

Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
Mental Health Block Grant

Program Monitoring Report

Utah

August 11-14, 2014

DRAFT

Executive Summary

The Division of State and Community Systems Development (DSCSD), Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services conducts at least 10 monitoring visits each year to ensure that states receiving mental health block grants (MHBG) pursuant to Section 1911 of the Public Health Service Act (PHSA) comply with grant requirements. As required by Subpart III, Section 1945 (g) of the PHSA, the CMHS conducts these investigations in partnership with the States to:

- Monitor the expenditures of mental health block grant funds;
- Assess compliance with required funding agreements and assurances;
- Identify strengths (e.g., best practices, exemplary efforts) of state and local mental health systems; and
- Recommend areas for improvement and possible technical assistance.

The Utah MHBG monitoring was held on August 11-14, 2014 utilizing video conferencing. The federal MHBG monitor and project officers had the opportunity to conduct a review of Utah's adult and children systems of care; a recovery consultant (non-federal) addressed the requirements of the Mental Health Planning Council and the principles of recovery and resilience throughout the system.

The Division of Substance Abuse and Mental Health (DSAMH) is authorized under Utah State Code Annotated §62A-15-103 as the single state authority in Utah. Utah is divided into 29 counties that collectively span an area of nearly 85,000 square miles. There are a total of thirteen Local Mental Health Authorities (LMHA) statewide. Eleven of the thirteen also serve as the Local Substance Abuse Authority (LSAA). Services are generally contracted to Community Mental Health Centers (CMHC) and by contract with private providers. The state is responsible for monitoring local compliance to the plan submitted by LMHA. The monitoring of the systems of care is operationalized by the state by implementing either on-site or virtual site visits with the LMHA and CMHC. The monitoring provides federal, state, and local input into the service array at the local levels. It also allows the dissemination of policy and best practices from the state to the local level.

The current priorities for the DSAMH are:

- Systems Integration;
- Suicide Prevention;
- Supported Employment; and
- Supported Education

Other priorities include the implementation of Mental Health First Aid, improving mental health promotion activities and programs, expanding peer support, and integrating services with school-based resources.

State legislation in 2011 made Utah an "Employment First" state. A requirement followed that all state departments and divisions serving populations with a disability give priority to services to assist that person in obtaining and retaining meaningful employment. Agencies are required to develop a plan to implement this policy, providing annual goals, reporting on those goals, and

making adjustments in response to relevant data. Division directives also specifically require the integration of recovery and resilience into the state mental health system through inclusion in area plans.

Peer support in Utah is provided by Certified Peer Support Specialists (CPSS) for adults and by Family Resource Facilitators (FRF) for children, youth, and families. Community partners have played a critical role in the development of peer support services. Utah has a strong history of working with partners to provide services using a system of care (SOC) approach, based on the core values of family-driven, youth-guided, community-based, with principles of cultural and linguistic competence.

The state and local systems have integrated mental health and substance abuse into an effective behavioral health system throughout most of the state. Utah also continues to make substantial progress towards integrating behavioral health with primary care and physical health through a focus on wellness and public health messaging. Financial resources remain an ongoing issue.

Summary of Technical Assistance Recommendations:

The monitoring team makes the following recommendations for technical assistance:

- The state requested and should receive technical assistance to enable it to quantify the return on investment of prevention efforts and programs, including working with Centers for Medicare and Medicaid Services (CMS) to address how capitation rates and prevention efforts can work against each other.
- The UBHPAC should receive technical assistance to facilitate its understanding and interpretation of the data that they receive from the division.
- The planning council should also receive technical assistance to augment its monitoring of Utah's behavioral health system.

Summary of Recommendations

The monitoring team makes the following recommendations:

- The state should explore ways to identify and recognize specific LMHAs for their expertise and use a train-the-trainer model to provide trainings to other local mental health providers and partners
- The state should use the telemedicine network to support non-therapeutic services, such as staff trainings, council meetings, and consumer outreach and feedback sessions.
- While the monitoring team recognizes the state has no current authority to provide oversight to private, for profit, residential treatment centers for out of state children, all states that send children for placement should be compliant with interstate compacts that require them to report and share information regarding the children entering those facilities. The state should enforce those regulations.
- The state should continue efforts to improve school-based and corrections-based services and data collection.
- The state should consider adding a more formal and integrated peer or consumer component to its onsite monitoring process.
- The UBHPAC does not have the principle state agencies mandated by statute with respect to mental health, education, vocational rehabilitation, criminal justice, housing, and social services (Public Law 102 – 321, Section 1914 (A) (i)). This must be addressed (if not

already done so) by the division and the council as the state was out of compliance at the time of the video conference monitoring.

- Documentation was not provided as to the submission by the state and review of the state behavioral health plan by the full council pursuant to section (1915(a)) and to submit to the state any recommendations of the council for modifications to the plan (Public Law 102 – 321, Section 1914, (b) (1)). This also is a compliance issue, as the statute indicates timely submission by the state and review by the full council. Minimally this should be documented in council minutes.
- The division in collaboration with consumer advocates and stakeholders should continue to work with the Utah legislature to raise the Medicaid reimbursement rate for peer support specialists.
- The division should facilitate a consumer-family forum annually within the state, in order to hear direct input from consumer and family members.

DRAFT

Table of Contents

| | |
|--|-----|
| Executive Summary | iii |
| PROGRAM MONITORING REPORT | 1 |
| Administration of Mental Health Services and Leadership Perspective..... | 1 |
| Performance Data, Quality Improvement and Decision Support..... | 7 |
| Adult Services | 7 |
| Children Services | 9 |
| Mental Health Planning Council | 12 |
| Consumer and Family Member Involvement..... | 15 |
| Appendix A- Listing of Federal Monitoring Team Members..... | 19 |
| Appendix B- Listing of State Staff Interviewed..... | 20 |

DRAFT

PROGRAM MONITORING REPORT

Administration of Mental Health Services and Leadership Perspective

The Division of Substance Abuse and Mental Health (DSAMH) is authorized under Utah State Code Annotated §62A-15-103 as the single state authority in Utah. DSAMH was formed in 2002, when Utah's legislature merged the Divisions of Substance Abuse and Division of Mental Health. DSAMH serves as both the state's Mental Health Authority (SMHA) and Substance Abuse Authority (SAA). DSAMH is a division of the state Department of Human Services (DHS). DHS is one of the largest departments in Utah state government and includes the following offices and divisions:

- Division of Services for People with Disabilities;
- Utah State Developmental Center;
- Division of Aging and Adult Services;
- System of Care;
- Partnership-Utah Marriage Commission;
- Utah State Hospital;
- Office of Public Guardian;
- Developmental Disabilities; and
- Partnership-State Education Specialist.

