

**+ Davis County**  
**FORM A - MENTAL HEALTH BUDGET NARRATIVE**  
**3 Year Plan (FY 2024-2026)**

**Local Authority: Davis County**

**Instructions:**

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

**1) Inpatient Services**  
*Adult Services*

*Leah Colburn*

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.**

Davis Behavioral Health maintains contracts and referral relationships with McKay Dee Hospital in Ogden, Holy Cross Hospital in Layton, Lakeview Hospital in Bountiful, Huntsman Mental Health Institute in Salt Lake City, Jordan Valley West Hospital in West Valley City, and Aspen Grove in Orem for clients who require a 24-hour protected environment for the purposes of safety, security, assessment and stabilization of acute behavioral healthcare emergencies or crises.

Therapeutic services must include medical care requiring 24-hour hospitalization with skilled nursing within the structure of a therapeutic milieu, with medical supervision by a physician and the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-occurring medical conditions.

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

DBH has a full-time hospital liaison who coordinates care with all inpatient facilities and assures that discharging clients have an appointment with us within 7 days of discharge. If the client does not keep that appointment our crisis team reaches out to the client to assess risk and reschedule while our hospital liaison works with the treatment teams. In addition, we have therapists maintain a hospital discharge slot on their calendars and we have a weekly Step Down clinic that any client discharging from an inpatient setting can attend, receive a risk assessment and a warm handoff to the appropriate treatment. When clinically appropriate clients may transition from a hospital inpatient setting through the CRU. Prior to discharging from the CRU, DBH can ensure recommended services are in place.

*Children's Services*

*Leah Colburn*

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.**

Davis Behavioral Health maintains contracts and referral relationships with McKay-Dee Hospital in Ogden, Huntsman Mental Health Institute in Salt Lake City, Primary Children's Hospital in Salt Lake City and Lehi, Aspen Grove Behavioral Hospital in Orem, and Utah State Hospital in Provo for children and youth who are experiencing a level of distress that may result in significant danger to themselves or others, requiring a secure treatment environment with the availability of 24-hour medical monitoring. Therapeutic services must include medical care requiring 24-hour hospitalization with skilled nursing within the structure of a therapeutic milieu, with medical supervision by a physician and the availability of an appropriate initial medical assessment and ongoing medical management to evaluate and manage co-occurring medical conditions.

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

DBH utilizes the Youth MCOT and Stabilization and Mobile Response (SMR) teams to initiate contact with families while the child is in the hospital. The Youth MCOT/SMR team will assess service needs including appropriateness for stabilization, and coordinate with the current outpatient therapist. If the youth is new to DBH, the team will assist in getting the family appointments scheduled and follow up after discharge to ensure service needs are met.

**2) Residential Care  
Adult Services**

*Leah Colburn*

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.**

DBHs Crisis Recovery Unit (CRU) is a 24-hour/seven days a week, short-term, crisis stabilization and short-term residential program for people with serious mental illness and/or substance use conditions who need a higher level of care than traditional outpatient services. CRU is also used as a step-down unit for clients who have been in inpatient psychiatric units and as a transition point for clients who are in the process of discharging from the Utah State Hospital. Admissions occur 24 hours per day, 365 days per year.

We provide active treatment (medication management, social detoxification, individual therapy, individual behavior management, skills groups, peer support services, and psychotherapy groups). While at the CRU every effort is made to include family and as appropriate identified healthy supports through scheduled family team meetings. Peer specialists also make follow-up calls after discharge to assure continuity of care. As an adjunct to residential treatment, we provide a dual diagnosis IOP group which targets clients who have both a serious mental illness and a substance use condition.

CRU has a few short-term transitional housing units for both males and females to help clients who are psychiatrically stable but have a housing barrier and are at risk for homelessness. This program, the Transitional Treatment Program (TTP), allows clients to transition from residential care to independent community living by having a safe place to live for up to 30 days while staff work with them to find appropriate housing, as well as teach clients daily living and illness management skills. Clients who are actively engaged in their treatment may receive up to two additional 30 day extensions at the recommendation of their treatment team.

In addition to the CRU, DBH has a Receiving Center. Please see the crisis section for more information.

Services are provided directly by DBH.

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

Access to this level of care is determined through clinical evaluation and risk assessment interview by a licensed master's level clinician. Many clients initiate and recognize the CRU as a helpful resource and intervention when stabilization is needed. Admissions and discharges are done in consultation with the in-house psychiatrist or on-call prescriber. A key performance metric for the effectiveness and accessibility of the CRU is our inpatient costs. Other tools are the OQ, monitoring of daily census, diversion to the Receiving Center, and client/family/partner feedback. In addition, the clinical utilization management committee reviews random records to monitor appropriate level of care and treatment response.

***Children's Services***

***Leah Colburn***

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding. Please identify your current residential contracts. *Please identify any significant service gaps related to residential services for youth you may be experiencing.***

When it is in the best interest of the child to be placed outside of the home, DBH works closely with partner agencies who may also be involved, such as DCFS, DSPD, and JJYS to help place youth in appropriate settings while also maximizing resources. USH remains our most used residential service. Current gaps and barriers include: 1) the lack of service providers, 2) room and board costs, 3) high acuity youth are rejected from contract providers as having behaviors that are too problematic.

We do not have any contracts in place for youth residential. We work with partners and use single case agreements when needed.

**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.**

Access to this level of care is determined through a clinical assessment by a master's level clinician. Youth must be experiencing high levels of symptoms that are causing significant impairment in age appropriate functioning or ability to maintain personal safety. Additionally, the symptoms must not be manageable through other levels of care or additional services such as respite, high fidelity wraparound, coordination with other agencies, or behavioral supports. When a child is placed in this level of care, DBH participates in staffings and treatment team meetings as appropriate. As the youth are getting closer to returning home, DBH works with the family, the placement, and other agencies to have services and supports in place that provide a seamless transition.

**3) Outpatient Care  
Adult Services**

***Leah Colburn***

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Define the process for referring an individual to a subcontractor for services. Include any planned changes in programming or funding.**

Through a multidisciplinary team, DBH uses evidence-based practices and treatment as usual at the Main Street Clinic Campus, as well as our Layton Campus, Bountiful Clinic, and [Syracuse Clinic](#). Services include: individual and group therapy, case and medication management, and skill development. In the calendar year 2024 we will expand outpatient services to the Syracuse area.

If a client requests services outside of DBH, or if DBH believes a client's needs can be better met elsewhere, our Compliance and Contract team work with the client and a network provider to establish care there.

Locations:

Kaysville Clinic: 934 South Main Street and 952 South Main Street, Layton, UT

Layton Clinic: 2250 North 1700 West, Layton, UT

Bountiful Clinic: 150 North Main Suite 101, Bountiful

[Syracuse Clinic: 1799 Antelope Drive, Syracuse, UT](#)

Provider: Davis Behavioral Health and some contracted providers throughout the county.

**Describe the approach to serving individuals with complex behavioral health presentations or who need multiple supports to remain in the community, including the programmatic approach to serving individuals in the least restrictive level of care. Identify your proposed fidelity monitoring and outcome measures.**

DBH believes that people have a right to live in their local communities. To support this belief, we have a robust MCOT program, an ACT-lite Team (we call "FAST"), intensive community case management services, more than 110 beds in community housing, a male and female house and two group housing units with live-in staff, medication clinic and medication delivery mornings and evenings, and in-home respite for families of adults discharging from USH.

We would welcome assistance in identifying fidelity measures for the above named services. The ACT fidelity tool is attached. Outcomes are measured via residential and inpatient costs, as well as discharges to homelessness.

**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.**

The DBH AOT and Committed Clients Program consists of therapists experienced in treating co-occurring substance and mental health disorders, a clinical program director, case managers, medication prescribers, certified peer specialists, and IPS specialists. This team meets together on a weekly basis to staff client progress and needs, and to assign action follow-up items. Situations where a higher level of care might be warranted are staffed to determine the most appropriate and least restrictive level of care.

Tracking processes include the following:

- Weekly meeting to create and implement an action plan for those clients who are experiencing clinical levels of symptoms, are non-compliant to their treatment, or are newly committed and need to connect to DBH services;
- Coordination of pick-up orders for non-compliant clients with MCOT (Mobile Outreach

- Crisis Team) or Davis County Sheriff's Department;
- Reviewing committed clients' missed appointments
- Assigning community outreach by the appropriate AOT team members to clients who have been missing appointments and/or are at-risk of needing a higher level of care. Outreach attempts include in person, phone, text, email and family contacts.
- On-going assessment from interactions, such as appointments, medications deliveries, and other staff interactions with the client(s).

Progress in treatment is measured by factors such as:

- client agreement with taking medications and engaging in prescribed services
- the frequency, latency, intensity, and duration of reported and observed mental health symptoms;
- client self-report to DBH staff and/or family and other supports
- family report, and
- OQ measures.
- Clients no longer meeting the criteria for continued civil commitment

### **Children's Services**

**Leah Colburn**

**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. Define the process for referring an individual to a subcontractor for services. Include any planned changes in programming or funding. Please highlight approaches to engage family systems.**

We use a multidisciplinary clinical team approach of providing services that assist children, youth and families to develop adaptive strategies and skills. We use evidence-based practices and treatment as usual at the Main Street Clinic Campus, as well as at our Bountiful and Syracuse Clinics and with school-based services. Services include: individual, family and group therapy; case management; individual and group skills development; respite; family peer support; and medication management. In the calendar year 2024, we will expand outpatient services to the Syracuse area.

If a client requests services outside of DBH, or if DBH believes a client's needs can be better met elsewhere, our Compliance and Contract team work with the client and a network provider to establish care there.

We continue to work on engaging families by providing education up front about the important role of parents and caregivers in the treatment process. We also try to identify and offer supports that parents may need such as respite, peer support, or their own treatment. We continue to work on increasing the amount of family therapy provided and parent/family group offerings. We have also added two additional groups aimed at parents - one to assist parents who have their own histories of relational trauma which may be impacting their ability to effectively respond to their children and another to help parents with practical tools to use with their children to build a strong self-worth and encourage secure attachment. Both of these groups are available to all clients at DBH, whether their children are in services or not.

Locations:

Kaysville Clinic: 934 South Main Street and 952 South Main Street, Layton, UT

Layton Clinic: 2250 North 1700 West, Layton, UT

Bountiful Clinic: 150 North Main Suite 101, Bountiful

Syracuse Clinic: 1799 Antelope Drive, Syracuse, UT

Provider: Davis Behavioral Health and some contracted providers.

