Arizona

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 08/15/2023 8.55.49 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State SAPT Unique Entity Identification

Unique Entity ID

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Arizona Health Care Cost Containment System (AHCCCS)

Organizational Unit Division of Grants Administration

Mailing Address 801 E Jefferson

City Phoenix

Zip Code 85034

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Sara

Last Name Salek

Agency Name Arizona Health Care Cost Containment System

Mailing Address 801 East Jefferson MD4100

City Phoenix

Zip Code 85034

Telephone 602-417-4000

Fax

Email Address sara.salek@azahcccs.gov

State CMHS Unique Entity Identification

Unique Entity ID

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Arizona Health Care Cost Containment System

Organizational Unit Division of Grants Administration

Mailing Address 801 East Jefferson

City Phoenix

Zip Code 85034

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Sara

Last Name Salek

Agency Name Arizona Health Care Cost Containment System (AHCCCS)

Mailing Address 801 E Jefferson MD4100

City Phoenix

Zip Code	85034
Telephone	602-417-4000
Fax	
Email Address	sara.salek@azahcccs.gov

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ○ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	
Last Name	
Telephone	
Fax	
Email Address	

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SUPTRS]

Fiscal Year 2024

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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Fiscal Year 2024

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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
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Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

Based on the guidance issued on October 11th, 2022, please submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL).

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

MHBG/SUPTRS Combined Application
FY2024-25
Planning Step 1

September 1, 2023

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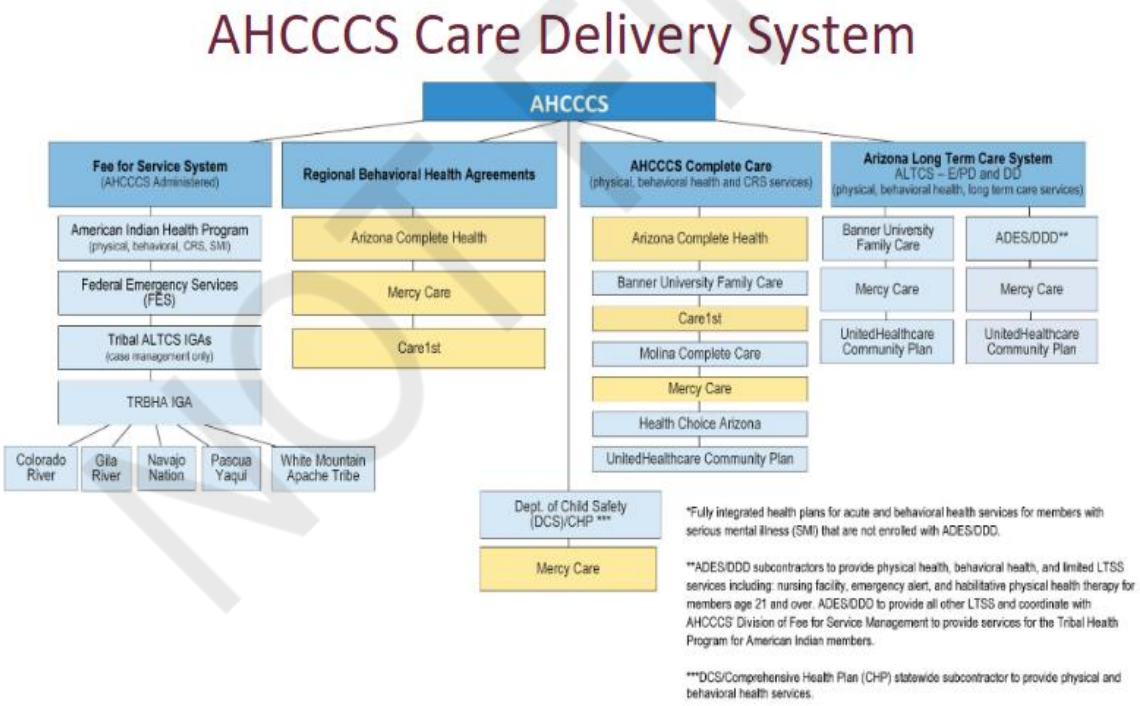
AHCCCS Overview

Arizona Health Care Cost Containment System (AHCCCS) is the single state Medicaid agency for the State of Arizona. In that capacity, it is responsible for operating the Title XIX and Title XXI programs through the State's 1115 Research and Demonstration Waiver, which allows for the operation of a total managed care model.

AHCCCS' mission "reaching across Arizona to provide comprehensive, quality health care to those in need" is implemented through the vision of "shaping tomorrow's managed care…from today's experience, quality, and innovation." Built on a system of competition and choice, AHCCCS' $14 billion program operates under an integrated managed care model.

Arizona Complete Care (ACC) Plans

ACC plans and AIHP provide a comprehensive network of providers to deliver all covered physical and behavioral health services to child and adult members without a Serious Mental Illness (SMI) designation and services for members with Children's Rehabilitative Services (CRS) conditions. ACC plans and AIHP address the whole health needs of our state's Medicaid population which is vitally important to improving service delivery for AHCCCS members and reducing the fragmentation that has existed in our healthcare system.



Through the ACC contracts, Managed Care Organizations (MCO's) are responsible for providing physical, behavioral, and long-term care services. AHCCCS also operates the American Indian Health Program (AIHP), a fee for service program that is responsible for care for American Indian members who select AIHP. AHCCCS also has five unique intergovernmental agreements with Tribal Regional Health Authorities (TRBHAs) for the coordination of behavioral health services for American Indian members enrolled with a TRBHA.

Contracted health plans coordinate and pay for physical and behavioral health care services delivered by more than 104,000 health care providers.

ACC - Regional Behavioral Health Agreements (RBHAs)

Three of the ACC plans are affiliated with current Arizona Complete Care with Regional Behavioral Health Agreements (RBHA) and align the RBHA and ACC contracts under one organization. A RBHA is a contracted Managed Care Organization (also known as a health plan) responsible for the provision of comprehensive behavioral health services to all eligible individuals assigned by the administration in addition to a provision for comprehensive physical health services to eligible persons with a Serious Mental Illness enrolled by the Administration. The function of the RBHAs include:

- Providing integrated services for Individuals with Serious Mental Illness.
- Development and support of a regional crisis system.
- For the near term, providing behavioral health services for children that are served by the Department of Child Safety (DCS).
- Allocation of non-title XIX funding including Substance Abuse and Mental Health Services Administration (SAMHSA) grants and other sources of funding

Arizona's three ACC - Regional Behavioral Health Agreements (RBHAs) are required to maintain comprehensive networks of behavioral health providers to deliver prevention, intervention, treatment, and rehabilitation services to members enrolled in AHCCCS.

- Mercy Care – RBHA serving central Arizona, including Maricopa, Pinal and Gila Counties
- Arizona Complete Health – RBHA serving southern Arizona, including Tucson
- Care 1st Arizona – RBHA serving Northern Arizona

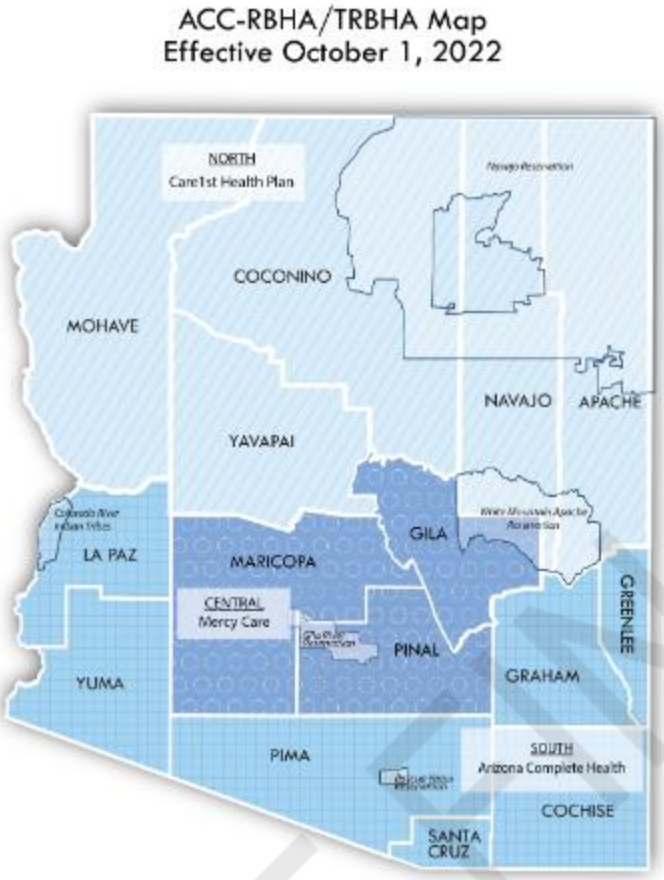
Tribal Behavioral Health Authorities (TRBHAs)

A Tribal Regional Behavioral Health Authority (TRBHA) is a tribal entity that has an intergovernmental agreement with AHCCCS, the primary purpose of which is to coordinate the delivery of comprehensive behavioral health to all eligible individuals assigned by the administration to the tribal entity. Tribal governments, through an agreement with the State, may operate a Tribal Regional Behavioral Health Authority for the provision of behavioral health services to American Indian members. Refer to A.R.S. §36-3401 and A.R.S. §36-3407.

- White Mountain Apache – TRBHA serving the White Mountain Apache Nation
- Gila River – TRBHA serving the Gila River Indian Community
- Pascua Yaqui – TRBHA serving the Pascua Yaqui Tribe
- Navajo Nation – TRBHA serving the Navajo Nation

The ACCs, MCOs, RBHAs, and TRBHAs are required to maintain a comprehensive network of behavioral health providers to deliver prevention, intervention, treatment, and rehabilitative services to members enrolled in the AHCCCS system. This structure allows communities to provide services in a manner appropriate to meet the unique needs of members and families residing within their local areas.

The following image shows the ACC-RBHA / TRBHA coverage map effective October 1, 2022.



Single State Authority (SSA) and State Mental Health Authority (SMHA)

In addition to overseeing the managed care organizations that provide Medicaid-funded health care services, AHCCCS serves as the Single State Authority on substance use and as the State Mental Health Authority (SMHA) responsible for the state public mental health service delivery system administration. AHCCCS is the agency responsible for mental health and substance use and provides oversight, coordination, planning, administration, regulation, and monitoring of all facets of the public behavioral health system in Arizona.

Service Delivery System

Regardless of the type, amount, duration, scope, service delivery method, and population served, AHCCCS requires all MCOs ensure that their service delivery system:

- Coordinate and provide access to high-quality health care services informed by evidence-based practice guidelines in a cost-effective manner
- Coordinate and provide access to high-quality health care services that are culturally and linguistically appropriate, maximize personal and family voice and choice, and incorporate a trauma-informed care approach
- Coordinate and provide access to preventive and health promotion services, including wellness services

- Coordinate and provide access to comprehensive care coordination and transitional care across settings; follow-up from inpatient to other settings; participation in discharge planning, and facilitating transfer from the children's system to the adult system of health care
- Coordinate and provide access to chronic disease management support, including self-management support
- Conduct behavioral health assessment and service planning following a Health Home model,
- Coordinate and provide access to peer and family delivered support services, based on member's needs, voice, and choice
- Provide covered services to members in accordance with all applicable Federal and State laws, regulations, and policies
- Coordinate and integrate clinical and non-clinical health care related needs and services across all systems
- Implement health information technology to link services, facilitate communication among treating professionals and between the health team and individual and family caregivers, and
- Deliver services by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider.

AHCCCS further requires that at all MCOS work in partnership to meet, agree upon, and reduce to writing joint collaborative protocols with each county, district, or regional office of:

- Administrative Office of the Courts,
- Juvenile Probation and Adult Probation,
- Arizona Department of Corrections and Arizona Department for Juvenile Corrections,
- Arizona Department of Child Safety (DCS),
- Tribal Nations and Providers (Refer to this section above),
- The Veterans' Administration, and
- The county jails.

Continuum of Care (Adult and Child Systems)

As a leader in the public behavioral health field, Arizona's approach to managed care and service delivery is nationally recognized. AHCCCS focuses its efforts and energies toward providing leadership in activities designed to integrate and adapt the behavioral health system to meet the needs of those we serve.

AHCCCS fosters an environment of person-centered planning that includes the voice and choice of the person being served, their family, identified persons of support, advocates (as designated) and service providers, as identified. The Individual Service Planning (ISP) progress is transparent, fluid and the ISP is a living and breathing document that can change as a persons' choices and treatment needs change. AHCCCS has an Adult System of Care (ASOC) that is a continuum of coordinated community and facility-based services and support for adults with, or at risk for, behavioral health challenges. The ASOC is organized into a comprehensive network to create opportunities to foster recovery and improve health outcomes by:

- Building meaningful partnerships with individuals served
- Addressing the individuals' cultural and linguistic needs and preferences, and
- Assisting the individual in identifying and achieving personal and recovery goals.

The ASOC developed the following Nine Guiding Principles to promote recovery in the adult behavioral health system and for engaging with adults who have a serious mental illness:

Nine Guiding Principles:

1. RESPECT: Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.
2. PERSONS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND PROGRAM DEVELOPMENT EFFORTS**:** A person in recovery has choice and a voice. Their self-determination in driving services, program decisions, and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
3. FOCUS ON INDIVIDUAL AS A WHOLE PERSON, WHILE INCLUDING AND/OR DEVELOPING NATURAL SUPPORTS: A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.
4. EMPOWER INDIVIDUALS TAKING STEPS TOWARDS INDEPENDENCE AND ALLOWING RISK TAKING WITHOUT FEAR OF FAILURE**:** A person in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.
5. INTEGRATION, COLLABORATION, AND PARTICIPATION WITH THE COMMUNITY OF ONE'S CHOICE: A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscore one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism are valued.
6. PARTNERSHIP BETWEEN INDIVIDUALS, STAFF, AND FAMILY MEMBERS/NATURAL SUPPORTS FOR SHARED DECISION MAKING WITH A FOUNDATION OF TRUST: A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.
7. PERSONS IN RECOVERY DEFINE THEIR OWN SUCCESS: A person in recovery – by their own declaration – discovers success, in part, by quality-of-life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.
8. STRENGTHS-BASED, FLEXIBLE, RESPONSIVE SERVICES REFLECTIVE OF AN INDIVIDUAL'S CULTURAL PREFERENCES: A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.

9. HOPE IS THE FOUNDATION FOR THE JOURNEY TOWARDS RECOVERY: A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

AHCCCS collaborated with the child, family, and others to ensure provided services are tailored to meet the needs of children with serious emotional disturbances and their caregivers. The goal is to ensure that services are provided to the child and family in the most appropriate setting, in a timely manner, in accordance with the best practices and respecting the child, family, and their cultural heritage.

Arizona/AHCCCS developed **The Twelve (12) Principles** for Children's in the Behavioral Health Service Delivery System:

Twelve (12) Guiding Principles:

1. COLLABORATION WITH THE CHILD AND FAMILY: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. FUNCTIONAL OUTCOMES: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
3. COLLABORATION WITH OTHERS: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, DCS and/or DES/DDD caseworker, and the child's probation officer. The team (a) develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan, and (d) makes adjustments in the plan if it is not succeeding.
4. ACCESSIBLE SERVICES: Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.
5. BEST PRACTICES: Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's

lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.

6. MOST APPROPRIATE SETTING: Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.
7. TIMELINESS: Children identified as needing behavioral health services are assessed and served promptly.
8. SERVICES TAILORED TO THE CHILD AND FAMILY: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.
9. STABILITY: Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.
10. RESPECT FOR THE CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.
11. INDEPENDENCE: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.
12. CONNECTION TO NATURAL SUPPORTS: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parent's own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

Overall, the Person-Centered Planning and Service Plan reflects the individual's strengths and preferences that meet the person's social, cultural, and linguistic needs and includes individualized goals and desired outcomes. Additionally, the planning process also identifies risk factors (including risks to member rights) and puts measures in place to minimize them with individual back-up plans and other strategies as needed.

Arizona Behavioral Health Planning Council (BHPC)

AHCCCS utilizes the Arizona Behavioral Health Planning Council to advise the state in planning and implementing a comprehensive community-based system of behavioral health and mental health Services. Arizona's BHPC has included integrated representation between mental health and substance use since 1999, with the participation of both professionals and individuals with lived experience. The BHPC meetings are planned in partnership with AHCCCS and convene via video conference once per month.

Office of Individual and Family Affairs (OIFA)

The AHCCCS Office of Individual and Family Affairs (OIFA) is staffed by individuals and family members whose lives have been affected by substance use and/or mental health disorders. As a part of the Behavioral Health Planning Council (BHPC), OIFA is in a unique position to bring more voices of the community into the oversight process. In addition to the AHCCCS OIFA, each AHCCCS health plan is contractually required to have its own OIFA. The health plan OIFAs extend the reach of the BHPC to increase prospects for more responsive and accountable substance abuse and behavioral health services.

Division of Grants and Innovation (DGI)

The Division of Grants and Innovation (DGI) is the point of contact related to the pursuit, implementation and oversight of grants administered by the agency, including the Community Mental Health Block Grant and Substance Use Prevention, Treatment, and Recovery Services grant. The Integrated System of Care and Housing Divisions joined DGI in Spring of 2023 to promote integration and fluidity in the fee-for-service and grant planning and implementation processes. DGI is inclusive of both programmatic and financial teams. Together, the teams work closely with each other to ensure effective communication, oversight, and implementation of all grants management for the agency. DGI staff positions include the State Opioid Treatment Authority/Opioid Treatment Network, Women's Treatment Network, National Prevention Network and National Treatment Network representatives, an Epidemiologist, Grant Administrators, and Grant Coordinators.