The division has the following primary responsibilities:

- Ensure that prevention/treatment services for substance abuse and mental health are available throughout the state;
- Ensure public funds are spent appropriately;
- Contract with local county governments statutorily designated as local substance abuse and local mental health authorities to provide prevention or treatment services;
- Provide oversight and policy direction to local authorities;
- Monitor and evaluation of mental health and substance abuse services through an annual site review process, reviews local area plans, and reviews program outcome data;
- Provide technical assistance and training to local authorities;
- Evaluate the effectiveness of prevention and treatment programs to disseminate the information to stakeholders; and
- Supervise the administration of the Utah State Hospital.

Utah is divided into 29 counties that collectively span an area of nearly 85,000 square miles. There are a total of 13 Local Mental Health Authorities (LMHA) statewide. Eleven of the thirteen also serve as the Local Substance Abuse Authority (LSAA). DSAMH contracts with the LMHA to provide mental health prevention and treatment services. The state publishes annual *Division Directives* that articulate state and federal minimum expectations and serve as request for proposals for LMHA. The LMHA then submit applications that serve as *area plans* that operationalize the minimum standards, address local service needs, and outline decision making. While the LMHA set the priorities to meet local needs, the area plans must include how the local entities will address the minimum standards set by the division and what services are to be provided with state, federal, and county money.

At a minimum, the following services must be addressed within each area plan:

- Inpatient care;
- Residential care;
- Outpatient care;
- 24-hour crisis care;
- Psychotropic medication management;
- Psychosocial rehabilitation, including vocational training and skills development,
- Case management;
- Community supports, including in-home services, housing, family support services, and respite services;
- Consultation and education services, including case consultation, collaboration with other county service agencies, public education, and public information; and
- Services to persons incarcerated in a county jail or other county correctional facility.

Services are generally contracted to Community Mental Health Centers (CMHC) and by contract with private providers. The state is responsible for monitoring local compliance to the submitted plan. This process involves the state perform either onsite or virtual site visits with the LMHA and CMHC. This state monitoring provides federal, state, and local input into the service array at the local levels. It also allows the dissemination of policy and best practices from the state to the local level. Both the state and local entities report how this process is also a valuable piece in creating and maintaining solid working relationships statewide. The state maintains a comprehensive data collection system that matches expectations articulated in the directives and provides feedback on all mandated services expected at the local level. DSAMH monitors each LMHA, either on site or remotely, on a yearly basis, per statute. Deficiencies are address by formal reports to the county authority; the LMHA responds with a corrective action plan which includes clear timeframes for the cited corrections.

The current priorities for the commissioner are:

- Systems Integration;
- Suicide Prevention;
- Supported Employment; and
- Supported Education

Other priorities include the implementation of Mental Health First Aid, improving mental health promotion activities and programs, expanding peer support, and integrating services with school-based resources.

In response to these priorities, DSAMH developed an overarching goal to ensure every person seeking recovery and treatment for substance use disorders and mental health is entitled to humane care and treatment in accordance with the prevailing standards accepted in medical practice, psychiatric nursing practice, social work practice, and clinical psychology. This is broken further into five operational goals:

- Focus on Prevention and Early Intervention;
- Development of a recovery-oriented system of care led by individuals in recovery that is trauma-informed and evidence-based;

- Strengthen the system of care for children and youth to become more family-driven, youth guided, community-based, and culturally and linguistically competent;
- Promote integrated programs that address the individual's substance use disorder, mental health and physical healthcare needs; and
- Increase in public awareness and understanding of substance use disorders and mental illness and promote successful strategies to improve the health and wellness of individuals, families and communities.

The state continues to encounter challenges and overcome obstacles in its attempt to implement programs toward these goals. As a state that has not participated in Medicaid expansion, Utah continues to struggle to find sufficient resources for the uninsured and underinsured. With decreases in funding, the state has been working with LMHAs, other government agencies, state and federal, to create partnerships that increase affordable housing and rental development opportunities. At the time of monitoring, the LMHAs were working with the CMHCs to develop ideas for housing programs. Together they have developed Housing/In Home Skills Programs (Treatment Based Housing Programs) and Supported Housing Programs in which clients live independently in the community or in freestanding facilities, leased at times by the CMHC at a subsidized cost to the clients. At the time of the video conferencing with the monitoring team, there were approximately 750 clients living in these arraignments developed or supported by the CMHC.

State legislation in 2011 made Utah an "Employment First" state. This created a requirement that all state departments and divisions serving populations with a disability give priority to services to assist that person in obtaining and retaining meaningful employment. Agencies are required to develop a plan to implement this policy and provide annual goals, report on those goals, and make adjustments in response to relevant data. DSAMH responded to the implementation of this legislation by partnering with the Interdepartmental Employment Partnership, as well as several other state departments and divisions. This group is responsible for creating local plans designed to address significant implementation challenges, such as staff training and identification of appropriate funding streams for training.

As part of the DSAMH contracts with the LMHA and LSAA, those local authorities are required to provide services to individuals experiencing homelessness with mental health and co-occurring substance use disorders. The division also administers the Projects for Assistance Transition from Homelessness (PATH) Grant, to serve individuals experiencing homelessness with mental illness and co-occurring substance use disorders and report serving 1,600 individuals in FY13. Despite these efforts, Utah continues to see increasing rates of homelessness among individuals experiencing substance abuse and mental health disorders in this same time period.

