown
SECTION I: UNI EMERGENCY RESPONSE PROCEDURES

I. CODE YELLOW ACTIVATION
   A. There are three phases or levels of response. All three can be initiated by calling the hospital operator at *40.

<table>
<thead>
<tr>
<th>Level of Response</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Code Yellow Assessment / Readiness Team</td>
<td>The purpose of the Code Yellow Assessment / Readiness Team is to evaluate a potential threat to UNI. A Code YELLOW “Readiness” team will be gathered if the nature of the threat is not imminent or the scope of the event is unknown. The UNI Operator or House Supervisor will contact the UNI Hospital Administrator On-Call and the UHC Emergency Preparedness Manager (via the Main Hospital Operator 1-2222). These individuals may contact other individuals as needed and will determine if UNI needs to go on Code Yellow status, at what level, and if the UHC Command Center should be activated. The team will consider a variety of factors, including but not limited to: 1. What happened? 2. What is the likely impact on the facility, staffing, and other key assets? 3. Can the impact be managed through daily operations and management practices? 4. Is this an event involving the media?</td>
</tr>
</tbody>
</table>
| Code Yellow ALERT | A Code YELLOW ALERT may be activated by the UNI Administrator On-Call or the UHC Emergency Preparedness Manager. During a Code YELLOW ALERT, the hospital will be in a state of readiness. The UNI Administrator On-Call will notify the UNI Operator. The UNI Operator will announce “Code YELLOW ALERT” overhead and will send a code YELLOW ALERT page to pre-designated individuals. See Attachment A for Code Yellow Alert Contact List. The following individuals will meet in the Command Center to evaluate current resources immediately available to the hospital and identify additional staffing and equipment needs.  
- Executive Director of the Hospital  
- Administrator on Call  
- Medical Director  
- Operations Director (Safety Officer)  
- Clinical Services Director  
- Environment of Care Safety Committee Chair |
Note: At night, on weekends or holidays, the Nurse / House Supervisor will assume the role of Incident Commander until the designated Incident Commander (Administrator on-call) physically arrives and conducts a transfer of command.

**Code Yellow ACTIVATE**

Code YELLOW ACTIVATE is the implementation of the UNI emergency response plan following a disaster or emergency situation. A Code YELLOW ACTIVATE may be initiated by the UNI Administrator On-Call, the UNI Command Center, or the UHC Emergency Preparedness Manager.

After the Code YELLOW ACTIVATE is initiated, the UNI Command Center or Administrator on call will contact the UNI Operator. The Operator will announce “Code Yellow Activate” overhead and a code YELLOW ACTIVATE page will be sent to pre-designated individuals. See Attachment B for Code Yellow Activate Contact List.

If the Command Center has not been activated during a Code Yellow Alert, then the following individuals will meet in the Command Center to implement the Emergency Operations Plan.

- Executive Director of the Hospital
- Administrator on Call
- Medical Director
- Operations Director (Safety Officer)
- Clinical Services Director
- Environment of Care Safety Committee Chair
- Fiscal Services Director
- Outpatient Clinics Operations Director
- Community Relations Representative

Note: At night, on weekends or holidays, the Nurse / House Supervisor will assume the role of Incident Commander until the designated Incident Commander (Administrator on-call) physically arrives and conducts a transfer of command.

**II. COMMAND CENTER**

**A. Command Center Location**

1. The UNI Command Center is located in Ross VanVranken’s office on the first floor.

**B. Functions of the Command Center when open:**

1. The Command Center will be in charge of ALL hospital operations and decisions.
2. The Command Center via the Labor Pool will oversee the identification process of all personnel (clinical and non-clinical) during the emergency.
3. The Command Center MD shall oversee the tracking and credentialing of the Professional Staff Labor Pool.

4. The Command Center will maintain documentation of the overall tracking of patients and staff via the Department Status Reports submitted by departments and units. (tracking details is the responsibility of each department or unit receiving, moving, etc. patients)

5. The Incident Command Team will wear identification vests indicating their role as displayed on the front and back.
   i. Operations Section Chief – Red vest
   ii. Logistics Section Chief – Yellow vest
   iii. Planning and Documentation Section Chief – Blue vest
   iv. Finance Section Chief – Green vest
   v. Other Team Members: White vests
   vi. Assistants/Runners: Orange Vests

   Note: Other personnel identification vests, stickers, etc. will be distributed as needed by the Labor Pool and will also follow the HICS color scheme or as determined by the Incident Command Team.

6. Modified vs. Full Command Center
   a) The Incident Commander may organize a modified Command Center (such as with a Code Yellow ALERT) or a full Command Center (such as with a Code Yellow Activate) as deemed necessary.
   b) A modified Command Center will at least consist of the Incident Commander and may involve one or more positions as needed

7. Command Center Communications – The communication devices and mechanisms used in the Command Center will depend upon need and with whom the Command Center needs to communicate with as follows:
   1. The Command Center will utilize the PIO to provide regular Disaster Website updates with information and instructions to leadership and employees using any or all means available. The Disaster Website is located on the intranet at https://pulse.utah.edu/site/EM/disaster-info and can also be accessed via Pulse at work and at home (https://pulse.utah.edu). If these mechanisms are not available or functional, every effort will be used to communicate with employees up to and including runners.

8. The Command Center will establish communications with UHC Emergency Management Department as needed.

9. The Command Center shall receive reports on the nature and scope of the disaster, make assessments, and set up an action plan to manage the event throughout all operational periods (the Planning Chief will play a significant role in this function).
10. The Command Center will receive bed counts from the nursing units through the Department Status Report Form and through bed board.

11. The Command Center shall monitor the usage of materials, pharmaceuticals, and other supplies. Any requests for sharing of personnel, equipment or supplies from other hospital partners will be coordinated by the UHC Emergency Management Department.

12. Once the Command Center has determined the need for additional personnel, the Command Center will instruct the Labor Pool to initiate and coordinate employee notification or employee recall. The number of employees needed will be determined by the nature and scope of the emergency or disaster. In the event there is an excess of personnel for the given situation, the Command Center will instruct the Labor Pool to communicate with department leadership regarding reassigning or rescheduling employees to address anticipated future needs such as employee rotation and replenishment for long term events.

13. The Command Center will manage the patients in hospital unless the hospital is no longer habitable or is in imminent danger to life and/or property. (e.g. an earthquake or wildfire)
   a) The hospital will then implement the evacuation plan.
   b) In the case of a disaster in which the hospital is not habitable and evacuation routes are blocked (e.g. a massive, community-wide earthquake), UNI will need to shelter patients and staff in the parking lot.
   c) At this point in the disaster, the Command Center will be contact with, and respond to direction from, the UHC Command Center. The UHC Command Center will be in contact with various community and national officials (Fire Department, FEMA, etc.).

C. Command Center Deactivation and Demobilization

1. Demobilization and recovery plans will be devised to stabilize and return operations to some level of normalcy. The Command Center will initiate incremental demobilization of employees, supplies, and other resources as deemed appropriate. All departments will begin restocking and replenishing supplies.

2. The decision to deactivate is made by the Incident Commander. Just as the response to the event was scaled to meet the needs of the incident, deactivation will be scaled in order to ensure that ongoing needs are addressed. The Demobilization Unit Leader will identify positions and functions that can be discontinued, those positions will then be notified by the Planning Section Chief to cease their disaster functions. Documentation of when this decision was made will be recorded in the Demobilization Unit Leader log, the position’s log that is being discontinued. Additionally, the Documentation Unit Leader should ensure that this information is recorded in the main hospital event record.
3. The UNI Command Center will handle small-scale, UNI-specific deactivation responsibilities. In making the decision to deactivate, the Command Center will consider a variety of factors, including but not limited to:
   a. The number of patients is at a level that can be managed using normal staffing patterns.
   b. Staff are able to come to work and relieve staff who have been at the hospital.
   c. Other responders are beginning their demobilization.
   d. Other critical community infrastructure returns to normal operations.

4. In the case of a large-scale disaster, the UHC Command Center will handle all deactivation responsibilities.

5. Notification of this termination will be passed on to hospital employees and staff via hand held radios and pages to code yellow alert and activate groups.

III. COMMUNICATION

A. Methods
   1. Multiple modes of communication are used in order to create redundancy including telephones which are always the first communications option. Other methods include: Cell phones, pagers, email, Emergency Management Website, Campus Alert System, 800 Mhz Radios, Overhead Paging System, Media (TV/Radio), Runners, Posted Notices within the Hospital.

B. Radios
   1. Handheld 800 MHz radio units are located on each inpatient unit, the Command Center, the Staffing Office, in maintenance and other key locations/offices/departments.
   2. The radios have 2 channels—one for intra UNI communication and one for communicating with the UHC Command Center.
   3. UNI has installed a radio repeater to provide a better radio signal.
   4. UNI also has a portable repeater that can be used if the hospital evacuates to an off-site location.
   5. Radio checks are performed to assess staff competency and to ensure operability of equipment.

C. Physicians and Staff
   Notifications to physicians and staff will be made using one or multiple modes of available communication including hand held radios for in house employees. Physicians and staff at home will be notified by one or more of the following methods: call tree, use of the Amcom eNotify system mass emails and pages. Notification and updates of any disaster situation will be posted on
the emergency preparedness website so that physicians and staff may find this information at any time. Lastly, information may be printed to paper and distributed by the non-medical manpower pool and posted on bulletin boards outside the cafeteria.

1. Initial notification
   The Staffing Office will be given instructions regarding calling in additional staff by the Incident Commander in the Command Center and will then be responsible for contacting staff by phone tree or use of the AmCom eNotify system. The UHC Emergency Preparedness Manager will contact the individual responsible for the Command Center website and initiate the disaster website.