DGI leverages the managed care services through contracts to provide access to care for substance use disorder intervention, treatment, and recovery support services through the Substance Use Prevention, Treatment and Recovery Services funding. The SUPTRS supports primary prevention services and treatment services for members with substance use disorders. It is used to plan, implement, and evaluate activities to prevent and treat substance use disorders. Grant funds are also used to provide early intervention services for HIV and tuberculosis disease in high-risk substance users. Arizona is not an HIV designated state, so there are not specific requirements that need to be met for SAMHSA, however prevention efforts have been continued to sustain the progress that has been made in reducing the rate of individuals who contract HIV.

Substance Use Prevention, Treatment, and Recovery Services - Primary Prevention

To streamline prevention services, effective July 1, 2021, AHCCCS made the decision to administer the prevention contracts directly. In addition to the administration of funding for local community-based prevention coalitions, AHCCCS has Intergovernmental Agreements (IGAs) with two of the state's

TRBHAs, the Pascua Yaqui Tribe and the Gila River Indian Community, to administer SUPTRS primary prevention funding to tribal populations within the state. In addition, AHCCCS has a relationship with the Governor's Office of Youth, Faith, and Family (GOYFF) to provide substance abuse prevention services through Evidence Based Practices (EBPs) and community-based organizations.

All SUPTRS Primary Prevention efforts are administered utilizing the Strategic Prevention Framework (SPF) Model from the Substance Abuse and Mental Health Services Administration (SAMHSA) with these funds. AHCCCS currently utilizes a variety of providers to implement prevention services, including community-based coalitions, schools, and various state agencies. AHCCCS prevention efforts currently focus on several substances, including alcohol, tobacco, prescription drugs, and opioids. AHCCCS prevention efforts include focusing on a Risk and Protective Factor Theory, which includes reducing risk factors, and increasing protective factors, in a variety of settings. To address the unique needs of the state with these funds, AHCCCS will also address Adverse Childhood Experiences (ACEs) and trauma to ensure all high-risk individuals are receiving the appropriate types of services. AHCCCS will continue to support all prevention providers in offering services virtually, as appropriate, to ensure the health and safety of all participants. All primary prevention services will serve populations according to the Institute of Medicine (IOM) categories as follows: Universal (Indirect and Direct), Selective, and Indicated.

All primary prevention activities are quantified into the six Center for Substance Abuse Prevention (CSAP) strategies. It should be noted that AHCCCS requires the utilization of all strategies, as each strategy alone has not been proven to be effective in the reduction of substance use, misuse, and/or abuse. Some strategies to be used by AHCCCS prevention providers as part of this funding include, but are not limited to:

- Information Dissemination: This strategy provides awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.
    - Tabling/booth events at health fairs, school parent nights, and local community events.
    - "Sticker Shock" campaigns, which is often a youth-driven project that seeks to inform, educate, and remind the community of the implications of selling and providing alcohol to underage youth. Prevention Education staff create a message, which is then printed onto stickers, and placed on products in liquor stores. o Dissemination of prevention flyers, posters, brochures, and other informational media at local grocery stores, doctor's offices, schools, etc.
    - Media campaigns aimed at increasing knowledge of local substance use and abuse trends and data, as well as focusing on risk and protective factors to reduce substance use and abuse within high-risk populations.
- Education: This strategy involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator/ facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.
    - Parenting/Family Education curriculum, such as Strengthening Families, Guiding Good Choices, and Triple P. These programs aim to enhance parenting behaviors and skills,

enhance effective child management behaviors and parent-child interactions and bonding, to teach children skills to resist peer influence, and reduce adolescent problem behaviors.
    - Curriculum that teaches youth life skills, such as LifeSkills, which are designed to prevent teenage drug and alcohol abuse, tobacco use, violence, and other risk behaviors by teaching students self-management skills, social skills, and drug awareness and resistance skills.
- Alternatives: This strategy provides for the participation of target populations in activities that exclude substance use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by, alcohol and drugs and would therefore minimize or obviate resort to the latter.
    - Drug-free community and/or youth events, including drug-free dances, sports tournaments, after-school youth groups/programs/clubs, etc.
    - Mentoring programs, such as Big Brothers/Big Sisters, that provide at risk youth with opportunities to connect with positive adult role models, and engage in healthy, drug-free activities.
    - Connection and engagement in cultural activities, tribal practices, and learning cultural and/or tribal ways.
- Problem Identification and Referral: This strategy aims to identify those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs to assess whether their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.
    - Programs/classes for youth who have broken school campus rules regarding alcohol, tobacco, and other drugs (ATOD), such as being in possession of ATOD or related paraphernalia. Classes aim to educate youth about the dangers of ATOD use, offer alternatives to substance use, and prevent future infractions.
    - Driving Under the Influence (DUI) education classes for first time offenders, that educate individuals around DUI, and includes steps to prevent future DUIs from occurring, harm reduction techniques, etc.
- Community-based process: This strategy aims to enhance the ability of the community to provide prevention and treatment services more effectively for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking. o Building and sustaining of community-based coalitions (there are currently 24 SUPTRS funded coalitions within the state).
    - Community mobilization training and capacity building within “prevention desert” areas to build primary prevention infrastructure. o Strategic planning at state and local levels, which includes bringing together key stakeholders from the following sectors to the table to engage in effective planning:
        - Youth,
        - Parents,
        - Law enforcement,
        - Schools,
        - Businesses,
        - Media,
        - Youth-serving organizations,

        - Religious and fraternal organizations,
        - Civic and volunteer groups,
        - Health care professionals,
        - State, local, and tribal agencies with expertise in substance abuse, and
        - Other organizations involved in reducing substance abuse.
    - Gathering of Native Americans (GONA), a culture-based planning process where community members gather to address community-identified issues. It uses an interactive approach that empowers and supports American Indian (AI) and/or Alaskan Native (AN) tribes. The GONA approach reflects AI/AN cultural values, traditions, and spiritual practices.
- Environmental: This strategy establishes, or changes, written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.
    - The passing of local ordinances that affect the sale, manufacturing, or availability of ATODs, including alcohol tax increases, moratoriums on alcohol/marijuana advertising around schools, parks, or places where youth are present, and moratoriums on the establishment or placement of medical marijuana stores in local areas.
    - The review of current ATOD policies within schools and/or communities, including the review of policies related to prevention of ATOD use amongst youth, review of policies regarding "punishment" of youth who use or are caught, what prevention strategies are used to decrease repeat behavior, and the eventual revision of policies to be prevention focused, rather than punishment focused.

AHCCCS currently requires the use of Evidence Based Practice (EBP), Research Based Practice (RBP), or Promising Practice (PP) and allows providers to utilize Promising and Innovative Interventions at a ratio of one Evidence, Research and/or Promising Intervention to every Innovative Intervention. AHCCCS currently accepts the guidance provided by the SAMHSA document "Selecting Best-fit Programs and Practices: Guidance for Substance Misuse Prevention Practitioners" as the standard to follow when selecting programs and practices, including the best practices lists and resources. AHCCCS is aware that every community is unique and has unique needs to be addressed with prevention programming. To support innovation within communities to meet these unique needs, AHCCCS has developed parameters regarding the use of these interventions. AHCCCS utilizes the "AHCCCS Innovative Prevention Program Intervention Protocol" for all SUPTRS Primary Prevention Activities that are not currently designated as Evidence or Research Based. The protocol, developed by AHCCCS staff, requires the prevention providers to formally submit documentation related to the intervention they are proposing to use, prior to the use of the intervention, for review and approval by AHCCCS. Upon review, AHCCCS designates an evidence-based status to the proposed intervention and provides feedback to the prevention provider regarding implementation.

AHCCCS currently employs a variety of methods to ensure primary prevention activities are equitable and include a focus on those at greater risk for health disparities. All AHCCCS primary prevention activities follow the SPF model, which requires the infusion of "cultural competence" into each phase of the SPF model. AHCCCS prevention efforts are currently moving to a "culturally responsive" approach in lieu of "cultural competency," but the premise of the strategies remain the same. As part of the SPF model, all AHCCCS prevention providers are required to utilize a local primary prevention needs

assessment that must be completed or renewed every three years. Mandatory data to be collected within the target communities include, but are not limited to, total population level, ages, educational attainment, housing, income level, poverty level, business/economical information, race and Hispanic origin, immigrant status, and veteran status. In addition to the needs assessment, each provider is also required to utilize a prevention strategic plan that is to be updated every three years. This plan must include the provider's plan to address equity within their target populations through cultural responsiveness, which include engaging stakeholders from various backgrounds in the planning and implementation of prevention efforts, representation on the coalition, and to identify any barriers in existence that will impede the provider's ability to provide culturally responsive services and a plan to address said barriers, as needed.

AHCCCS is aware that every community is unique and has unique needs to be addressed with prevention programming. Arizona's population and demographics are changing and has required the state to develop systems to enhance culturally responsive and equitable approaches to substance abuse prevention. To support innovation within communities to meet these unique needs, AHCCCS has developed parameters regarding the use of these interventions. As discussed previously, AHCCCS utilizes the "AHCCCS Innovative Prevention Program Intervention Protocol" for all SUPTRS Primary Prevention activities that are not currently designated as evidence or research based. AHCCCS currently contracts with community based coalitions and local providers that tailor primary prevention efforts directly towards populations at high risk, with coalitions serving and focusing efforts on LGBTQ+ youth, Hispanic populations, refugee populations, border populations where health literacy and outcomes are low when compared to other areas of the state, border cities where illegal drug trade/activities are impacting youth, as well as focusing on areas of prevention deserts that historically have not had substance abuse prevention infrastructure present within the community.

AHCCCS also utilizes a "culture as prevention" framework when it comes to Arizona's indigenous and diverse populations. Primary prevention services are currently being implemented within two of AHCCCS' Tribal Regional Behavioral Health Authorities (TRBHAs), the Pascua Yaqui Tribe, and the Gila River Indian Community. Because the pandemic impacted Arizona's tribal communities at a rate disproportionate to other communities, AHCCCS regularly meets with TRBHAs to develop and research dedicated substance abuse prevention strategies to help mitigate the impact on these communities. Primary prevention interventions that included multiple outcomes in substance abuse prevention, mental health promotion, suicide prevention, and domestic violence/intimate partner violence prevention were explored to ensure that the tribal communities could select substance abuse primary prevention interventions that had a larger impact on other community needs during the pandemic. AHCCCS' tribal partners lead the way to develop the prevention strategies that work best within their communities, focusing on cultural values, teaching of traditions, and spiritual practices.

AHCCCS maintains a strong presence within the community to ensure all backgrounds and voices of Arizonans are represented within primary prevention program assessment, planning, implementation, and evaluation. AHCCCS has demonstrated this through various ways, including the facilitation of a statewide substance abuse prevention plan that includes data and stakeholders' feedback from over 40 local, regional, and state level prevention providers, and through regular participation and attendance at the Substance Abuse Coalition Leaders of Arizona meetings. AHCCCS regularly meets with stakeholders to elicit open communication and collaborative problem-solving to meet identified needs specific to their specialties and locations.

Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Treatment

SUPTRS funds are used to ensure access to interventions, treatment, and long-term recovery support services for (in order of priority):

1. Pregnant women (including teenagers) who use drugs by injection,
2. Pregnant women (including teenagers) who use substances,
3. Other persons who use drugs by injection,
4. Substance using women and teenagers with dependent children and their families, including females who are attempting to regain custody of their children, and
5. All other individuals with a substance use disorder, regardless of gender or route of use, (as funding is available).

Behavioral health providers (contracted through the RBHAs and TRBHAs) are required to provide specialized, gender-specific treatment and recovery support services for females who are pregnant or have dependent children and their families in outpatient and residential treatment settings. Services are also provided to mothers who are attempting to regain custody of their children, and the family is treated as a unit. Providers must admit both mothers and their dependent children into treatment. The following services are provided or arranged as needed:

- Referral for primary medical care for pregnant females,
- Referral for primary pediatric care for children,
- Gender-specific substance use treatment, and
- Therapeutic interventions for dependent children.

Contractors must ensure the following issues do not pose barriers to access to obtaining substance use disorder treatment:

- Childcare
- Case management
- Transportation

The Contractors require any entity receiving funding from the SUPTRS grant for operating a treatment program for substance use disorders to follow procedures which address how the program:

- Will, directly or through arrangements with other public or nonprofit private entities, routinely make available tuberculosis services as defined in [45 CFR 96.121] to each individual receiving treatment for such abuse,
- In the case of an individual in need of such treatment who is denied admission to the program based on the lack of the capacity of the program to admit the individual, will refer the individual to another provider of tuberculosis services, and
- Will implement infection control procedures designed to prevent the transmission of tuberculosis, including the following:
    - Screening of patients,
    - Identification of those individuals who are at high risk of becoming infected,
    - Meeting all State reporting requirements while adhering to Federal and State confidentiality requirements, including [42 CFR part 2], and
    - Will conduct case management activities to ensure that individuals receive such services.

Interim Services are required for those who meet the priority populations of pregnant women, women with dependent children, or intravenous drug users if there is a waitlist to engage in services. The purpose of interim services is to reduce the adverse health effects of substance use, promote the health of the members, and reduce the risk of transmission of disease. The minimum required interim services include:

- Education that covers prevention of and types of behaviors which increase the risk of contracting HIV, Hepatitis C, and other sexually transmitted diseases,
- Education that covers the effects of substance use on fetal development,
- Risk assessment/screening,
- Referrals for HIV, Hepatitis C, and tuberculosis screening and services, and
- Referrals for primary and prenatal medical care.

AHCCCS Contracts ensure services covered through the AHCCCS Medical Policy Manual are provided in a culturally competent manner utilizing evidence-based practices. The services target members and individuals who have a behavioral health diagnosis and identify as being a part of an identified group with norms not always addressed through traditional treatment modalities, including, but not limited to veterans, LGBTQ+, elderly, homeless, rural, and diverse populations. The Managed Care Organizations (MCOs) utilize Cultural Diversity Specialists and Community Liaisons who work with providers and communities through training, education, and technical assistance to ensure implementation and monitoring of the appropriate programs and services.

Community Mental Health Block Grant (MHBG)

The MHBG is allocated to provide community mental health treatment services to adults with a Serious Mental Illness (SMI) designation, children with Serious Emotional Disturbance (SED), and individuals with an Early Serious Mental Illness (ESMI) including first episode psychosis (FEP). The program makes funding available throughout Arizona to provide community mental health services with the objective to support grantees in carrying out plans for providing comprehensive community mental health services.

MHBG funds are used to provide treatment services in accordance with AHCCCS Medical Policy Manual (AMPM) 300-2B and AMPM 320-T1 and to ensure access to an integrated and comprehensive system of care, including employment, housing, case management, rehabilitation, dental, and health services as well as mental health services and supports.

Adults with a Serious Mental Illness (SMI) designation includes persons aged 18 and older who have a diagnosable behavioral, mental, or emotional condition as defined by the American Psychiatric Association's *Diagnostic and Statistical Manual* (DSM) of *Mental Disorders* in addition to functional impairment that substantially interferes with, or limits, their ability to function in the community.

Serious Emotional Disturbance (SED) includes persons up to age 18 who have diagnosable behavioral, mental, or emotional issues (as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM)). Their condition results in a functional impairment that substantially interferes with, or limits, a child's role or functioning in family, school, or community activities.

Early Serious Mental Illness (ESMI), including First Episode Psychosis (FEP), services are supported by the 10 percent set aside for ESMI/First Episode of Psychosis (FEP) and support evidence-based programs that provide treatment and support services for those who have experienced a first episode of psychosis

within the past two years or individuals recently diagnosed with an SMI qualifying diagnosis. Psychosis is a brain condition that disrupts a person's thoughts and perceptions, making it difficult to differentiate between what is real and what is not. FEP Program models may include principles or core components identified by National Institute of Mental Health (NIMH) via the Recovery After an Initial Schizophrenia Episode (RAISE) initiative and practice a Coordinated Specialty Care model of early intervention.

Five percent of the MHBG is set aside for crisis services to support an evidence-based crisis system. Arizona's crisis continuum of care services has gained national recognition for their innovative approach to behavioral health crisis services. The AHCCCS crisis care continuum encompasses a comprehensive range of services, including crisis telephone response, mobile crisis team intervention, facility-based stabilization (including observation and detox), and all other covered services available to any Arizona resident, regardless of insurance coverage. Ensuring recovery-oriented and person-focused care, the crisis services aim to stabilize individuals promptly, enabling them to return to their baseline of functioning.

AHCCCS is the designated unit of the executive branch that is responsible for administering the MHBG. AHCCCS ensures the following performance requirements are met:

- Subrecipients must submit a plan explaining how they will use MHBG funds to provide comprehensive, community mental health services to adults with serious mental illnesses and children with serious emotional disturbances,
- Subrecipients to provide annual reports on their plans,
- Subrecipients may distribute funds to local government entities and non-governmental organizations,
- Subrecipients must ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs,
- Subrecipients must comply with general federal requirements for managing grants. They must also cooperate in efforts by SAMHSA to monitor use of MHBG funds. For example, each year, CMHS conducts investigations (site visits) of at least ten grantees receiving MHBG funds. This is to assess how they are using the funds to benefit the population. These evaluations include careful review of the following:
    - How the grantees are tracking use of MHBG funds and their adult and child mental health programs,
    - Data and performance management systems,
    - Collaboration with consumers and the grantees' mental health planning council, and
    - Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.
    - Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

MHBG/SUPTRS Combined Application
FY2024-25
Planning Step 2

September 1, 2023

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Overview

The Arizona Health Care Cost Containment System (AHCCCS) utilizes several data feeds, surveys, systemic evaluations, as well as stakeholder forums to determine statewide need for services. AHCCCS works in tandem with the ACC Plans with Regional Behavioral Health Agreements (ACC-RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) to ensure efficient resource allocation that correlates system capacity with service demand. AHCCCS utilizes and continually works to enhance data driven decision-making processes when assessing prevention, intervention, treatment, and recovery needs for behavioral health disorders.