Division directives specifically require the integration of recovery and resilience into the state mental health system through inclusion in area plans. The state has continued efforts to expand rehabilitation services, including developing clubhouses (at the time of the monitoring, three were certified and three more working on certification), case management, peer run day support and rehabilitation programming. DSAMH is committed to continue these changes through the use of contract requirements, practice guidelines, division directives and data requirement modifications. Initiatives such as Peer Support, Access to Recovery (ATR), Trauma-Informed Care, Supported

Peer Support Services and Employment and Supported Education are examples of these efforts to support recovery and resiliency. These initiatives have been systemic across all levels of care, training, support and services.

Peers give encouragement, hope, assistance, guidance and understanding to those working toward recovery. Individuals who have lived experience with substance use and mental health disorders play an important role. Peer support in Utah is provided by Certified Peer Support Specialists (CPSS) for adults and by Family Resource Facilitators (FRF) for children, youth, and families. Community partners have played a critical role in the development of peer support services. These partners include: Allies with Families, Empowerment Services, National Alliance on Mental Illness (NAMI) Utah, New Frontiers for Families and Utah Support Advocates for Recovery Awareness (USARA).

Currently, peers are employed in each of the local mental health authorities and in several other partner agencies. This opportunity strengthens the peer commitment to their own recovery, helps others recover and over time, changes the culture of the agency and system in which they work.

ATR was expanded through a federal grant this year (2014) that facilitated piloting the initiative to adults with serious mental illness (SMI) and youth with serious emotional disturbance (SED). Approximately 190 individuals will be served in the first year pilot. The concept of self-directed care and client choice is central to the program. Individuals who come to ATR for assistance have multiple needs and navigating public resources can be overwhelming. Case managers provide direction, support and motivation to clients. They also assist individuals to develop a recovery plan and choose services and providers. Individuals develop a personal recovery plan. Vouchers may be used for preventative services, treatment or recovery support.

The advent of ATR has significantly increased the types of services available. Vouchers can be used for bus passes, emergency housing, supportive sober housing, general education development (GED) testing, assistance securing state identification cards, child care, online recovery support, medication assisted recovery, and educational services. Case managers maintain close contact, support clients, and are available to resolve concerns or modify recovery plans, as needed. They also help individuals identify other resources in the community not available through ATR.

Six months after entrance, 80 percent of surveyed participants are not using alcohol or drugs and 96 percent have had no arrests in the prior 30 days. In addition, participants are finding jobs, going to school, and finding a permanent place to live. Since its inception, ATR has served 6,846 individuals in Salt Lake, Utah, Weber and Davis counties. The average cost per client for ATR services is \$639. This compares favorably with the cost of serving an individual in the traditional system. In addition, as the program provides supports such as housing and transportation, it increases the likelihood that an individual attending traditional treatment will maintain services for a longer period of time.

In state fiscal year 2013, ATR was expanded and began serving individuals paroling from state prisons. This program is called Parolee-Access to Recovery (PATR). Parolees, parole officers, and corrections administration agree this has filled a need within corrections for parolees entering back into the community with a history of substance use disorders. To date PATR has served 279

individuals with an average cost per parolee of \$854. Six months after starting PATR, 92 percent of respondents are not using alcohol or drugs, 100 percent have had no arrests within the past 30 days, 82 percent were employed or attending school and 89 percent had a permanent place to live in the community.

As most individuals with substance use disorders and mental illness are also dealing with trauma and as part of a Department of Human Services (DHS) initiative to implement a trauma-informed approach, DSAMH engaged a consultant to provide training on January 8-9, 2013, on trauma-informed care for the department directors and managers. As a result of this training, DSAMH, along with the other DHS divisions are developing and implementing a plan to incorporate a trauma-informed approach in its services, practices, policies, and procedures. The division will continue in its efforts over the next several years to incorporate a trauma-informed approach in their services by changing policies and practices and providing training and technical assistance for the local authorities and community partners.

Supported employment uses a vocational rehabilitation approach for individuals with SMI by placing them in competitive employment and providing them with ongoing support services so they may succeed on the job. Valley Mental Health in Tooele County received funding from DSAMH to pilot supported employment services to young people with mental health conditions transitioning into adulthood. The Ticket to Work program was also initiated, which allows the Social Security Administration to receive additional funding to support individuals who receive Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) benefits. In fiscal year 2013, an employment specialist met with 148 individuals and placed at least 39 in meaningful employment.

Supported education is similar to supported employment in the philosophy and approach. DSAMH provided funding to Valley Mental Health in Tooele County to implement this complementary program. In fiscal year 2013, the part-time education specialist worked with 50 individuals. Six individuals completed secondary education (obtaining high school diploma or GED) and 35 enrolled into post-secondary, education (university or technical school/college).

Utah has a strong history of working with partners to provide services using a system of care (SOC) approach, based on the core values of family-driven, youth-guided, community-based, with principles of cultural and linguistic competence. In 2013, the division received a one-year planning grant to work with the Divisions of Child and Family Services, Juvenile Justice Services, and Services for People with Disabilities. This group developed a comprehensive, statewide, strategic plan to improve and expand services using a SOC approach. The plan addressed providing services for children and youth, from birth to 21 years of age, and their families, who have, or are at risk of developing, serious mental health conditions. In addition, a comprehensive strategic plan was also developed by a steering committee (representative of the state) to improve, implement, expand and sustain services and supports using the SOC approach statewide. This plan was shared with local community-based service systems and was modified and adapted based on local needs and resources. As state agencies and local communities work together, they can ensure that children, youth, and their families receive effective, community based services.

The state and local systems have integrated mental health and substance abuse into an effective behavioral health system throughout most of the state. Utah also continues to make substantial progress towards integrating behavioral health with primary care and physical health through a focus on wellness and public health messaging. While some gains have been made through partnerships with local health care providers and state Department of Health, challenges remain with finding appropriate funding streams to support these efforts.