**Describe the approach to serving individuals with complex behavioral health presentations or who need multiple supports to remain in the community, including the programmatic approach to serving individuals in the least restrictive level of care. Identify your proposed fidelity monitoring and outcome measures.**

The acuity level of youth and families is something that is constantly changing in response to what is happening for them at that moment. Because of this, high acuity youth are identified in several ways and staffed regularly. These youth include: 1) clients currently participating in day treatment; 2) clients who have recently utilized crisis services and/or had interaction with law enforcement; 3) clients who have been admitted to and/or recently discharged from an inpatient setting; and 4) clients who do not currently fall into one of the first three categories but are at risk of doing so. These youth are staffed weekly to monthly until the youth and/or family has stabilized or decreased their need for more intensive services.

DBH is committed to keeping youth in their homes and communities as much as possible and providing services that will support this. In keeping with System of Care guiding principles, we work on identifying what the needs of the client and/or family are and what individualized services can be put in place to address those needs rather than recommending more generic levels of care. We also continue to partner and coordinate with other child-serving agencies and actively participate in meetings such as the juvenile court multi-agency staffing, Davis County Interagency Council, and the Integrated Support Team.

Fidelity and outcome tools include regular peer reviews, YOQ scores, MHSIPs, and fidelity monitoring of EBPs. Additionally data on inpatient hospitalizations is tracked, including overall number of hospitalizations, lengths of stay, and clients with multiple admissions.

#### **4) 24-Hour Crisis Care Adult Services**

*Jennifer Hebdon-Seljestad*

**Please outline plans for the next three years for 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 the criminal justice system. Identify what crisis services are currently provided in your area, where services are provided, and what gaps need to still be addressed to offer a full continuum of care to include access to a crisis line, mobile crisis outreach teams, and facility-based stabilization/receiving centers. 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 DHHS systems of care, law enforcement and first responders, for the provision of crisis services. Include any planned changes in programming or funding.**

DBH works in conjunction with the Huntsman Mental Health Institute to provide mobile response services triaged by the Utah Crisis Line. We also respond to direct requests from clients, Law Enforcement, local hospital Davis School District, JJYS and other DHHS and DBH community partners.

DBH is fortunate to have both an MCOT and Youth MCOT/SMR team to provide crisis response services to all Davis County residents. The combined teams operate 24 hours per day, seven days per week, 365 days per year, and the team consists of at least one Mental Health Officer or Designated Examiner, and one Peer Support/FPSS/Case Manager. These teams screen, evaluate and treat clients for the purpose of mitigating imminent risk, reducing current behavioral health symptoms, and making triage decisions regarding the immediate and long-range therapeutic services that can be provided. An on-call psychiatrist is also available 24-hours/day, seven days/week for consultation.

DBH has a Receiving Center in Layton which is a 24-hour/seven days a week, short-term, crisis stabilization and social detox facility for people with mental health, substance related, or behavioral crisis who require immediate support, crisis stabilization and resource facilitation. The program provides services to people regardless of their ability to pay and provides crisis risk assessments, safety/relapse prevention planning, medication assisted treatment, substance use and mental health evaluation, and onsite peer support services. The program utilizes Behavioral Health Service Technicians (HST) and Peer Recovery Support Specialists (RSS) who offer engagement strategies, case management assessments, and targeted case management, support with coordination of care, skills development and recovery groups. The staff at the Receiving Center conduct outreach and regular follow-up with clients post discharge. Peer Support Services are also offered to each client at discharge.

**Describe your current and planned 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 and key performance indicators are available if needed, please describe any areas for help that are required.**

DBH has not had a formal evaluation process for crisis services. We do use OSUMH data to see if we are operating within statewide norms and to identify areas of strength and improvement.

*Children's Services*

*Jennifer Hebdon-Seljestad*

**Please outline plans for the next three years for 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 the criminal justice system. Identify what crisis services are provided, where services are currently provided in your area, where services are provided, and what gaps need to still be addressed to offer a full continuum of care (including access to a Crisis Line, Mobile Crisis Outreach Teams, facility-based stabilization/receiving centers and In-Home Stabilization Services). Including if you provide SMR/Youth MCOT and Stabilization services, if you are not an SMR/Youth MCOT and Stabilization provider, how do you plan to coordinate with SMR providers in your region? 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, JJYS and other DHHS systems of care, law enforcement and first responders, schools, and hospitals for the provision of crisis services to at-risk youth, children, and their families. Include any planned changes in programming or funding.**

Please see the adult section for an overview of DBH crisis services. The largest gap in crisis services for children and youth continues to be emergency/crisis respite options, especially for individuals under the age of 10.

In addition, Children, Youth and Families (CYF) will continue to offer SMR stabilization services as well as telephone support and community outreach through our youth MCOT team. DBH will continue to offer stabilization services in line with the SMR Policies and Procedures to anyone in Davis County who meets the criteria.

DBH collaborates with stakeholders including, but not limited to, 988 the Statewide Crisis Line, law enforcement, emergency medical personnel, schools, and hospital emergency departments. We also continue to partner and coordinate with other child-serving agencies and actively participate in meetings such as the juvenile court multi-agency staffing, Davis County Interagency Council, and the Integrated Support Team to identify youth in Davis County that are in need of crisis stabilization and support.

**Describe your current and planned 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 and key performance indicators are available if needed, please describe any areas for help that are required.**

The youth MCOT program collects data on every mobile outreach and follow up as required by the state data specifications. This data is reviewed monthly to ensure that families are receiving appropriate follow up and referrals and to identify youth who may be appropriate for intensive stabilization services through SMR. Youth and families participating in intensive stabilization services have additional data collected at every contact and this is also reviewed monthly. Additionally data on inpatient hospitalizations is tracked, including overall number of hospitalizations, length of stay, and clients with multiple admissions.

## 5) Psychotropic Medication Management Adult Services

*Pete Caldwell*

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding. Please list any specific procedures related to continuity of medication management during transitions between from or between providers/agencies/level of care settings.**

Medication management at DBH includes the following elements: Assessing and diagnosis for use of medication; medication reduction based on clinical judgment; addressing behaviors related to medications, reducing side effects of medication; monitoring for adverse reactions; conducting AIMS assessment; documenting in the client chart.

DBH has psychiatrists and nurse practitioners to diagnose and prescribe medications to treat both mental health and addiction related issues. We have a long-acting injectable clinic that offers all available LAI medications that are available for treatment of mental health or addiction, including haloperidol decanoate, fluphenazine decanoate, Risperdal Consta, Invega Sustenna, Invega Trinza, Invega Hafyera, Aristada, Abilify Maintenna, Zyprexa Relprevv, Vivitrol, and Sublocade. We also have a Clozapine monitoring program. We have an Esketamine Clinic for those with treatment resistant depression, and also have the ability to refer for ECT treatment if they are decided to be appropriate treatment by the prescriber. We are still planning to add transcranial magnetic stimulation as another option for treatment resistant depression as we secure funding for the device.

Nursing medication management is offered in the Kaysville clinic and on the Layton Campus. Our

FAST team delivers medications to clients who are likely to decompensate without medication and have difficulty coming into the clinic. An RN participates on the FAST team and acts as a liaison between the primary care physician and our agency. In addition, the med clinic nurses notify case managers each day regarding clients who did not pick up medication and the case managers perform outreach to help engage the Med Clinic clients in care. Medication management is included as part of our residential care services. It includes evaluation and treatment by a psychiatrist, as well as medication management services provided by an RN, who will assess for side effects as well as educate the clients regarding their medications. We are also providing Medication Assisted Therapy for those with opioid or alcohol use disorders.

DBH has a hospital liaison to assist with transition of care from hospital to outpatient level of care. The liaison assists in scheduling appointments and monitoring until the patient attends their first appointment post hospitalization. Medical assistants help coordinate transfer of care from specialized psychiatric care to primary care when the prescriber deems transfer is appropriate.

Location: 934 S. Main Layton, UT 84041  
2250 N. 1700 W. Layton, UT 84041  
Provided: Directly and through contracted provider

**Children's Services**

**Pete Caldwell**

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding. Please list any specific procedures related to continuity of medication management during transitions between providers/agencies/level of care settings.**

Children, Youth and Families (CYF) medication management at DBH includes the following key elements: evaluation for use of the medication; medication reduction based on clinical judgment and client request; addressing behaviors and possible side effects of the medication; monitoring for adverse reactions; conducting AIMS assessment; documenting in the client chart. We also offer specialized first episode psychosis care that includes a prescriber trained in the medication management of first episode psychosis. We also offer MAT to teens with opioid addiction upon referral of their therapist.

DBH has a hospital liaison to assist with transition of care from hospital to outpatient level of care. The liaison assists in scheduling appointments and monitoring until the patient attends their first appointment post hospitalization. Medical assistants help coordinate transfer of care from specialized psychiatric care to primary care when the prescriber deems transfer is appropriate.

Location: 934 S. Main Layton, UT 84041  
Provided: Directly and through contracted provider

**6) Psychoeducation Services & Psychosocial Rehabilitation**

**Adult Services**

**Leah Colburn**

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.**

Journey House is an evidence based psychosocial rehabilitation program for adults with serious

and persistent mental illness. It is a strength-based program which compliments traditional therapy to ensure that the client is able to work on personal recovery goals, including employment, education, decreasing isolation at home, social skill development and basic living skills.

Journey House is a Clubhouse International Accredited program (SAMHSA recognized). Journey House just completed the 3 year accreditation review receiving the highest possible outcome. Journey House will continue to be a leader in the Clubhouse Utah coalition and assist programs around the state who are seeking accreditation to achieve that goal. Matt, the director, will continue to be a faculty member of Clubhouse International. As a part of this, he conducts accreditation visits twice a year and assists the standard review committee for Clubhouse International. This helps ensure that Journey House remains vibrant and in alignment with the most current and best practices for Clubhouse evidence based practices.

Individual Placement and Support (IPS) is a model of supported employment for people with serious mental illness. IPS supported employment helps people living with behavioral health conditions obtain, work at, and maintain regular jobs of their choosing. Although variations of supported employment exist, IPS refers to the evidence-based practice of supported employment. Education and technical training can also be included as ways to advance career paths and obtain employment.

These programs use psychoeducation, targeted case management, and psychosocial rehabilitation as their framework.

Journey House-2250 N. 1700 W. Layton, UT 84041  
IPS-934 S. Main Layton, UT 84041

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

Journey House is open to anyone with a history of mental illness. Referrals are made by DBH therapists, CRU staff, and a variety of community resources. Once the referral is made, the prospective member is invited up to Journey House for a tour and to see if it is a program that they would like to be involved in. Referrals are then tracked in our clerical unit to ensure that they are followed up with. If the client does not return for orientation, mobile outreach is conducted to invite the client to return to Journey House for orientation. If the client does not respond, the referring therapist is notified to look at other treatment options. Effectiveness is measured in decreased hospital stays, increased employment outcomes, increased social activities and daily participation in the program.