AHCCCS maintains active policies that allow for the assessment and monitoring of unmet needs at the contract level, in communities, and within specified populations either accessing or in need of behavioral health services statewide. The AHCCCS Contractor Operations Manual (ACOM) Policy 415 Provider Network Development and Management Plan - Periodic Network Reporting Requirements ensure that regular assessments of need are occurring. This policy applies to AHCCCS Complete Care (ACC) and ACC-RBHAs. The policy states that provider networks shall provide a foundation that supports an individual's needs as well as the membership in general. This policy establishes Contractor requirements for the submission of the Network Development and Management Plan and other periodic network reporting requirements allowing AHCCCS to assess and monitor both programmatic and financial activities. Specific requirements of activities contractors are required to manage and report on include, but are not limited to:

- Contractor's Workforce Development Plan
- Contractor's Value Based Purchasing/24/7 Access Points Report
- Evaluation of the prior year's Network Plan including:
- Actions proposed in the prior year's plan,
- Network issues over the past year that required intervention,
- Interventions taken to resolve network issues,
- Barriers to the interventions, and
- Evaluation of the effectiveness of the interventions.
- Contractor's current network gaps
- Contractor's network development steps for the coming year based upon its review of the prior year's Network Plan, current identified gaps, and any other priorities identified in the current plan
- Contractor's analysis demonstrating it has the capacity and the appropriate range of services adequate for the anticipated enrollment in its assigned service area
- Description of the integrated network design by GSA for the following populations:
    - Members undergoing substance use disorder treatment:
        - Pregnant Women and/or Pregnant Women with Dependent Children,
        - Persons who use drug by injection,
        - Adults, and
        - Children.

- General membership requiring access to the following types of substance use disorder treatment:
    - Medication Assisted Treatment,
    - Outpatient,
    - Intensive Outpatient,
    - Partial Hospitalization, and
    - Residential Inpatient.
- A description of subcontracts for substance use treatment and recovery through the Substance Use Prevention, Treatment and Recovery Services (SUPTRS) Block Grant utilizing capacity data including wait list management methods for SUPTRS Block Grant Priority populations.

As the designated unit of the executive branch that is responsible for administering the Community Mental Health Services Block Grant (MHBG), AHCCCS ensures the following performance requirements are met:

- Subrecipients must submit a plan explaining how they will use MHBG funds to provide comprehensive, community mental health services to adults with serious mental illness (SMI) designation, children with serious emotional disturbances (SED), and Early Serious Mental Illness (ESMI) including First Episode Psychosis (FEP)
- Subrecipients to provide annual reports on their plans.
- Subrecipients may distribute funds to local government entities and non-governmental organizations.
- Subrecipients must ensure that community mental health centers provide such services as screening, outpatient treatment, emergency mental health services, and day treatment programs.
- Subrecipients must comply with general federal requirements for managing grants. They must also cooperate in efforts by SAMHSA to monitor use of MHBG funds. For example, each year, CMHS conducts investigations (site visits) of at least ten grantees receiving MHBG funds. This is to evaluate how they are using the funds to benefit the population. These evaluations include careful review of the following:
    - How the grantees are tracking use of MHBG funds and their adult and child mental health programs,
    - Data and performance management systems,
    - Collaboration with consumers and the grantees' mental health planning council, and
    - Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.
- Grantees receiving MHBG funds are required to form and support a state or territory mental health/behavioral health planning council.

The National Survey on Drug Use and Health (NSDUH), prepared by the Substance Abuse and Mental Health Services Administration (SAMHSA) provides the underlying methodology used by AHCCCS to quantify the need for substance abuse treatment in Arizona. On an annual basis, prevalence information from the NSDUH compares census data, both actual and estimated, for the State of Arizona. The results

outlined treatment needs based on race/ethnicity, gender, and age group for the state, and then for each county and/or sub-state planning area.

AHCCCS policy requires that members with behavioral health needs undergo a clinical assessment, administered by a clinician through a mental health or substance use treatment program. The information gathered during this assessment process includes several identifiable factors, such as race and ethnicity, gender, and reasons for seeking treatment. According to AHCCCS' Annual Report: Substance Use Treatment Programs State Fiscal Year 2022, between July 1, 2021, and June 30, 2022:

- 226,774 members were served with a substance use disorder,
- 15.4 percent were served by the northern GSA, 28.3 percent by the southern GSA, and 56.3 percent by the central GSA,
- 55.2 percent were male; 44.8 percent were female,
- 51.6 percent were white, 8 percent African American, 9.2 percent American Indian,
- 8.9 percent were under the age of 25; 79 percent were between the age of 25-64 and 12.1 percent were over the age of 65, and
- 9.9 percent used opiates, 10 percent alcohol, 5.4 percent marijuana, and 8 percent methamphetamines.

The Arizona Substance Abuse Partnership (ASAP) Epidemiology Workgroup was created in 2004 as a requirement of the Strategic Prevention Framework State Incentive Grant (SPF SIG) and continues to serve as an invaluable resource. The membership roster includes statisticians, data analysts, academics, holders of key datasets, other stakeholders from various state and federal agencies, tribal entities, private and non-profit substance abuse-related organizations, and universities. This group provides data management and analytics related to substance use and impacts within Arizona. The objective is data-driven analytics to inform decision-making to prevent, assess risks, evaluate treatments, and develop priorities. The analysis integrates, links, and associates data from multiple sources in Arizona for a comprehensive view of status and trends. AHCCCS membership and attendance at this group is necessary to ensure data reports and trends are incorporated into the planning of all substance abuse prevention, treatment, and recovery efforts. The Epidemiology Workgroup has been an integral part to AHCCCS' substance abuse prevention planning efforts, including the development and implementation of statewide needs assessments, strategic plans, and evaluation efforts.

In 2017, the ASAP launched an interactive data dashboard to provide timely data about the opioid epidemic in Arizona. The dashboard is a tool that the Arizona Department of Health Services (ADHS), Governor's Office of Youth, Faith, and Families (GOYFF), and AHCCCS use to develop interventions that will keep Arizona's communities safe. Data is displayed at multiple levels, across demographics, and over time, including tables, graphs, maps, and downloadable data files covering a variety of reporting and visualization needs.

According to current data on the dashboard, the rates of opioid and other drug related deaths have decreased over the past year while the number of people accessing substance use treatment services has steadily increased.

AHCCCS also relies on the results of data management and numerous qualitative surveys to determine need and direct resources accordingly. Data management on process-related performance measures occurs with contracted providers and partners reporting independent numbers no less than quarterly. The reports are then aggregated by the AHCCCS Office of Data Analytics (AODA) within the Division of Health Care Services (DHCS). Data management and analysis on impact and outcome measures occur across the partner agencies. Sending this information to AHCCCS ensures a central location for consistent packaging and reporting to SAMHSA and for public dissemination. Qualitative surveys are critical to identifying potential service gaps, as they capture the human component and the effect a lack of services can have on a community which quantitative analysis cannot adequately determine.

Needs and Gaps of Arizona's Substance Use Disorder Primary Prevention Continuum

AHCCCS finalized a statewide substance abuse prevention needs assessment in September 2018 that highlighted areas of needs in the current statewide primary prevention system structure. The assessment generated a community prevention inventory, conducted focus groups throughout AZ, conducted key informant interviews throughout AZ, conducted an online Substance Use Prevention Workforce survey, and synthesized secondary data analysis for a multitude of data sources. In response to the completed needs assessment and following the Strategic Prevention Framework (SPF) model, AHCCCS began a Strategic Planning process utilizing an outside vendor. More than 40 stakeholders representing statewide prevention efforts were a part of the planning process, including but not limited to the following entities: local community coalitions, RBHAs, TRBHAs, Governor's Office of Youth, Faith, and Family (GOYFF), Drug Enforcement Agency (DEA), High Intensity Drug Trafficking Area (HIDTA), Arizona National Guard Counter Drug Task Force, Arizona State University (ASU), and University of Arizona (UA) were involved in the planning efforts within the development of the Strategic Plan. "Individuals, families and communities across Arizona are informed, connected, engaged, and health" was the vision developed during the planning process, the following items identified as the purpose for AHCCCS prevention services:

- Engage stakeholders to minimize duplication, ensure efficiency, and build capacity,
- Assess strengths and needs to address root problems and ensure all communities are served,
- Respect and engage different cultures and perspectives to ensure an inclusive process and equitable outcomes,
- Educate and inform stakeholders to increase understanding and buy-in, and
- Collect and monitor data on implementation and outcomes to guide continuous quality, improvement and ensure program effectiveness.

The data collected as part of the 2018 needs assessment contributed to the following 10 major findings related to substance use and mental health needs:

- An increasing number of Arizonans of all ages and in all regions are suffering from untreated mental health issues that are leading to substance use and/or misuse.

- LGBTQ+ identified individuals in all regions are experiencing significantly more risk factors for, consequences of, and issues with substance use and/or misuse as compared to non-LGBTQ+ identified individuals.
- Vaping (e-cigarettes, etc.) is increasing in Arizona for youth in middle and high schools and is significantly higher than national averages.
- The counties that are experiencing the most severe consequences of substance use in Arizona are: (1) Gila County, (2) Navajo County, (3) Mohave County, and (4) Pima County.
- A lack of social support and/or someone to turn to/talk to is a protective factor for substance use and/or misuse to which many Arizonans do not have access.
- The normalization of marijuana and other substances may be leading to increased substance use.
- Reductions in funding and resources for schools prohibit effective prevention programs from being delivered to high needs communities.
- Recent efforts to combat the prescription drug opioid crisis in Arizona are leading to increased street drug use.
- Prevention programs that are culturally competent, engaging, and up to date are more effective and should be prioritized.
- If basic needs are not being met (e.g., shelter, food, safety, physical health, mental health, social support, etc.) then prevention programs and efforts often fail.

While this assessment was completed prior to the onset of the COVID-19 pandemic, and the pandemic inevitable changed the landscape of behavioral health and other related needs, AHCCCS has also collected updated data regarding primary prevention needs through the 2020 AHCCCS Statewide Substance Abuse Prevention Strategic Plan. AHCCCS contracted with Lecroy & Milligan Associates (LMA) to develop the strategic plan, which included the following updated assessment of needs and findings:

- Qualitative data collection with prevention providers (online surveys, February 2020 ("pre-COVID-19" and August 2020 "post-COVID-19") and treatment professionals (interviews) to provide a preliminary overview of the impact of the pandemic on prevention needs.
- Analysis of AHCCCS behavioral health claims and encounter data from January to June 2019, and January to June 2020
- Review of data from the FEMA and SAMHSA Crisis Counseling Assistance and Training Program (CCP)

Key findings from these additional data collection activities include:

- Long-term consequences: increased drug overdoses and drug-related death rates, increased trauma and need for trauma informed care, increased health inequities, increasing mental health challenges, disconnection and isolation from COVID-19, increase in telehealth/virtual care, increase in domestic violence and child abuse
- Behavioral health problems: opioids, alcohol, and methamphetamines were the substances of the greatest concern at the time, which is consistent with conditions prior to the pandemic,

marijuana/cannabis was reported to be widespread and considered to have some likelihood of changeability.

Additionally, focus groups were conducted to inform primary prevention media campaigns in 2021 and 2022. In July 2021, Riester advertising agency conducted 12 focus groups virtually across Phoenix, Flagstaff, and Tucson among early adolescents, mid adolescents, late adolescents, and parents/caregivers/guardians of youth. Participants were screened to have tried mairjuana, vapes, or alcohol themselves at least once or had a friend or someone in their social circle admin to the same. Parents of qualifying and participating youth were recruited for the parent groups. Key takeaways from these data include:

- No other substance has been categorized legally as “medical” and “recreational”.
- Mariajuana is becoming the new social norm to follow the vaping phase of adolescence.
- Parental positivity toward legalization may contribute to normalization among young people
- Youth exhibit little to no awareness of the negative impacts of marijuana usage

Focus groups to inform the development of a second campaign were conducted in November 2021, among similar population groups and key findings also pointed to increasing mental health concerns as risk factors for substance use.

The Arizona Department of Health Services (ADHS) recently released opioid related death data, and 2020 numbers show that the state has seen an increase in opioid deaths since the onset of the pandemic (confirmed through death certificate data reported to ADHS Vital Records). Figure 1 shows the increase based on current numbers:

Figure 1. Arizona Opioid Deaths 2019 & 2020 (ADHS, 2021)

Month	2019	2020*
January	105	142
February	81	118
March	105	159
April	103	144
May	110	181
June	89	212
July	133	224
August	128	196
September	129	136
October	128	159
November	118	165
December	130	124
TOTAL Year to Date	**1359**	**1960**

The counties that have seen the highest increased rates of opioid deaths per 100,000 citizens are Maricopa (30.59), Pima (30.25), and Yavapai (27.54) (ADHS, 2021). The age group experiencing the highest rates of opioid deaths continues to be Arizonans aged 25-34, with this age group reporting 603

deaths in 2020, and 362 deaths in 2019 (ADHS, 2021). Arizona's youth have shown an uptick in opioid-related deaths, with 14 deaths in the under 15 years age group (data suppressed in 2019 due to less than 10 occurrences), and 361 deaths in the 15-24 age groups (reported 227 deaths in 2019) (ADHS, 2021). In terms of substances involved within verified opioid overdoses, fentanyl was the outlier reported in 42.4 percent of overdoses. Oxycodone was the second highest substance reported at 15.2 percent. Heroin and benzodiazepines each reported at 10.7 percent of Arizona's overdoses (ADHS, 2021).

The 2022 Arizona Youth Survey administered by the Arizona Criminal Justice Commission (ACJC) shows that the top substances used by student survey participants in grades 8, 10, and 12 in the past 30 days prior at survey administration were alcohol (13.5%), marijuana (10%) e-cigarettes (9.6%), and marijuana concentrates such as wax pend/THC oil, shatter, etc. (8.1%). When asked for the reasons for using substances, participants cited the following reasons, in order of prevalence:

1. To have fun (42.5%),
2. To get high or feel good (35.9%)
3. To deal with the stress from my school (35.8%)
4. To deal with the stress from my parents and family (30.2%), and
5. I was feeling sad or down (30.1%).

Reasons participants cited for *not* suing substances include:

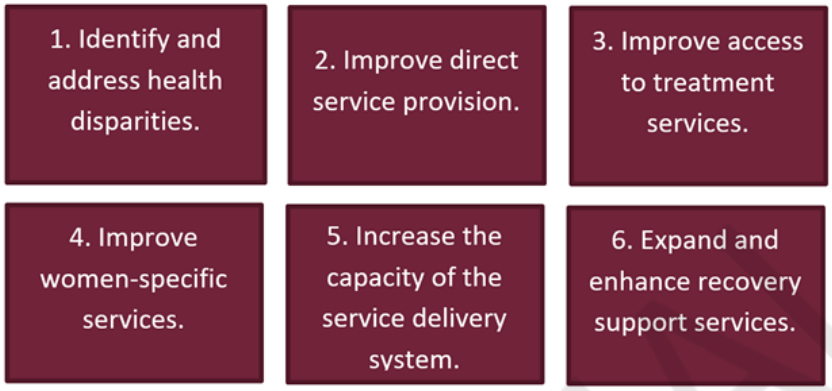
1. Not interested in drugs (87.9%)
2. Parents would be disappointed (70.7%)
3. It can harm my body (69.8%)

Arizona recently put forth an initiative to identifying and address areas of "prevention deserts'' within the state. These are areas of high need based on substance abuse rates, substance abuse related consequences, rate of population growth in the last 10 years, and location within the state such as border towns or regions considered frontier with little to no prevention services or infrastructure. Arizona has identified and prioritized the following areas as prevention deserts that must be targeted for enhanced development and prevention service infrastructure building. Some of these are now being served with prevention funding through State Opioid Response (SOR) funding, and Arizona continues to seek ways to offer these areas prevention resources.

- Avondale,
- Casas Adobes,
- Gilbert,
- Goodyear,
- Queen Creek,
- San Tan Valley,
- Surprise,
- Winslow/Holbrook, and
- Yuma.

Needs and Gaps of Arizona's Substance Use Disorder Service Continuum

Arizona has identified six key areas of need and gaps related to intervention, treatment, and recovery services.