The population distribution of Utah creates various service challenges as is seen in both highly urban and frontier service systems. Issues related to costs and staff turn-over negatively affect the state ability to consistently implement evidence-based practices. As the state demographic profile continues to develop, the state and local systems have had some difficulty maintaining cultural diversity in staff assignments.

DSAMH integrates cultural competency requirements into all training, contracts and activities. The division requires all local providers of mental health services to have a cultural competency plan in place. The state monitors the implementation of the plan. To assist these providers, the division ensures that the LMHA provides culturally sensitive service access; within the LMHA service array requirements are linkages to translation resources.

Three Mental Health Statistics Improvement Program (MHSIP) survey instruments are used to collect consumer satisfaction information: the MHSIP Adult Satisfaction Survey, the Youth Services Survey, and the Youth Services Survey for Families. Each survey contains five measured domains:

- General satisfaction;
- Good service access;
- Quality and appropriateness/cultural sensitivity;
- Participation in treatment planning; and
- Positive service outcomes.

Recommendations/Technical Assistance

The monitoring team makes the following recommendations:

- The state should explore ways to identify and recognize specific LMHAs for their expertise and use a train-the-trainer model to provide trainings to other local mental health providers and partners
- The state should consider the use of the telemedicine network to support non-therapeutic services, such as staff trainings, council meetings, and consumer outreach and feedback sessions.
- While the monitoring team recognizes the state has no current authority to provide oversight to private, for-profit, residential treatment centers for out-of-state children, all states that send children for placement should be compliant with interstate compacts that require them to report and share information regarding the children entering those facilities. The state should enforce those regulations.
- The state requested and should receive technical assistance to enable it to quantify the return on investment of prevention efforts and programs, including working with Centers for Medicare and Medicaid Services (CMS) to address how capitation rates and prevention efforts can work against each other.

Performance Data, Quality Improvement and Decision Support

DSAMH uses the annual site visits conducted at the LMHA as its primary management tool for the state mental health system. The visits involve a review of prior visit findings, LMHA area plan, division directives, consumer satisfaction surveys, the LMHA implementation of the ten mandated services and expenditures. Additionally, the division staff interviewed clinical supervisors and the management team. The process can also include visits to local partner agencies and service locations such as schools, jails, and residential locations.

All local data is collected by the state and summarized in DSAMH scorecards. These scorecards are the source for much of the required data submitted to the federal government. They are driven primarily by the ten mandated services, the division directives, and other division priorities. Originally created approximately seven years ago, the scorecards have made small adjustments over time in response to shifting priorities and data needs.

Scorecards are also used throughout the decision-making process at both the state and local levels. During monitoring, the state uses the scorecards to identify areas of strength or weakness for the LMHA. From these annual findings, the LMHA is expected to create a response plan. Each subsequent monitoring visit looks at how the agency has adjusted to prior findings and implemented its response plan. Adjustments to data findings or problems with data collection are also addressed as part of the review.

The LMHA are able to track data at the individual clinical level. While there are separate mental health and substance abuse scorecards, the local agencies are able to track data for individuals with co-occurring mental health and substance abuse disorders. The LMHA are also able to track prevention data separately using a different scorecard.

The data collected statewide through the annual monitoring process is aggregated and analyzed at the state level with a view to patterns, trends, or gaps (either across the state or when compared to national data). This process directly informs DSAMH development of the division directives. The division directives serve as the focus for the LMHA contract.

Recommendations

The monitoring team makes the following recommendations:

- The state should continue efforts to improve school-based and corrections-based services and the corresponding data collection.
- The state should consider adding a more formal and integrated peer or consumer component to the onsite monitoring process.

Adult Services

The DSAMH approach to issues within the adult system of care is characteristically systemic and comprehensive. The division characteristically is inclusive, collaborative and reflective in its service delivery and in considering obstacles and barriers encountered, as well as in selecting the

means to address these challenges. Substantial collaborative planning and coordination are brought to bear, to address various facets of the Utah behavioral health system to increase quality and augment accessibility and accountability of service delivery for adults. The division uses both existing and newly developed tools to address such issues. The following examples are presented to highlight aspects of the state adult system of care that address the needs of adults with serious mental illness (SMI), a primary, target population of the MHBG.

PASSRR

An outreach effort to adults of particular note uses the Pre-Admission Screening Resident Review (PASRR), which is managed by the division. PASRR guarantees that appropriate individuals are suitably placed in Medicaid Certified Nursing Facilities to ensure that they obtain the appropriate resources. In 2011, the PASRR group within the state received the Governor's Award for Excellence in the class of Innovation and Efficiency for the advancement of an electronic framework that transformed PASRR from a paper to an electronic system. This electronic framework diminished patient/family wait times for PASRR determinations from 10 days to 48 hours, while enhancing the content of those assessments. The online application has increased efficiency and decreased workload, resulting in decreased costs.

REDI Program

DSAMH together with the Utah State Hospital (USH) and the LMHA created the Readiness Evaluation and Discharge Implementation (REDI) Program, which is a tool for improving patient discharge process and hospital communication practices. The REDI program was developed specifically to address discharge challenges and barriers and to insure professional discharge planning is in place. REDI is also a tracking system to document home and community-based services needed by patients preparing for discharge; this system identifies barriers and other system issues, as a first step to enable individuals with mental illness and co-occurring substance abuse disorders to live in the community, when transitioning from institutional treatment settings. REDI also increases local level participation, as another prevention strategy of unnecessary or prolonged institutional placements. The program also gives the LMHA increased accessibility to patient information. DSAMH is using this program as a tool both to monitor local providers and ensure that they are actively working on a plan for individuals who are ready for discharge to the community.