2. Ongoing communication
   Radio updates will be given to the inpatient units as frequently as new information presents itself. The Command Center staff will communicate posting information regarding the situation to the person updating the Pulse Emergency Preparedness home page (https://pulse.utah.edu/site/EM) with instructions for staff about the status of the hospital such as lockdown, capacity, needed staff and other incident specific information.

D. External authorities
   Communications with external stakeholders will be accomplished via the methods noted in 1 above. Refer to the UHC EOP for more information on communications with external stakeholders and the UHC Crisis Communication Plan.

E. Patients and families
   In the event patients need to be evacuated from the facility, this information will be communicated to their family members immediately. In the event of loss of major infrastructure and family members are unable to be reached a complete log of patients and transfer locations will be taken by a team of hospital employees to a location with functioning infrastructure. The PIO will provide a contact phone number to the media for dissemination so that persons looking for evacuated patients will know who to contact.

   1. Internal
      Communications with patients and families will take place when the individual unit manager, in consultation with the Command Center, has a need to disseminate information necessary for preservation of life and other safety issues. Nursing staff will communicate information given from the unit manager.

   2. External
      Individuals calling in to the hospital for information regarding their family members in house will be delivered an initial scripted message as determined by the Command Center.
F. Media
Refer to the UHC EOP for information on the Joint Information Center.
1. Public Information Officer
Media will be managed by the UNI Public Affairs Officer. The PIO will provide the release of information to the press. They will manage reporters and requests for information.

2. Location
Media will be staged in an area designated by the University Hospital Emergency Management Department. All media should be directed to this area for updates. The public information officer on duty will request additional support if necessary and available.

3. Staff limitations
All communications will be coordinated through the PIO. Staff should NOT release any information or speak to the press in any form unless the PIO is present. If staff are approached by members of the press and asked to answer questions, staff should direct them to the PIO.

G. Other Health Care Organizations
1. See the UHC EOP for more information on the UHA Inter-Hospital Master Mutual Aid Agreement. Radios and cell phones will be used to communicate with other health care organizations.

2. All staff will maintain the confidentiality of patient information in accordance with HIPAA standards. HIPAA information will be released to third party individuals such as the Red Cross, Health Departments and other hospitals when dissemination of this information is necessary for patient care, patient safety and/or continuity of care.

H. Third Parties
Communication with various third parties will be accomplished by phone or via the UHC Satellite Phone and/or radio system. Patient information will only be communicated when it becomes necessary for patient care or hospital safety.

I. Vendors
UNI has developed a list of vendors that can provide services before, during, and after an emergency event. This list will be updated at least annually or as changes occur and will be made available to the Command Center. See the UHC EOP for more information on obtaining vendor services. In accordance with current policy, vendors must wear and display their hospital issued identification badge. Admittance to the hospital will be denied without presence of a badge.
IV. RESOURCES AND ASSETS

A. Supply inventories
   1. Resource usage monitoring
      Once a Code Yellow is activated, all entities procuring supplies for the event
      will utilize the established disaster organization identity (Org ID). Refer to
      the UHC EOP for more information.
   2. Documentation
      A master inventory list of all disaster equipment and supplies is found in
      Attachment E, maintenance, and purchasing offices. In addition
      Purchasing maintains current stock levels of in house supplies. A list of
      contacts for distributors in case of emergency or disaster situations is
      maintained in the UNI Command Center. Contacts for distributors are also
      maintained in the UHC command center.

B. Personal protective equipment
   UNI maintains Personal Protective Equipment (PPE) to treat its current
   inpatients.

C. Water
   1. Potable
      a. In the event of disruption of water service, Mount Olympus Waters Inc.
         will have 2.5 gallon water containers available. Under this agreement
         UNI will be responsible for pick up and delivery of the containers.
         Mount Olympus Waters Inc.
         1825 South 3730 West
         SLC, Utah  84104

      b. Three culinary hot water tanks located in the boiler room can also be
         accessed for drinking, cooking and other personal care needs.

      c. Other water suppliers are:
         Sysco Corporation
         1659 Industrial Rd.
         972-5484

         Smiths
         876 East, 800 South
         355-2801
   2. Non-potable
      In an effort to decrease our need for non-potable water a plan has been
      developed to turn off the majority of the toilets in the hospital and instead
      use a WAG bag which will conserve water needed for flushing
      toilets. Currently we have over 3,000 WAG bags stored in the facility. At
      the direction of the Operations Director, the Environmental Services
Team will lock some bathrooms and post signage on others explaining how to use the WAG bags.

D. Food
The Dietary Department will have an emergency menu and keep on hand sufficient inventory to feed ADC of 150 patients and corresponding staff for 96 hours. The emergency menu will be located in the Dietary Standards manual and will come under the direction of the Dietary Department.

E. Fuel
1. Building operations
   a. In the event of disruption of natural gas service, Questar will provide continuation of natural gas by providing a mobile fuel tank. Questar will attach this temporary service to the main gas line entering the building. (See agreement between UNI and Questar located in the Maintenance Department).
   b. In the event generator power must be used the Incident Command Staff would initiate a power conservation plan to conserve as much fuel as possible. The generator will be able to provide power to those areas that are deemed absolutely essential to patient care, including maintaining temperatures to protect patient health and safety as well as for the safe/sanitary storage of provisions.
   c. Additional diesel fuel resources can be accessed through UHC—see the UHC EOP for more information.

2. Essential transport
   See UHC EOP for more information on transportation resources.

F. Pharmaceutical
An evaluation of the top 10 medications that are most commonly used within the hospital as well as average amounts of medications that are routinely used have been conducted and are available upon request from the Inpatient Pharmacy Director. For more information on Pharmaceutical Supplies, refer to the UHC EOP.

G. Supplies
1. Medical supply inventories are maintained by Purchasing.
2. UHC maintains an overstock of critical items (including sleeping cots) in the CAMT building which could be easily accessed by UNI.
3. Supplies are also available at the Orthopaedic Hospital or the Madsen Clinic.

H. Medical equipment
   Refer to the UHC EOP.
I. **Supply replenishment**  
Refer to the UHC EOP for information on the following supplies: Medical, Personal Protective Equipment, Pharmaceutical Caches and Stockpiles.

1. **Linen**  
In the event of an extended disruption in our linen delivery, we will attempt to maintain linen supplies for as long as possible by several methods. Housekeeping will monitor & maintain linen supplies. Linens can be retrieved from the Orthopedic Hospital. Washers & dryers on each patient unit can be available to recycle soiled linen as needed. UHC also maintains an emergency contact list for our linen vendor who has an emergency preparedness plan in place.

2. **Trash**  
University Health Care has multiple dumpsters for trash management on campus. Trash would be sorted, with only potentially infectious waste going into our covered trash compactor, which will expand capacity. Other trash will be placed in multiple areas where dumpsters are located. Please see attachment C for complete waste management plan.

J. Repair and/or Return to stock  
Refer to the UHC EOP.

K. External Resources and Asset Support  
Refer to the UHC EOP.

L. **Staffing**  
1. Depending on the directive from the Command Center, the Staffing Office will ask staff to stay by the phone and await further instructions or tell staff to come in to the hospital. The Staffing Office should not call in every staff member to respond to the initial situation. Staff should work no longer than 12 consecutive hours. It is important that the Staffing Office quickly identifies personnel who will provide relief staffing. As the magnitude of any disaster expands, the UHC Incident Commander can pull in staff from other University Hospitals and Clinics. If roads are impassable, and staff cannot report to work or are trapped at work, managers of every unit and department will develop a rest / work cycle.

3. **Identification**  
   a. Staff functioning in a HICS role during a disaster will be clearly identified by a colored vest with the name of their position on both the front and back of the vest.
   b. UNI staff will wear their UNI ID Badges.
   c. UHC staff will wear their UHC badges.
   d. Staff from external facilities will be issued a temporary ID badge.
3. **Physicians, APRNs, and Psychologists (Credentialed Staff)**  
   a. The Credentialed Staff pool is located in the Resource Office in the first floor lobby. All available physicians and psychologists will report to the Credentialed Staff pool where they will receive Emergency credentials and receive a large yellow sticker to be worn on their back denoting they are Medical manpower. See Attachments F and G for complete instructions on the Emergency Credentialing Plan. A packet located in the Command Center labeled Credentialed Staff Pool contains all necessary equipment to run this station.  
   
b. Members of the UNI Professional Staff receive a letter from the Medical Staff Office addressing the practitioners’ role(s) in an emergency response and to whom that practitioner reports in an emergency. The Medical Director has oversight for all practitioners. The Medical Director, or designee, will determine and assign the specific duties of each member of the Credentialed Staff Labor Pool in accordance with the needs of the hospital at the time of the emergency.  

4. **Licensed (non-credentialed) Staff**  
The Medical Manpower Pool is located in the Meditation Room in the first floor lobby. All available nurses, psychiatric technicians, pharmacists, social workers, expressive therapists, nursing aides, and other medical professionals will report to the Medical Manpower pool. There they will register with the Medical Manpower leader where they will receive a large yellow sticker to be worn on their back denoting they are Medical manpower. See Attachment F for complete instructions on managing volunteer licensed staff. A packet located in the Command Center labeled Medical Manpower Pool contains all necessary equipment to run this station.  

5. **Non-clinical**  
The non-medical manpower pool will be staged in Meeting Room A. Messengers, Environmental Services, Maintenance, Dietary as well as office personnel will report to the Non-Medical Manpower Pool. There they will register with the Non-Medical Manpower leader and they will receive a large orange sticker to be worn on their back denoting they are Non-Medical Manpower. See Attachment H for complete instructions on managing volunteer staff. A packet located in the Command Center labeled Non-Medical Manpower Pool contains all necessary equipment to run this station.  