Referrals for IPS are made by members of the client's treatment team. IPS services are covered by all Medicaid plans and exceptions to this can be made for clients on civil commitment and those with a psychotic disorder and/or are approved by the UM committee. All clients who begin IPS services will complete a career path assessment where goals are created. Effectiveness is measured by client enrollment in education or obtaining employment. Effectiveness of the IPS program is determined using the IPS fidelity scale. The higher the score on the IPS program fidelity scale the higher the expected job outcomes.

***Children's Services***

***Leah Colburn***

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services**

**directly or through a contracted provider. Include any planned changes in programming or funding.**

Psychosocial rehabilitation at DBH is provided by skills development specialists and case managers who serve as role models and mentors to teach and reinforce appropriate behavior in community settings. These mentors coordinate closely with the families of clients and with the treatment staff. These services help to ensure treatment success and assist in mastery of behavioral, cognitive and emotional functioning skills that have been lost as a result of mental illness. Services are provided in both individual and group settings, as well as in the home.

DBH and Davis School District also offer Quest, a day treatment program for adolescents. This program combines on-site education with psychosocial rehabilitation and therapy services. Quest works with youth and their parents to target and resolve issues that are preventing the youth from being successful in the typical school setting, strengthen the parent/child relationship, teach and reinforce effective communication and social skills, and identify and maximize familial and community resources in support of the youth and their parents. Quest provides a weekly evidence-based education group, Strengthening Families, to parents/caregivers and youth. Daily social skills training and group therapy for youth are core components of the Quest program. Davis School District employs a part-time certified special educator to meet Quest clients' educational requirements and needs. Students are engaged in three hours of daily instruction both during the regular school year and the summer break. Respite services are provided by DBH over school holidays and include education, social skills training, group therapy and therapeutic activities designed to encourage teamwork, self-reflection, personal growth and change. Quest staff coordinate with school personnel at both admission to and discharge from the Quest program. Referral sources for the program include therapists, inpatient hospital staff, JJS, school personnel, family peer support, and DCFS.

Location: 934 South Main Street in Layton, Utah and in the community

Provider: Davis Behavioral Health

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

Clients are identified for psychosocial rehabilitation services through an assessment by a master's level clinician who then refers to the program and prescribes the service. The client's progress is documented after each session and evaluated every two to three months for progress by the skills staff and their supervisor. For those clients participating in our psychosocial rehabilitation groups, the Strengths and Difficulties Questionnaire (SDQ) is administered at the beginning and again after each of the three units.

For day treatment, youth must be experiencing symptoms that are causing significant impairment in age appropriate functioning or ability to maintain personal safety. Additionally, the symptoms must not be manageable through a lower level of care. The DLA is completed on all referrals to day treatment to objectively assess their current functioning and ensure they meet medical necessity for this level of care. The DLA will be readministered at regular intervals and these scores will be tracked to help with determining ongoing medical necessity, areas to target while in day treatment, and to determine outcomes (baseline versus final).

**7) Case Management  
Adult Services**

*Hailee Hernandez*

**Describe the activities you propose to undertake over the three year period 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. Include any planned changes in programming or funding.**

Adult outpatient case managers work to actively coordinate, advocate, link and monitor services that assist clients with accessing needed services. Case managers complete a case management needs assessment on all clients through the use of the DLA. From this assessment they develop a written, individualized service plan to ensure the client's access to needed services with input from the client, family and other agencies who have a knowledge of the client's needs.

Case managers are integrated into all levels of care within DBH's adult services and are taking on an increased role in providing individual skills development and life skills for clients where that is clinically appropriate.

Case Managers have received additional training in response to the growing demand to help persons apply for further insurance benefits. In addition to training on Medicaid Eligibility, case managers are also poised to aid persons in applying for marketplace and other benefits to better serve clients with the changing topography of Medicaid expansion and Integrated Health Plans.

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

Case Management Services are referred to by any DBH employee and some community partners, particularly primary care providers. Eligibility is determined by client needs and their current insurance. If the client has Medicaid, the CM services are covered; if the client is unfunded, underinsured or insured and needs CM services, we offer a range of options from self-pay to grant funded services. The effectiveness of this service is measured by the DLA and client report.

### *Children's Services*

*Hailee Hernandez*

**Describe the activities you propose to undertake over the three year period 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. Include any planned changes in programming or funding.**

Case managers provide targeted case management and skills development services to children and their families. Case managers assess and document a client's need for community resources and services. The DLA is the assessment tool used to identify a client's needs. Case managers work closely with families and therapists to ensure that clients gain access to needed services. These services include housing and living environments, school placement, physical and medical needs, multi-agency needs, vocational training, employment, and safety needs. They help link families to resources and services and then monitor the delivery of the services. They advocate for individuals and families who need assistance when encountering barriers in accessing services. Services are provided in the home, office, school, and community settings. DBH has a referral process to identify clients with urgent case management needs.

Examples of services provided by case managers include:

- Individualized service plans consisting of mutually agreed upon goals and objectives
- Strengths, needs, and cultural discovery assessments

- Wraparound services
- Individual, family, and group skills using evidenced based interventions to decrease symptoms and improve functioning. This is done in conjunction with the recovery coordinator
- Assisting families in developing natural supports and resources so they may become independent of agencies

Many CYF case managers are licensed as Social Service Workers upon hire. For those that are not, they are trained on children’s case management using the curriculum and field guide developed by OSUMH. This training and the administration of the certification exam are provided by a licensed SSW. Individuals also complete the required practicum, if applicable. All case managers are also trained on Medicaid rules and regulations. Certification expiration dates are tracked by human resources and case managers and supervisors are notified when this date is nearing. Case managers are expected to complete their education/training hours and maintain documents to verify their training.

Location: 934 South Main Street in Layton, Utah and in the community

Provider: Davis Behavioral Health

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

In order to be eligible for case management, the client must meet SED criteria and have a documented need for the services provided. The assigned case manager will complete an assessment using the DLA and then develop a service plan from this, in conjunction with the family. The DLA and service plans are reviewed and updated every 60 days and when the case is closed.

**8) Community Supports (housing services)**

**Adult Services**

*Pete Caldwell*

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.**

DBH has more than 114 beds from a variety of housing resources (HUD sponsored group homes; tax credit properties, and DBH funded properties). We provide extensive in-home support to clients in our housing. These services range from medication delivery and observation, to in-home skill development, grocery shopping, cleaning assistance, and any service deemed clinically necessary to help maintain stable living.

DBH works with clients to expunge felonies so that clients have more housing options. We also provide a weekly “Housing 101” class as a way for staff to help more clients at once access vouchers and community housing applications.

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

DBH does not have a formal housing assessment tool. We determine eligibility based on client need, including those with significant barriers to community living placed at the top of the list.

People with low incomes, legal charges, history of past evictions and discharges from USH are priority placements. Outcomes are measured by the DLA, OQ, as well as the client's ability to develop self-reliance and obtain and maintain their own housing.

***Children's Services (respite services)***

***Cody Northup***

**Describe the activities you propose to undertake over the three year period 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. Include any planned changes in programming or funding.**

DBH currently offers weekly respite groups covering the ages of 4-17. Additionally, individual respite in both the home and community is provided to youth as indicated. We also partner with JJYS facilities to provide short term respite options for adolescents.

Respite services are considered an important part of the continuum of care at DBH. While respite can and is available for any youth experiencing an SED, it is particularly important for helping to avoid out-of-home placements. By providing both scheduled and crisis respite, caregivers can have temporary relief from the stresses of caring for their child, which often allows them to continue to work on treatment issues with their child in the home. Respite services are also an important component of the SMR program.

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

Eligibility for respite is determined by the therapist in conjunction with the family. The youth must meet SED criteria. Priority youth include those who are at risk of out-of-home placement. At this time, DBH does not have a formal evaluation process for respite services and would welcome technical assistance. Possible outcomes could include the number of youth at-risk for out-of-home placement who were able to remain home and pre/post parental measures of stress they are experiencing and ability to manage their child's behaviors or symptoms.

**9) Peer Support Services**

***Adult Services***

***Heather Rydalch***

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.**

Davis Behavioral Health Adult Peer Support Services are provided exclusively by Certified Peer Support Specialists (CPSS). Peer services are open to all DBH clients as resources allow. One of the integral roles of a peer is to teach recovery-based coping skills based on lived-experiences. Peers serve as advocates with other agencies and services, such as housing, employment, treatment and other basic needs. Peers facilitate our evidence-based IMR (Illness Management and Recovery) groups, provide outreach to clients leaving acute settings, are part of the Mental Health Court team, and provide hope in recovery for staff and clients. DBH has peer support available to all levels of care including MCOT.

Services are provided directly through DBH at both our Layton and Kaysville campuses as well as in the community.

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

Referrals for peer support services typically are provided by a client's medical provider or therapist. Peer specialists work as a part of the client's overall treatment team, and they coordinate directly with members of the team on a regular basis.

Peer specialists can use DLA to measure areas of need, strength and progress. CPSSs also observe individual progress through direct service provision, and meet with their supervisor each week to discuss client progress, as well as limitations and barriers to client progress.

**Children's Services**

*Amy Campbell*

**Describe the activities you propose to undertake over the three year period 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 Health & Human Services child serving agencies, including DCFS, DJJYS, DSPD, and HFW. Include any planned changes in programming or funding.**

FPSSs are based in offices available at DBH and at schools. Most are providing services in schools, homes and the community. They work closely with the parents of the children who are identified as needing these services. These FPSSs are uniquely skilled at navigating and balancing the demands of an agency with the needs of families. They are adept at engagement, finding resources, helping families identify natural supports, bringing teams together and representing family voice in professional settings. When working with families who are multi-system involved, the need for family peer support is assessed and referrals for this are made as appropriate with close coordination in order to avoid duplication of services.

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

In school-based settings, families are identified as benefitting from FPSS by school staff and the therapists. In the clinic, families are identified by the treatment team and the service is prescribed by the clinician. Priority families include those with youth at risk of out-of-home placement, parents who have had difficulty engaging in the treatment process, or families with multi-system involvement. Effectiveness is measured by the outcomes as reported by the family and family peer support specialist.

**10) Consultation & Education Services**

**Adult Services**

*Cody Northup*

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.**

Davis Behavioral Health has a partnership with local law-enforcement agencies in Davis County and responds to LE requests to assist with situations that involve mental health or substance use related issues as well as provide support and debriefing for officers, deputies, dispatch and others affiliated with the law enforcement system. In addition, DBH continues its monthly collaboration

meeting with all law enforcement agencies in Davis County for the purpose of reviewing cases in respective jurisdictions; building operational procedures; and developing policy to assist our shared consumers.

DBH will also continue in a collaborative manner to help police officers throughout Davis County become CIT certified. DBH also provides training to agencies/providers statewide in civil commitment and designated examiner processes.

DBH is active in educating community members by sponsoring seminars and training on mental health, substance use, prevention and topics related to recovery. We sponsor Davis County's Annual Resilience Conference, screenings for depression at the county senior centers, screening for behavioral health needs for Davis School district, and our staff are regular presenters and planners for state and local conferences and seminars.