Service outreach efforts to special populations are addressed in the DSAMH contracts with the LMHA and LSAA to serve Individuals experiencing homelessness with mental illness and co-occurring substance use disorders. The division also utilizes the PATH Grant to address the issue of homelessness; PATH served 1,600 people in FY 2013. Utah saw a significant increase among those with co-occurring substance use and mental health disorders with individuals experiencing homelessness during the same period. The LSAA report serving 8.6 percent of 15,995 individuals served and the LMHA report serving 5.8 percent of 28,981 served, in FY 2013

Criminal Justice Services

Crisis Intervention Teams (CIT) Utah

CIT officers are volunteers from uniformed patrol divisions. These officers have received training in the identification of characteristics of numerous mental disorders. Along with a newfound understanding and empathy, officers in this program are trained to provide safer interventions for

a person experiencing a mental health crisis, family members, the community, and the officers. The CIT officers maintain their responsibilities as patrol officers, but become primary responding units in situations involving a person experiencing a mental health crisis.

There are two forward-looking goals of the CIT Program in Utah:

1. To establish a cadre of CIT law enforcement officers within all Utah jurisdictions.
2. To establish a system that includes law enforcement as a team member of mental health care. Once the initial situation is under control, the priority is the identification of appropriate treatment alternatives which benefits the consumer and the community. These alternatives are determined in collaboration with community resources.

Community Response Team (CRT)

CRT provides immediate, short-term response to the Metro Jail when an inmate is being diverted from jail or is being discharged and has been identified as seriously, mentally ill. Valley Behavioral Health (VBH – a nonprofit network of clinics in three Utah counties) then develops a discharge plan to enhance the likelihood of successful re-entry.

Mental Health – Alternatives to Incarceration Transportation

The CRT program has been further enhanced in coordination with VBH's CORE residential program. VBH is now notified by the Metro Jail when an inmate with SMI is ready for release and transportation is arranged to transport directly to VBH services. This service ensures that these individuals are immediately engaged in community services as well as the appropriate medication therapy continues uninterrupted.

Mental Health Services in Jail

The Salt Lake County Council, serving as the LMHA, appropriates close to two million dollars annually for mental health services in the jail. This appropriation is made directly to the Salt Lake County Sheriff's Office. The office has decided to incorporate a mixed model of mental health care. The Sheriff Office utilizes eight mental health professionals, three discharge planners, one unit clerk and five registered nurses to provide care for individuals in the jail. These mental health providers are contracted by the county for their services. The healthcare services, including mental health services, have recently been awarded accreditation from the National Commission on Correctional Healthcare (NCCHC.) Additional county funds are used to fund medications, primary healthcare, and supportive services to persons in the jail who have serious mental illness. Salt Lake County continues to focus on alternatives to incarceration.

As in many areas, the Utah system of care has engaged in appropriate, collaborative planning and organizational adjustments to provide behavioral services and support to its criminal justice system.

Children Services

Co-occurring Disorders

Utah has policies and procedures in place to ensure services are provided to children/adolescent populations that have co-occurring disorders. For children/adolescents with a diagnosis of SED

and substance abuse (SA) the following items are part of the state's comprehensive system approach:

- A statute that integrates substance abuse and mental health services;
- A combined Medicaid State Plan;
- Monitoring and ongoing review of co-occurring disorders on each hospital chart;
- Ten mandated services including inpatient care, residential care, outpatient care, 24-Hour crisis care, psychotropic medication management, psychosocial rehabilitation, case management, community support (respite), consultation and education services and services for incarcerated youth;
- Increasing staff knowledge and skills with a focus on children's coordinators, which includes convening a statewide children's coordinator meeting and development of a statewide adolescent coordinator meeting; and
- A family resource facilitator service across all child serving agencies and within family drug court.

An identified gap in the child system is services for children/adolescents with SED and intellectual disability (ID) and developmental disability (DD). This is the most common type of case that is brought before the high level staffing committee. This committee includes leaders in the state Department of Human Services (DHS). At the time of the program monitoring, the legislative waiver for services was not sufficiently funded. Training is available for mental health staff working with clients with ID; but staff turnover is high. Some of the LMHA consider themselves capable of handling this population, while others appear to separate completely ID/DD from mental health. The state Medicaid plan does allow LMHAs to prescribe medications to ID clients and this service is provided in rural areas to improve accessibility. There is a high rate of children/adolescent with autism disorder in Utah. State Medicaid covers the physical health needs of autism, however, does not address the co-occurring mental health aspect of autism. Reportedly, Utah legislature provides significant funding for Autism Mental Health pre-schools. The Utah Autism Initiative (UAI) led by the medical director of Children with Special Health Care Needs Bureau (CSHCN) coordinates services across all state agencies. Once children with autism reach adolescence, an interruption in services occurs in many cases due to lacking resources for transitional youth. Services that address the needs of these youth, and consequent improved outcomes, need to be developed.

Utah has services for children/adolescents with a diagnosis of SED and physical impairments, such as, Early Childhood Utah provided through the Department of Health (DOH); and programs that include BabyWatch and a Home Visiting Program through the Bureau of Child Development. Additionally, the Interagency Coordinating Council (ICC) comprised of key decision makers from DOH, Child and Family Services (CFS), as well as parent members meet bi-monthly to coordinate services.

Specialized services and coordination are evident in the state system for children with SED. These policies and procedures are provided in collaboration with the DSAMH and other systems that interact with children with SED; these systems include child welfare, juvenile services/criminal justice, department of education, substance abuse services, and housing services including rural areas and children experiencing homelessness.

Monthly meetings with CFS include the Utah State Hospital (USH) Continuity of Care Committee in which the Office of Education participates. USH Continuity of Care meetings are held with LMHAs and other key stakeholders to discuss discharge plans. The Community of Practice with the Office of Education (OE) and CFS has been meeting for three years to coordinate school based interventions.

Division of Juvenile Justice Services (DJJS) and CFS work jointly with the Juvenile Court improvement Project, which services dually involved youth. CFS links with the court system to contract private providers to conduct juvenile competency examinations. CFS coordinates with court system to address issues that arise from assessment results. Also, CFS and DJJS work together through the Juvenile Receiving Centers (JRC), which provide overnight crisis respite as needed. These centers are essential in preventing youth from entering the system or being placed out of home, reducing the involvement of youth in the juvenile justice system.