V. **STAFF SUPPORT**  
   A. **Housing**  
      Refer to UHC EOP.  
   
   B. **Transportation**  
      Refer to UHC EOP.
C. Incident Stress Debriefing and Mental Health Support  
Refer to the UHC EOP.

D. Staff Family Support  
Refer to the UHC EOP for Staff Family Preparedness, Child Care, Elder Care, Pet Care, and Mental Health Support for Family Members.

VI. SAFETY AND SECURITY
A. Emergency Operation  
In the event of a code YELLOW ALERT, ACTIVATE or other disaster situation the Incident Commander will assign the role of the Security Director. This person will immediately evaluate the need for additional lockdown or re-direction of traffic.

B. Role of Community Agencies  
The University of Utah Police Department will be called in to support as necessary. If needed, additional support from local and state police departments will be coordinated by the University of Utah PD.

C. Facility access and egress control  
1. Lockdown will be initiated by the administrator on call/hospital supervisor acting as the incident commander. This decision will be communicated to maintenance at which point maintenance will begin performing the steps necessary to lockdown the hospital.

2. All persons entering the hospital must show identification and sign in with a hospital representative before being allowed into the hospital. Staff must present their hospital ID badge for admittance.

D. Vehicular traffic control  
Traffic control for the hospital entrance when needed will be managed and maintained by maintenance and/or University PD. In the event of a large scale event in which police resources are taxed, Non-Medical manpower will take over this responsibility entirely.

VII. DEPARTMENT RESPONSIBILITIES
Department Responsibilities during code YELLOW ALERT or ACTIVATE:

1. Fill out the department status report and send it to the Command Center.

2. Managers are responsible for accounting for their staff, patients, and visitors in their Department.

3. All units and departments will turn on their hand held radio

4. In the event of a horizontal or vertical evacuation, the nurse manager or designee in all inpatient units is responsible for knowing the location and status of their staff and patients. Nurse Managers or designees should communicate closely with the Command Center via their hand held radio to coordinate this effort.
VIII. STAFF RESPONSIBILITIES

A. Alternate roles
The Environment of Care Committee is responsible for the development of role cards. These role cards will help employees to understand what their role is during a disaster.

B. Staff Responsibilities
1. All staff must know their role in a code YELLOW ALERT or ACTIVATE event.
2. All staff must know the location of their disaster boxes and the Code Rings.
3. All staff will be required to show their University of Utah Hospital photo identification card to gain entrance into the hospital.

C. Identification
1. Badges
   All staff are required to wear their hospital ID badge at all times while at work.
2. Vests, etc.
   The Command Center staff will be identified by colored vests. Operations (patient care) will wear red, planning (Command Center leader) will wear blue, and logistics (facilities) will wear yellow. The name of the position they are filling will be clearly printed on the front and back of their vest.
3. Staff filling emergency positions (e.g. runners, traffic control, and lock down monitoring) will be identified by orange vests. The name of the position they are filling will be clearly printed on the front and back of their vest.

IX. UTILITIES MANAGEMENT

1. Supply limitations
   a. Electricity, Ventilation, Oxygen, Backup Sources
      Please see Utilities Management Plan.
   b. Water for consumption and care activities, equipment, and sanitation
      Please see Section C above.
   c. Fuel for building operations
      Please see Maintenance Procedures.
   d. Fuel for essential transport
      Fuel from the University campus motor pool and from the gas station on 1300 East and 900 South will be used. UNI has equipment in its disaster trailer which enables gasoline to be siphoned from unessential vehicles in the parking lots.
X. FIRE SAFETY MANAGEMENT
For information on the location and use of alarm systems, signals, sprinkler systems, fire extinguishers, and methods of containing fire, see the UNI Fire Safety Management Plan.

XI. PATIENT CLINICAL AND SUPPORT ACTIVITIES
A. Triage
1. The Triage Director or designee will direct all triage operations. These responsibilities include:
   a. Command Center communication
   b. Calling for assistance in triage
   c. Assigning triage roles
   d. The Triage Director or designee will contact EMS to transport patients to the University Emergency Department.

2. Other Triage Staff and functions include:
   a. Scribe – track casualties’ status and location on triage log
   b. Transporter – relocate casualties
   c. Runners – communicate between areas

3. ALL CASUALTIES will initially be taken for triage to the CAC and then assigned:
   • Red (emergent- life threatening problems) – CAC interview rooms (arrange transportation to ED)
   • Yellow (urgent- need evaluation and treatment with the least delay possible) – CAC Waiting Room (arrange for eventual transportation to ED)
   • Green (delayed–simple fractures, lacerations or other medical needs that do not need to be immediately addressed) – North Clinic Waiting Rooms (May be returned to patient unit after evaluation and treatment.)
   • Black (deceased or shortly will be) – Department of Psychiatry Waiting Room. (arrange transportation to mortuary services)

B. Discharge
In conjunction with established discharge criteria and protocol the following are additional factors that must be taken into account for patient discharge during a disaster. First, infrastructure must be in place to accommodate civilian traffic (I.e. roads passable to regular traffic). Second, can the patient secure his/her own ride home? And third, given a disaster, will this patient be able to procure follow up care should the need arise.

C. Patient hygiene and sanitation
In accordance with established protocols, patient hygiene and sanitation will not change unless a disaster affecting infrastructure occurs. In that event, refer to the UHC EOP. Additionally, UNI maintains a stock of 3000 wag bags designed to dispose of human waste without the use of water.
D. Mortuary services
   Refer to the UHC EOP.

E. Patient documentation
   All patient documentation will be done on paper. Charts are to stay with the
   patient, with charting done at the bedside until discharged or transferred.

F. Patient tracking
   Once it is established that the event is large enough in scope to necessitate the
   need for outside assistance in patient tracking the American Red Cross is our
   primary contact. Without violating HIPAA standards we are able to
   communicate patient information for family members to locate loved ones in a
   large scale catastrophe.

XI. RECOVERY
   A. Business continuity
      Refer to the UHC EOP.

   B. Continuity of information
      a. Refer to the UHC EOP

   C. Prioritization of restoration activities
      Ensuring the hospital and its utilities are structurally sound and safe for
      inhabitation is the first priority. Second, medical services will be restored this
      will include patient care units, pharmacy, housekeeping, laboratory, medical
      supplies, and dietary operations. Third will be financial services to ensure the
      hospital is collecting revenue in order to ensure that the hospital can continue
      providing services and pay employees.

   D. Closing and Restocking Hospital Command Center
      The decision to close the hospital Command Center will be planned and
      implemented during the deactivation and termination phases of the recovery
      effort. Restocking of all supplies for the Command Center will be completed by
      the Environment of Care Safety Committee.
SECTION II---PLANNING

I. ADMINISTRATIVE

A. INTRODUCTION

1. The EOP includes, but is not limited to, an All-Hazards approach, Hazard Vulnerability Analysis (HVA), the Four Phases of Emergency Management (mitigation, preparedness, response and recovery), the six critical areas of emergency management (Communications, Resources and Assets, Safety and Security, Employee Roles and Responsibilities, Utility Management, Patient Clinical and Support Activities), the National Incident Management System (NIMS), the Hospital Incident Command System (HICS), a brief overview of UNI’s role in community Emergency Management, organizational structures to support Emergency Management Planning, general employee accountabilities and specific response expectations according to event type.

2. The EOP shall meet the requirements set forth in NFPA 99 (2012) and 42 CFR Section 482.15.

3. Section I of the EOP (and relevant attachments) is placed in all Emergency Preparedness boxes throughout the hospital. This section is considered an employee’s guide to Emergency Management response.

B. SCOPE

UNI is a 154-bed inpatient psychiatric hospital, with two day-time partial hospitalization and one evening intensive outpatient programs. This plan also covers the Teenscope South Program—an off-site day-time partial hospitalization program. The hospital is committed to providing an effective response to emergencies or disasters that affect our hospital. UNI is not a mass casualty receiving hospital. If UNI needs community, state, federal, or other assistance it will access those resources through the University Health Care Emergency Operations Plan. UNI may seek assistance from the University of Utah Healthcare Emergency Management Team at any time.

C. EMP OBJECTIVE

The main objective of the UNI Emergency Management Procedures is to describe the approach to emergencies by using the four phases of emergency management in order to maintain a safe environment for effective patient care.

II. EMERGENCY MANAGEMENT PROCEDURES OVERVIEW

A. EMERGENCY MANAGEMENT PROCEDURES

1. The EMP provides an organized process for initiating, managing, and recovering from a variety of emergencies, both internal and external. The EMP includes but is not limited to a comprehensive “all-hazards” command structure for coordinating the six critical areas of emergency management (communications, resources and assets, safety and security,
employees roles and responsibilities, utility management, and patient clinical and support activities) while also using the four phases of emergency management (mitigation, preparedness, response, and recovery) to address specific emergency plans driven by the Hazard Vulnerability Analysis (HVA).

2. UNI maintains updated emergency plans to establish the necessary guidelines needed to prepare for, effectively respond to and recover from emergencies and disasters. These plans will be tested through drills, exercises and real events. A formal critique and review process will help determine and measure the functional capability of the EMP, and the HVA specific plans. The EMP is monitored and evaluated on a regular basis and a formal review of the EMP is conducted at least annually. The Environment of Care Committee Chair reviews and revises the EMP and then presents the revisions to the Environment of Care Committee and the UNI Quality Council for comment and approval.

3. The HVA is monitored and evaluated on a regular basis. A formal review of the HVA is conducted in conjunction with the EMP at least annually. The most recent University of Utah Healthcare HVA is reviewed and considered during the UNI formal review process to help ensure that UNI has not overlooked any significant threat or vulnerability that needs to be addressed on these HVA’s.