Location: 934 South Main Street in Layton, Utah and in the community

Provider: Davis Behavioral Health

**Children's Services**

**Cody Northup**

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.**

Davis Behavioral Health has a partnership with local law-enforcement agencies in Davis County and responds to LE requests to assist with situations that involve mental health or substance use related issues as well as provide support and debriefing for officers, deputies, dispatch and others affiliated with the law enforcement system. In addition, DBH continues its monthly collaboration meeting with all law enforcement agencies in Davis County for the purpose of reviewing cases in respective jurisdictions; building operational procedures; and developing policy to assist our shared consumers.

DBH will also continue in a collaborative manner to help police officers throughout Davis County become CIT certified. DBH also provides training to agencies/providers statewide in civil commitment and designated examiner processes.

DBH is active in educating community members by sponsoring seminars and training on mental health, substance use, prevention and topics related to recovery. We sponsor Davis County's Annual Resilience Conference, screenings for depression at the county senior centers, screening for behavioral health needs for Davis School District, and our staff are regular presenters and planners for state and local conferences and seminars. Additionally we frequently attend back-to-school nights and/or parent education nights held at area schools, meet with local PTAs, and participate in youth suicide prevention events.

**11) Services to Incarcerated Persons**

**Cody Northup**

**Describe the activities you propose to undertake over the three year period 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. Include any planned changes in programming or funding.**

Mental health services are provided to inmates of the Davis County Jail. Two full-time therapists and a part-time case manager provide a variety of services including:

- Assessment of inmates' mental health needs and referral to medical staff for psychiatric medications.
- Crisis evaluations, classifications, and supervision determinations that jail personnel request on inmates.
- Review of inmates who enter the jail with psychiatric medications and triage services with outside providers. Individual counseling for immediate needs of inmates
- Assessment and community referrals when inmates leave the jail
- Group therapy interventions for jail inmates in the areas of anger management, cognitive behavior modification, self-esteem, emotional control issues, and interpersonal relations
- Screening for potential Mental Health Court participation
- Partnership with the Veterans Administration and the Davis County Jail to implement the Veterans Justice Outreach (VJO) program in the Davis County Jail and the administration of Vivitrol to inmates prior to release.
- Coordination with jail personnel, to provide Vivitrol injections and subsequent outpatient MAT for inmates with OUD in the Davis County jail.

DBH has honed its relationship with deputies, supervisors, medical staff, and the Sheriff in a way that we have on-going, regular open conversations about needs, strengths and areas of improvement. In addition, our Intensive Services Director is in the jail weekly soliciting feedback and jail personnel actively participate in our monthly law enforcement meetings.

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

Completing the inmate screening form at intake  
Requesting mental health services through the jail system.  
Identification from nursing staff  
Referral from jail deputies  
Referral from arresting officers at booking  
Referral from other inmates, if indicated.

DBH does not have a formal evaluation process for measuring effectiveness in this domain and would welcome technical assistance.

**Describe the process used to engage clients who are transitioning out of incarceration. As per HB0167 (2025 legislative session), local mental health authority shall, to the extent feasible, coordinate with the Department of Corrections to ensure the continuity of mental health services for county residents who are on probation or parole. Please describe this process for your agency.**

During incarceration, inmates who were previously receiving medication through DBH receive coordinated medical care between DBH and jail nursing staff. Providing medication during the jail stay facilitates a smoother discharge plan and keeps inmates engaged in care.

Inmates with SMI who identify as having alcohol or opioid issues are asked if they are interested in the Vivitrol shot. If the inmate is interested, they are assigned to have their chart reviewed by the jail medical doctor, and the Vivitrol shot is prescribed for the inmate to receive the day they leave the jail. DBH jail staff notify DBH outpatient MAT staff that an inmate has started MAT and will be

calling for an appointment. Inmates are also given the contact information for DBH so that continued MAT can occur. Given the unpredictable nature of release, we have not been able to set up appointments at discharge. In addition, inmates are given the dates and time of our Rapid Access Clinics (walk-in) so they can engage in care within 1 – 7 days of release. We also provide crisis contact information and information on the DBH Receiving Center so inmates are able to access services immediately upon release.

In addition to MAT continuation of care, DBH has a case manager who will assist inmates who are transitioning out of jail with case management and community re-entry needs. [To the extent possible, the case manager will assist with scheduling appointments for ongoing treatment and conduct outreach to help with continued engagement. DBH will also attempt to obtain releases of information in order to coordinate and communicate with probation/parole officers.](#)

## 12) Outplacement Adult Services

*Cody Northup*

**Describe the activities you propose to undertake over the three year period with outplacement funding, and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.**

DBH uses outplacement funds for a variety of purposes in order to maintain people who have been at USH, or who are at risk of going to USH, in the community. Some of the things we have done with these funds include:

- Paying for cleaning services to help these clients maintain stable and independent housing in the community.
- Medications for clients without funding. Sometimes these funds are only used until Medicaid benefits are reinstated and sometimes the funds are indefinite (as in the case of foreign nationals who have a green card and no other benefits).
- CRU transitional housing so that we can move people out of the USH in a timelier way.
- Nursing and case management costs associated with obtaining benefits and patient assistance for medication.
- Stays at CRU as part of trial visits when discharge from USH is being contemplated
- Short-term and long-term rent assistance
- Furniture and household basic needs such as groceries and clothing
- Staff support in a few DBH housing units to help clients remain in the community
- We added a respite worker to help a family keep their daughter in their home after a very long stay at USH.
- A permanent rent allocation to a client who was discharged from USH and was unable to remain in a group home setting.

## *Children's Services*

*Cody Northup*

**Describe the activities you propose to undertake over the three year period with outplacement funding, and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.**

DBH uses outplacement funds for a variety of purposes in order to maintain people who have been at USH, or who are at risk of going to USH, in the community. Some of the things we have done with these funds include:

- Medications for clients without funding. Case management costs associated with obtaining benefits and patient assistance for medication.
- Proctor treatment home care
- Families First in-home treatment services
- Gas cards and to get to treatment and/or to participate in family therapy at USH
- Therapy (both outpatient and day treatment) and respite services for children without funding
- Cost sharing for youth residential with DCFS and JJS youth.
- Community activities to help youth remain active in the local community

Location: 934 South Main Street in Layton, Utah and in the community

Provider: Davis Behavioral Health

### 13) Unfunded Clients

#### *Adult Services*

*Leah Colburn*

**Describe the activities you propose to undertake over the three year period 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. Include any planned changes in programming or funding.**

Davis Behavioral Health continues to see a significant number of inquiries for services from people with commercial insurance and people without funding. Our objective is to offer some level of service to any Davis County resident who asks DBH for help; this includes providing awareness of and help accessing other community resources that may be helpful.

As part of the Davis County Behavioral Health Network, DBH sees people without funding who are discharging from inpatient and emergency departments who need follow-up behavioral health care. These patients are seen by a therapist within 7 days of discharge. Unless a client has a psychotic disorder, for people requesting medication, we request care first be established with Midtown CHC in order to have a health home that can be utilized for medication maintenance once the client is stable.

DBH Treatment and Prevention services offer:

- Up to 5-10 sessions of individual or family therapy on a sliding fee. Additional services can be offered based on clinical need.
- Individual, family and group therapy with limits defined by insurance
- Cool Minds (mindfulness based stress reduction class for teens)
- MBSR (Mindfulness Based Stress Reduction)
- Parenting classes
- Medication consultation evaluation
- Medication Management
- Crisis Recovery Unit Care Services (acute adult mental health stabilization)
- Davis Receiving Center (acute crisis stabilization and withdrawal management services)

DBH provides 3 visits for individuals who lose their insurance in order to allow time for treatment to be completed, their insurance to be reinstated or, if needed, complete a hardship waiver to request more unfunded services based on clinical need.

Services are provided at all DBH clinical facilities.

**Describe agency efforts to help unfunded adults become funded and address barriers to maintaining funding coverage.**

Those who call DBH seeking services will speak with an intake specialist who reviews their ability to pay for treatment. For those who are uninsured or underinsured, intake specialists will help the caller determine if they qualify for Medicaid. If it appears they may qualify, they are referred to Workforce Services (DWS). Because DBH doesn't turn individuals away due to an inability to pay, those who are referred to DWS and those who are uninsured or underinsured are placed on a sliding scale until the time they obtain insurance.

All Case Managers have received additional training in response to the growing demand to help persons apply for additional insurance benefits. In addition to training on Medicaid Eligibility, case managers also help people apply for marketplace and other benefits.

DBH Utilization Management Team meets with DWS each week to review people who have lost their Medicaid or may be eligible for Medicaid. The DWS worker problem solves barriers and expedites access. The UM team also makes referrals for case management to assist with financial hardship waivers and accessing community insurance options.

***Children's Services***

***Leah Colburn***

**Describe the activities you propose to undertake over the three year period 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. Include any planned changes in programming or funding.**

In addition to the Living Well Clinic, we continue to serve unfunded children and youth who meet the SED criteria in our school-based and traditional outpatient services. Services are provided directly at our Kaysville Clinic, our Bountiful Clinic, and through school-based services.

**Describe agency efforts to help unfunded youth and families become funded and address barriers to maintaining funding coverage.**

In addition to what is described in the adult unfunded section, CYF has made a concerted effort to take a team approach to identifying youth who are unfunded and attempting to help them access resources. When any member of the team becomes aware that a youth does not have Medicaid or any other funding source, they contact the case management or FPSS teams. All youth case managers and FPSSs have received additional training in response to the growing demand to help persons apply for additional insurance benefits. The case manager or FPSS will reach out to the family and work with the DBH Medicaid Eligibility Specialist to help them apply or reapply.

**14) First Episode Psychosis (FEP) Services**

***Jessica Makin***

**Describe the activities you propose to undertake over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding.**

DBH's PREP program offers services through a coordinated specialty care model to individuals between the ages of 16 and 26 who are experiencing their first episode of psychosis and clients up to age 25 who are identified as at clinical high risk. Services include individual therapy, family therapy, multi-family group therapy with family support, case management, supported education and employment, and medication management. We also offer a part-time occupational therapist as part of a contract with the Utah State Hospital. PREP services are provided in the setting that is most comfortable to the client and family (office, home, school, community, etc.). Additionally, as part of the PREP program services, community education is offered to other providers (both private and public) on clinical high risk and early psychosis and the need for early intervention.

All services are provided directly by DBH and the contracted occupational therapist.

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

Clients in the PREP program are often initially identified by their primary providers, either at DBH or in the community, as exhibiting symptoms that may indicate a more serious mental health disorder. The PRIME screener is completed and, if indicated, the client is referred for additional assessment through the SIPS and/or the SCID, which is completed by the PREP team. Individuals can also contact DBH to self-refer or to refer a friend or family member. In these cases, a member of the PREP team reaches out to the potential client to complete the screening.