1. Identify and Address Known Health Disparities Related to Substance Use Disorder (SUD).

- SUD treatment and recovery needs of Arizonans differ across the state and populations based on a variety of factors. AHCCCS seeks to identify prominent health disparities among gender, age, race/ethnicity, sexual orientation, and geography based on data, establish baseline data, and track measurable outcomes, and determine where resources are inadequate or inaccessible to meet SUD intervention, treatment, and recovery needs. A Report on the Delivery of Substance Use Disorder Services (Health Management Associates, 2021) provided the identification of health disparities such as under-utilization of behavioral health service in the Northern counties of the state, under-utilization by Black or African American and Native American or Alaska Native, and under-utilization by individuals living in rural areas of the state, as well as disproportionate increase in drug overdose deaths involving synthetic opioids among Black or African Americans.
- AHCCCS is using SUBG supplemental funding such as the COVID-19 Supplemental funds (also referred to as CRRSAA) and SUBG ARPA funds to further identify and address health disparities. One example is a partnership with Arizona State University (ASU) to conduct an environmental scan of high risk substance use needs among women and map these needs against location of substance use treatment providers with the expertise to serve them. Another agreement with ASU under these funds is supporting the development of a disparities impact statement that focuses on identifying the needs and barriers related to SUD treatment among Black, Indigenous and other People of Color (BIPOC), Lesbian, Gay, Bisexual, Transfer, and Queer/Questioning (LGBTQ), and rural populations, and ways to address them.
- AHCCCS' fiscal year 2022 Strategic Plan includes an objective to "reduce health disparities." AHCCCS needs to improve care for American Indian/Alaska Native (AI/AN) women. AI/AN women are more likely to have substance use disorder, have access to fewer services, and have higher utilization costs than women of other races. According to Census data, American Indians comprise 5.3 percent of the Arizona population, yet 11 percent of the Arizona women with

substance use disorder are American Indians. In contrast, 82.6 percent of the Arizona population is Caucasian, and 50 percent of the Arizona women with SUD are Caucasian. In an analysis of 2018-2020 medical claims data of women with substance use disorder accessing medical services, for outpatient services, AI/AN women were below the statewide average in four of seven of the highest use categories, indicating they have access to fewer services than women of other races. Expenditures per Caucasian woman averaged $90.73 per woman, per month in 2020, yet the cost per AI/AN woman was $207.37 for the same year, nearly double.

2. Improve Direct Service Provision Among SUD Treatment Providers.

The following treatment needs and gaps emerged from results of the Independent Case Review of SUD treatment member case files from state fiscal year 2022 (SFY22).

- Coordinating with other agencies at discharge - 61% of member case files reviewed documented coordinating care such as referrals to lower levels of care or other services at discharge, a 10% decrease from the previous year.
- Incorporate social determinants of health (SDoH) into individual service plans (ISPs) - Addressing SDoH issues is an important part of successful treatment outcomes as members cannot fuly engage in the treatment process if basic needs such as food and housing are not being met. Seventy seven percent of member case files incorporated SDoH into ISPs, a decline of 2% from last fiscal year.
- Screening for infectious diseases
    - Tuberculosis (TB) - Only 46% of member case files documented screening for TB
    - Hepatitis C, HIV, and other infectious diseases - only 53% of member case files documented screening for these infectious diseases
- American Society of Addiction Medicine (ASAM) - only 83% of member case files documented ASAM was used to determine the proper level of care at intake
- Women-specific services
    - Only 45% of member case files among females with a history of domestic violence had a documented safety plan completed
    - Fifty seven percent of member case files among females had documented evidence of gender specific treatment services (e.g. women's-only group therapy sessions). This is an increase over the previous year, which was only 18%.

3. Expand and Enhance a Range of Recovery Support Services.

- Recovery housing - Arizona's epidemiological profile suggests a lack of affordable recovery housing throughout the state due to increased substance use during the COVID-19 pandemic. The demands for treatment services, recovery services/supports, and affordable housing have escalated in the past year. There is a need to create additional recovery housing options and sustain these options over time. As of August, 2023, AHCCCS has received proposals from each ACC-RBHA requesting to implement SUD recovery housing with the SUBG supplemental funds.
- Peer support services - 54% of member case files documented that peer support services were offered. This is an increase from the previous year, which was 26%. Additionally, use of peer

support services improved from 40% to 86%, which is a trend Arizona seeks to continue to enhance.

Needs and Gaps of Arizona's Mental Health Services Continuum

AHCCCS assesses the mental health services continuum needs and gaps through multiple means, including qualitative feedback from ongoing stakeholder engagement efforts, needs assessments, tracking of mental health service utilization trends, and assessment of quality metrics. In 2022, AHCCCS engaged Health Management Associates (HMA) to conduct the Arizona Behavioral Health Needs Assessment for the Uninsured and Underinsured to evaluate and make recommendations for improving the state's Non-Title XIX/XXI behavioral health delivery system. Depression, anxiety, and stress were frequently identified as the most pressing mental health issues, exacerbated greatly by the COVID-19 pandemic. Increasing people's knowledge of available resources and confidence in behavioral health services in addition to accessibility of services were identified as recommendations for improvement in Arizona's system of care.

AHCCCS is committed to meeting the behavioral health needs of all Arizonans who have the desire to access treatment as evidenced by multiple projects and initiatives to overcome barriers to care. Based on the review of the data sources, the mental health services continuum needs and plans include:

1. **Development of a statewide standardized process to identify, refer, and assess children for an SED designation and informed connection to behavioral health services.**

To address the mental health needs of children in Arizona, the appropriate identification and referral mechanisms for assessment of SED must exist for child-serving systems. The systems that most commonly interface with children include the education system as well as primary care providers. Informing and providing the education system and primary care providers with a user-friendly interface for referral for SED assessment will improve early identification and initiation of service delivery for children designated as SED. Based on a statewide analysis, it was determined that there is variation of how functional impairment is defined and applied for SED designation and, as such, Arizona would benefit from standardization of the functional impairment criteria for SED designation. This strategy will augment Arizona's behavioral health in schools initiatives as well as the Targeted Investments efforts to improve access to mental health care in educational and primary care settings and connect children and families to local community behavioral health resources.

To meet this need, beginning on Oct. 1, 2023, Arizona will be implementing a standardized SED identification, referral and assessment process for children with an SED designation. The process includes an assessment/evaluation with a qualified clinician that occurs no later than seven business days after a request for designation is made; the required assessment and supporting documentation is then sent to a single, statewide vendor to determine qualification for an SED designation based on diagnosis and standardized functional impairment criteria. The vendor psychiatrist(s) conducts a review of all documentation then sends a notice of the results in writing, to the individual (or legal guardian) within three, 20, or 60 days depending on each individual case. The vendor will additionally notify Arizona Health Care Cost Containment System (AHCCCS) and/or the individual's commercial/private

health insurer, the Tribal Regional Health Authority (TRBHA), Tribal Arizona Long Term Care System (ALTCS) Case Manager, ACC-RBHA, and the member's provider as is applicable to the child. If a child is not already engaged in behavioral health services, a service provider within the geographic service area of the ACC-RBHA's contracted provider network can be identified and communicated to the child and family. This process not only encourages statewide standardization in designation, but also ensures that uninsured or underinsured children with an SED designation and their families are informed of and can access all available clinically indicated services regardless of insurance coverage.

2. Enhanced capacity and accessibility of behavioral health services for children designated SED and their families, adults and older adults designated SMI, individuals with SMI or SED in the rural and homeless populations, individuals with an ESMI, and individuals in need of behavioral health crisis services.

The need for behavioral health services has seen a nationwide increase since the COVID-19 pandemic and Arizona is no exception. The overall count of individuals receiving behavioral health services from the Arizona Non-Title XIX programs increased by 22.5% from 2019 to 2020 with notable increased utilization of Case Management, Rehabilitative, and Support Services in the adult (including older adults) with an SMI designation population. Arizona's behavioral health utilization per 1,000 population is greater in the Northern region than the Southern region, both considered rural areas of the state with fewer resources than the densely populated Central region. Barriers to utilization in the Non-Title XIX populations included a lack of knowledge of available resources and a lack of appropriate and accessible services.

To increase statewide accessibility of behavioral health services, especially in the rural areas, AHCCCS has expanded the use of and coverage for telehealth behavioral health services. Telehealth is a well-demonstrated and effective tool for managing behavioral health conditions and promotes increased access to services in rural populations as well as populations with limited transportation. During the pandemic, Arizona experienced a sixfold increase in telehealth use for Non-Title XIX/XXI behavioral health services. In July 2021, the Telehealth Advisory Committee was established and in June 2022, released their Telehealth Best Practice Guidelines for Health Care Providers. The guidelines have been implemented statewide and include specific guidelines for Tele-mental Health, Telehealth Implementation of Applied Behavioral Analysis, and Opportunities to Improve Access, Quality, and Cost in Pediatric Care. AHCCCS additionally revised policies and procedures outlining that telehealth services are to be conducted and covered with the same expectations as in-person visits. Reported barriers to telehealth utilization among the Non-Title XIX/XXI populations include a lack of computer/phone and/or reliable internet access. AHCCCS continues to assess and collaborate with ACC-RBHA's/TRBHA's regarding the need for additional locations with telehealth technology located closer to or within remote communities to increase accessibility for individuals with limited access to the required equipment, service capabilities, and/or reliable transportation.

To increase capacity and accessibility to crisis stabilization services for children and adolescents with an SED designation, AHCCCS and the ACC-RBHA in the Northern region, Care 1st, have contracted with providers in both Coconino and Mohave Counties to develop two 23-hour crisis child and adolescent

observation units and expand short-term residential settings for children/adolescents transitioning from crisis. The rural counties in Northern Arizona currently lack services at this level of care requiring children in need of these services to be transferred outside of their geographic service area, creating barriers to family engagement in their treatment and/or connection to their established network of professional and community supports. The addition of these two facilities to serve the Northern region reduces the likelihood that children will need to leave their area to receive needed treatment. This project additionally enhances local wrap-around services for children and families providing support following a crisis event and ongoing support services to reduce the need for future crisis intervention and promote ongoing stability.

AHCCCS is contracting with National Wraparound Innovation Services, a leader in providing an empirically based model for Wraparound services, to develop and procure an Arizona Center of Excellence in serving children with SED designation and their families. Wraparound is an evidence-based model of care coordination that is utilized for children with an SED designation and/or a CALOCUS score of 4 or higher. The contract also includes FOCUS, a time-limited intermediate care coordination model that supports decreased involvement with high level of intensity systems while building connections and supports for families through community-based resources and Mobile Response and Stabilization (MRSS) services to encourage de-escalation and crisis resolution within the home and reduce the need for hospitalization and/or residential treatment services. Professional development for the Arizona workforce, including local coaching candidates, will allow for sustained statewide implementation of this evidence-based practice.

To increase capacity and accessibility of services for individuals with an SMI or ESMI/FEP designation, including the unsheltered homeless, AHCCCS is partnering with the ACC-RBHA's in Northern (Care 1st) and Southern (AzCH) Arizona to expand development, provide technical assistance, and monitor fidelity of Permanent Supportive Housing. These partnerships will expand housing outreach, navigation and support services in these regions, bridging an identified gap in coverage for these services in these regions.

3. Expanding the primary care workforce capacity to serve children designated with SED or symptoms of a first episode of psychosis through access to child and adolescent psychiatrists.

Arizona, like other states, has a shortage of psychiatrists and other licensed mental health professionals to serve individuals with an SED, ESMI/FEP designation, especially in rural communities. Although AHCCCS has made progress with expanding access to mental health care through primary care providers based on integration efforts, including the Targeted Investment Program, additional capacity is necessary to serve the increasing number of people who present with mental health needs. In partnership with the University of Arizona, AHCCCS is supporting the Arizona Pediatric Psychiatry Access Line (A-PPAL) which will provide primary care providers with direct access to child and adolescent psychiatrists.

4. Expanding evidence-based practices for adults designated with SMI and ESMI/FEP (Seriously Mental Illness) including Assertive Community Treatment (ACT), Supportive Housing, and Peer Support.

Historically, the development and fidelity monitoring of these services focused on Maricopa County, the most populous county in Arizona, however, AHCCCS has contracted to conduct a balance of state analysis by September, 2025. Existing service providers in the Northern and Southern regions currently benefit from extensive technical assistance to develop the infrastructure and provide services that meet fidelity to criteria established by SAMHSA.

Considering the additional difficulties in accessing affordable housing brought forth during and since the COVID-19 pandemic, there is a critical need to expand upon the supportive housing services available, while also ensuring that housing, once located, can be maintained. Housing maintenance needs include intensive supportive services focused on individuals at risk of eviction to ensure that they are not displaced from their homes.

To meet these needs, as previously described above, AHCCCS is partnering with the ACC-RBHA's in Northern (Care 1st) and Southern (AzCH) Arizona to expand development, provide technical assistance, and monitor fidelity of Permanent Supportive Housing. These partnerships will expand housing outreach, navigation and support services in these regions, bridging an identified gap in coverage for these services in these regions.

Peer Recovery Support Specialists (PRSS) and Family Support Specialists (FSS) provide an invaluable service supporting individuals and family members to remain engaged in the recovery process and focus on achieving goals through shared understanding and mutual empowerment. To bolster the workforce by increasing current peer and family support capacity in addition to ensuring provider compliance with AHCCCS requirements and national best practice in delivery of these services, it was determined via provider feedback that a specialized training course was required. To meet this need, AHCCCS has partnered with the Arizona Peer and Family Career Academy (PFCA) to develop and deliver curricula targeted at training/certification of Peer and Family Support Specialists in addition to curricula targeted at Supervisors of Peer and Family Support Specialists including but not limited to, clinicians, social workers, and behavioral health professionals. In partnership with the AHCCCS workforce development team, the final Supervisor training course, including a final exam, will be loaded into Relias - the digital training platform of the AHCCCS registered provider network. By mandating a specialized training program for providers employing Peer Recovery Support Specialists and/or Family Support Specialists, AHCCCS can ensure oversight requirements and criteria are understood and documented as required statewide.

According to SAMHSA's National Guidelines for Behavioral Health Crisis Care, Arizona's crisis continuum of care is currently in the program sustainment phase of implementation. Statewide utilization of crisis services has exhibited a consistent upward trend, with a notable surge following the introduction and promotion of the national lifeline, 988, and AHCCCS is committed to ensuring the service continues to meet demand. AHCCCS is partnering with first responders, law enforcement, and healthcare

professionals to provide crisis intervention training to enhance their ability to identify and assist individuals in need of behavioral health crisis services. AHCCCS is additionally working to promote improved integration and coordination between crisis services, mental health facilities, law enforcement, and social support programs for a more comprehensive crisis response approach.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Tuberculosis

Priority Type: SUT

Population(s): TB

Goal of the priority area:

Strategies to attain the goal:

Priority #: 2

Priority Area:

Priority Type: SUT, SUR

Population(s): PWWDC

Goal of the priority area:

Strategies to attain the goal:

Priority #: 3

Priority Area: Harm Reduction

Priority Type: SUT, SUR

Population(s): PWWDC, PWID, EIS/HIV

Goal of the priority area:

Strategies to attain the goal:

Priority #: 4

Priority Area: Recovery

Priority Type: SUT, SUR

Population(s): PWWDC, PWID, EIS/HIV, TB

Goal of the priority area:

Strategies to attain the goal:

Priority #: 5

Priority Area: Equity/Addressing Disparities

Priority Type: SUT, SUR

Population(s): PWWDC, PWID, EIS/HIV, TB

Goal of the priority area:

Strategies to attain the goal:

Priority #: 6

Priority Area: Reduction in Suicide Rate

Priority Type: SUP, SUT, SUR, MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS, PWWDC, PP, PWID

Goal of the priority area:

Reduce the Arizona Suicide Rate to 18.4% per 100,000 by the end of calendar year (CY) 2024 and to 18.0% by the end of calendar year (CY) 2025. (The rate is currently 18.7% per 100,000).

Strategies to attain the goal:

AHCCCS will continue to work collaboratively with other state agencies and stakeholders to implement suicide prevention strategies for all Arizonans. Strategies will include but are not limited to community and conference presentations, social media messaging, social marketing/public awareness campaigns, youth leadership programs, gatekeeper (including teachers, healthcare providers, and first responders) trainings, reduction of stigma, promotion of early intervention, increased capacity of the suicide prevention helpline, encouragement of help-seeking behavior among at-risk populations including LGBTQIAS+, Older Adults, Veterans, Teens, American Indians, and Suicide Attempt Survivors, improved data surveillance, and ongoing collaboration and partnerships with stakeholders for systemic improvement.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reduce suicide fatality rate per 100,000 to 18.0% by end of CY2025.

Baseline Measurement: 18.7% per 100,000

First-year target/outcome measurement: 18.4% per 100,000

Second-year target/outcome measurement: 18.0% per 100,000

Data Source:

Arizona Department of Health Services
https://www.azdhs.gov/prevention/tobacco-chronic-disease/suicide-prevention/index.php

Description of Data:

Information on death by suicide is compiled from the original documents filed with the ADHS, Bureau of Vital Records and from transcripts of original death certificates filed in other states but affecting Arizona residents. Rate is calculated by dividing the count of suicide deaths by the population for the given time period and multiplying by 100,000.

Data issues/caveats that affect outcome measures:

Priority #: 7

Priority Area: Crisis Services in Rural Communities

Priority Type: MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Increase the availability of crisis stabilization beds in rural Northern Arizona communities by 30 beds by the end of calendar year 2025.

Strategies to attain the goal:

AHCCCS will support development of additional crisis stabilization facilities in Northern Arizona including financial resources, technical assistance, consultation, and collaboration with the ACC-RBHA and providers in the Northern GSA.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Increase number of Crisis Stabilization beds in Northern Arizona by 30 by end of CY 2025.

Baseline Measurement: Current count is 29

First-year target/outcome measurement: 29

Second-year target/outcome measurement: 59

Data Source:

RBHA in Northern Arizona, AHCCCS Crisis Utilization data

Description of Data:

Number of licensed Crisis Observation facilities including capacity report.

Data issues/caveats that affect outcome measures:

Increase number is dependent upon the completion of planned and/or contracted projects by targeted end date.