B. HVA MITIGATION ACTIVITIES
The HVA is used as a mitigation tool from which preventative measures are devised and implemented, plans are written, equipment is purchased, training and education is based, drills and exercises are conducted. Specific plans are located in the EOP Appendices, as noted in the Table of Contents.

C. AUTHORITY, SUCCESSION PLANNING AND CONTINUITY OF OPERATIONS
1. The positions authorized to activate the UNI Emergency Response are: 1) UNI Executive Director, 2) UNI Administrator on Call, 3) UNI Nurse Supervisor. An Emergency Response may also be activated under the authority of the UHC Emergency Operations Plan.
2. The Incident Commander has the authority to manage the response, terminate the response, and initiate the recovery phase.
3. Continuity of Operations is part of our normal business processes and is addressed in this Emergency Management Plan.

D. ALL HAZARDS COMMAND STRUCTURE
1. UNI uses an integrated all-hazards command structure that is consistent with University Health Care. See the UUHC Emergency Operations Plan for more details.
2. UNI faces a number of hazardous conditions, both internal and external, which may require emergency action. This plan is intended
to provide UNI with an “All-Hazards” approach to meet the challenge and complexity of any emergent condition. Specific plans may be developed based on identified threats.

E. NIMS ADOPTION, HICS, AND FMEA TRAINING
To be more efficient and effective in our response and recovery role, UNI adopts and complies with NIMS. See the UHC Emergency Operations Plan for more information

F. INSPECTING, TESTING, AND MAINTAINING EMERGENCY POWER SYSTEMS
1. The emergency generator is tested 12 times per year with testing intervals not less than 20 days and not more than 40 days apart. These tests are conducted for 30 continuous minutes or more under full building load.
2. In addition to the monthly tests, the emergency generators are tested annually with a load bank according to the applicable code procedures. The test may not be needed unless the monthly 30% of nameplate rating is not met.
3. In addition, at least every 36 months the generators are tested for a minimum of 4 consecutive hours at a load that is at least 30% of nameplate rating.
4. All automatic transfer switches are tested 12 times per year with testing intervals not less than 20 days and not more than 40 days apart.
5. If any of these tests fail, the hospital implements interim measures to compensate for the risk to patients, visitors, and staff until necessary repairs or corrections are completed. The hospital will perform a retest after making any necessary repairs or corrections resulting from the failed test(s).
6. Battery powered lights required for egresses are tested at 30 day intervals for a minimum duration of 30 seconds.
   a) These lights are tested for 1.5 hours every 12 months.

G. DRILLS, EXERCISES, AND REAL EVENTS
In accordance with regulatory requirements, at least two full-scale hospital exercises are conducted annually. These exercises address specific vulnerabilities described on the HVA. In addition, these drills and exercises are designed to be scalable and escalate. A real incident may replace the exercises. The following debrief critique and resolution process is used for all drills, exercises and real events.
H. COMMUNICATION WITH EMPLOYEES

1. Employees can receive event information and event communication through several means including but not limited to information provided through the following:
   a) Emergency Management website (pulse.utah.edu)
   b) Overhead Announcements
   c) Text messages
   d) EM cell phone app push notifications
   e) Local Leadership
   f) Campus Alert System
   g) Disaster Hotline 801-585-8888
   h) LIP Disaster Hotline 801-581-5898
   i) Twitter

2. **Note:** Placing event information on the website is a manual process. Due to this being a manual process, information delays may occur. The goal is to have timely and accurate information available as quickly as possible (approximately every 10 – 15 minutes or as things change). Understanding this process may help minimize false assumptions that information is being withheld.

I. CRITICAL AREAS OF EMERGENCY MANAGEMENT

Please refer to the UHC Emergency Operations Plan for more information on planning the following: Communications, Resources and Assets, Safety and Security, Employee Responsibilities, Utilities, and Patient Clinical and Support Activities.

J. 96 HOUR SUSTAINABILITY SUMMARY

UNI will work with the UHC Command Center in cases of a prolonged emergency. UNI has plans and resources to stand alone for up to 96-hours.
Depending on the event or circumstance(s), this may not be possible. See the UHC Emergency Operations Plan for more information.

III. PLANNING PROCESS

A. HVA
1. UNI identifies potential emergencies that could affect the demand for services or the ability to provide those services, the likelihood of those events occurring, and the consequences of those events. The Hazard Vulnerability Analysis (HVA) is designed to assist in gaining a realistic understanding of vulnerabilities and to help focus resources and planning efforts.
2. A formal review of the HVA is conducted in conjunction with the EMP at least annually or as needed. The most recent UHC HVA is reviewed and considered during the formal review process to help ensure that UNI has not overlooked any significant threat or vulnerability. Based on the results of the HVA, specific plans are written or updated. These plans include the use of the Four Phases of Emergency Management (mitigation, preparedness, response, recovery).

B. EMRA AND PACE PLANS
1. In addition to the HVA, UNI may also perform other risk, threat, and vulnerability assessments by using an Emergency Management Risks Assessment form. (see the UHC Emergency Management Plan Appendix H) A P.A.C.E. Plan (Primary, Alternate, Contingent, Emergent) form may be used anytime there is a known or suspected issue, a repair required, upgrades or modernization which may affect life safety. (see the UHC Emergency Management Plan Appendix H)
2. An EMRA may be conducted if a problem is detected or to better understand potential levels of risk or vulnerability.
   a) Risks identified in the EMRA are communicated to those impacted such as leadership and staff.
   b) Corrective action plans developed as a result of the EMRA will be monitored by the Environment of Care Committee, the Quality Council, and other committees as appropriate. The frequency and type of communication will be determined by severity, duration, and impact of the risk itself.

C. LEADERSHIP, MEDICAL STAFF, AND UHC INVOLVEMENT
1. The EMP is reviewed and approved by the Environment of Care Committee. The UHC Safety Officer is a member of this committee. The Committee Chair may also contact the UHC Emergency Management Director for assistance in writing the plan.
2. In addition to the Environment of Care Committee, the EMP is reviewed and approved by the Quality Council.
3. These committees include representatives from the professional staff, clinical disciplines, operations, and administration.

D. THE FOUR PHASES OF EMERGENCY MANAGEMENT
1. Mitigation: Within UNI, Mitigation is done continuously. As part of every drill, exercise or real event, problem areas are identified and action plans are implemented to track and correct these issues. The Environment of Care Committee works to sustain these corrections as well as bring new problems or questions to light.
2. Preparedness: Preparedness activities include but are not limited to drills, exercises, training, education, stockpiling of essential supplies, development and writing new plans, review and modification of existing plans and coordination of UNI’s role within the community.
3. Response: Response to a disaster depends on the event, its size and scope.
4. Recovery: Recovery is managed in the Command Center. In the event that UNI operations are interrupted, services will be brought back online using the following guidelines:
   a) One inpatient unit at a time
   b) Operations necessary to support patient care: nutrition services, etc.
   c) Financial services
   d) ECT
   e) Day Treatment Services
   f) Intensive Outpatient Services
   g) Other services

E. HOSPITAL COMMAND CENTER
The adopted and integrated all-hazards Command Structure used by UNI is consistent with community partners. UUHC adopts a modified version of the May 2014 Hospital Incident Command System (HICS). UNI reserves the right to conduct business believed to be most effective and beneficial for the operation and population served. See the UHC EOP for more information on this structure.

F. COMMAND CENTER STAFF ROLES
1. Incident Commander (IC) – will organize and direct the Command Center affairs and provide overall direction and instruction to the hospital and all other licensed facilities. The IC will initiate and authorize operational decisions up to and including staged or full evacuation.
2. Medical Director (Medical Technical Specialist) – will oversee the Professional Staff Manpower Pool, support and advise the Incident Commander (IC) and Operations Section Chief with recommendations, treatment, operational needs, etc.
3. Liaison Officer – Ensures that the Emergency Operations Plan (EOP) is implemented. Supports and provides recommendations to the Incident Commander (IC) and other Command Staff. Works to establish
communications among internal and external employees and partners. Will organize and coordinate overall Command Center functions to ensure operability.

4. **Safety Officer** – Supports and provides recommendations to the Incident Commander (IC) and other Command Staff. Provides ongoing assessments to identify hazards, risks and unsafe conditions and will intervene when the safety of life or property is believed to be compromised.

5. **Public Information Officer** (PIO) – Will provide information to the news media as appropriate. The PIO will oversee and determine the appropriate location for the Media Reception Center based on the event. The PIO will provide ongoing information and updates to employees through any means possible or available (i.e., Disaster website, etc.).

6. **Operations Section Chief** – The Operations Section is responsible for tactical operations (e.g., patient care, clean up) to carry out the plan using defined objectives and directing all needed resources. Many incidents that are likely to occur involve injured or ill patients. The Operations Section is responsible for managing the tactical objectives outlined by the Incident Commander. This section is typically the largest in terms of resources to marshal and coordinate.

7. **Logistics Section Chief** – The Logistics Section provides infrastructure support from Maintenance, Environmental Services, Materials Management, ITS, etc. to keep the infrastructure and other essential services up and running in order to support the operational objectives set by Incident Command. For UUHC to respond effectively to the demands associated with a disaster, support requirements will be coordinated by the Logistics Section Chief.

8. **Planning Section Chief** – The Planning Section collects and evaluates information for decision support, maintains resource status information, prepares documents, and maintains documentation for incident reports. Planning is also responsible for preparing status reports, displaying various types of information, and developing the Incident Action Plan (IAP). The effectiveness of the Planning Section has a direct impact on the availability of information needed for critical, strategic decision-making done by the Incident Commander (IC) and the other Command and General Command Staff positions.