The PREP program tracks the following data to measure outcomes: hospitalizations, enrolled in education, employment, services received, physical health services and coordination, and housing status. GPRA data is collected on clients identified as clinical high risk (CHR) at the time they enter the program and again every six months to track outcomes. We also collect data using OSUMH's evaluation tool at intake, every 6 months, and at discharge. Additionally, CHR clients are re-assessed every 90 days using the SIPS to track changes in symptoms and functioning.

**Describe plans to ensure sustainability of FEP services. This includes: financial sustainability plans(e.g. billing and making changes to CMS to support billing) and sustainable practices to ensure fidelity to the CSC PREP treatment model. Describe process for tracking treatment outcomes.**

Because of its dedication to people with serious mental illness, DBH is committed to sustaining a scaled back version of the PREP program. The therapist will no longer be exclusively dedicated to PREP, case management services will be picked up by the transitional youth case manager, and DBH will no longer be able to market or take unfunded, out-of-county young people.

Upon completion of the grant, treatment outcomes will continue to be tracked through an evaluation tool managed by DBH, similar to the one currently used by OSUMH, with information collected at intake and discharge, at a minimum. Additionally, we will continue to reassess CHR clients every 90 days using the SIPS to track their symptoms and functioning.

**15) Client Employment**

*Sharon Cook*

**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. Include any planned changes in programming or funding.**

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

DBH's employment specialists have assisted transition aged youth and clients with severe mental illness and co-occurring disorders obtain competitive employment. Employment specialists have provided an employment assessment, helping identify clients' career interests and needs, identify education and training, resume building, job interviewing skills, completing job applications, on the job coaching, and navigating transportation issues. In addition, IPS services are integrated into our adult outpatient, AOT, and PREP programs and IPS referrals are welcomed for any DBH client. IPS provides information and employment resources to transition-age youth and their families who are participating in the PREP program. IPS staff attend staff meetings with adult mental health therapists and medical providers. IPS is coordinating with the substance use Recovery Support Specialist team in providing a monthly orientation about IPS Services and how employment is part of substance abuse recovery and treatment.

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

Clients are referred by any member of the client's treatment team. As part of the ongoing assessment process, clients are asked by their treatment providers if they would like long-term support with employment and when the client expresses a desire to work a referral to IPS is initiated. IPS does not wait for the client to be "ready" for work; they start at whatever stage of engagement the client is.

Clients are also referred directly from Voc Rehab Services. Sometimes, this requires connecting the client to DBH services to receive mental health treatment as it has been identified by Voc Rehab as a service needed in conjunction with obtaining and/or maintaining employment.

**Collaborative employment efforts involving other community partners.**

DBH is authorized to be a Community Rehabilitation Program Provider (CRP) for Vocational Rehabilitation (VR). This means that clients who previously did not have a funding source can receive IPS services paid via VR.

Journey House is also an active participant in finding community partners who are willing to partner with DBH in providing competitive employment opportunities. Within the JH/IPS program, community coordination for employment/education occurs with multiple businesses and educational partners. We have monthly coordination with the Office of Vocational Rehabilitation. IPS workers attend Davis Technical College, Ogden Weber Technical College and DWS training in order to increase partnering and collaboration efforts. IPS collaborates with ADA Counselors from secondary education providers in coordinating education accommodations for education success. IPS partners with Davis Adult Education and VISTA education to assist youth and adult clients in obtaining resources to complete their high school diploma or GED.

IPS and JH develop long term business relationships with employers. IPS has established a steering committee which will represent participation from community partners, clients and employers. This will measure IPS goals and outcomes on a quarterly basis, and the possibility for additional IPS sustainability.

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

DBH has people with self-identified, lived experience in every area of the organization. We have debated having each of these people participate in the peer specialist training but, due to funding and service capacity issues, have chosen not to. Although we do not specifically advertise for a "lived experience" in our recruitment efforts (unless the position is a peer specialist role), we see personal experience with mental illness and substance use recovery as a plus in our recruitment efforts.

#### **Evidence-Based Supported Employment.**

At DBH the evidence-based employment programs are the clubhouse model (Journey House) and IPS.

### **16) Quality & Access Improvements**

**Identify process improvement activities over the next three years. Include any planned changes in programming or funding.**

**Please describe policies for improving cultural responsiveness across agency staff and in services, including "Eliminating Health Disparity Strategic Plan" goals with progress. Include efforts to document cultural background and linguistic preferences, incorporate cultural practice into treatment plans and service delivery, and the provision of services in preferred language (bilingual therapist or interpreter). *For questions - Jessica Makin***

**DBH has hired a Health Disparity Officer named Shanna Stevens.**  
**service capacity**

#### **Policies for Improving Cultural Responsiveness**

DBH implements a Cultural Humility Plan and Annual Cultural Humility Training for all employees.

#### **Efforts to Document Cultural Background and Linguistic Preferences**

DBH intake staff complete the Clinical Information/Demographic Form as part of the intake process. Intake staff collects information regarding preferred language and interpreter services.

#### **Incorporate Cultural Practice into Treatment Plans and Service Delivery**

Treatment staff at DBH are encouraged to perform assessments, treatment, and discharge planning, and take into consideration holistic approaches, cultural beliefs and values, family and other natural support systems, community resources, and any communication barriers that may be present.

#### **Provision of Services in Preferred Language (Bilingual Therapist or Interpreter)**

The Human Resources Department includes all non-English languages spoken by staff in the Human Resource Information System (HRIS). Languages spoken by providers are listed on DBH's Provider Directory. Oral interpretation services are available for all languages and written translation is available in prevalent languages, including auxiliary aids such as TTY/TDY and American Sign Language (ASL).

#### **Eliminating Health Disparity Strategic Plan**

DBH's short and long-term goals include improving staff knowledge of cultural humility practices and efforts to meet the CLSW principal standards of providing high quality culturally competent services to persons with diverse cultural health beliefs, practices, and languages.

**Service Capacity: Systemic approaches to increase access in programs for clients, workforce recruitment and retention, Medicaid and Non-Medicaid funded individuals, client flow through programming. Please describe how the end of the Public Health Emergency and subsequent unwinding is expected to impact the agency's services and funding. *For questions - Cody Northup***

### Increasing Access

DBH set a company-wide standard of no more than a 5 business day wait for people requesting services. While we do not always meet this standard, we are typically within 7 days. This standard has forced increased attention to initial access and has resulted in overbooking as a strategy in order to have more availability for clients. (The overbook process allows us to schedule more clients as we anticipate no shows, thereby increasing access.) We also have a Rapid Access clinic for clients who have not shown their evaluation appointment so that they, too, can quickly access care without taking up a scheduled slot with someone whose history indicates they may not show again. The use of telehealth has allowed for our off-site providers (i.e., MCOT, school-based) who may have availability in their schedules to assist with completion of initial assessments, thereby increasing access.

### Workforce Recruitment and Retention

- Targeted job advertisements for each open position, including comprehensive information surrounding compensation and benefits as well as information regarding expectations.
- Active and quick responses to all potential candidates to schedule interviews, answer questions, and assist with the application process.
- Text messages sent to potential candidates upon receipt of résumés via online job boards to instruct candidates to complete the official employment application. Language about the specific position the candidate expressed interest in as well as link to DBH employment page included in all text messages.
- Regular analysis and adjustment to salaries.
- Employee referral incentive up to \$1,500 available for current employees.
- Educational assistance programs.
  - Approved site for the Health Care Workforce Financial Assistance Program loan repayment program.
  - Tuition reimbursement for MSW, APRN, and nursing programs (currently limited to 3 participants).
- Front-loaded vacation for new hires.
- Up to 120 hours compensated time every two (2) years provided to complete CEUs based on professional licensure (MD/DO/APRN, RN/LPN, LCSW/CMHC/MFT, PhD/PsyD, SSW, SUDC), or certification (CPSS/FPSS, TCM). Registration for select trainings may be available.
- Comprehensive employee benefits package, including incentive for employees who opt out of medical and/or dental insurance. Long-term care option added to benefits package for the 2024/25 benefits year. Employee Assistance Program (EAP) available to all employees – full-time and part-time – and their immediate family members.

### Medicaid and Non-Medicaid Funded

DBH does not have separate standards for people with and without Medicaid funding. If someone lives in Davis County, we try to provide services.

### Client Flow Through Programming

DBH's client flow begins with a clinical or medical assessment and then referral to the right level of care. We operate in a trauma informed manner by educating clients on the purpose and intended duration of treatment thereby setting the expectation that treatment is an intervention and not a

way of life. We also have a Clinical Utilization Management Coordinator who assists therapists in moving people out of or to the right level of care. In addition, she guides a utilization review process to monitor 1) high service utilizers, 2) high risk clients and 3) clients with long-term stability whose needs may be able to be met in primary care settings. We have also implemented a Skills Group that is open to all clients who have plateaued at the individual therapy level of care, but are reluctant to leave services. This process also identifies people needing assistance with insurance applications or other funding assistance.

Unwinding's Impact to Funding and Care

DBH has taken a proactive stance in helping client awareness of the unwinding. And, as with all clients who have insurance gaps, we will provide 3 sessions to clients at no cost while we work with them to establish Medicaid or some other insurance. If they remain uninsured, we will provide services on a sliding fee scale. We anticipate some loss of funding, but remain committed to providing essential care to our core population.

**Describe how mental health needs and specialized services for people in Nursing Facilities are being met in your area. *For questions - Scott Smid***

DBH prescribers are available to consult with local nursing facilities. A prescriber goes to the care center, does a medication evaluation, and makes recommendations to the care center physician for any psychotropic medications. In addition, we have a strong relationship with Rocky Mountain Care Center which is near our Layton Campus. We continue to provide case management services and also welcome DBH clients residing at Rocky Mountain to attend Journey House. Although Mountain View Care Center is not in Davis County, they have been willing to take some of our most compromised clients because we have agreed to continue with case management supports. DBH has been able to preserve these care center placements by offering a respite stay at our Crisis Residential Unit (CRU) when psychiatric symptoms become problematic.

**Telehealth: How do you measure the quality of services provided by telehealth? Describe what programming telehealth is used in. *For questions - Pete Caldwell***

DBH uses the OnCall telehealth platform. This system provides better integration to DBH's electronic medical record system. DBH will continue to use the DHHS and Doxy platform, when necessary, for case management, peer support, and other telehealth needs. Outcomes will be monitored via the DLA, Y/OQ system, clinician report and client grievances. We use telehealth in outpatient therapy and case management, medication management, evaluation, MCOT, SMR, and peer services. While we encourage in person services for evaluations, if the client prefers telehealth and there is a payor, we provide telehealth if the client prefers it.