Priority #: 8

Priority Area: Crisis Utilization

Priority Type: MHS, ESMI, BHCS

Population(s): SMI, SED, ESMI, BHCS

Goal of the priority area:

Increase utilization of Arizona's Crisis Continuum of Care by 200% in year 2024 and an additional 100% in year 2025.

Strategies to attain the goal:

AHCCCS will support development of additional crisis stabilization facilities including financial resources, technical assistance, consultation, and collaboration with the ACC-RBHA and providers. AHCCCS will increase the capacity and accessibility of the suicide prevention helpline ensuring that individuals in crisis have immediate access to trained professionals and resources, reduce barriers to seeking help and providing critical support in times of need. Increase community education and awareness to reduce stigma and encourage help-seeking behavior among at-risk populations.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Arizona will increase statewide utilization of crisis services by 300% by the end of 2025.

Baseline Measurement: Metric will be determined based on utilization totals at the end of 2023 and outlined in the annual report.

First-year target/outcome measurement: Statewide utilization of crisis services will increase 200% between 2023 to 2024.

Second-year target/outcome measurement: Statewide utilization of crisis services will increase and additional 100% between 2024 to 2025.

Data Source:

AHCCCS contractors, including ACC-RBHA contractors providing crisis services.

Description of Data:

As outlined in AMPM Policy 590, ACC-RBHA Contractors are required to submit a Crisis Services Report as specified in contract. All reported data is separated out and reported based upon the region in which the crisis calls originated, including call metrics. The report additional requires detailing unmet metrics and notable trends when compared to previous reporting periods and interventions implemented based on the trends identified. This data is aggregated and analyzing by AHCCCS.

Data issues/caveats that affect outcome measures:

None at this time.

Priority #: 9

Priority Area: SMI Unsheltered Homeless

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Arizona will reduce the statewide occurrence of unsheltered homeless individuals with an SMI designation by 5% by the end of fiscal year 2025.

Strategies to attain the goal:

Partner with RBHA's to bolster Permanent Supportive Housing services statewide, with particular focus on rural Northern and Southern regions. Improve outreach and engagement, including improved correlation with existing PATH providers, RBHA's, and the behavioral health homes to which individuals with an SMI designation are assigned. Strategically augment resources to enhance the implementation of the AHCCCS Housing and Health Opportunities (H2O) demonstration targeting individuals with an SMI designation who are currently unsheltered homeless and/or who are at high risk of homelessness upon release from institutional settings such as psychiatric inpatient facilities, correctional facilities, and/or the Arizona State Hospital.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reduce the statewide incidence of individuals with an SMI designation by 5% by the end of FY2025.

Baseline Measurement: The statewide occurrence of unsheltered homeless with a SMI designation is currently 20%.

First-year target/outcome measurement: Statewide occurrence will be reduced to 18% in the first year.

Second-year target/outcome measurement: Statewide occurrence will be reduced to 15% in the second year.

Data Source:

Maricopa County and Balance of State total unsheltered homeless and unsheltered homeless with a SMI designation monthly reports.

Description of Data:

AHCCCS utilizes HMIS and additional measures to track the unsheltered homeless population statewide, including those with an SMI designation, on a monthly basis. The Arizona Department of Economic Security also releases a State of Homelessness report annually, including Point-in-Time counts in three service areas referred to as Continuums of Care: Maricopa, Tuscon/Pima, and a balance of state.

Data issues/caveats that affect outcome measures:

None identified at this time.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$71,753,665.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$7,001,554.00									
b. Recovery Support Services										
c. All Other	$64,752,111.00									
2. Primary Prevention[d]	$19,134,311.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
a. Substance Use Primary Prevention	$19,134,311.00									
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services	$0.00									
6. Early Intervention Services for HIV	$0.00									
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$4,783,578.00									
12. Total	**$95,671,554.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: Planning Period End Date:

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]											
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]											
4. Other Psychiatric Inpatient Care											
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital											
8. Other 24-Hour Care											
9. Ambulatory/Community Non-24 Hour Care											
10. Crisis Services (5 percent set-aside)[f]											
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]											
12. Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	0	0
2. Women with Dependent Children	0	0
3. Individuals with a co-occurring M/SUD	0	0
4. Persons who inject drugs	0	0
5. Persons experiencing homelessness	0	0

Please provide an explanation for any data cells for which the state does not have a data source.

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Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$35,876,833.00		
2 . Substance Use Primary Prevention	$9,567,155.00		
3 . Early Intervention Services for HIV[4]	$0.00		
4 . Tuberculosis Services	$0.00		
5 . Recovery Support Services[5]			
6 . Administration (SSA Level Only)	$2,391,789.00		
7. Total	**$47,835,777.00**	**$0.00**	**$0.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
2. Education	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
3. Alternatives	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
4. Problem Identification and Referral	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			

	Selected			
5. Community-Based Processes	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			
	Selected			
6. Environmental	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			
	Selected			
7. Section 1926 (Synar)-Tobacco	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			
	Selected			
8. Other	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$0**	**$0**	**$0**
Total SUPTRS BG Award[3]		**$47,835,777**	**$0**	**$0**
Planned Primary Prevention Percentage		**0.00 %**		

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct			
Universal Indirect			
Selected			
Indicated			
Column Total	**$0**	**$0**	**$0**
Total SUPTRS BG Award[3]	**$47,835,777**	**$0**	**$0**
Planned Primary Prevention Percentage	**0.00 %**		

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☐	☐	☐
Tobacco	☐	☐	☐
Marijuana	☐	☐	☐
Prescription Drugs	☐	☐	☐
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☐	☐	☐
Fentanyl	☐	☐	☐
Prioritized Populations			
Students in College	☐	☐	☐
Military Families	☐	☐	☐
LGBTQI+	☐	☐	☐
American Indians/Alaska Natives	☐	☐	☐
African American	☐	☐	☐
Hispanic	☐	☐	☐
Persons Experiencing Homelessness	☐	☐	☐
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☐	☐	☐
Rural	☐	☐	☐

Underserved Racial and Ethnic Minorities	☐	☐	☐

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Planning Tables

Table 6 Non-Direct-Services/System Development [SUPTRS]

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024 A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems					
2. Infrastructure Support					
3. Partnerships, community outreach, and needs assessment					
4. Planning Council Activities (MHBG required, SUPTRS BG optional)					
5. Quality Assurance and Improvement					
6. Research and Evaluation					
7. Training and Education					
8. Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total			**$**	**$**

Please wait while data loads...

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

AHCCCS provides comprehensive integrated health care services for individuals with serious mental illness (SMI), Early Serious Mental Illness (ESMI) including First Episode Psychosis (FEP), pregnant women with substance use disorders, women with substance use disorders who have dependent children, persons with substance use disorders who have, or are at risk for, HIV or TB, persons with substance use disorders in the justice system, persons using substances who are at risk for overdose or suicide, other adults with substance use disorders, children and youth with serious emotional disturbance (SED) or substance use disorders, and co-occurring mental and substance use disorders through Managed Care Organizations (MCOs). The majority of AHCCCS members receive integrated health services through their chosen acute care program, one of seven AHCCCS Complete Care (ACC) plans throughout the state. Services include, but are not limited to, primary health care, mental health individual and group counseling, case management, psychiatric and psychologist services, peer support services, family support services, individual and group skills training, vocational training, substance use disorder treatment, medication for opioid use disorder (MOUD), and medication for the treatment of alcohol use disorder. The ACC Contractors with Regional Behavioral Health Agreements (ACC-RBHAs) specifically serve individuals with a Serious Mental Illness (SMI) designation, Serious Emotional Disturbance (SED) and Early Serious Mental Illness (ESMI) including First Episode Psychosis (FEP) while also providing crisis, other grant-funded, and state-only funded services. Additionally, the Arizona Long Term Care System (ALTCS) program provides health insurance for individuals who are age 65 or older or who have a disability. American Indians and Alaska Natives (AI/AN) enrolled in AHCCCS or CHIP (KidsCare) may choose to receive their coverage through the American Indian Health Program (AIHP), Tribal ALTCS, or Tribal RBHAs (TRBHAs enter into Intergovernmental Agreements with AHCCCS for behavioral health care management) or one of the AHCCCS-contracted managed health plans.

The core principles of AHCCCS' system of care are based on the concepts of recovery, member input, family involvement, person-centered care, communication, and commitment. AHCCCS MCOs are expected to demonstrate an unwavering commitment to these principles, while demonstrating creativity and innovation in their oversight and management of an integrated service delivery system. MCOs are required to develop and promote care integration activities, such as establishing integrated settings which serve members' primary care and behavioral health needs and encouraging member utilization of these settings. MCOs are also required to consider the entirety of the member population's health needs during network development and provider contracting to ensure member access to care, care coordination, and management, and to reduce duplication of services.

Arizona's model is based upon the premise that people want and deserve dignity, respect, inclusion, and safety. Based on four elements:
1. Affording people dignity, compassion and respect
2. Offering coordinated care, support or treatment
3. Offering personalized care, support or treatment
4. Supporting people to recognize, as well as develop, their strengths and abilities enables them to live a fulfilling and independent life.

In Arizona, we have established and are expanding the multiple services offered to individuals experiencing mental health, substance abuse, or co-occurring disorders by our RBHAs, TRBHAs, contractors including Peer-Run Organizations, Family-Run Organizations, and Specialty Providers that provide services based on the principles of recovery and resiliency. To increase statewide access to services, AHCCCS is supporting multiple expansions and initiatives through use of the MHBG and SABG dollars. Examples include: Arizona Peer and Family Career Academy. Recognizing the need to bolster the behavioral health workforce to increase accessibility, the Academy focuses on offering professional development and advanced level training to Peer Recovery Support Specialists and Family Support Professionals to ensure these specialized service providers are receiving targeted training to support individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. The Arizona Peer and Family Career Academy is also creating and implementing a specialized training program for clinical supervisors that will be mandated by AHCCCS for providers responsible for the supervision of these unique service providers.

Through SABG supplemental funds, Arizona has shifted the culture in the treatment of pregnant and postpartum parents by raising awareness, providing training to providers serving this population, improving referral pathways to local and culturally responsive programming, and coordinating with other state and local agencies to create a multi-systemic collaborative approach necessary to serve this population. Projects such as the Arizona Women's Recovery Center Childcare Initiative support retention in SUD treatment for women/families with child care needs by connecting families with meaningful age-appropriate childcare or activities and a specialty residential programs for maternal health, pregnancy care, SUD treatment and recovery support services to pregnant and parenting women. To support children and adolescents demonstrating symptoms of a Serious Emotional Disturbance and their caregivers, MHBG is supporting the Arizona-Pediatric Psychiatry Access Line to expand access to pediatric psychiatric resources throughout the state, particularly rural and underserved areas with few of these specialized resources. Both MHBG and SABG dollars are being utilized to support individuals with mental, substance use, and co-occurring disorders involved in the justice system including justice navigation providers, court liaisons, and care coordination efforts leading up to and following release. SABG funded providers are simplifying accessibility by bringing services to people where they are through the Intensive Treatment Systems Mobile Methadone Van designed to conduct outreach to touchpoints for high-risk opioid use in jails, syringe distribution locations, homeless shelters, SUD treatment programs, and building trust and establishing relationships with underserved populations that would not otherwise access care while advocating for a harm reduction approach. Similarly, MHBG is leveraging supplemental grant dollars for the development of additional FEP treatment programs including a unit to provide mobile FEP services in two rural Arizona counties, and expanded outreach efforts and training for ESMI/FEP service providers in rural areas.

To reduce barriers in accessing care, AHCCCS has recently provided clarification and technical assistance to contractors on the

identification of ESMI and utilization of ESMI dollars with the goal of reducing barriers to care at this clinically critical intervention period. Through the use of MHBG ARPA dollars, AHCCCS is supporting the expansion of Permanent Supported Housing programs in rural Northern and Southern Arizona geographic service areas increasing access to evidence-based Permanent Supportive Housing (PSH) models for serving persons experiencing homelessness, persons with behavioral health needs including mental illness or substance use disorders (SUD) and co-occurring disorders premised on: 1) access to and availability of both affordable housing subsidies and capacity, and, 2) individualized wrap around housing focused supportive services to support housing placement, stability and coordination with member's other service goals and resources. Arizona is utilizing MHBG ARPA Crisis resources to establish two child and adolescent crisis stabilization units and intensive wrap-around services in Northern Arizona to substantially expand access to these services in this underserved rural area of the state. Arizona's myriad of efforts demonstrate dedication to reducing barriers to accessing care to all Arizonans.

To ensure individuals with mental health and substance use co-occurring disorders have a voice and play a role in the design of the behavioral health system, AHCCCS requires that all contracted health plans have an Office of Individual and Family Affairs (OIFA). These OIFAs serve as counterparts to the AHCCCS OIFA expanding opportunities for peer and family participation in decision-making committees, workgroups and advisory councils. This representation must reflect all populations served by the contractor including members with co-occurring disorders. These decision making bodies exist at all levels of the behavioral health system from AHCCCS, to health plan, and to the provider level. This ensures that the community participation and oversight is itself reflecting a fully integrated health system. This representation provides feedback to AHCCCS and the health plans as a way of overall system transformation.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

AHCCCS serves as both the SSA and state medicaid system for Arizona. In response to the Centers for Medicare & Medicaid Services' (CMS) Medicaid Mental Health Parity Final Rule (herein referenced as "Parity" to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries. This final rule, set on March 30th, 2016, works so that most insurance providers cover mental health and substance abuse services the same way they cover physical health services. The AHCCCS Contractor Operations Manual, Policy 110 - Mental Health Parity (www.azahcccs.gov/Shared/Downloads/ACOM/PolicyFiles/100/110.pdf) outlines the contractors' requirements to achieve and maintain compliance with the Mental Health Parity and Addiction Equity Act of 2008 and apply to all mental health and substance use disorder members. These requirements include mental health parity analysis requirements (including SUD), standard parity requirements including identification of applicable conditions and defining MH/SUD benefits. AHCCCS contracts with Mercer Government Human Services Consulting (Mercer) to provide technical assistance with assessing compliance with parity. Parity applies when any portion of the benefit to enrollees is provided through an MCO. The 2022-2023 AHCCCS Delivery System Integration information outlines that all members have equitable coverage for physical, behavioral, children's rehabilitative or long term care services. https://www.azahcccs.gov/shared/Downloads/2022_Delivery_SystemIntegration_10012022.pdf

AHCCCS also aligns systems for members who are dually-eligible for Medicare and Medicaid. Being its own distinct and complex system of care with little to no interface with state Medicaid programs, the over 180,000 Arizonans with dual-eligibility can be overwhelmed by navigating these two separate systems and are more likely to fall through the cracks, receive inefficient care, and not achieve optimal health outcomes. As part of integrated care efforts, AHCCCS contracts with Medicare Advantage Dual Special Needs Plans (D-SNPs) that are each affiliated with its partner AHCCCS Complete Care Medicaid Health Plan. Requiring each ACC Medicaid health plan to offer a partner Medicare D-SNP promotes the enrollment or alignment of dual eligible members in the same health plan for both Medicare and Medicaid services to the greatest possible extent and allows dual eligible members to receive all of their health care services, including prescription drug benefits, from a single, integrated health plan. (https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/CY23_DSNP_ReferenceTables.pdf)

While AHCCCS supports and promotes multiple initiatives to ensure parity in coverage, parity implementation "in practice" encounters challenges statewide, particularly due to a shortage of adequately trained health professionals. According to the October, 2022 Arizona Department of Health Services Biennial Report, 82 of Arizona's 126 Primary Care Areas (PCAs) are designated as medically underserved areas. The Health Resources and Services Administration designates the geographic majority of Arizona, particularly (but not exclusively) the rural areas, as Health Professional Shortage Areas (HSPA) in behavioral health. Approximately forty percent of Arizonans live in a Mental Health Professional Shortage Area while, during and since the pandemic, there is an increased need for mental health and substance use treatment for both adults and children. To address these challenges, the Arizona Department of Health Services collaborated with multiple public health, community partners, subject matter experts, and dedicated stakeholders at the state and local levels, including the then AHCCCS Director, Jami Snyder, to create the Arizona Health Improvement Plan (AzHIP) for 2021-2025. The plan outlines action steps and tactics to increase access to mental health management resources, with a particular focus on remote options (telehealth therapy/psychiatry/addition support appointments, virtual support groups, mental health first aid, etc.); increase awareness and utilization of population-based mental health and wellness resources/outreach where they exist and develop strategies to close gaps, and increase the number of public facing/front line staff who receive an approved evidence based suicide prevention training by identifying organizations to receive the training and expand the statewide training capacity in a manner that ensure cultural humility in health equity are a priority. They prioritized addressing health professional shortage by building a diverse healthcare workforce employing multiple tactics including: developing strategies to reduce financial and other barriers for underserved students in health professional education programs, build/grow health care workforce which is representative of the communities served, quantifying healthcare professional shortages in rural and urban underserved areas, developing a curriculum to address local community

priorities/concerns, and implementing curriculum with consideration of tribal communities' needs and cultural understanding. AHCCCS is actively involved in these initiatives to overcome these challenges to ensure all Arizonans receive integrated care.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

AHCCCS provides comprehensive integrated health care services for individuals with co-occurring mental and substance use disorders through Managed Care Organizations (MCOs). The majority of AHCCCS members receive integrated health services through their chosen acute care program, one of seven AHCCCS Complete Care (ACC) plans throughout the state. Services include, but are not limited to, primary health care, mental health individual and group counseling, case management, psychiatric and psychologist services, peer support services, family support services, individual and group skills training, vocational training, substance use disorder treatment, medication for opioid use disorder (MOUD), and medication for the treatment of alcohol use disorder. The ACC Contractors with a Regional Behavioral Health Agreement (ACC-RBHAs) specifically serve individuals with a Serious Mental Illness (SMI) designation, Serious Emotional Disturbance (SED) and Early Serious Mental Illness (ESMI) including First Episode Psychosis (FEP) while also providing crisis, other grant-funded, and state-only funded services. Additionally, the Arizona Long Term Care System (ALTCS) program provides health insurance for individuals who are age 65 or older or who have a disability. American Indians and Alaska Natives (AI/AN) enrolled in AHCCCS or CHIP (KidsCare) may choose to receive their coverage through the American Indian Health Program (AIHP), Tribal ALTCS, or Tribal RBHAs (TRBHAs enter into Intergovernmental Agreements with AHCCCS for behavioral health care management) or one of the AHCCCS-contracted managed health plans.