9. **Finance Section Chief** – The Finance Section monitors costs related to the incident while providing accounting, procurement, time recording, and cost analyses. The costs associated with the response must be accounted for from the beginning of the incident. These costs can come from multiple sources such as overtime, loss of revenue generating activities, repair, replacement, and/or rebuild expenses. Daily financial reporting requirements are likely to be modified and in select situations, new requirements outlined by state and federal officials may apply.

F. **RESOURCES AND ASSETS INVENTORY**
1. UNI has identified and documented the resources and assets that are available on-site or nearby on campus prior to an incident. This information is maintained in the Emergency Management Resource Binder located in the Command Center. This record accounts for but is not limited to the following:
   a) Water
   b) Fuel
   c) Medical supplies
   d) Medications

2. **Par Level** – UNI constantly works to identify par levels for Emergency Management stockpile items in order to ensure a basic level of availability of select items that may be needed during an emergency. Some disaster stockpile items may not have an identified par level as it is difficult if not impossible to predict exactly what and how much of a given resource may be needed during an emergency or disaster. A Critical Care Items Listing has been developed by Emergency Management and is part of the UHC 96-Hour sustainability plan.

### IV. TRAINING AND DRILLS

**A. Training**

1. All new employees receive online training in Emergency Management.
3. See the UHC EOP for more information on system wide training, Utah Hospital Association Training, and NIMS compliance.

**B. Drills**

1. UNI performs at least 2 drills every year. The Hospital Command Center will be activated, facility response will be tested and evaluated to find gaps and to identify opportunities for improvement.
2. No drills are intended to affect or interfere with normal patient care.
3. Real events may take the place of drills.

**C. Observation, Critique, and Reports**

1. Observation and evaluation of disaster drills will be done by UNI and/or UHC staff. All observers will fill out the disaster drill evaluation form to ensure that the critical areas of emergency management are assessed.
2. The Environment of Care Committee Chair will debrief with observers and drill participants. This data will be compiled into a report regarding strengths, weaknesses, and areas for improvement.
3. The report will be reviewed by the Environment of Care Committee and the Quality Council.

**D. Implementation of Corrective Actions**

1. The Environment of Care Committee Chair will coordinate the implementation of corrective actions identified in the Drill Report.
2. Re-evaluation of corrective actions will be done during the following drill to ensure the proposed solution was effective.

V. ANNUAL GOALS
A. The Environment of Care Committee establishes annual goals for process improvement related to Emergency Management. The goals are submitted to, and approved by, the Quality Council. Goals are developed based on drills and other performance monitoring described in this plan.
B. Achievement of annual goals is evaluated as part of the Committee’s annual review process.
C. The current year’s goal is:
   1. Determine if a combined Emergency Management Plan (the Main Hospital and UNI) would work for both parties. If so, assist the Main Hospital in developing UNI-specific portions of the plan.

VI. ANNUAL EVALUATION AND REVIEW
The UNI Emergency Management Plan is reviewed and revised at least annually. Annual reviews also include the review of the HVA and specific disaster response plans. The plan evaluation report is submitted to the Environment of Care Committee and the Patient Safety and Quality Council. The plan is also approved annually by these bodies.

VII. REFERENCES
A. UHC Emergency Operations Plan
B. UNI Utilities Management Plan
C. UNI Fire Safety Management Plan

HISTORICAL INFORMATION -
ORIGIN DATE: 12/13/17
REVIEW DATES: 12/10/18; 2/7/18, 1/16/18; 10/16/17
REVISION DATES: 12/10/18; 2/7/18, 1/16/18; 10/16/17
APPROVAL DATES: 1/9/19; 2/28/18; 12/13/17
OWNER: Environment of Care Committee
APPROVAL BODY: Quality Council

Amendment Record
This policy is reviewed to ensure its continuing relevance to the systems and process that it describes. A record of the most recent contextual additions or omissions is given below:

<table>
<thead>
<tr>
<th>Section No.</th>
<th>Revision</th>
<th>Date</th>
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<tbody>
<tr>
<td>Page 7</td>
<td>Functions of the Command Center</td>
<td>12/10/18</td>
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<td>9</td>
<td>The Command Center will <strong>maintain documentation of the overall tracking of patients and staff via the Department Status Reports submitted by departments and units.</strong></td>
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<tr>
<td>45</td>
<td><strong>Communication plan</strong>&lt;br&gt;Notifications to physicians and staff will be made using one or more modes of available communication including handheld radios for in house employees. Physicians and staff at home will be notified by one or more of the following methods: call tree, use of the Amcom eNotify system mass emails and pages. Notification and updates of any disaster situation will be posted on the emergency preparedness website so that physicians and staff may find this information at any time.</td>
<td></td>
</tr>
<tr>
<td>34</td>
<td><strong>Alternate Care Site Plan</strong>&lt;br&gt;3. Staff Tracking&lt;br&gt;   a. The Command Center will use the HICS Form 252 to track where staff are sent.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Updated Emergency Supplies Inventory</strong></td>
<td></td>
</tr>
</tbody>
</table>
III. ATTACHMENTS

A. Code Yellow Alert List

Main Hospital Administration
CAC Manager
UHC Emergency Manager
5West Nurse Manager
All Nurse Managers
All Unit Charge Nurses
Night Supervisor
Purchasing
Psychology Manager
Patient Access Supervisor
UNI Medical Director
Adult Services Medical Director
Youth Services Medical Director
Social Work Manager
Information Systems Coordinator
Executive Director
Clinical Services Director
Operations Director
Maintenance Supervisor
Pharmacy Director
Safety Committee Chair
Fiscal Services Director
Outpatient Clinics Operations Director
B. Code Yellow Activate List

Main Hospital Administration
CAC Manager
UHC Emergency Manager
5West Nurse Manager
All Nurse Managers
All Unit Charge Nurses
Night Supervisor
Purchasing
Psychology Manager
Patient Access Supervisor
UNI Medical Director
Adult Services Medical Director
Youth Services Medical Director
Social Work Manager
Youth Services Social Work Lead
Information Systems coordinator
Executive Director
Clinical Services Director
Operations Director
Maintenance Supervisor
Pharmacy Director
Safety Committee Chair
Manager, Kidstar
Manager, Teenscope
Manager, Recovery Works
Medical Records Manager
Staffing Office
All Full Time Physicians
All Full Time Psychologists
Fiscal Services Director
Outpatient Clinics Operations Director
### C. Waste Management Plan

<table>
<thead>
<tr>
<th>FACILITY</th>
<th>RECEPTACLE</th>
<th>OP / CLOS</th>
<th>CBC YDS</th>
<th>CBC YRDS</th>
<th>Emptied</th>
<th>Type of trash</th>
</tr>
</thead>
<tbody>
<tr>
<td>University</td>
<td>1 ea Compactor</td>
<td>Closed</td>
<td>30</td>
<td>60</td>
<td>Daily Daily</td>
<td>Pot. Inf Waste</td>
</tr>
<tr>
<td>Hospital</td>
<td>2 ea Cnst</td>
<td>Open</td>
<td></td>
<td></td>
<td>Bi Monthly</td>
<td>Waste Const Waste</td>
</tr>
<tr>
<td></td>
<td>1 ea Rcyl</td>
<td>Closed</td>
<td>20</td>
<td></td>
<td></td>
<td>Waste Recycle Waste</td>
</tr>
<tr>
<td></td>
<td>dumpster</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UOC</td>
<td>1 ea Compactor</td>
<td>Closed</td>
<td>25</td>
<td>450</td>
<td>Wkly Wkly</td>
<td>Non-infect waste</td>
</tr>
<tr>
<td></td>
<td>1 ea Rcyl</td>
<td>Closed</td>
<td>20</td>
<td></td>
<td>Mnthly Wkly</td>
<td>Non-infect waste</td>
</tr>
<tr>
<td></td>
<td>Dumpster</td>
<td>Closed</td>
<td>4</td>
<td></td>
<td></td>
<td>Pot infect waste</td>
</tr>
<tr>
<td></td>
<td>10 ea bins</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Madsen</td>
<td>1 ea Compactor</td>
<td>Closed</td>
<td>20</td>
<td></td>
<td>Wkly</td>
<td>Pot infect waste</td>
</tr>
<tr>
<td>Clinic</td>
<td>1 ea</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moran</td>
<td>1 ea Compactor</td>
<td>Closed</td>
<td>30</td>
<td></td>
<td>Bi monthly</td>
<td>Pot infect waste</td>
</tr>
<tr>
<td>HCH</td>
<td>1 ea Compactor</td>
<td>Closed</td>
<td>30</td>
<td>20</td>
<td>Daily</td>
<td>Non-infect waste</td>
</tr>
<tr>
<td></td>
<td>1 ea Dumpster</td>
<td>Open</td>
<td></td>
<td></td>
<td></td>
<td>Boxes</td>
</tr>
<tr>
<td>Bldg 550</td>
<td>1 ea. Compactor</td>
<td>Closed</td>
<td>25</td>
<td></td>
<td>Not in use</td>
<td></td>
</tr>
<tr>
<td>UNI</td>
<td>2 ea Dumpsters</td>
<td>Open/close</td>
<td>8</td>
<td>8</td>
<td>Daily Daily</td>
<td>Non-infect waste</td>
</tr>
<tr>
<td></td>
<td>8 ea bins</td>
<td>Closed</td>
<td>360</td>
<td></td>
<td>Bi mnthly</td>
<td>Recycle waste</td>
</tr>
<tr>
<td></td>
<td>1 ea bin</td>
<td>Closed</td>
<td>4</td>
<td></td>
<td>Bi weekly</td>
<td></td>
</tr>
</tbody>
</table>

Total Cubic yards equal 212 cubic yards of closed waste space which is used for potentially infectious waste and 88 cubic yards of open waste space which is used for general waste.