DHS works with the Housing Prevention and Rapid Re-housing program to provide services to homeless families. DHS works with Volunteers of America (VOA) to provide homeless services including open house meals, laundry and personal hygiene, as well as homeless resource center. In rural areas vouchers are provided for mental health treatment, food bank services and motel vouchers until affordable housing can be obtained. However, homelessness continues to be a problem that surpasses available services. DHS requests that local area plans address each of their strategies to improve services to individuals experiencing homelessness.

Utah provides various transitional services to children with SED. Continuity of care meetings at USH, are held proactively to anticipate and prepare for the discharge of children with SED from the hospital. These meetings that include but are not limited to LMHA, Office of Education and CFS representatives takes the necessary course of planning and coordinating to provide continuity of care goals beyond the hospital. Rule 523 in the Human Services, Substance Abuse and Mental Health section of the Utah Administrative Code indicates that LMHAs must provide liaison services for the most appropriate discharge of children with SED. These liaison services may indicate placement in a step-down facility prior to returning home. A case in which a child cannot safely be discharged from the hospital is elevated to high level staffing in which DHS leadership reviews and adjudicates the case. Civil commitment may be the result of such action. In some instances a child with SED must be transitioned from one educational setting to another.

Utah Coordinating Council for Youth in Care (UCCYIC or YIC) is instrumental in influencing positive education outcomes for youth with SED. In addition, the OE hires Transitional Planning Specialists. Utah is not routinely involved in out-of-state placement. In USH, youth who are “aging out” of the child system (turning 18) have six months to transition to the adult side of USH. If youth does not meet criteria for the adult side of USH then they are transitioned to a community home. LMHA processes vary for youth with SED transitioning to adult with SMI services. The LMHA in rural areas have a generalist approach in which youth can stay with same service providers once they reach adulthood. LMHA processes in urban settings are more specific in the transition to adult services. Passages, Youth Peer Support and Youth Move Chapter programs provide transition to adult services by way of supported education, supported employment and access to family resource facilities. In fall 2015, Utah will be holding a Youth in Transition Academy for young adults.

At the time of monitoring, the governor had not yet announced a decision on Medicaid expansion. He has asked the state health department to bring together a workgroup to examine cost-effective alternatives. The governor had proposed the Healthy Utah Plan as an alternative to Medicaid expansion. Under this plan the governor would request that the federal government put Medicaid expansion funding into a block grant that would allow the state to administer its own program. This block grant would fund a waiver program for low income Utah citizens. The waiver program would provide assistance for health insurance in private markets.

DHS has implemented multiple evidenced based practices (EBP) for children services. Some of these include wrap around fidelity, which is tied to family peer support. The National Child Traumatic Stress Trauma Grant supports trauma informed care which includes a parent-child interactive training. The mobile crisis team provides school based mental health services. Some EBPs used in the school system include Strengthening Families, Prime for Life, and Community of Practice. These are some of the many EBPs that impact Utah's children services system.

Recommendations\Technical Assistance:

It should be noted that the state may request technical assistance through its MHBG Project Officer to address any of the recommendations. The following recommendations are made to the state by the monitoring team with regard to its Child Service System:

- Continue to develop a process for ensuring the best possible training and education for providers of co-occurring disorders.
- Continue to monitor how co-occurring disorders are being managed in the local areas where SA/MH has yet to be combined.
- DHS reports an 8 year waiting list for children with DD/ID/MH and the discomfort of providers handling this population; DHS needs to continue to develop a system that addresses this shortfall.
- Develop a process for addressing the gap in services that occur when children with autism transition to adolescence and adulthood.
- Develop needed services for children/adolescent with SED and intellectual disability/developmental disability (ID/DD).
- Coordinate with all LMHA to develop a system in which a key partner is identified that can respond holistically to the children service issues that intersect systems.
- Lastly, continue to work with local areas to develop robust area plans that address improvement efforts in services to children and families experiencing homelessness.

Mental Health Planning Council

In 2011, the Utah mental health planning council (MHPC) and the substance abuse council merged in order to form a behavioral council for the state, the Utah Behavioral Health Planning and Advisory Council (UBHPAC). The DSAMH and the council requested and received technical assistance from SAMHSA for this integration process. The UBHPAC consists of up to 35 members, representing peers, providers, and community advocate/partners from across the state. Members of the council continue to advise the Utah DSAMH with regard to policies and use of resources in providing behavioral health services.

UBHPAC members spent time in FY 2012-13 to update the council by-laws and reach consensus on a joint mission. The stated mission, as set down in the bylaws, is to support collaboration among providers, peers, community partners/advocates and state leadership in the responsible provision of integrated services relating to the prevention and treatment of, and recovery from, mental illness and substance use disorders. The vision of the council is that quality, integrated services relating to the prevention and treatment of, and recovery from, mental health and substance use disorders are available to all individuals, families, and communities throughout Utah. DSAMH and the council have adopted the SAMHSA definition of recovery.

UBHPAC elects its members; presently 30 of its 35 seats are filled. However, federal statute-mandated state agency representatives currently are not represented nor are the state agency representation required by the UBHPAC by-laws (Public Law 102 – 321, Section 1914 (A) (i)). The council has a youth member and a sufficient ratio of parents of children, with SED. Consumers and family members on the council are representative of consumers and family member organizations within the state.

An executive committee meeting of the planning council is generally held prior to the council meeting. The agenda for the meeting is made available to members on the Friday before the meeting. Requests for budget and program presentations are sent to the chair who reviews the request before it is placed on the agenda. UBHPAC follows Robert's Rules of Order for conducting its meetings. The council has encountered challenges in maintaining consistent meeting attendance from its members. Members who have three consecutive unexcused absences from planning council meetings are subject to removal by the executive committee. Recruitment of members, who are from various geographical areas and different ethnic/racial minorities, has been an ongoing challenge.

The council meets monthly in Salt Lake City. All meetings are open to the public. Individuals who desire to become UBHPAC members must attend two meetings and submit an application to the membership committee. The application is then voted on by both the executive committee and the entire council before the individual is selected as a member of the council. Newly elected members must attend orientation training for new members.