AHCCCS provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability by: outlining and upholding AHCCCS values within required member handbooks, policy, contracts, performance measures, long term strategies, person centered care, and peer run organizations. The utilization of member handbooks provides individuals with the education and guidance needed to navigate through the integrated system and are required by all MCOs. In addition, MCO's utilize Health Information Exchange (HIE) that connects Electronic Health Record (EHR) systems of providers and clinicians allowing them to securely share health information with other providers and bridge integrated systems of care. AHCCCS MCOs function as the single entity responsible for administrative and clinical integration of health care service delivery for members with an SMI designation, which includes coordinating Medicare and Medicaid benefits for these members who are dually eligible. Coordinating and integrating physical and behavioral health care produces improved access to primary care services, increased prevention, early identification, and intervention to reduce the incidence of serious physical illnesses, including chronic disease. Increasing and promoting the availability of integrated, holistic care for members with chronic behavioral and physical health conditions helps members to achieve better overall health and an improved quality of life.

AHCCCS is pursuing long-term strategies that bend the cost curve while improving member health outcomes. The overall mission is to leverage the AHCCCS managed care model toward value-based health care systems where members' experience and population health are improved through aligned incentives with MCOs and provider partners, and a commitment to continuous quality improvement and learning. One critical tool, VBP, encompasses a variety of initiatives for payment reform, including Alternative Payment Models (APMs), Differential Adjusted Payments (DAP), Directed Payments and Targeted Investments (TI). Through VBP, AHCCCS is committing resources to leverage the state's successful managed care model to address inadequacies of the current health care delivery system, such as fragmentation and paying for volume instead of quality.

Beginning in 2016 and renewed in 2021, AHCCCS's Targeted Investment (TI) Program supports participating providers in delivering integrated and coordinated care at the provider-level. The program aims to reduce fragmentation between physical and behavioral health providers, increase efficiencies in integrated service delivery, and improve health outcomes for adults and children with behavioral health needs who are at high risk for complex care including those experiencing ESMI/FEP, SED, SMI, Substance Use Disorders (SUD), and co-occurring MH/SUD disorders, including justice involved individuals. The TI program incentivizes requirements aimed at building the necessary infrastructure to enable an integrated and high-performing health care delivery system that enhances care coordination and improves health and financial outcomes. For the first three years of the five-year program, participating providers received payments for achieving milestones focused on development of infrastructure, and implementation of processes and policies that support behavioral health and physical health integration and coordination. In years four and five, providers were eligible to receive performance-based incentive payments based on quality measurements for the targeted populations. The TI program incentives and supports a comprehensive approach to integrated care in any setting in which a member may receive either physical or behavioral health services; participants are incentivized to establish and maintain numerous protocols, policies, and systems of care that support the provision of person-centered integrated care including:
*Integrated care plans for members with behavioral health needs
*Primary Care screening for behavioral health using standardized tools for depression, substance use disorders, anxiety and suicide risk
*Primary Care screening, intervention and treatment for children with developmental delays, including early childhood cognitive and emotional problems
*Protocols for behavioral health providers to identify physical health concerns and to effectively connect the member to appropriate physical health care
*High risk registries, health risk assessment tools, predictive analytic systems and other data mining structures to identify

individuals at high risk of a declines in acute and/or behavioral health status
*Trauma-Informed Care protocols including screening for Adverse Childhood Events (ACEs), referral processes for children that screen positive, and use of Evidence Based Practices (EBPs) and trauma-informed services
*Protocols to send and receive core Electronic Health Record (EHR) data with the state's Health Information Exchange (Health Current) and receipt of Admission, Discharge, and Transfer (ADT) alerts to notify providers when their patients are hospitalized.

The TI Program additionally supported establishment of 13 co-located, integrated clinics where primary care and behavioral health providers deliver services to justice-involved individuals recognizing the unique circumstances and needs of this population. Co-located or adjacent to probation and parole offices, these clinics prioritize access to appointments for individuals with complex medical and/or behavioral health conditions, including same-day access to appointments on the day of release and during visits to the probation/parole office and non-emergency medical transportation for medically necessary services. AHCCCS additionally established Medicaid suspension agreements with the majority of counties, allowing for members who are incarcerated for less than one year to be automatically re-enrolled into AHCCCS coverage vs. having to complete a new eligibility determination. AHCCCS additionally requires that MCOs have reach-in policies, mandating that they engage individuals with complex health and behavioral health conditions (including substance use) with high criminogenic needs prior to their release, ensuring that they are able to access care immediately upon transition back into the community.

TI program participants (except hospitals) are required to complete the Integrated Practice Assessment Tool (IPAT) to assess their level of integration on the SAMHSA Levels of Integrated Care continuum at the end of each program year. At the end of the initial five-year TI program, participants regularly reported that they changed "how they do business" due to the systems of care they established as a result of implementing the TI Program requirements and noted improved quality of service delivery and coordination as a result of the enhanced communication protocols between primary care and behavioral health counterparts. The majority of participants, 60%, reported an increase in integration by at least one IPAT level and 38% by at least two IPAT levels. Most notably, nearly 25% (46 clinics) of PCP participants attested to increasing IPAT scores by four or more levels - transitioning from levels one or two (minimal coordination) to levels five or six (fully integrated care), within one year of participation. This higher level of integration among participating PCPs means that members are able to consistently access behavioral health services when the PCP's screening identifies a need within the integrated practice setting. The number of behavioral health providers successfully transitioning to co-located care (levels three or four) or fully integrated care (levels five or six) increased by threefold by year three with continued levels of greater integration by years four and five.

Based on the success of the initial five-year initiative, AHCCCS renewed the TI Program in 2021 to expand provider participation, sustain the integrated point of care infrastructure and protocols, and enable more members to receive greater levels of point of care coordination and integration, especially as the public health emergency intensified the need. The 2021-2026 renewal, TI Program 2.0, is broken into two participant cohorts - "extension" and "expansion."
The "extension" cohort supports participating TI program providers to continue their current work and take the next step to incorporate non-clinical or social needs into point of care systems to provide a more holistic, person-centered approach to care. TI Program 2.0 requirements for this cohort are designed to foster collaboration between providers and community based organizations (CBOs), particularly those crucial to addressing social risk factors such as housing, food, employment, and non-medical transportation for members while retaining high value physical-behavioral health integration requirements from the original program.

The "expansion" cohort includes primary care practices, behavioral health providers, and integrated clinics without prior participation in the TI Program. In addition to the requirements of the original TI Program, qualified participants of TI Program 2.0 will meet requirements such as a certified EHR capable of bi-directional data exchange, minimum volume thresholds, and commitment to participate in the Learning/Quality Improvement Collaborative established to support TI program participants. The structure of the program for this cohort is modeled on the original TI program with updates to emphasize Social Determinants of Health (SDOH) screening, adverse childhood event screening and intervention, telehealth, data sharing, and cultural competency. The "expansion" cohort will also include co-located justice clinics. Eligibility will generally align with the original program requirements with enhanced emphasis on: justice partner commitment, co-location flexibility, development in areas of the state currently underserved by this resource (e.g. rural counties) and inclusion of individuals adjudicated through diversion programs such as drug courts and veterans courts.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

The AHCCCS Medical Provider Manual (AMPM) dedicates a full chapter to Care Coordination Requirements for primary care providers, member transitions, member transfers between facilities, coordination of care with other government agencies, children's rehabilitative services care coordination and service plan management, provider case management, and behavioral health crisis services and care coordination.

AMPM Policy 510 - Primary Care Providers (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/510.pdf) outlines the care coordination responsibilities of primary care providers for "ongoing treatment coordination" including behavioral health services. When a primary care provider has initiated medication management services for a member to treat a behavioral health disorder, the Contractor provider policies and procedures shall address guidelines for referral to a behavioral health provider, specific guidelines for transfer of a member with a Serious Mental Illness (SMI) designation for ongoing treatment coordination, notifying entities of the transfer, the transfer/sharing of medical records, transition of prescription services including notification of the individual's current medications ensuring that the member does not run out of prescribed medication prior to the first appointment with a behavioral health provider, and monitoring activities to ensure that members are appropriately transitioned for care.

AMPM Policy 541 - Coordination of Care with Other Government Agencies (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/541.pdf) establishes Contractor requirements for maintaining collaborative relationships with other government entities that delivers services to members and their families, ensuring access to services, and coordinating care with consistent quality. Contractors are responsible for ensuring collaboration with government agencies, including but not limited to involvement in the member's Child and Family Team (CFT) or Adult Recovery Team (ART). In serving high needs children, adolescents and families involved with the Arizona Department of Child Safety, contractors are mandated to ensure that a behavioral risk assessment is performed that identifies the behavioral health needs of the child, and the child's parents and family or caregivers, that is based on the Arizona Vision - 12 Guiding Principles; coordinate behavioral health services, activities, and AHCCCS Behavioral Health System Practice Tools: Transition to Adulthood, Unique Behavioral Health Services for Needs of Children, Youth and Families involved with DCS, and CFT, Working with the Birth Through Five Population and Psychiatric and Psychotherapeutic Best Practices for Children: Birth Through Five Years of Age. AHCCCS considers the removal of a child from his/her home to the protective custody of the DCS to be an urgent behavioral health or physical need and at risk for negative emotional consequences and future physical and behavioral health disorders. As such, the policy outlines specific care coordination activities in AHCCCS' Rapid Response Process in these instances. Other government agencies with specific contractor case coordination requirements include: Arizona Department of Child Safety Arizona Families FIRST (Families in Recovery Succeeding Together) Program which provides expedited access to substance use treatment for parents/families/caregivers referred by DCS and that "substance use disorder treatment for families involved with DCS shall be family centered, provide sufficient support services, and shall be provided in a timely manner to promote permanency for children, stability for families, to protect the health and safety of abused/neglected children and promote economic security for families." The policy outlines care coordination with the Arizona Department of Education, Schools, or Other Local Educational Authorities to ensure that behavioral health providers collaborate with schools and help a child achieve success in school, including provision of appropriate behavioral health services in school settings; the Arizona Department of Economic Security to ensure behavioral health providers coordinate member care with Arizona Early Intervention Program; the Arizona Department of Economic Security/Rehabilitation Services Administration requiring a Interagency Service Agreement (ISA) to be in place to provide specialty employment supports for members determined to have a SMI; and Courts and Corrections to ensure that behavioral health providers are collaborating and coordinating care for members with behavioral health needs (including substance use disorders and co-occurring disorders) involved in the Arizona Department of Corrections, Arizona Department of Juvenile Corrections, Administrative Office of the Court, and the County Jail System. Coordination requirements include assimilation of information and recommendations contained in probation or parole case places when developing the service plan and ensuring that the behavioral health provider evaluates and participates in transition planning prior to release and arranging/coordinating the person's behavioral health care upon release.

AMPM Policy 570 - Provider Case Management (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/570.pdf) establishes requirements for provider case management (including care coordination activities) for behavioral health providers. AHCCCS covers provider case management as a supportive service intended to improve treatment outcomes and meet individuals' Service or Treatment Plan goals. Examples of case management activities include but are not limited to:
1. Assistance in maintaining, monitoring, and modifying behavioral health services.
2. Assistance in finding necessary resources other than behavioral health services.
3. Coordination of care with the individual/Health Care Decision Maker (HCDM), designated representative (DR), healthcare providers, family, community resources, and other involved supports including educational, social, judicial, community, and other State agencies.
4. Coordination of care activities related to continuity of care between levels of care (e.g. inpatient to outpatient care) and across multiple services (e.g. personal care services, nursing services, and family counseling) and providers.
5. Assisting individuals in applying for Social Security benefits when using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach.
6. Outreach and follow-up of crisis contacts and missed appointments.

Provider case managers are responsible for monitoring the individual's current needs, services, and progress through regular and ongoing contact with the individual. The frequency and type of contact is determined during the treatment planning process, and is adjusted as needed, considering clinical need and individual preference, though generally falls within one of the following categories
1. Assertive Community Treatment (ACT) Case Management (Adult): One component of a comprehensive model of treatment based upon fidelity criteria developed by the Substance Abuse and Mental Health Services Administration. ACT case management focuses upon individuals with severe and persistent mental illness that seriously impairs their functioning in community living, in conjunction with a multidisciplinary team approach to coordinating care across multiple systems (e.g. social services, housing services, health care).
2. High Needs Case Management (Children/Adolescents): Focuses upon providing case management and other support and

rehabilitation services to children with complex needs and multiple systems involvements for whom less intensive case management would likely impair their functioning. Children with high service intensity needs who require the assignment of a high needs case manager are identified as:
a. Children 0 through five years of age with two or more of the following:
i. Other agency involvement; specifically: Arizona Early Intervention Program (AzEIP), DCS, and/or DDD, and/or
ii. Out of home placement for behavioral health treatment (within past six months), and/or
iii. Psychotropic medication utilization (two or more medications), and/or
iv. Evidence of severe psycho-social stressors (e.g. family member serious illness, disability, death, job loss, eviction), and
b. Children six through 17 years of age: CALOCUS level of 4, 5, or 6.
3. Medium Level of Intensity Case Management (Adult): Focuses upon individuals for whom less intensive case management would likely impair their functioning. Supportive case management provides assistance, support, guidance and monitoring in order to achieve maximum benefit from services. Caseloads may include individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.
4. Low Level of Intensity Case Management (Adult): Focuses on individuals who have largely achieved recovery and who are maintaining their level of functioning. Case management involves careful monitoring of the individual's care and linkage to service. Caseloads may include both individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.

In addition to the levels of Case Management as listed above, Forensic Assertive Community Treatment Teams (FACT) function in Maricopa County to address the unique needs of people diagnosed with SMI and have had involvement with the criminal justice system. The goal of the FACT teams is to reduce recidivism and assist members with high needs through an array of integrated, community based services, resources, and supports.
The FACT team utilizes evidence-based practices to:
*Identify and engage members with complex, high needs.
*Remove barriers to services and supports.
*Address the whole person and provide a full range of community-based services and supports wherever and whenever they are needed.
*Reduce hospitalizations and contact with the criminal-justice system, improve health outcomes and help establish and strengthen natural community supports.
FACT team staff have experience in psychiatry, nursing, social work, rehabilitation services, substance-abuse interventions, employment support, independent-living skills and housing. A key member of the team is a peer support person who has lived experience with behavioral health challenges and prior interaction with the criminal justice system likened to the members served. The team assists members with adhering to treatment plans, activities of daily living, employment-related services, finding and maintaining affordable housing, budgeting, obtaining benefits, and engaging in community activities through delivering services in accordance with SAMHSA evidence-based practices (EBP/s).
AHCCCS/Maricopa County also offers Medical Assertive Community Treatment Teams (MACT). The difference between a regular ACT team and the MACT team is that the individuals not only have a diagnosis of a SMI but also have significant medical comorbid conditions. MACT employees have experience in Psychiatry (Behavioral Health Medical Provider), nursing, social work, rehabilitation services, and licensed substance use specialists who provide individual and group counseling, interventions/supports, employment support, independent living skills and housing supports. The MACT team additionally employs a Primary Care Medical Provider and closely monitors the medical and physical condition of the member along with their behavioral health condition providing integrated care for the unique challenges the combination of these conditions can present.

AMPM Policy 590 - Behavioral Health Crisis Services and Care Coordination (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/590.pdf) is applicable to all Arizona residents regardless of Medicaid enrollment or eligibility and establishes requirements related to the behavioral health crisis system for Title XIX/XXI and Non-Title XIX/XXI eligible members. The ACC-RBHA Contractor is responsible for the full continuum of crisis services to all individuals in their respective service areas to prevent a potentially dangerous condition, episode, or behavior. Crisis services include crisis telephone response, mobile crisis response, and facility-based stabilization (including observation and detoxification) and all other associated covered services delivered by crisis service providers. Additionally, the ACC-RBHA Contractor is responsible for all related telephonic crisis system follow-up activities, non-emergency transportation to remediate a crisis, and transportation provided by mobile crisis teams to a crisis stabilization facility. The ACCRBHA Contractor shall collect, report, and analyze crisis system data as an important element in evaluating the service, efficiency, sufficiency, and quality of the crisis delivery system. For AHCCCS-enrolled members, the health plan of enrollment is responsible for coordinating medically necessary services and care provided to members after the initial 24 hours of a crisis episode, or discharge from a crisis stabilization setting, whichever occurs first, covering all emergency transportation and non-emergent transportation from crisis receiving facilities. Ongoing stabilization services and related covered services are the responsibility of the member's health plan of enrollment, regardless of whether the services are provided within or outside the health plan's Geographic Service Area (GSA).