Environmental Services would perform the following steps:
1. Separate out potentially infectious waste to conserve dumpster capacity.
2. Hospital's averages 13 cubic yards / day of potentially infectious waste and 10 cubic yrd of general waste for a total of 23 cubic yards.
3. During the disaster all facilities will be contacted to determine existing waste capacity and availability for use.
4. Environmental Service box van will be dedicated for trash distribution only.
D. Disaster box contents

This is a list of general contents. Some boxes may have other contents, e.g. Nicotine gum.

1. Copy of UNI Emergency Management Procedures

2. Copy of Role cards job descriptions during a code YELLOW ALERT or ACTIVATE for each category of employee in the unit or department.

- Emergency Blankets
- First Aid Kit
- Toilet Paper
- Batteries
- Flashlight
- Multi Tool
- Rope
- Paper/Pencil
- Wipes
- Candy
- Suntan Lotion
- Sanitary Pads
- Kleenex
- Attends
- Radio
- Water
- Kirlex
- Plastic Booties
- Rope

OPTIONAL SUPPLIES

Drinking water for patients and staff
### E. EMERGENCY MANAGEMENT SUPPLIES INVENTORY

<table>
<thead>
<tr>
<th>Item Name</th>
<th>Quantity</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blanket, emergency</td>
<td>354</td>
<td>Trailer</td>
</tr>
<tr>
<td>Burrito (patient containment device)</td>
<td>3</td>
<td>Trailer</td>
</tr>
<tr>
<td>Doxycycline (1 course of 10 day tx)</td>
<td>525</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>Extension Cords (2-100ft, 3-25 ft, 14-50 ft)</td>
<td>19</td>
<td>Trailer</td>
</tr>
<tr>
<td>Fans</td>
<td></td>
<td>Trailer</td>
</tr>
<tr>
<td>Fire Extinguisher</td>
<td></td>
<td>Trailer</td>
</tr>
<tr>
<td><strong>Food</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fuel--Mobile Natural Gas Tanks</td>
<td></td>
<td>Questar</td>
</tr>
<tr>
<td>Generator, 6500 Watt, Master Generator, Honda Engine</td>
<td>2</td>
<td>Trailer</td>
</tr>
<tr>
<td>Glasses, Safety, Clear Lens, Black Frame</td>
<td>5</td>
<td>Trailer</td>
</tr>
<tr>
<td>Gloves, CONDOR Leather Palm Glove</td>
<td>5</td>
<td>Trailer</td>
</tr>
<tr>
<td>Hard Hat</td>
<td>4</td>
<td>Trailer</td>
</tr>
<tr>
<td>Headlamp Batteries</td>
<td>64</td>
<td>Units, Other</td>
</tr>
<tr>
<td>Headlamps (10 in trailer)</td>
<td>127</td>
<td>Units, Other</td>
</tr>
<tr>
<td>Lantern Batteries</td>
<td>10</td>
<td>Units, Other</td>
</tr>
<tr>
<td>Lanterns</td>
<td>38</td>
<td>Units, Other</td>
</tr>
<tr>
<td>Leg Wraps (patient containment)</td>
<td>3</td>
<td>Trailer</td>
</tr>
<tr>
<td>Light, Work, 1000 Watt Dual Portable</td>
<td>7</td>
<td>Trailer</td>
</tr>
<tr>
<td>Linen</td>
<td></td>
<td>Conserve, use washers and dryers</td>
</tr>
<tr>
<td>Megaphone, 25 Watts, range 1000 yards</td>
<td>3</td>
<td>Trailer</td>
</tr>
<tr>
<td>MRE (Meals Ready to Eat)</td>
<td>300</td>
<td>Trailer</td>
</tr>
<tr>
<td>Plug Strips</td>
<td>7</td>
<td>Trailer</td>
</tr>
<tr>
<td>Radios,</td>
<td>34</td>
<td>Units, Other</td>
</tr>
<tr>
<td>Siphon Pump, Heavy-Duty Polyethylene</td>
<td>1</td>
<td>Trailer</td>
</tr>
<tr>
<td>Tents (walls and canopies) 10' x 20'</td>
<td>10</td>
<td>Trailer</td>
</tr>
<tr>
<td>Toilet System</td>
<td>16</td>
<td>Trailer</td>
</tr>
<tr>
<td>Torso Wraps (patient containment)</td>
<td>3</td>
<td>Trailer</td>
</tr>
<tr>
<td>Trailers</td>
<td>2</td>
<td>East Parking Lot</td>
</tr>
<tr>
<td>Vests (blue)</td>
<td>2</td>
<td>Command Center</td>
</tr>
<tr>
<td>Vests (orange)</td>
<td>10</td>
<td>Command Center</td>
</tr>
<tr>
<td>Vests (red)</td>
<td>3</td>
<td>Command Center</td>
</tr>
<tr>
<td>Vests (yellow)</td>
<td>2</td>
<td>Command Center</td>
</tr>
<tr>
<td>WAG bags (boxes of 100)</td>
<td>62</td>
<td>Trailer</td>
</tr>
<tr>
<td>Water Drum, 55 gal.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hot Water Tanks--Boiler Room</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mount Olympus Water</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sysco Corp</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smith’s Grocery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Asset #</td>
<td>Make</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------</td>
<td>---------</td>
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<tr>
<td>Ross's Office</td>
<td>20977</td>
<td>Motorola</td>
</tr>
<tr>
<td>Administration</td>
<td>39348</td>
<td>Kenwood</td>
</tr>
<tr>
<td>Day Treatment</td>
<td>32265</td>
<td>Motorola</td>
</tr>
<tr>
<td>South Clin</td>
<td>39350</td>
<td>Kenwood</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>39346</td>
<td>Kenwood</td>
</tr>
<tr>
<td>Recovery Works</td>
<td>27836</td>
<td>Motorola</td>
</tr>
<tr>
<td>Financial Services</td>
<td>27640</td>
<td>Motorola</td>
</tr>
<tr>
<td>ECT</td>
<td>32264</td>
<td>Motorola</td>
</tr>
<tr>
<td>Front Desk</td>
<td>39351</td>
<td>Kenwood</td>
</tr>
<tr>
<td>CAC</td>
<td>27637</td>
<td>Motorola</td>
</tr>
<tr>
<td>Staffing Office</td>
<td>20976</td>
<td>Motorola</td>
</tr>
<tr>
<td>Dept. Psychiatry</td>
<td>UNI 903</td>
<td>Kenwood</td>
</tr>
<tr>
<td>Kitchen</td>
<td>32266</td>
<td>Motorola</td>
</tr>
<tr>
<td>Purchasing</td>
<td>27642</td>
<td>Motorola</td>
</tr>
<tr>
<td>Dennis</td>
<td>27639</td>
<td>Motorola</td>
</tr>
<tr>
<td>Maintenance</td>
<td>6872</td>
<td>Motorola</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>UNI 904</td>
<td>Kenwood</td>
</tr>
<tr>
<td>2 North</td>
<td>18903</td>
<td>Motorola</td>
</tr>
<tr>
<td>2 East</td>
<td>35462</td>
<td>Kenwood</td>
</tr>
<tr>
<td>2 South</td>
<td>6892</td>
<td>Motorola</td>
</tr>
<tr>
<td>2A</td>
<td>39345</td>
<td>Kenwood</td>
</tr>
<tr>
<td>2B</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 North</td>
<td>27638</td>
<td>Motorola</td>
</tr>
<tr>
<td>3 South</td>
<td>18904</td>
<td>Motorola</td>
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<tr>
<td>4 South</td>
<td>34521</td>
<td>Kenwood</td>
</tr>
<tr>
<td>4 North</td>
<td>32193</td>
<td>Motorola</td>
</tr>
<tr>
<td>Teenscope South</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
G. VOLUNTEER CREDENTIALING PLAN

If the incident commander determines the event is one that persons may present to the hospital to volunteer the following plan will be implemented. The incident commander will assign two people to get the Credentialed Staff and Medical Manpower Boxes in the Command Center. Credentialed staff (physicians, APRNs, and psychologists) will be processed in the Staffing Office in the first floor lobby. All other medical personnel will be processed in the Meditation Room in the first floor lobby.

Volunteer Disaster Box Contents (located in the Command Center)
1. Red stickers for ID badges
2. Volunteer tracking sheet
3. Plastic envelopes for ID badges with clips
4. Markers/Pens
5. Paper or notebook
6. Disaster Privileges Forms

EMERGENCY CREDENTIALING FOR PHYSICIANS AND PSYCHOLOGISTS:

Disaster privileges are granted only when the following conditions are present:
1. The Emergency Operations Plan (EOP) has been activated
2. The organization is unable to meet immediate patient care needs
3. As determined necessary by the Incident Commander or Medical Director

The Incident Commander, Executive Director, or Medical Director, may grant disaster privileges to volunteer LIP’s. The Medical Director or designee will oversee the Credentialed Staff Labor Pool and will grant disaster privileges by using the privileging verification processes and will ensure the following:

1. Direct observation, mentoring, and clinical record review will be performed to oversee the professional performance of volunteer practitioners who receive disaster privileges.

2. Upon verification, volunteer practitioners who have been granted disaster privileges will readily be identified with a temporary disaster identification ID badge provided by the Labor Pool.