**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. *For questions -Leah Colburn***

DBH has one therapist in the CYF program trained and certified in Parent-Child Interaction Therapy (PCIT). PCIT is an evidence-based model for children ages 2-7 exhibiting behavioral problems and their parents. We also have one therapist trained in Child-Parent Relationship Therapy, which is an evidence-based program for parents of children ages three to eight. CPRT is effective for treating behavioral, emotional, social, and attachment disorders. DBH continues to make itself available as a resource for local Head Start programs.

DBH provides the following services to address maternal perinatal issues.

- Postpartum Support Group  
A free weekly support group for new mothers struggling with depression, anxiety, or other mental health concerns (up to 2 years after the most recent birth). Join a licensed clinician and other women learning to manage the challenges of motherhood and learn basic coping skills. Babies welcome.
- We have two APRNs as well as several therapists from our [outpatient teams \(adult MH, youth MH, and SUD\)](#) who have been trained in the maternal mental health model (Perinatal Mood Disorders: Components of Care and Advanced Perinatal Mental Health Psychotherapy) and try to coordinate with the State Maternal Mental Health Specialist.

**Describe how you are addressing services for transition-age youth (TAY) (age 16-25) in your community. Describe how you are coordinating between child and adult serving programs to ensure continuity of care for TAY. Describe how you are incorporating meaningful feedback from TAY to improve services. [For questions - Jessica Makin](#)**

DBH has implemented a transition age youth program called Praxis. Priority populations include clients who are homeless or at-risk of homelessness, who are aging out of the child welfare or juvenile justice systems, or those leaving long term institutional care; however, any transition age youth with an SED or SMI is eligible. Services include assertive outreach and engagement, individual and group skills development, case management, recreation/leisure activities, peer support, family support and education, and ongoing coordination with therapists and/or medication providers. The overall goals are to have successful continued engagement with mental health and/or SUD services (as needed) and success in adult outcomes and overall recovery. Skill areas of focus include, but are not limited to, life skills training, education, employment, housing, physical healthcare, healthy living, healthy relationships, communication skills, problem solving skills, and transportation. The program consists of one full-time case manager and one half-time peer support specialist, with clinical oversight by a licensed therapist. The case manager and peer support specialist coordinate with the youth mental health and SUD programs, as well as adult serving programs such as the Crisis Recovery Unit and the Receiving Center to identify young adults who would benefit from the services. Clients regularly participate in choosing the group activities and are actively involved in the planning process. Clients also are encouraged to take ownership of the facility and participate in the care and maintenance.

For young adults not involved in the Praxis program, transitions of care occur when developmentally appropriate and at appropriate times in the treatment process. When a client turns 18 while in treatment and is enrolled in high school, the youth team will continue to work with them until the end of their senior year. They are then assessed to determine whether their developmental and treatment needs are still most appropriately served in youth services or if they would be more appropriate for the adult team. If transferred, the therapist will outline the client's progress and current treatment goals for the receiving team, as well as any additional services that may be recommended. If other team members are involved (i.e., a case manager), these services will also transfer when most appropriate with coordination happening between teams. All decisions are made with input from and in conjunction with the client and, as appropriate, the client's family.

[Feedback from TAY is requested anytime we observe drops in engagement or program participation. For example, we recently solicited feedback about groups due to a drop in attendance and made changes to the schedule and structure of group based on the client responses.](#)

**Other Quality and Access Improvement Projects (not included above)**

17) Integrated Care

Pete Caldwell

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

Davis Behavioral Health meets regularly with the local Health Department to discuss access to behavioral health treatment, suicide and other health related issues. DBH has contracted with and provides behavioral health services to each of the four ACO's. Further, DBH participates with Select Health in areas such as opioid treatment and treatment for ED high utilizers. Individuals can be referred by their primary care physician to a DBH medical provider for med consultation that may last up to three visits before the individual is referred back to their primary care provider for continued service. DBH regularly coordinates with primary care providers in the community as well as Midtown Clinic. For patients whose illness may impair their ability to effectively seek primary care, case managers will link the patient to the PCP and may take them to their appointment; for some patients our nurses contact the PCP regarding treatment recommendations including medication changes or need for labs, etc. Our physicians also provide consultation to interested PCPs.

DBH has a "speciality clinic" relationship with Midtown CHC where clients are established at Midtown in primary care and then referred to DBH to receive medication services until the patient is stable at which time the patient is transferred back to Midtown to receive ongoing medication management through primary care with ongoing consultation from our prescribers to theirs. .

**Describe your efforts to integrate care and ensure that children, youth and adults have both their physical and behavioral health needs met, including training, screening and treatment and recovery support (see Office Directives Section E.viii). Identify what you see as the primary barriers to implementing integrated care at your agency and your efforts to overcome those barriers. Please also describe how you will provide education and referrals to individuals regarding physical health concerns (i.e., HIV, TB, Hep-C, Diabetes, Pregnancy).**

DBH provides clients with the skills, knowledge and strategies necessary for a healthy, complete lifestyle in recovery. The focus of treatment includes treating the person as a whole. This means working with the clients to assess their emotional, physical, behavioral health and other needs. We jointly plan services and work with clients to obtain indicated interventions and assistance from DBH or other outside agencies. We also work with families and other formal and informal supports to link and connect with needed resources that will ensure clients have the best potential for recovery.

DBH emphasizes treatment for people who are dually diagnosed with mental health and substance use conditions. We have a dual IOP group for people with SMI and SUD. In our CYF program, substance use providers are fully integrated in the youth team and assess all SUD clients for co-occurring MH conditions. Youth substance use therapists have been working with the mental health team to increase screening for substance use disorders. The Quest day treatment program is also fully co-occurring, with interventions targeting both mental health and substance use issues. Additionally, the youth program has a part-time Recovery Support Specialist who can provide support, education, and early recovery skills to any youth who has a history of substance use.

In addition, DBH adult teams screen for SUD and MH needs in their respective programs. Providers ask about co-occurring medical conditions during the initial assessment and collaborate

with pediatricians/PCPs as indicated. In CYF, the most common physical health concerns have been related to disordered eating behaviors and sexual health.

CRU case managers meet with clients within 24 hours of admission and perform a DLA assessment. As part of that assessment, clients' medical issues as well as their connection to a PCP and other needed medical providers are identified. If they are lacking needed providers, CRU staff help find and schedule clients, and at times provide transportation to those appointments as well. CRU Psychiatrists, nurses and therapists also assess for client medical needs at admission and on a continual basis, knowing that a big part of stabilizing mental health is by taking care of physical health needs.

Barriers to finding PCP and other medical providers include the following: there is no primary care physician on staff at DBH, meaning outside providers must be found; at times clients have balances with the doctors they've been seeing, and cannot see them until those balances have been paid; providers may not take their type of insurance; clients sometimes cannot afford medication co-pays, and therefore cannot get prescriptions filled; poor client follow-through with showing up to appointments in the past have made it so providers will no longer schedule them; clients may have been resorting to the ED's to treat all medical needs that can be managed by a PCP.

CRU staff work to overcome these barriers by learning what providers take which insurances; building working relationships with outside providers; educating clients on when and when not to use to use ED services; providing regular communication brokered by the CRU staff between the client and their providers; connecting to needed providers and services in the community; and providing on-going assessment and reassessment of the clients mental and medical health, considering how one may be impacting the other at all times.

**Describe your efforts to incorporate wellness and wellness education into treatment plans for children, youth and adults. Please consider social determinants of health in your response.**

For clients with co-occurring MH/SUD conditions who receive psychiatric care at DBH coordination with primary care physicians is conducted by e-faxing coordination documentation of visits with psychiatric medication providers to the primary care physician. 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 their primary care physician. If needed, recovery support specialists 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 clients not seeing a prescriber at DBH, 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 Midtown Community Health Center or the Health Department.

Nicotine dependence screening is completed on evaluation and again at each follow-up by medical assistants. Patients are encouraged to discontinue smoking/vaping, and MAT is proved as needed/desired, with referral to a smoking cessation class to aid in the patient's smoking cessation efforts. Therapists who identify smoking cessation needs refer to nursing for education around use of MAT. In addition, medical assistants assess nicotine use status and are offered NRT as part of smoking cessation efforts at each medication management visit.

As part of the initial evaluation we ask about a client's physical health and encourage them to enter into an on-going dialogue about how physical and mental health are interrelated. In addition, DBH case managers use the DLA (Daily Living Assessment) to assess, address and monitor a multitude of social determinants of health ranging from physical and mental health to food and housing.

**Quality Improvement: What education does your staff receive regarding health and wellness for client care including children, youth and adults?**

DBH Human Resources shares a monthly wellness letter to all staff. Our medical providers ask about physical health concerns and make appropriate referrals. Also, behavioral health therapists and CM who work with co-occurring populations routinely ask about HIV, TB, Hep-C, etc. Several DBH substance use and nursing employees are providing HIV and Hep-C quick result testing and result counseling.

**Describe your plan to reduce tobacco and nicotine use, 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%.**

DBH continues nicotine / tobacco cessation across all its campuses, programs, and services. Notice of tobacco / nicotine free policy signs continue throughout our campuses. Due to continued grant funding, we are able to continue onsite nicotine replacements (varying doses of gums, patches, lozenges) to appropriate clients (began March 9, 2021) – offering a start to finish of the recommended NRTs (including combination). DBH continues to use a Fagerstrom scale to help determine appropriate dosing that are reviewed by our medical providers, as refills are obtained.

Staff continue to be trained and educated in nicotine prevention. We offer a brief individual model, called the Individual Nicotine Cessation Counseling (INCC) – follows a 2As and C (ask, advise, and connection) model. This reinforces continuous evaluation and intervention (referrals, quit-plan, etc.) according to client decrease/quit interest as they receive services throughout their care. We have and will continue to offer Dimensions: Tobacco Free Program groups.

**Describe your efforts to provide mental health services for individuals with co-occurring mental health and intellectual/developmental disabilities. Please identify an agency liaison for OSUMH to contact for IDD/MH program work. *For questions - Ashley Donham***

DBH provides behavioral health treatment for people who are neuroatypical as co-occurring behavioral health conditions arise in all populations. All youth therapists, case managers, and FPSSs have received general training on adapting basic interventions for these individuals such as using visual aids and reminders, teaching social skills, using concise and concrete language, etc. Therapists also understand the importance of working with the parents and family members in order to help them adapt their parenting styles and communication styles, especially if they have other children who do not require these adaptations and accommodations.

Case managers and FPSSs frequently assist families with accessing resources and supports in the community specific to autism and other developmental disorders, such as the Utah Parent Center. When appropriate, DBH works closely with other agencies such as DSPD and the schools in order to coordinate services and provide the most effective treatment. Adult mental health therapists have received general training, but struggle to effectively determine where mental health needs supersede behavior needs. We will continue to seek training and provide contracted services when we are unable to effectively meet needs. We also have many prescribers who provide

psychotropic medication to these populations.