UBHPAC standing committees include an executive, membership, block grant, budget, and advocacy. Committee creation and membership is confirmed by a majority of members. Executive committee duties include the oversight of standing and ad-hoc committees, requests for technical assistance, and development of by-laws. Executive committee officers include two chairs and a secretary, who are elected by majority vote of the full council. The term of these officers is for two calendar years from the time that they are elected. The membership committee reviews new applications and the block grant committee reviews the state plan for the council before it is submitted to SAMHSA. Ad-hoc committees may be formed by a quorum of the council. All committee actions must be confirmed by a majority of the full council.

DSAMH provides administrative support to the council. Division staff record council meeting minutes and bring programmatic updates to council meetings. A review of meeting minutes confirm that reports by DSAMH staff are given on such topics as Medicaid services to the under-insured or un-insured, Social Security, etc. Members report that they do not receive any utilization

data from the state until the day of the meeting. DSAMH staff report that members can receive a stipend for expenses for attendance at council meetings; however, members reported that they are unsure as to how to request this type of reimbursement.

Council members did identify instances of when they performed their statutory duties and as advocates for individuals with severe and persistent mental illness. They recounted that they had worked with the Utah legislature in acquiring \$2.7 million for the un-insured and the under-insured who have mental health and substance abuse treatment needs. Members of the council were also instrumental in obtaining Medicaid reimbursement for Peer Certified Support Specialists. UBHPAC members have also discussed the possibility with DSAMH that two council members accompany state staff on the annual area mental health program site visits. The details of this arrangement were still being worked out, at the time of the monitoring.

Members of the monitoring team had an opportunity to interview the council chair during the video conference monitoring. The chair also gave members of the team written responses of three council members, who were not able to be present. Council members shared their concern that they did not feel as if they were partners with the state in the development of policy and procedures. Members reported that they did not have an opportunity to give input into the state annual mental health budget. Council members had also requested that they be given data and results of annual mental health authority site visits made by the division, as needed information for the council to fulfill its monitoring responsibilities. Members have requested technical assistance pertaining to monitoring the state behavioral health system.

The council chair stated to members of the monitoring team that UBHPAC had a block grant committee, which reviewed the state mental health block grant plan before it was submitted to SAMHSA. DSAMH staff also reported that planning council members on an individual basis had an opportunity to go on-line and personally comment on the plan before submission. However, there was no documentation that UBHPAC members had collectively reviewed the state block grant plan before it was submitted to SAMHSA, as federal statute mandates (Public Law 102-321, Section 1914, (b) (1)). Also, members of the planning council indicated that they did not receive periodic updates from DSAMH staff on the progress, the state was making on the block grant plan throughout the year.

Members of the planning council identified access to services, Medicaid expansion, and the Medicaid match from counties, as a few of the most significant mental health issues facing the state. DSAMH staff also had identified these same issues, as most critical.

The monitoring team commends UBHPAC and DSAMH for reorganizing its state MHPC with substance abuse representatives into a behavioral health planning council in 2011. UBHPAC members expressed an interest in being more of an active partner in the development of state policies and procedures related to the development of the behavioral health system, as well as the state behavioral health plan.

Recommendations/Technical Assistance

The monitoring team makes the following recommendations to DSAMH and UBHPAC:

- The division should provide periodic updates on the progress the state is making on the behavioral health block grant plan, to the council.
- The division should provide the necessary fiscal and programmatic materials for council meetings, at least one week prior to the meeting.
- The division should provide data and other relevant materials to planning council members with regard their annual mental health area program site visits.
- The planning council should receive technical assistance to understand and interpret the data that they receive from the division.
- The council should form a data committee initially to review the fiscal materials received from division and report on its findings to the full council.
- The division should consider the possibility for council members to receive mileage/hotel reimbursement for attending meetings, instead of a stipend reimbursement, as a means to obtain equity for all members and to increase geographical diversity of the membership.
- The planning council should consider moving the location and time of its meetings to improve attendance.
- The council should continue its efforts to recruit members from different geographic locations and ethnic/racial populations in order to increase diversity on the council.
- The UBHPAC should receive technical assistance to augment its monitoring of Utah's behavioral health system.
- The UBHPAC does not have the principle state agencies mandated by statute with respect to mental health, education, vocational rehabilitation, criminal justice, housing, and social services (Public Law 102 – 321, Section 1914 (A) (i)). This must be addressed (if not already done so) by the division and the council as the state was out of compliance at the time of the video conference monitoring.
- Documentation was not provided as to the submission by the state and review of the behavioral health plan(s) by the full council pursuant to section (1915 (a)) and to submit to the state any recommendations of the council for modifications to the plan (Public Law 102 – 321, Section 1914,(b) (1)). This also is a compliance issue, as the statute indicates timely submission by the state and review by the full council. Minimally this should be documented in council minutes.

Consumer and Family Member Involvement

Consumers and family members report that recovery and resilience are an integral part of the Utah system of care and that consumers are encouraged to be active partners in their treatment. Services reflect a holistic approach, and this approach includes housing, employment, and health care. DSAMH requires that each local mental health area program submit a plan, in which recovery and resilience are integrated into the service array. If the division identifies a deficiency, it requires the local mental health area authority to submit a corrective action plan. Consumers and family members report a good relationship with DSAMH.

A DSAMH Recovery and Resiliency Peer Program Manager, conducts focus groups statewide to obtain feedback from consumers; this gives consumers a means of effecting system change. DSAMH also requires that each local mental health area authority have a family resource facilitator, as another means of obtaining input from consumers and family members. Once a year, the facilitators hold a focus group composed of consumers and family members in each area, as

part of the area mental health programs annual site visit. Input from the forum is then given to DSAMH, to ensure that services at each LMHA are consumer and family driven.

DSAMH has a number of consumer and family organizations that it supports with MHBG funds, as well as other funding, to support recovery and resilience. Members of these organizations report that technical assistance is readily available to them from the division, when it is requested for implementation of programs that the division funds.