3. While disaster privileges are granted on a case-by-case basis, volunteers considered eligible to act as licensed independent practitioners must, at a minimum, present a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport) AND at least one of the following:
   a. A current hospital picture ID badge that clearly identifies professional designation.
   b. A current license to practice.
   c. Primary source verification of the license.
   d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), MRC, ESAR-VHP, or other recognized state or federal organization / group.
e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
f. Identification by a current hospital or medical staff member(s) who possess personal knowledge regarding the volunteer’s ability to act as a licensed independent practitioner during a disaster.

4. Credentialed Staff must fill out the Disaster Privileges form.
   a. The form must be signed off by the Medical Director before the volunteer can work.
   b. Fax the form to the Medical Staff Office 801-585-1605 where the credentials can be verified in accordance with UNI Professional Staff Bylaws.

5. Fill out the volunteer tracking sheet, record volunteer’s name, profession/occupation, and state of licensure, and license #, time, and date.

6. Write name, credentials, occupation and the date and time on the RED badge place it in the plastic envelope (follow example in Volunteer disaster box) and put it on a lanyard.

7. Volunteers should not work for longer than 12 hours. Instruct them to return to you when 12 hours has expired, they must return the badge and check out with you.

8. The medical staff will oversee the professional practice of volunteer licensed independent practitioners. In addition, direct observation, mentoring, and clinical record review will be performed throughout this process.

9. A decision will be made by the Command Center Medical Director, the Incident Commander or both (based on information obtained regarding the professional practice of the volunteer) within 72-hours related to the continuation of the disaster privileges initially granted.

10. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72-hours from the time the volunteer practitioner provides care, treatment, and services under the disaster privileges.

11. In the extraordinary circumstance that primary source verification of licensure, certification, or registration cannot be completed in 72-hours, it will be conducted as soon as possible. This extraordinary circumstance will be documented by outlining why primary source verification could not be performed in the required time frame, evidence of a demonstrated ability to continue to provide adequate care, treatment, and services, and an attempt to rectify the situation as soon as possible.

* Licensed volunteers must work under the supervision of a hospital staff member.*

Communicate with the Command Center for any additional staffing or equipment needs. Stay in contact with the Command Center, they will let you know the hospital’s volunteer needs. If there is no further need for volunteers at that time, direct volunteers to return to the Volunteer Tracking Leader at a specific time. Coordinate breaks and staff rotation as needed.
RECEIVING LICENSED VOLUNTEERS

1. While disaster privileges are granted on a case-by-case basis, volunteers considered eligible to act as licensed independent practitioners must, at a minimum, present a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport) AND at least one of the following:
   
   a. A current hospital picture ID badge that clearly identifies professional designation.
   b. A current license to practice.
   c. Primary source verification of the license.
   d. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), MRC, ESAR-VHP, or other recognized state or federal organization / group.
   e. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).

2. Fill out the volunteer tracking sheet, record volunteer’s name, profession/occupation, and state of licensure, and license #, time, and date.

3. Write name, occupation and the date and time on the RED badge place it in the plastic envelope (follow example in Volunteer disaster box) and put it on a lanyard.

4. If they have additional certifications i.e. ACLS, ATLS etc. please place it on badge.

5. Volunteers should not work for longer than 12 hours. Instruct them to return to you when 12 hours has expired, they must return the badge and check out with you.

6. Primary source verification of licensure begins as soon as the immediate situation is under control, within 72-hours due to extraordinary circumstances or as soon as possible if 72 hours is still not feasible.

7. In the extraordinary circumstance that primary source verification of licensure, certification, or registration cannot be completed in 72-hours, it will be conducted as soon as possible. This extraordinary circumstance will be documented by outlining why primary source verification could not be performed in the required time frame, evidence of a demonstrated ability to continue to provide adequate care, treatment, and services, and an attempt to rectify the situation as soon as possible.

*Licensed volunteers must work under the supervision of a hospital staff member.*

Communicate with the Command Center for any additional staffing or equipment needs. Stay in contact with the Command Center, they will let you know the hospital’s volunteer needs. If there is no further need for volunteers at that time, direct volunteers to return to the Volunteer Tracking Leader at a specific time. Coordinate breaks and staff rotation as needed.
H. UNIVERSITY OF UTAH NEUROPSYCHIATRIC INSTITUTE
DISASTER PRIVILEGES

To be completed by applicant and approved by the Medical Director.

| Applicant Name: ________________________________ Date: _________________ |
| Other Name used by Applicant (i.e., maiden name, etc.)_______________________ |
| Specialty: ______________________________________________________________ |
| Primary Office Address: _________________________________________________ |
| City: _______________________________ State: ____________ Zip: _____________ |
| Phone Number: ( ) _______________ Date of Birth___________ |
| SS#__________________________ |
| Medical School:  ________________________________ Year Graduated: ______ |
| Board Certified: Yes ☐ No: ☐ DEA No: ________________________________ |
| License #: ________________________________ State: ____________________ |

Please answer the following questions: (If Yes to any, attach an explanation on a separate sheet of paper.)

1. Have proceedings been instituted to have your license to practice medicine limited, suspended, revoked, denied, restricted or voluntarily withdrawn? Yes ___ No ___

2. Have you ever terminated, voluntarily or involuntarily, any medical training program, such as medical school, internship, residency or fellowship program? Yes ___ No ___

3. Have any of your clinical privileges been denied, revoked, suspended, reduced, limited, not renewed, or voluntarily relinquished? Yes ___ No ___

4. Have you been investigated by or suspended, sanctioned, or restricted from participating in any private, federal or state health insurance program, HMO, PPO, provider network or regulatory agency (e.g., Medicare, Medicaid)? Yes ___ No ___

5. Do you have or have you had in the past, any physical or mental health conditions(s) that have affected or could affect your ability to perform the mental and physical functions related to the specific clinical privileges you are requesting? Yes___ No ___

6. Have you been denied professional liability insurance or has your policy been canceled, limited, or been denied renewal? Yes ___ No ___

7. Have you ever been a defendant in criminal proceedings related to the practice of medicine? Yes ___ No______ (over)
Consent and Authorization

• I authorize the Hospital, its Medical Staff, and their representatives to consult with administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character, and ethical qualifications, and I hereby consent to the release of such information.

• I consent to the inspection by the Hospital, its Medical Staff, and its representatives of all records and documents (including medical records at other hospitals) that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges.

• I am aware that the Medical Staff Office may query the National Practitioner Data Bank and the Federation of State Medical Boards as a part of the application process.

• I confirm that I have sufficient malpractice insurance for the scope of my practice.

Attestation

I hereby certify that the information in this questionnaire is true and complete and that it accurately discloses all matters requested.

Applicant’s Signature___________________________________ Date: ___________

To be completed by the Medical Staff Office

FSMB Query: _____ Date: __________

NPDB Query: _____ Date: __________

License verified: _____ Date: __________

Malpractice Coverage Verified: Date: __________

Results sent to requesting department: Date: __________
I. NON-MEDICAL MANPOWER POOL PLAN

The Command Center will assign someone to manage the Non-Medical Manpower Pool. This person is responsible for assigning non-clinical hospital staff to do jobs and tasks necessary in an emergency. Supplies for running the Non-Medical Manpower pool are in the Non-Medical Manpower Pool box found in the Command Center.

Assigning Hospital Volunteers
1. Review Job Assignments Spread Sheet
2. Contact Command Center to identify critical need areas
3. Assign staff to jobs.
   • Write down the staff’s name and the hours they are expected to work in that job.
   • Instruct staff to check back with the Non-Medical Manpower at the end of their shift/completion of the job.

Receiving Unlicensed Volunteers
1. Verify identification of volunteer with a picture ID
2. Fill out the volunteer tracking sheet, record volunteer’s name, state of residence, date, and time.
3. Write name, date, and time on the BLUE badge and place it in the plastic envelope (follow example in Volunteer disaster box) and put it on a lanyard.
4. Volunteers should not work for longer than 12 hours.
5. Instruct them to return to you when 12 hours has expired or upon completion of their job.
6. They must return the badge and check out with you.
J. EVACUATION PLAN
Patient and staff safety is always the first priority in any evacuation situation. The scope of evacuation will be determined by the extent of the situation. If the area involved is a small area or easily contained, it may be necessary to only evacuate all persons from the immediate area to another location on the same floor but on the other side of the fire doors. Lateral or horizontal evacuation should always be the first choice if an area must be evacuated. If time allows, the patients chart, medications in their medication drawer in the Omni cell and their belongings should be placed in a pillow case and transferred by staff. In any evacuation situation the nurse manager or designee is responsible for maintaining patient and staff accountability.

Horizontal Evacuation
1. A code YELLOW ACTIVATE should be initiated as soon as possible.
2. Patients closest to the immediate danger should be moved first and all personnel should be moved toward the nearest and safest protected area away from the source of danger.
3. Instruct patients and visitors to line up, hold hands, and follow a leader to a safe area.
4. One employee is to be assigned to each evacuation group. Do not leave the patients unattended.

Vertical Evacuation
1. The Nurse Manager or designee should choose the safest and most easily accessible evacuation route to the Gym or Cafeteria.
2. Stairwells should be utilized, do not use elevators unless instructed by the Command Center that it is safe to do so.
3. Use handheld radios to give information and receive direction from the Command Center.
4. Patients should be accompanied by one or more staff. If possible, have patients line up, hold hands and follow a leader to designated area. Patients having difficulty ambulating, can be evacuated one of the following ways:
   a. Use of Paraslyde Evacuation sleds
   b. Three-man and four-man blanket carry
   c. Two man swing carry
5. The order of evacuation is from the top of the hospital to the bottom of the hospital. The last person leaving the area should radio the Command Center and report that the area has been cleared.
6. As rooms are evacuated on the floor the doors should be shut and a large X should be placed on the door which will indicate to others that the area has been cleared and all persons are evacuated.
Building Evacuation
1. In the event an incident is specific to UNI with no other valley entities affected, in accordance with established MOUs, patients will be transferred to the most appropriate local facility with the given acuity. Contact UHC Command Center to arrange these transfers.
2. If it is a disaster which affects facilities valley-wide, an assessment will be done, according to acuity, to prioritize those patients who are in need of immediate transfer from UHC. Contact UHC Command Center to arrange these transfers.
3. Patients may need to be maintained at an Alternate Care site or by Sheltering in Place until they can be transported to another health care organization or they can be returned to UNI. See the Alternate Care Site Plan and Shelter in Place Plan for more information.