Liaisons:

- For systemic implementation: [Kim McComas](#)
- For Adult Mental Health: David McKay
- For Children and Youth: [Ryann Albritton](#)
- For Substance Use Treatment: [Callie Murray](#)

**18) Mental Health Early Intervention (EIM) Funds**

*Leah Colburn*

**Please complete each section as it pertains to MHEI funding utilization.**

**School Based Behavioral Health: Describe the School-Based Behavioral Health activities or other OSUMH approved activity your agency proposes to undertake with MHEI funding over the three year period. Please describe 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. Include any planned changes in programming or funding.**

**Please email Leah Colburn [lacolburn@utah.gov](mailto:lacolburn@utah.gov) a list of your **FY26** school locations.**

We presently have therapists providing services in 14 different schools within Davis School District, providing assessments and therapy services to identified youth. We also provide family peer support specialists in these schools who assist families with getting connected to the therapists, as well as other resources and services in the community. The FPSS are not funded through MHEI. The school-based team coordinates with school personnel and participates in IEP meetings and other staffings as appropriate. The therapists regularly outreach parents to engage them in family therapy. They are available during after school hours and on days when school is closed, which also allows them to provide additional opportunities for family therapy. All school-based employees have access to telehealth and utilize this to meet with clients who may be absent from school and as an additional way to engage the caregivers in family therapy.

All services are provided by DBH staff. None are provided by contracted providers.

**Please describe how your agency plans to collect data including MHEI required data points and YOQ outcomes in your school programs. Identify who the MHEI Quarterly Reporting should be sent to, including their email.**

The school-based therapists, family peer support specialists, and the program supervisor all work closely with school personnel to collect the required MHEI data points, including grade point averages and DIBELS scores. YOQs are completed at least monthly either by the client/parent during their session, by emailing it to the parent, and/or through home visits by the Family Peer Support Specialist.

Quarterly reporting should be coordinated through [Alex Valencia \(alexv@dbh.utah.gov\)](mailto:alexv@dbh.utah.gov).

**Family Peer Support: Describe the Family Peer Support activities your agency proposes to undertake with MHEI funding over the three year period and identify where services are provided. For each service, identify whether you will provide services directly or through a contracted provider. Include any planned changes in programming or funding. For those not using MHEI funding for this service, please indicate "N/A" in the box below.**

DBH does not use MHEI funding for school-based FPSS. However, we see this as integral to the program therefore, we have 2.5 FTE family peer support positions who provide wraparound and other peer support services in 12 schools in Davis School District. We are careful to make sure that we are offering but not duplicating services and have been able to have a good relationship with partners such as DCF, JJYS and Intensive Care Coordination so that clients get what they need and gaps are filled.

Family peer support specialists are based in offices available at DBH and at schools. Most are providing services in homes and the community. They work closely with the parents of the children who are identified as needing these services. These FPSSs are skilled at navigating and balancing the demands of an agency with the needs of families. They are adept at engagement, finding resources, helping families identify natural supports, bringing teams together and representing family voice in professional settings.

**Mobile Crisis Team: Describe the *Mobile Crisis Team* activities your agency proposes to undertake with MHEI funding over the three year period and identify where services are provided. Include any planned changes in programming or funding. For those not using MHEI funding for this service, please indicate "N/A" in the box below.**

N/A

#### 19) Suicide Prevention, Intervention & Postvention

Carol Ruddell

**Identify, define and describe all current strategies, programs and activities in place in suicide prevention, intervention and postvention. Strategies and programs should be evidence-based and align with the Utah State Suicide Prevention Plan. For intervention/treatment, 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? Include the evaluation of the activities and their effectiveness on a program and community level. If available, please attach the localized agency suicide prevention plan or link to plan.**

Davis HELPS is the prevention coalition dedicated to helping Davis County be a healthy place to live. This long standing coalition takes the lead on coordinating community prevention efforts with a focus on suicide prevention. This group actively participates in county wide plans, assessments and progress reports. Together the coalition is able to plan and implement a wide variety of activities addressing suicide prevention, intervention and postvention programs for people throughout the lifespan. The coalition includes agencies such as Davis County Health Department, Davis County Sheriff's Office, Davis School District, Davis Behavioral Health, USU Extension, Intermountain Healthcare, Juvenile Court, Hill Airforce Base, LDS Church Public Affairs, Head Start, Safe Harbor, Veteran Affairs, survivors and other non-profit agencies. These partners not only represent their agency but they are parents and residents in the county as well.

Davis County received a Comprehensive Suicide Prevention grant in 2022 which is coordinated by the Davis County Health Department. Some of the current strategies in suicide prevention, intervention and postvention are:

Suicide **prevention:**

- Collaborate with community partners to develop a Community Health Improvement Plan includes strategies, goals, objectives, and measures to address suicide prevention in Davis County.
- Coordinate and expand the Davis HELPS prevention coalition to strategically align strategies, programs, and partnerships to make a larger impact.
- Implement a local suicide prevention education campaign using the Live On toolkit and safe messaging courses
- Support suicide prevention activities among populations at greater risk (veterans, men, LGBTQ+, worksites).

**Suicide intervention:**

- Provide Hope Squads in Davis County schools mini-grant funds and resources to conduct peer-to-peer support.
- Conducting youth mental health screenings for youth preschool-12th grade
- Participate in and promote gatekeeper trainings such as QPR and CALM
- Provide Means Safety education and tools to the community (gunlock distribution, prescription Take Back events, etc.).

**Suicide postvention:**

- Identify key partners and gaps in current postvention activities.
- Convene a Community Suicide Postvention Workgroup to develop a coordinated postvention response plan.
- Develop tools to connect individuals, agencies, and the community during a postvention response.
- Assess worksite postvention plans.
- Support worksites in the development of individual postvention response plans.

**Prevention** activities through Davis Behavioral Health include:

- Building healthy relationships through family parenting classes (Strengthening Families, EveryDay Strong, Mindfulness classes)
- Building peer and community support through Communities that Care Coalitions
- Connecting people to resources through mental health screenings, and EVERYMAN groups.

**Intervention** activities through Davis Behavioral Health include:

- Connecting people to resources through community events, mental health directories, crisis response centers and crisis response worker trainings
- Working to improve access to care especially for those who are uninsured or underinsured through the Davis Behavioral Health Network

**Postvention** activities through Davis Behavioral Health:

- Providing support to survivors through a suicide loss support group
- Providing grief support and counseling through the school district, faith community, mortuaries or suicide prevention groups like NUHOPE

DBH trains staff and community partners on risk assessments, ASQ, and Mental Health First Aid. DBH trains front desk and billing staff on handling distressed and possibly suicidal consumers. Along with this, we have trained about 50% of DBH therapists in CAMS (Collaborative Assessment and Management of Suicidality) and have about 33% percent of our clinical and non-clinical staff trained in CALM (Counseling on Access to Lethal Means).

DBH has implemented the ASQ risk assessment in all levels of care, including the Davis County Jail. DBH has implemented a suicide education and prevention initiative and Vivitrol injection program at the Davis County Jail and continues its monthly meeting with all Davis County law enforcement agencies to review specific high risk cases and develop strategies for assisting with potentially suicidal people in the community.

When DBH clients are assessed via the ASQ or OQ to have suicide risk, they are referred for CAMS, Seeking Safety, or DBT treatment, depending on their clinical need. Often clients will learn the skills of emotion regulation and then need to address deeper triggers. All clients with risk of suicide or self-harm are asked to engage in a safety planning process. DBH continues to use the Stanley Brown as its safety plan template. If a client is referred for treatment to these programs from the MCOT team, outpatient or inpatient facilities and does not show up for their appointment, DBH provides outreach via peers, case managers, or the hospital liaison to try and engage the client in care.

With the resources from MCOT and Youth MCOT, DBH has mobile outreach and stabilization services for our consumers and their families 24/7/365. In addition, DBH has staff follow up calls on all crisis calls. Furthermore, all hospital and CRU discharges are scheduled for follow-up appointments within five days. DBH has joined DSD crisis workers in offering education and support to parents, educators, and family members after a suicide or suicide attempt, as well as professional training on parasuicidal behaviors. DBH provides debriefing to community members when there has been a death that has community impact.

In addition, as part of our Zero Suicide efforts, DBH now holds monthly fatality process reviews where we look for training and process improvements. We then disseminate information via supervisor and team staff trainings. We have added a review process for high risk situations that could have resulted in an adverse event or death. We are also updating our DBH Risk Assessment and Fatality Review policies to reflect current practices and have modified our peer review tools to check for ASQ and safety plan completion.

**Identify at least one staff member with suicide prevention responsibilities trained in the following OSUMH Suicide Prevention programs. If a staff member has not yet been identified, describe the plan to ensure a staff member is trained in the following:**

- 1. Suicide Prevention 101 Training**
- 2. Safe & Effective Messaging for Suicide Prevention**
- 3. Suicide Prevention Gatekeeper training, such as Question-Persuade-Refer (QPR), Mental Health First Aid (MHFA), Talk Saves Lives or Applied Suicide Intervention Skills Training (ASIST)**

Suicide prevention gatekeeper trainings are an important part of prevention efforts in Davis County. Efforts are made to track, encourage and support current instructors of various curriculums from multiple agencies. Instructors are available to teach the following curriculums: Question-Persuade-Refer, Mental Health First Aid, Youth Mental Health First Aid, Safe & Effective Messaging, ASSIST, Vital Cog and VA SAVE (spreadsheet of instructors is kept and report from RedCap is tracked). Teresa Smith from the Davis County Health Department is the contact for the training(s) to be completed.

**Describe all current strategies in place in suicide postvention including any grief supports. Describe your plan to coordinate with Local Health Departments and local school districts to develop a plan that identifies roles and responsibilities for a community postvention plan aligned with the Utah Suicide Coalition for Suicide Prevention Community Postvention Toolkit. Identify existing partners and intended partners for postvention planning. If available, please attach a localized suicide postvention plan for the agency and/or broader local community or link to plan.**

DBH coordinates with the Davis County Health Department and Davis School District on a regular basis. The Prevention Leadership Council meets every other month to collaborate on various prevention projects including suicide prevention, intervention, and postvention initiatives.

Davis Behavioral Health partners with the Davis School District crisis workers in offering education and support to parents, educators, and family members after a suicide or suicide attempt, as well as professional training on parasuicidal behaviors.

#### **Davis County Suicide Postvention Workgroup**

The Davis County Suicide Postvention Workgroup was formed in September 2023. The purpose of the group is to address gaps in coordinated postvention by increasing collaboration, aligning resources, and creating a community suicide postvention plan. Meetings are held quarterly.