Empowerment Services is Utah's first peer-run organization. It is a non-profit organization whose mission is to develop and implement consumer-driven programs and services that promote the empowerment, recovery, inclusion, dignity, and acceptance of consumers of mental health services and to end the discrimination associated with mental illness. It is funded by SAMHSA and the division. DSAMH also sponsors an annual peer conference. The state offers scholarships to mental health consumers who otherwise could not attend.

The Utah Family Coalition is composed of three nonprofits which have come together to support youth and family involvement through training and mentoring. The three nonprofits are NAMI, Allies with Families, and New Frontiers for Families. NAMI is a non-profit organization that provides support classes (free of charge) for the community and advocates for persons living with mental illnesses. Allies with Family is a family controlled non-profit organization that provides information and support to families of children with emotional, behavior, and mental health needs and conducts family advocacy for system change. New Frontiers for Families is a family advocacy agency for at risk children in rural Utah. New Frontiers for Families subscribes to a system of core values and principles and utilizes the wraparound process to bring providers, educators, businesses, community leaders, and neighbors in collaboration to create services and supports that meet their needs.

DSAMH has helped to fund a number of youth organizations for youth who have mental health and substance abuse challenges. Communities That Care helps community stakeholders and decision-makers understand and apply remedies to issues in their community that are proven to make a difference in promoting healthy youth development. Specific issues include underage drinking, substance abuse, violence, delinquency, school dropout, anxiety and depression.

Utah has a Youth Move Chapter, which hosts contests and community events that are open to all youth under the age of 26. The chapter also provides training and other opportunities for members to develop their own leadership and advocacy skills.

As part of its cultural diversity outreach to individuals from special populations, DSAMH meets with the Tribal Indian Issues Committee (TIIC) at its bi-monthly meeting. The division collaborates with the state's nine tribes by participating in prevention efforts to reduce the risk of substance abuse and mental illness among the Native American tribes. Some Native American tribes now have peer support specialists. DSAMH also integrates cultural competency requirement into all training contracts and activities. As already indicated, it requires its local mental health area authorities to have a cultural competency plan in place. All area local mental health area authorities also have Spanish speaking staff.

Consumers and family members can serve on a number of boards, councils, and committees in order to effect system change in the state. Alongside the UBHPAC, the Utah Disability Rights' Protection and Advocacy for Individuals with Mental Illness (PAIMI) advisory council operates within the state and is composed of more than 60 percent consumers and family members. Utah also has a youth advisory board, where youth members who are recipients of mental health and substance services can become members and help effect system outcomes. The youth advisory council is made up of 10-12 young adult peers in recovery with backgrounds and involvement in mental health, substance use issues, Juvenile Justice Services, Division of Child and Family Services, and Division of Services for People with Disabilities. Youth serve as advocates and arrange activities around awareness of youth and youth-in-transition in recovery from mental health and/or substance use disorders, statewide.

As already indicated, in December 2012, Utah Administrative Rules R523-2 and 523-3 were finalized establishing the Adult Peer Support Specialist Training and Certification, and Child/Family Peer Support Specialist Training and Certification programs. These rules established the requirements to become a peer support specialist for both substance use disorder and mental health services or a child family peer support specialist. Peer support specialists are employed in all of the mental health authorities and in several partner agencies. Utah uses Whole Health Action Management (WHAM) in conjuncture with the work of certified peer support specialists to enhance their work with individuals with behavioral health issues. WHAM is used to encourage increased resiliency, wellness, and self-management of health and behavioral health among people with mental health and substance use disorders.

There are more than 300 trained certified peer support specialists in Utah and over 50 family peer support specialists. One of the barriers that consumers and family members identified to is that some consumers in process of becoming peer support specialists have to pay a large fee to receive the training and certification. In addition, the reimbursement rate provided by Medicaid to peer support specialists is low, discouraging some providers from hiring the specialists and keeping the employment rate for peer support specialists low.

DSAMH has helped consumers and family members affect system change. The monitoring team commends DSAMH, as well as both consumers and family members in the state, for their work in getting both Adult Peer Support Specialist Training and Certification, and Child/Family Peer Support Specialist Training and Certification programs approved by the legislator, in 2012.

Recommendations/Technical Assistance:

The monitoring team makes the following recommendations to DSAMH:

- The division in collaboration with consumer advocates and stakeholders should continue to work with the Utah legislature to raise the Medicaid reimbursement rate for peer support specialists.
- The division should facilitate a consumer-family forum annually within the state, in order to hear direct input from consumer and family members.

Conclusion

The monitoring team recognizes the State of Utah for its exemplary, behavioral health system of care and its focus on adults with SMI and children\youth with SED. As with many states, Utah is struggling with resource limitations in terms of both funding and its workforce. At the same time, the federal team was impressed by the leadership's clear vision and focus, and the deliberative processes apparent throughout the system. The DSAMH website is user friendly and provided relevant information in terms of the basic systems of care, as well as appropriate and informative links to county information and related programs. The state's development and use of data is also noteworthy, as well as the annual reports provided to the legislature and stakeholders. Significant collaborations are evident throughout the behavioral health systems. The formation of the UBHPAC is also recognized as an important development that should be followed up by additional training and support to enhance it, as a fully functioning partner and resource for the state.

The monitoring team thanks the leadership and staff, the chair of the planning council, its members and consumer stakeholders for their preparation, onsite participation and spirit of welcome to the team.

DRAFT

Appendix A- Listing of Federal Monitoring Team Members

Patrick Weld, MHBG Federal Monitor
Monique Browning, MHBG Project Officer
Alexia Blyther, MHBG Project Officer
Jeff McCloud, Recovery Support Specialist

DRAFT

Appendix B- Listing of State Staff Interviewed

Janida Emerson – State Planner

Doug Thomas - Commissioner

Paul Korth - Fiscal

Dinah Weldon – Program Administrator (Children/Youth Mental Health)

Jeremy Christensen – Assistant Director

Eric Tadehara – Program Manager (Children/Youth Mental Health)

Michael Newman – Recovery and Resiliency Peer Program Manager

LeAnn Huff – Adult State Planner

Lori Cerar – Planning Council Chair

DRAFT