Authorization
Building Evacuation must be authorized by the Executive Director, the Hospital Administrator on call, or the Fire Department.

Evacuation Process
1. All staff & patients will evacuate from the nearest exit & immediately move towards one of the two Emergency Assembly points: 1. the south upper tier of the East Parking Lot or 2. The west parking lot.
2. Emergency Disaster Kits will be taken to the evacuation location.
3. Charge Nurses are responsible for tracking patients and designating staff persons to evacuate medical records.

Vulnerable Populations
UNI will make every reasonable effort to provide clinical services for vulnerable populations during an evacuation, including pediatric, geriatric, addicted, and limited mobility patients. If beds are unavailable to hold these patients, transport to an appropriate acuity receiving facility will be coordinated. If this is not possible, the Command Center will determine the best course of action on a case-by-case basis.
K. ALTERNATE CARE SITE PLAN

UNI is prepared for the possibility that buildings or the general hospital site may be rendered unsafe or unusable. Radio the UHC Command Center to request assistance with relocating to an alternate care site. Refer to the UHC Emergency Operations Plan for information on Evacuation and Alternative Care Sites.

1. Alternate Care Site Locations: See the UHC Emergency Operations Plan

2. Transportation (Coordinate with UHC)
   a. Patients: Campus shuttles, UTA buses and or ambulances will be positioned at all EOPs. Patients will then be transported via bus, shuttle or ambulance to the alternative care site.
   b. Staff: Patient care providers will be transported with the patients in order to provide care during transport in campus shuttles and or UTA buses. Staff not involved in direct patient care will be transported via campus shuttle and UTA bus after all patients have been evacuated.

4. Medication
   a. Prior to patients being evacuated from the floor their medications will be pulled from the OmniCell for the upcoming eight hours and transported with the patient along with their medical record. Narcotics and medications requiring refrigeration will be excluded. The actual OmniCells will be physically transported via University Box truck to the alternate care center where it will be re-supplied and maintained by pharmacy. Narcotics and medications requiring refrigeration will be managed by pharmacy which will follow its policies.

5. Equipment
   a. All essential equipment necessary for immediate patient care such as IV pumps, oxygen canisters etc. should be transported with the patient. Additional key items will be tagged by the nurse manager with TRANSPORT written on surgical tape and moved to a central location in the unit so that it is easily identifiable. Members of the Non-medical manpower pool will retrieve the equipment.

6. Patient Care Critical Documents
   a. Bedside care providers are responsible for printing and compiling critical documents necessary for evacuation. The following documents will be printed for each patient (as appropriate):
      i) H&P
      ii) Last 24 Hours: Vitals, I/O
      iii) Last 72 Hours: Labs, Radiology reports, Physician notes, Orders
   b. IT downtime boxes will be used and downtime procedures will be implemented.
7. Patient tracking
   a. The charge nurse will obtain a copy of the patients that are on the unit and take a copy of this list to the Command Center. Once given the order to evacuate, the charge nurse will begin the process, calling the Command Center on the handheld radio to inform the Command Center when the unit has been completely evacuated to one of the collection points.
   b. The Command Center will designate the alternative care site and provide two Rally Point Leaders at the parking lot evacuation point.
   c. Units should check every patient in with the Rally point leader. The Rally point leader will document time the patient has arrived and the time when the patient is transported to the alternative care site. The Rally point leader will also document all staff who has reported to the Rally point. The Rally point leader will then relay this information to the patient tracking officer in the Command Center.
   d. Refer to the UHC EOP Plan for specific Patient Access procedures regarding tracking patients.

8. Staff Tracking
   a. The Command Center will use the HICS Form 252 to track where staff are sent.

9. Communication with the Command Center and the Alternate Care Site
   a. UNI will maintain communications with the Alternate Care Sites by using one or more methods as described in the Communication Section of this plan.
   b. Once the alternate care site has been established, the site will contact the Command Center to establish an Alternate Care site Command Center at the location of the alternate care site to ensure that continuous communication, leadership and documentation will occur.
   c. The preferred communication methods to and from alternate care site(s) will take place via cell phones, pagers, and Emergency Management disaster radios.

10. Community assistance
    a. Requests for community assistance will be made through the University Health Care Command Center to the UDOH, UHA, county and or State EOC depending on the size and scope of the disaster.

9. Return to facility
    a. The decision to return to the hospital will be made by the Executive Director, or designee, once the facility has been deemed safe for inhabitation.
L. SHELTER IN PLACE

1. In Hospital

   In the event the hospital is notified of an environmental contaminant and instructed to shelter in place all external air handlers will be turned off immediately. An overhead announcement will be made instructing all inpatient units to turn their handheld radios on and in house clinics will receive a page through eNotify which will provide information on the situation. A recommendation will be made at this time for our outpatient population as well as our inpatient visitors regarding when it will be safe to leave the building. This message will be communicated by hand held radio, pager, flyers and posted on all exterior doors. Persons arriving to the hospital will not be permitted entry.

2. In Parking Lot

   In the case of a disaster in which the hospital is not habitable and evacuation routes are blocked (e.g. a massive, community-wide earthquake), UNI will need to shelter patients and staff in the parking lot.

   a. Building Evacuation Procedures should be followed as noted above. If possible, mattresses should be removed to the parking lot.

   b. The Command Center will assign individuals to set up the shelter in place facilities as noted below.

   c. The Emergency Management Trailers are situated on the first tier of the East Parking Lot near the loading dock area. They contain supplies to shelter in place. Maintenance and Purchasing have keys to the trailer as well as an updated supply list.

   d. Tents: The trailer contains 8 tents for patient units and 2 for staff. One tent should be used as a staff sleeping “room”.

   e. Toilets: The trailer contains 16 toilets and a supply of WAG bags. Toilets should be set up in proximity to the tents so patients can be observed but at a distance where odor will not be detrimental to patients and staff.

   f. Beds: Use any mattresses that were removed from the building for beds. The trailer also contains emergency blankets to keep people warm. Cots are available in the CAMT building.

   g. Lighting: The trailer contains 7 work lights.

   h. Generator: The trailer contains two portable generators, which can be powered by using the siphon to siphon gas from cars in the parking lot.

   i. Water: The trailer contains two 55 gallon water drums that can be used to hold water. Water can also be obtained from other sources as noted earlier in the Emergency Management Procedures.

   j. Food will need to be removed from the kitchen and preserved as well as possible given the shelter in place conditions.

   k. Miscellaneous Items:

      i. 3 Burrito Wraps: If patients need to be restrained during a shelter in place situation, the trailer contains 3 burrito wraps with chest and arm straps.

      ii. Work Gloves and Hard Hats in the trailer can be used when clearing debris.
iii. The megaphones in the trailer can be used for mass communications.
M. INFLUX OF PSYCHIATRIC PATIENTS
In the case of an evacuation at another psychiatric facility (5 West or the VA Hospital), UNI will be placed on Code Yellow Alert.

Code Yellow Alert
1. Contact the CAC to determine bed availability
2. Contact UHC Command Center with bed numbers
3. Instruct CAC to hold admissions
4. Contact Emergency Departments to hold admissions
5. Contact units—no staff to go home early.

Code Yellow Activate
1. Instruct CAC to go on divert
2. Instruct evacuating facilities that incoming patients should be accompanied by their medical records, as appropriate, and staff to care for those patients.
3. Instruct evacuating facilities to bring patients to gym entrance (if mass evacuation).
4. Contact staffing office to bring in more staff.
5. Page the following personnel to the gymnasium to assist with intake:
   - All physicians
   - All CAC staff
   - Paige Strate—bring laptops and be available for ITS support
   - Nurse Managers
   - Social Work Manager
6. Assign someone to set up the Medical Manpower pool in the gymnasium to accept staff from evacuating facility.
7. Patients will be admitted to UNI if they meet UNI admission criteria. This process will be facilitated by a physician to physician conference between the UNI on call physician and/or the UNI Medical Director and the evacuation facility (ies) on call physician(s).
N. **CODE YELLOW LOCKDOWN**

A Code Yellow Lockdown will be used when there is a need for staff, patients, and visitors to stay inside the building. All external facility doors will be locked to prevent a safety concern on the outside from entering the building.

1. A Code Yellow Lockdown may be initiated and cleared by Police, UHC Emergency Management, or UNI Leadership.

2. Staff are expected to stay inside for their own safety. If staff choose to leave, they must do so through either the Front Lobby door or the East Staff Entrance. Before exiting, they may be required to sign a waiver.

3. The Incident Commander, or designee, will communicate with all visitors that the hospital is on lock down and that people need to stay inside for their safety. 
   a. People may choose to leave the building at their own risk. They need to leave through either the Front Lobby door or the East Staff Entrance. They need to notify the Incident Commander so UNI is aware of who has left and who remains in the facility. Before exiting, they may be required to sign a waiver.

4. Admittance to the building may occur on a limited case by case basis. Entry will be granted through the Front Lobby Doors, the Ambulance Bay Doors, or the East Staff Entrance Doors. The Incident Commander shall assign someone to monitor the entry points.