For AHCCCS enrolled members, the ACC-RBHA Contractor shall ensure notification is provided to the member's plan of enrollment, providers (e.g., TRBHA, health home, Primary care provider, if known), and other appropriate parties when an enrolled member engages with the crisis system. This notification shall occur within 24 hours of an enrolled member first engaging in the crisis system, seven days a week, 365 days a year, including weekends and holidays. The ACC-RBHA Contractor shall develop and maintain effective systems to ensure notifications of an enrolled member's interaction with the crisis system include, at a minimum: 1. Enrolled member demographic information (e.g., name, date of birth, AHCCCS ID, health plan of enrollment). 2. Nature of reason for contacting crisis. 3. Acuity level. 4. Final outcome or disposition of the crisis event. 5. Summary of interventions and clinical recommendations related to the need for any follow-up and continuing services.

The ACC-RBHA Contractor shall ensure individuals receive a Post-Crisis Care Plan which includes information related to the individual's needs post-crisis and interventions to meet these needs including access to services, prescription medications, and referrals as clinically indicated. For enrolled members, the Post-Crisis Care Plan shall be provided to the member's health plan of enrollment so that subsequent services can be initiated. The member's health plan of enrollment shall ensure that post crisis care coordination and service delivery occur when an enrolled member engages in crisis services, with the objective to address the member's ongoing needs and ensure resolution of the crisis. Refer to AMPM Policy 1040 for outreach and engagement requirements and ACOM policy 417 for general behavioral health appointment standards. Care coordination shall occur between the member's health plan of enrollment, the ACC-RBHA Contractor, crisis providers and, if applicable, TRBHAs serving the member. TRBHAs are responsible for care coordination as outlined in their Intergovernmental Agreement (IGA). The Contractor shall have policies establishing post-crisis care coordination expectations that shall provide for: 1. Transfer of medical records of services received during a crisis episode, including prescriptions. 2. Tracking of admission, discharge, and re-admissions, including admission setting (e.g., emergency departments, inpatient and outpatient hospitals, detoxification, residential). 3. Requirements for follow-up directly with the individual, within 72 hours, when discharged from a crisis setting to ensure: a. Immediate assessment of the individual's needs, identification of the supports and services that are necessary to meet those needs, and connecting the individual to appropriate services, including a plan for suicide prevention and safety, as appropriate, and b. Provide solution-focused and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration, or placement in a more restrictive setting. 4. Engagement of peer and family support services when responding to post-crisis situations, as preferred and identified by enrolled members. 5. The provision of ongoing care in an expedient manner, in accordance with the timeliness expectations specified in ACOM Policy 417. The Contractor shall regularly evaluate post-crisis care coordination activities and work to improve internal and external collaboration efforts. Care coordination activities shall include use of Health Information Technology (HIT), as available, to improve member outcomes.

MCOs are required to submit an annual Provider Case Management Plan that addresses how the Contractor will implement and monitor provider case management standards and caseload ratios for adult and child individuals. The Provider Case Management Plan includes performance outcomes, lessons learned, and strategies targeted for improvement. MCOs must also ensure that provider sites where provider case management services are delivered have regular and ongoing member and/or family participation in decision making, quality improvement, and enhancement of customer service.
AHCCCS' Division of Fee for Service Management (DFSM) has been targeting improvement in care coordination within the tribal health care delivery system. This has included, but is not limited to, the establishment of the American Indian Medical Home, investing in the Health Information Exchange to implement notifications related to admissions, discharges and transfers (ADTs), and working to coordinate with TRBHAs regarding Emergency Department (ED) and inpatient admissions for care management follow-ups. AHCCCS has also implemented its American Indian Medical Home Program (AIMH) for IHS/638 facilities for enhanced primary care case management and care coordination, as well as the implementation of Care Coordination Agreements between IHS/638 facilities and non-IHS/638 facilities to improve the delivery system for American Indians by increasing access to care and strengthening the continuity of care. The American Indian Medical Home (AIMH) Program is for American Indian/Alaska Native (AI/AN) members enrolled in the American Indian Health Program (AIHP). The AIMH Program is the first of its kind in the nation and was brought to fruition through a robust partnership between AHCCCS and tribal leadership. The AIMH Program supports Primary Care Case Management (PCCM), diabetes education, and care coordination for its AIHP enrolled members.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Arizona has a rich tradition of addressing both mental health and substance use needs in an integrated system of care. The AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Contractor Operations Manual (ACOM) provide mandates to support the integration of medical and behavioral health services throughout the lifespan. AMPM Chapter 200 - Behavioral Health Practice Tools encompasses policies related to the use of quality assessment and best practice to strengthen the capacity of Arizona's Behavioral Health System in response to the needs of children, adolescents, and young adults. Links to assessment tools, guidance on their utilization, and additional resources are provided as attachments to the policies and utilized by both primary care and behavioral health providers. The primary Behavioral Health Practice Tool utilized for the screening and assessment of co-occurring mental health and substance use disorders for individuals under 18 years of age in Arizona is the Child and Adolescent Level of Care Utilization System (CALOCUS). The CALOCUS dimensional rating system is used to determine the intensity of a child or adolescent's service needs on 7 levels over 6 dimensions: Risk of Harm, Functional Status, Comorbidity, Recovery Environment, Resiliency and Treatment History, and Treatment Acceptance and Engagement (scored with 2 scales - A. for the Child/Adolescent and B. for the parents/primary caregivers).

AMPM Policy 220 - Child and Family Team (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/200/220.pdf) describes universal Child and Family Team (CFT) practice in the AHCCCS System of Care, indicators contributing to a child's and family's complexity of needs, how the essential CFT practice activities are implemented on a continuum based on individualized needs, and how the CALOCUS is utilized in the AHCCCS System of Care. This policy outlines requirements in procedure for CFT practice consisting of nine activities:
1. Engagement of the Child and Family.
2. Immediate Crisis Stabilization.
3. Strengths, Needs, and Culture Discovery (SNCD).
4. CFT Formation/Coordination of CFT Practice.
5. Service Plan Development.
6. Ongoing Crisis Planning.

7. Service Plan Implementation.
8. Tracking and Adapting.
9. Transition.

AMPM Behavioral Health Practice Tool 220, Attachment B provides a table matrix to describe how the CFT practice may be implemented for children and families with varying needs and service intensity levels. While the CALOCUS suggests a level of service intensity, the CFT identifies the specific services and supports that will best meet the identified needs. Service planning should always be individualized, family driven, culturally competent and flexible. Children are resilient and families are adaptable and strong, and therefore, as their needs vary over time, service intensity will adjust to correspond with these changes. Policy 220 additionally outlines transition planning for youth adjudicated and sentenced to the Arizona Department of Juvenile Corrections, their release to the community, or entering/leaving foster care specific to behavioral health, including SUD, services. Additionally outlines are requirements for the transition planning of any child involved in behavioral health care to the adult behavioral health system when the child reaches age 16.

AMPM Chapter 300 - Medical Policy For Covered Services and 320 - Services with Special Circumstances encompass all policies related to the provision of medical and behavioral health, including substance use disorder, and integrated services. AMPM Policy 320-O - Behavioral Health Assessments, Service, and Treatment Planning (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320-O.pdf) specifies provisions for Behavioral Health Assessments Service and Treatment Planning and requires the contractors to ensure assessments, service, and treatment planning are conducted in compliance with the Adult Behavioral Health Services Delivery System including that they are conducted by an individual within their scope of practice, incorporate the concept of a integrated "team" established for each member receiving behavioral health services, and an indication of agreement or disagreement with the service plan and awareness of the right to appeal if not in agreement with the service plan. Specialized requirements are in place and outlined for individuals with a SMI designation within this policy. The policy provides specific details regarding comprehensive behavioral health assessment including an evaluation of the member's: 1) Presenting concerns, 2) Information on the strengths and needs of the member and his/her/their family, 3) Behavioral health treatment, 4) Medical conditions and treatment, 5) Sexual behavior and, if applicable, sexual abuse, 6) Substance abuse, if applicable, 7) Living environment, 8) Educational and vocational training, 9) Employment, 10) Interpersonal, social, and cultural skills, 11) Developmental history, 12) Criminal justice history, 13) Public (e.g., unemployment, food stamps, etc.) and private resources (e.g., faith based, natural supports, etc.), 14) Legal status (e.g., presence or absence of a legal guardian) and apparent capacity (e.g., ability to make decisions or complete daily living activities), 15) Need for special assistance, and 16) Language and communication capabilities. ii. Additional components of the assessment shall include: 1) Risk assessment of the member, 2) Mental status examination of the member, 3) A summary of impressions, and observations, 4) Recommendations for next steps, 5) Diagnostic impressions of the qualified clinician, 6) Identification of the need for further or specialty evaluations, and 7) Other information determined to be relevant. In alignment with SAMHSA's Evidence-Based Practice,

Arizona utilizes the American Society of Addition Medicine (ASAM) Criteria level of care assessment tool that provides clinicians with a structured interview for assessing and caring for individuals with addictive, substance-related and co-occurring conditions. In the event of positive results, the information shall be shared with the providers involved with the member's care if the member has authorized sharing of protected health information. To assist in decision-making and treatment planning, AHCCCS provides an ASAM to AHCCCS Level of Care Crosswalk (https://www.azahcccs.gov/PlansProviders/Downloads/CurrentProviders/ASAM_AHCCCS0_LevelOfCareCrosswalk.pdf) identifying the ASAM Level of Care Title, Number, and Description with the AHCCCS Facility Type/Level of Care Title, Code, and detailed Description. In situations when a specific assessment is duplicated, the results of such assessments shall be discussed collaboratively with any other provider that may have completed an assessment to address clinical implications for treatment needs in addition to the differences being addressed within the "team" with participation of providers within and outside of behavioral health as indicated.

AHCCCS MCOs are required to develop processes to identify Health Homes within their network and assign members with an SMI designation, including those with co-occurring SMI and substance use conditions, to a Health Home within five days of enrollment. The assigned Health Home is responsible for either directly providing, or coordinating the provision of, all medically necessary health care services. In order to treat the whole person, the Health Home is also responsible to provide or coordinate a range of integrated, recovery-focused services to members, such as medication services, counseling for mental health and/or substance use disorder treatment, medical management, case management, transportation, peer and family support services, and health and wellness groups. Additionally, to support continuity of care and ensure coordination across systems, the Health Home is required to ensure timely follow-up and continuing care post-crisis engagement. AHCCCS MCOs are additionally required to maintain and execute policies and procedures describing the implementation of comprehensive and coordinated delivery of integrated physical and behavioral health services, including administrative and clinical integration of health care service delivery. Integration strategies and activities are expected to focus on improving individual health outcomes, enhance care coordination (including care coordination for Medication Assisted Treatment (MAT), and increase member satisfaction.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race ◉ Yes ○ No

b) Ethnicity ◉ Yes ○ No

c) Gender ◉ Yes ○ No

d) Sexual orientation ◉ Yes ○ No

e) Gender identity ◉ Yes ○ No

f) Age ◉ Yes ○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ◉ Yes ○ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ◉ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ◉ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? ◉ Yes ○ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ◉ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight?

The AHCCCS Executive Management team prioritizes reducing health disparities as part of continuous quality improvement within the AHCCCS Strategic Plan. The Strategic Plan describes the role of AHCCCS in meeting its short and long-term challenges and is developed within the context of Arizona's economy and with a view toward the future health and economic well-being of the citizens of Arizona. In September, 2022 AHCCCS updated and implemented a 5-year strategic plan (SFYs 2023-2027) charting the course for the agency's work in three critical goal areas: provide equitable access to high quality, whole person care; implement solutions that ensure optimal member and provider experience; and maintain core organizational capacity, infrastructure and workforce planning that effectively serves AHCCCS operations. The Strategic Plan is revised and updated annually. The current and previous Strategic Plans are publicly available on the AHCCCS website at: https://www.azahcccs.gov/AHCCCS/AboutUs/#CStrategicPlan.

Healthy People 2030 defines health equity as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." In July 2020, AHCCCS established the Health Equity Committee to better understand health disparities in Arizona and develop strategies to ensure health equity for all members. This committee communicates health equity strategies being implemented by the agency, identifies needed improvements to existing strategies (if appropriate), develops and/or evaluates key metrics, and articulates future interventions aimed at eliminating health disparities. It is responsible for oversight and management of health equity considerations as they relate to policy, data, health plan oversight in addition to emerging health care innovation strategies and identifying health disparities among members by analyzing utilization and quality improvement data to advance policy and/or contracting strategies to improve the health equity across all AHCCCS programs and populations served.

Health Equity Committee Goals:
1. Understand health disparities within the AHCCCS members.
2. Effectuate policy changes and support the implementation of strategies for positive improvement where known disparities exist, creating opportunities for the more equitable provision of services and supports.
3. Raise the visibility of AHCCCS' commitment to health equity and the strategies in place to ensure the equitable provision of services and supports.
4. Improve health outcomes for AHCCCS members.
5. Identify challenges and barriers that AHCCCS members have in accessing covered services.

Please indicate areas of technical assistance needed related to this section

Examples of how other states structure and format their data collection systems to most effectively capture demographics that are self-reported by members such as race/ethnicity, and sex/gender other than male and female would be appreciated.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM/NASEM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[3] The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance use disorder and Mental Health Services Administration.

[4] National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focused on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Navigate	6
OnTrack	3
Acceptance and Commitment Therapy	9
Cognitive Behavioral Therapy for Psychosis	9

Solution-Focused Brief Therapy	9
Cognitive Enhancement Therapy	9

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
2420760	2420760

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

AHCCCS contracts with three AHCCCS Complete Care Contractors with a Regional Behavioral Health Agreement (ACC-RBHAs): Mercy Care, Care 1st, and Arizona Complete Health, for the provision of SAMHSA Community Mental Health Block Grant (MHBG) funding. These Contracts delineate the requirements of the ACC-RBHAs, including their responsibilities for implementing and monitoring subcontractors who are the providers of direct care services and treatment. Notwithstanding any relationship(s) the ACC-RBHA may have with any subcontractor, the ACC-RBHA maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. ACC-RBHAs subcontract with providers in their Geographic Service Area (GSA) to ensure members may access services within their communities. Provider networks must meet access-to-care standards for the populations served. AHCCCS additionally holds Intergovernmental Agreements (IGAs) with four (4) Tribal Regional Behavioral Health Authorities (TRBHAs): Gila River, Navajo Nation, White Mountain Apache, and Pascua Yaqui, for the provision of MHBG funding. The IGAs ensure that services and treatment funded under the federal block grants meet the legal requirements of the respective block grant. The TRBHAs are responsible for implementing and monitoring direct care services and treatment and for the development and implementation of primary substance abuse prevention services. All ESMI and FEP services are billed per service rendered regardless of type of insurance and/or use of block grant dollars. Any service paid with block grant dollars is identified with a specified modifier in the AHCCCS system. The AHCCCS Division of Grants and Innovation meets with ACC-RBHAs every other month and on an as needed basis. These meetings are called by AHCCCS DGI, and facilitated by the AHCCCS DGI Compliance Manager who coordinates agenda needs from all DGI units (such as SUPTRS, MHBG, SOR, crisis, etc.) as well as from the ACC-RBHAs. Necessary updates and/or technical assistance are provided within these meetings or on an ad-hoc meeting basis.

Contracts/IGAs are updated and amendments are executed on a scheduled and as needed basis to revise and implement reporting, monitoring, evaluation, and compliance requirements. The Non-Title XIX/XXI contracts with the ACC-RBHAs are updated annually, amendments executed by October 1 each year. This contract amendment is facilitated by the AHCCCS Division of Health Care Services, Contracts Unit, reviewed and revised by all pertinent AHCCCS divisions and subject matter experts. Once suggested contract revisions are completed by AHCCCS, they are posted for public comment opportunity. Public comments are received, reviewed, and addressed by AHCCCS prior to contract execution. The IGAs are updated on a 5-year cadence. The IGA updates are negotiated between the AHCCCS Division for Fee for Service Management (DFSM) and the TRBHAs. The latest update occurred in 2021 and DGI provided requested revisions related to SABG and MHBG. NTXIX/XXI Contracts and IGAs are posted on the AHCCCS website at the links below:

ACC-RBHA NTXIX/XXII Contracts
https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/contracts.html

AHCCCS-TRBHA IGAs
https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/TRBHA.html

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

AHCCCS utilizes ACC-Regional Behavioral Health Agreements (ACC-RBHAs) to select and conduct fidelity oversight of FEP programs with implementation of evidence-based practices in their geographic service area (GSA). In Northern Arizona, Care1st Health Plan is the ACC-RBHA contracted and they have the following FEP programs in their region: Mohave Mental Health Center, Polara, and The Guidance Center. In Central Arizona, Mercy Care is the contracted ACC-RBHA and they have selected Resilient Health and Valleywise Health to be their FEP providers. In Southern Arizona the contracted ACC-RBHA is Arizona Complete Health and they have selected Banner (EPICenter) and Intermountain Center for Human Development (ICHD). Please find below the descriptions of each program:

Mohave Mental Health Center (MMHC) is located in Mohave County, Arizona and serves the communities and surrounding areas of Kingman, Bullhead City, and Lake Havasu City and was established as an FEP provider in October of 2017. MMHC accepts individuals between the ages of 12-30 and utilize the CSC model by utilizing NAVIGATE in addition to other EBP as determined clinically applicable to meet each member's needs. Although MMHC does not provide PCP services on site, their case managers coordinate with local Federally Qualified Health Centers to ensure integrated and effective continuum of care in relation to primary care services. Their assigned FEP personnel consist of a clinical director and 2 Behavioral Health Technicians at this time. Members are able to receive medication

management/psychiatric services at each clinic via tele-health or in-person appointments.