- 4 meetings were held in FY25. There are 32 workgroup participants with an average of 14 in attendance at each meeting. The [workgroup member roster](#) includes first responders, hospitals, faith leaders, the health department, behavioral health, the school district, survivors, etc.
- Input from the workgroup finalized the process and wording of the community plan, provided input on the website and connection card, brainstormed promotion of the plan, helped coordinate presentations about the plan, and provided input and feedback on additional tools needed to improve postvention work.

#### **Davis County community postvention plan**

- The [Davis County Suicide Postvention Plan](#) was completed in 2025. The plan outlines a coordinated response, identifies roles and responsibilities, defines communication and privacy guidelines, and provides ready response templates to use as needed.
- Tools to support the plan were also developed, including a website and a [connection card](#).
  - The [Davis County Grief and Loss website](#) includes education on grief and resources to support those who have lost a loved one unexpectedly. There is also a section specific to suicide loss.
  - A connection card was created to be given by first responders, neighbors, friends, church leaders, etc. that links to the webpage. The card also includes

the phone number of a therapist at DBH who will help individuals through grief and connect to resources (Link to view [outside](#), [inside](#) of card).

- DBH offers a Suicide Loss Grief Support Group for adults in Davis County who have lost a loved one to suicide. The support group will be held at the Davis Mindfulness Center on the 2nd and 4th Tuesday of each month.
  
- A Postvention [community training/outreach plan](#) was created to begin spreading the word about the plan and resources available. More than 377 community partners have received a presentation on the plan. Additional information has been included in various newsletters. More outreach is needed to make the plan effective.
- Training materials created to present the plan include a [slide presentation](#) and a [handout](#).
- A [rack card](#) with general information about the website and grief resources was created to share with the general public (image in Appendix B).
- Encouraged worksites to develop agency unexpected death response plans.

**For Local Authorities participating in the Garrett Lee Smith State Youth Suicide Prevention and Early Intervention Grant Program or the Project AWARE grant, 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 either of these grant programs, please indicate "N/A" in the box below.**

N/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.**

We are working on completing activities listed in the grant for July 2022 to June 2025 that was submitted. It is linked [here](#).

We have completed 2 screening events, conducted Davis HELPS monthly, participated in the Behavior Health Network, worked on completing objectives during the last year of the CHIP (see 2022 Progress Report [here](#)). Worked on an updated Community Health Assessment (CHA - will be published May 2023) for mental health and suicide in Davis County, wrote for additional suicide prevention funds to assist partner agencies in their prevention work, assessed and promoted health relationship curriculums, promoted LiveOn campaign in Davis County, working to promote the updated CALM training as well as means safety activities.

## 20) Justice Treatment Services (Justice Involved)

*Thom Dunford*

**What is the continuum of services you offer for justice-involved clients and how do you address reducing criminal risk factors?**

**Please consider 2025 HB0039:**

**(8)(a)The department shall coordinate with a local mental health authority to complete the requirements of this Subsection (8) for an offender who:**

**(i)is a habitual offender as that term is defined in Section 77-18-102;**

**(ii)has a mental illness as that term is defined in Section 26B-5-301; and**

**(iii)based on a risk and needs assessment:**

**(A)is at a high risk of reoffending; and**

**(B)has risk factors that may be addressed by available community-based services.**

**(b)For an offender described in Subsection (8)(a), at any time clinically appropriate or at least three months before termination of an offender's parole or expiration of an offender's sentence, the department shall coordinate with the Department of Health and Human Services and the relevant local mental health authority to provide applicable clinical assessments and transitional treatment planning and services for the offender so that the offender may receive appropriate treatment and support services after the termination of parole or expiration of sentence.**

**(c)The local mental health authority may determine whether the offender:**

**(i)meets the criteria for civil commitment;**

**(ii)meets the criteria for assisted outpatient treatment; or**

**(iii)would benefit from assignment to an assertive community treatment team or available community-based services.**

**(d)Based on the local mental health authority's determination under Subsection (8)(c), the local mental health authority shall, as appropriate:**

**(i)initiate an involuntary commitment court proceeding;**

**(ii)file a written application for assisted outpatient treatment; or**

**(iii)seek to have the offender assigned to an assertive community treatment team or available community-based services.**

**A "habitual offender" is an individual who:**

**(a)(i)has been convicted in at least five previous cases for one or more felony offenses in each case; and**

**(ii)the conviction for each case referred to in Subsection (10)(a)(i) occurred within the five-year period immediately preceding the day on which the defendant is convicted of the new felony offense before the court-**

Davis Behavioral Health provides two full-time LCSW's and a part-time case manager who are assigned to the Davis County Jail to provide and/or facilitate the following services: evaluations,

screenings, individual therapy, medication management, case management, and risk assessments. All Davis County inmates are eligible for screening into the mental health court.

In addition, clients at Davis Behavioral Health are evaluated with a biopsychosocial evaluation that assists clinicians in assessing both mental health and substance use treatment needs. When indicated, the following tools are also used:

- ASQ and Stanley Brown Safety Plan for suicide risk assessment and safety planning.
- COWS (Clinical Opiate Withdrawal Scale) when referred for MAT
- DLA (Daily Living Assessment) for building recovery supports based on client choice.

DBH will have a case manager assigned to track habitual offender referrals from the Department of Corrections. The case manager will coordinate with clinical staff, including MCOT, to provide clinical assessments and/or initiate civil commitment proceedings as needed. The case manager will also assist with scheduling appointments for ongoing treatment and conduct outreach to help with continued engagement.

**Describe how clients are identified as justice involved clients**

Clients are identified as justice involved during screening by intake when they request information regarding the client's referral source. The information is confirmed and the applicable release of information obtained during initial clinical diagnostic evaluation and assessment for level of care. At intake a client signs an applicable ROI for their referring justice system representative. DBH is able to coordinate with the referring justice system. DBH also takes referrals directly from justice involved agencies. Direct justice system agencies that regularly direct refer to our programs: Justice courts, speciality courts, Adult Probation and Parole, and Davis County Sheriff's Department. All local law enforcement agencies are able to refer offenders directly to our Receiving Center.

**How do you measure effectiveness and outcomes for justice involved clients?**

DLA, and State Reporting

**Identify training and/or technical assistance needs.**

Clients in mental health courts do not currently get screened for high criminogenic risk. Our mental health providers could benefit from training.

**Identify a quality improvement goal to better serve justice-involved clients.**

Improve coordination with the substance use treatment staff in the jail

**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.**

Davis Behavioral Health actively participates in the Davis County Criminal Justice Coordinating Council. We also initiated a Davis County law-enforcement/mental health committee that meets on a monthly basis to review any issues and situations that include mental health and substance use clients who may have had interaction with law-enforcement. This committee reviews relevant situations, civil commitment intricacies, coordination between law-enforcement and Davis Behavioral Health, and any other issues that would benefit our clients and community.

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

DBH regularly continues to partner and coordinate with other child-serving agencies and actively participate in meetings such as the juvenile court multi-agency staffing, Davis County Interagency Council, and the Integrated Support Team. Significant coordination occurs between DBH and juvenile probation for those youth that are justice involved, including weekly reports and monthly 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. We have also implemented a quarterly meeting with DCFS to address any issues, concerns, or barriers either agency is experiencing. Additionally, DBH attends the multi-agency staffing held each week at the juvenile court along with representatives from DCFS, JJS, HFW, and Davis School District.

**21) Specialty Services**

*Pete Caldwell*

**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. Include any planned changes in programming or funding. If not applicable, enter NA.**

N/A

**22) Disaster Preparedness and Response**

*Jennifer Hebdon-Seljestad*

**Outline your plans for the next three years to:  
Identify a staff person responsible for disaster preparedness and response coordination. This individual shall coordinate with DHHS staff on disaster preparedness and recovery planning, attending to community disaster preparedness and response coalitions such as Regional Healthcare Coordinating Councils, Local Emergency Preparedness Committees (ESF8), and engage with DHHS in a basic needs assessment of unmet behavioral health disaster needs in their communities.**

**In addition, please detail plans for community engagement, to include partnership with local councils and preparedness committees as well as plans for the next three years for staff and leadership on disaster preparedness (to include training on both internal disaster planning and external disaster preparedness and response training). Please detail what areas your agency intends to focus on with training efforts and timeline for completing training.**

The Chief Executive Officer (Brandon Hatch) is responsible for disaster preparation and response coordination. Assignments in our response plan in regard to DBH and the community are listed below.

Damage Assessment/Salvage/food, clothing, bedding, toiletries etc: CEO, CFO, IT Vendor, Maintenance Supervisor, Housing Mgr., Program Managers  
Clinical Services: Clinical Director; CMO, Program Managers  
Transportation: CFO, Housing Mgr., Program Managers  
Public Information: CEO  
Personnel: HR Director, Support Staff

Technology: HR Director, IT Vendor

Communications: HR Director, Compliance Officer, Office Mgr

Safety and Security: Compliance Officer, Maintenance Supervisor

Accounting/Data Systems: CFO, Controller

The CEO and/or CFO of Davis Behavioral Health, participate on multiple community councils or committees that address disaster preparedness and planning. Those committees include; The Local Emergency Planning Committee (plan attached), Intermountain Community Planning Board, Council of Government, and Davis County Board of Health. In addition, DBH's Clinical Director is trained in psychological first aid in order to help the community respond to disasters when needed. We also send staff to trainings held by OSUMH on disaster preparedness as well as the crisis counselor summit with the hopes that we will be able to respond to community needs should the occasion warrant.

Davis Behavioral Health leadership reviews its Business Continuity Plan for Emergencies, Disasters and Recovery on an annual basis and then provides those plans to employees annually. In addition, DBH provides safety protocols to employees on a quarterly basis. Training to these plans will be done in individual team meetings annually.

### 23) Required attachments

- **List of evidence-based practices provided to fidelity and include the fidelity measures.**  
*For questions - Cody Northup*
- **Disaster Preparedness and Recovery Plan to coordinate with state, regional, and local partners in Disaster Preparedness Planning and Supporting Disaster Behavioral Health Response.** *For questions - Jennifer Hebdon-Seljestad*
- **A list of metrics used by your agency to evaluate client outcomes and quality of care.**  
*For questions - Pam Bennett*
- **A list of partnership groups and community efforts (i.e. Multi-Agency Coordinating Committees, Regional Advisory Councils, High Fidelity Wraparound teams, Local Interagency Councils, Local Recovery Community, Peer Advocacy Groups, County Attorney, Law Enforcement, Local Education Agencies, Courts including Mental Health Court, Regional Healthcare Coalitions, Local Homeless Councils, State and Local government agencies, and other partnership groups relevant in individual communities)** *For questions - Cody Northup*
- **As per HB0199, provide an inclusive list of providers of mental health services for individuals within the local mental health authority jurisdiction, in a form and format usable by a first responder.** *For questions - Pam Bennett*
  - *DBH is in the process of developing a card for first responders (business card or quarter sheet) which will provide a list of providers and an overview of services available.*