Polara Health, located in Prescott, AZ, services Yavapai County and was established as an FEP provider in October of 2017. Polara accepts individuals between the ages of 12-30 and implements the CSC model by utilizing NAVIGATE. Polara Health is a fully integrated healthcare clinic and provides integrated behavioral health and PCP services on-site. Their FEP personnel consist of 5 case managers to coordinate each member's service needs.

The Guidance Center (TGC), located in Flagstaff, AZ, serves the Coconino County region and was established as an FEP provider in October of 2017. TGC accepts individuals between the ages of 12-30 and implements the CSC model by utilizing NAVIGATE. Although TGC does not provide PCP services on site, they do coordinate with local Federally Qualified Health Centers to ensure integrated and effective continuum of care in relation to primary care services. TGC's FEP personnel consist of a program manager, therapist, Behavioral Health Medical Practitioner, and (2) FEP care managers.

Banner Early Psychosis Intervention Center (EPICenter), is located in Tucson, AZ, founded in 2010, and was developed from the CSC model utilizing NAVIGATE programming. Banner EPICenter is the only 5-year program of its kind in the nation, providing evidence-based and intensive stage-specific treatment including wraparound services for adolescents and young adults (aged 15 to 35) in the early stages of a psychotic illness. The program offers members three core functions: (a) Early detection, (b) Acute care during and immediately following a psychiatric crisis, and (c) Recovery-focused continuing care, featuring multimodal interventions to enable young people to maintain or regain their social, academic, and career trajectory during the critical first 2-5 years following the onset of illness. Since 2015, Banner EpiCenter has been located within the Banner University Whole Health Clinic (WHC), an integrated clinic that offers primary and behavioral health in one location. FEP personnel consists of 3 psychologists, 2 psychology externs, specialized recovery coordinator, peer support specialist, and a communication specialist.

Intermountain Center for Human Development (ICHD) is also located in Tucson, with satellite services and rural clinicians delivering services in Cochise, Santa Cruz and Yuma Counties. ICHD was established as an FEP provider in October of 2021 and began receiving referrals in January of 2022. ICHD was formed using the CSC model and provides individuals with NAVIGATE programming. Wraparound resources are provided to individuals between the ages of 15-25 having experienced a psychotic episode within the previous year. The average duration for treatment is between 12-18 months and evaluated by individual need. ICHD works with the community to provide education and early detection of psychosis to assist in identifying individuals into comprehensive specialized services earlier. This is done by creating referral pathways with inpatient facilities, emergency departments, schools, crisis intervention services, and the criminal justice system. Integrated health clinics offering FEP and primary care services are offered in Pima, Cochise, Yuma counties, and are working on creating a primary care office in Santa Cruz County. FEP personnel consist of a clinical director, 4 clinicians, 2 outreach engagement specialists, care coordinator, peer support, BHMP, and FNP to ensure integrated service delivery onsite.

Resilient Health, located in Phoenix, AZ, serves Maricopa county and was established as an FEP provider in August of 2018. Resilient Health utilizes the CSC approach by implementing OnTrackNY programming that is 18 to 24 months in duration and serves ages 15 to 30 with a qualifying diagnosis who are within the first 2 years of their first psychotic episode. FEP Personnel consist of a clinical director, clinical manager, family support specialist, peer support specialist, registered nurse, rehabilitation specialist, resiliency practitioner, and 2 therapists. The team has received formal training in the CSC model; using a team-based, multi-element approach to treating FEP, the program focuses on early intervention services and works to prevent future symptomatic relapses. The program includes rapid service engagement to reduce duration of untreated psychosis, assertive case management, patient psychoeducation, family psychoeducation, low dose pharmacologic treatment, Cognitive Remediation, and vocational and education support. Resilient health also offers primary care services on site.

Valleywise Health First Episode Center has two locations that serve the most populated county in Arizona, Maricopa. A third location is in development, and the potential for mobile FEP services are being considered to expand coverage of Pinal and Gila counties. All locations provide care to individuals ages 15-25 with a qualifying diagnosis given within the last 12 months with agreement from the person or guardian for the referral. In addition, all locations utilize the CSC model and apply OnTrackNY programming to divert the usual trajectory of a diagnosis of a primary psychotic disorder. The program focuses on educating members about their diagnosis, learning about the tools and resources available to them to overcome the derailment caused by psychosis symptoms can cause in a young person's life. Valleywise Health FEP programs implement strategies and modalities such as Shared Decision Making, Cognitive Enhancement Therapy, mindfulness meditation, integrated care, primary care, and more. Valleywise Health in the West Valley was the first location to be established as an FEP provider in February of 2017 and is located in Avondale,AZ. Valleywise Health, West Valley location personnel consist of: clinical director, clinical coordinator, medical assistant, patient services specialist, peer support specialist, program assistant, rehabilitation specialist, and team specialist. Valleywise Health in the East Valley, located in Mesa, AZ, was approved as an FEP provider in November of 2022. Valleywise Health at this location personnel consist of a clinical director, clinical coordinator, peer support specialist, (2) team specialist, and a rehabilitation specialist.

5. Does the state monitor fidelity of the chosen EBP(s)?

(●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

(●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

AHCCCS implements an integrated model of health care, combining coverage of medical and behavioral health under one managed care health plan. Contracted health plans coordinate and pay for physical and behavioral health care services delivered by more than 104,000 health care providers to more than two million Arizonans. Three of the seven AHCCCS Complete Care Plans are designated as ACC - Regional Behavioral Health Agreements (ACC-RBHAs) which are fully integrated health plans for acute and behavioral health services for members with ESMI/FEP, serious emotional disturbance (SED), and serious mental illness (SMI). The ACC-RBHAs are responsible for the coordination of care for members with behavioral health needs which includes those with ESMI and FEP. AHCCCS Complete Care encourages consistent coordination between both medical and behavioral health providers within the same network, reducing fragmentation and leading to better overall health outcomes for members.

In addition to the requirements for providers to implement EBP for FEP, the recent integration of physical, dental, and behavioral health under one plan for children in foster care, helps to ensure these children, who are at increased risk for psychosis, have access to comprehensive individualized treatment and integrated care. The earlier children in foster care, especially those who may be experiencing psychosis, receive integrated physical and behavioral health care, the better their health outcomes may be.
Further, the use of Child and Family Teams (CFT) for children and Adult Recovery Teams (ART) for adults ensure that children, youth, and young adults with psychosis receive integrated health care through the use of EBPs, not just for the treatment of early psychosis but for their other mental health needs as well as physical health.

The State of Arizona utilizes the Coordinated Specialty Care (CSC) model as the foundation of all acceptable EBPs to be utilized for the 10 percent set-aside of ESMI/FEP programs. The Northern and Southern regions of Arizona utilize NAVIGATE programming and Central Arizona utilizes OnTrackNY; continual training and consultation from appointed EBP programs are provided to ensure all staff are adequately trained with the most current information. In conjunction with NAVIGATE and OnTrackNY, provider programs also report utilizing the following EBP: Acceptance and Commitment Therapy (ACT), Cognitive Behavior Therapy (CBT) for psychosis, Cognitive Enhancement Therapy (CET), Cognitive Remediation, Personal Medicine, Certified Clinical Trauma Specialist–Individual (CCTSI), Dialectical behavior therapy (DBT), EMDR and Family Therapy Model, Motivational Interviewing (MI), Peer support, Solution-focused brief therapy (SFBT), Systemic Family Therapy, and Somatic Experiencing.

AHCCCS understands how imperative it is to utilize the CSC model for FEP and ESMI populations for the best quality of care; to assure this is accomplished, consistent monitoring of EBP training and recertification initiatives has been implemented. Utilization is monitored through deliverables set forth in contracts and policies.

CSC is an evidence based model studied and shown effective in the Recovery After an Initial Schizophrenia Episode (RAISE) project. CSC focuses on offering psychotherapy, medication management, family education and support, case management, supported education and employment, in a recovery-oriented manner, with an emphasis on shared decision making. Each member works with the team of specialists and the family as much as is possible and appropriate to create an individualized treatment plan that works best for the individual. Each team of specialists is composed of professionals to meet the key roles and functions, although the staffing in each program may vary based on local needs.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

AHCCCS processes regarding MHBG funding allocations specific to ESMI/FEP set aside include ACC-Regional Behavioral Health Agreements (RBHAs) contracts, budget requests, and oversight through deliverables of programmatic initiatives will continue through FFY 2024 and FFY 2025. The current process is as followed: AHCCCS analyzes historical expenditures and outcomes to develop an allocation schedule for all funding sources, communicates to the ACC-RBHAs of their respective allocation in relation to ESMI/FEP and requests they submit program plans and budgets for the dollars from their designated providers and subcontractors. AHCCCS MHBG Administrator and Coordinator then review each budget proposal and compare it to each ACC-RBHA's Attachment K for alignment with outlined goals, objectives and desired outcomes from both a programmatic and a fiscal lens. MHBG then works with each ACC-RBHA to make revisions when applicable, then formally stamps and approves the program plans and budgets. This annual process occurs throughout August and September with the goal to approve all program plans and budgets by September 30th of each year. Programs are able to request budget revisions throughout the year for the success of programming and services and to ensure full expenditures of the grant dollars. Through this standard process and collaboration with each ACC-RBHA, AHCCCS is continually assessing and innovating projects and initiatives for the successful implementation of ESMI/FEP programming across the state.

AHCCCS plans to continue strong oversight of (CSC) model implementation and consistent monitoring of EBP training and recertification initiatives, assuring that integrated care including all key components of the (CSC) model are being offered at all facilities including: case management, group counseling, family education, individual counseling, medication management, peer support, primary care, supported employment/education, and the accessibility of services throughout the State of Arizona for individuals diagnosed with ESMI/FEP.

These plans are already in motion for the next FFY as AHCCCS works with all ACC-RBHAs to obtain or get recertified in their designated EBP of choice, NAVIGATE and/or OnTrackNY. AHCCCS is also actively working with the ACC-RBHAs to bolster and expand ESMI/FEP services, particularly in the rural, frontier areas of the state in addition to already planned expansions in the central region.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

Per AHCCCS Medical Policy Manual (AMPM) 320-T1, the following are diagnoses that qualify specifically for FEP programming. These are

not intended to include conditions that are attributable to the physiologic effects of substance abuse disorder (SUD), are attributable to an intellectual/developmental disorder, or are attributable to another medical condition:
a. Delusional Disorder,
b. Brief Psychotic Disorder,
c. Schizophreniform Disorder,
d. Schizophrenia,
e. Schizoaffective Disorder,
f. Other specified Schizophrenia Spectrum and Other Psychotic Disorder,
g. Unspecified Schizophrenia Spectrum and Other Psychotic Disorder,
h. Bipolar and Related Disorders, with psychotic features, and
i. Depressive Disorders, with psychotic features.

The diagnoses identified as ESMI (and SMI) are the following:

Psychotic Disorders
F20.0 Schizophrenia
F20.1 Disorganized Schizophrenia
F20.2 Catatonic Schizophrenia
F20.3 Undifferentiated Schizophrenia
F20.5 Residual Schizophrenia
F20.9 Schizophrenia, unspecified
F21 Schizotypal Disorder
F22 Delusional Disorder
F25.0 Schizoaffective Disorder
F25.1 Schizotypal Disorder
F25.8 Other schizoaffective disorders
F25.9 Schizoaffective Disorder, Unspecified
F28 Other psychotic disorder not due to a substance or known physiological condition
F29 Unspecified psychosis not due to a substance or known physiological condition

Bipolar Disorders
F31.0 Bipolar I Disorder, Current or most recent episode hypomanic
F31.1 Bipolar I Disorder, Current episode manic without psychotic features
F31.10 Bipolar I Disorder, Current episode manic without psychotic features, Unspecified
F31.11 Bipolar I Disorder, Current episode manic without psychotic features, mild
F31.12 Bipolar I Disorder, Current episode manic without psychotic features, moderate
F31.13 Bipolar I Disorder, Current episode manic without psychotic features, severe
F31.2 Bipolar I Disorder, Current episode manic with psychotic features
F31.30 Bipolar I Disorder, Current episode depressed, mild to moderate severity, unspecified
F31.31 Bipolar I Disorder, Current episode depressed, mild
F31.32 Bipolar I Disorder, Current episode depressed, moderate
F31.4 Bipolar I Disorder, Current episode depressed, severe
F31.5 Bipolar I Disorder, Current episode depressed, severe, with psychotic features
F31.60 Bipolar I Disorder, Current episode mixed, unspecified
F31.61 Bipolar I Disorder, Current episode mixed, mild
F31.62 Bipolar I Disorder, Current episode mixed, moderate
F31.63 Bipolar I Disorder, Current episode mixed, severe, without psychotic features
F31.64 Bipolar I Disorder, Current episode mixed, severe, with psychotic features
F31.70 Bipolar I Disorder, currently in remission, most recent episode unspecified
F31.71 Bipolar I Disorder, in partial remission, most recent episode hypomanic
F31.72 Bipolar I Disorder, in full remission, most recent episode hypomanic
F31.73 Bipolar I Disorder, in partial remission, most recent episode manic
F31.74 Bipolar I Disorder, in full remission, most recent episode manic
F31.75 Bipolar I Disorder, In partial remission, Current or most recent episode depressed
F31.76 Bipolar I Disorder, In full remission, Current or most recent episode depressed
F31.77 Bipolar I Disorder, in partial remission, most recent episode mixed
F31.78 Bipolar I Disorder, in full remission, most recent episode mixed
F31.81 Bipolar II Disorder
F31.89 Other Bipolar Disorder
F31.9 Bipolar Disorder, unspecified
F34.0 Persistent mood (affective) disorder

Depressive Disorders
F32.0 Major Depressive Disorder, Single episode, mild
F32.1 Major Depressive Disorder, Single episode, moderate

F32.2 Major Depressive Disorder, Single episode, severe
F32.3 Major Depressive Disorder, Single episode, with psychotic features
F32.4 Major Depressive Disorder, Single episode, in partial remission
F32.5 Major Depressive Disorder, Single episode, in full remission
F32.89 Other specified depressive episode
F32.9 Major depressive disorder, single episode, unspecified
F33.0 Major Depressive disorder, recurrent, mild
F33.1 Major Depressive disorder, recurrent, moderate
F33.2 Major Depressive disorder, recurrent, severe without psychotic features
F33.3 Major Depressive disorder, recurrent, severe with psychotic features
F33.4 Major Depressive disorder, recurrent, in remission
F33.40 Major Depressive disorder, recurrent, unspecified
F33.41 Major Depressive Disorder, recurrent, in partial remission
F33.42 Major Depressive Disorder, recurrent, in full remission
F33.9 Major Depressive Disorder, recurrent, unspecified
F34.1 Dysthymic Disorder

Other Mood Disorders
F39 Unspecified mood (affective) disorder

Anxiety Disorders
F40.00 Agoraphobia, unspecified
F40.01 Agoraphobia, with panic disorder
F40.02 Agoraphobia, without panic disorder
F41.0 Panic Disorder
F41.1 Generalized Anxiety Disorder
F41.8 Other specified anxiety disorders
F41.9 Anxiety Disorder, unspecified

Obsessive-Compulsive Disorder
F42.2 Mixed obsessional thoughts and acts
F42.8 Other obsessive-compulsive disorder
F42.9 Obsessive-compulsive disorder, unspecified
F43.12 Post-traumatic stress disorder, chronic

Dissociative Disorder
F44.81 Dissociative identity disorder

Personality Disorders
F60.0 Paranoid Personality Disorder
F60.1 Schizoid personality Disorder
F60.3 Borderline Personality Disorder
F60.4 Histrionic Personality Disorder
F60.5 Obsessive-compulsive personality disorder
F60.6 Avoidant Personality disorder
F60.7 Dependent Personality disorder
F60.81 Narcissistic personality disorder
F60.89 Other specific personality disorders
F60.9 Personality Disorder, unspecified

Qualifying diagnoses and functional limitations are reviewed annually by the AHCCCS Coding Benefit Review Team (CBRT) to align with current best practice and/or updates to the DSM.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

AHCCCS utilized both deliverable data collected by ACC-Regional Behavioral Health Agreements (ACC-RBHAs) and OnTrackNY interactive tool to illustrate the estimated incidence of individuals with first episode psychosis. Utilizing the OnTrackNY interactive tool, the total number of new active individuals receiving services per year was estimated at 276 individuals. This is comparable to deliverable data received for fiscal year 2022 identifying 150 new active individuals receiving services. The OnTrackNY interactive tool also projected the number of incident cases approached being 553 individuals. AHCCCS deliverables identified 462 number of incident cases approached.

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

Through AHCCCS utilization of ACC-Regional Behavioral Health Agreements (ACC-RBHAs) selected to conduct fidelity oversight of FEP(first episode psychosis) programs in their geographic service area (GSA) and AHCCCS integrated model of health care, combining coverage of medical and behavioral health under one managed care health plan, outreach and engagement for those with FEP is accomplished. ACC-

RBHA's are required to conduct outreach and engagement events for FEP targeted populations. All ACC-RBHA's provide education and availability of resources to providers within their network and encourage the utilization of FEP services. Additional innovative outreach and engagement efforts are accomplished by media campaigns, community outreach events such as resource fairs and festivals, and integrated emergency care and FEP programming alliances. AHCCCS will continue to require outreach and engagement initiatives as a part of FEP programming and encourage innovative forms of accomplishment.

Please indicate areas of technical assistance needed related to this section.

None at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

1. Does your state have policies related to person centered planning? (●) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

AHCCCS has implemented person-centered planning for all populations served. This has been a collaborative effort and partnership with the individuals , family members, advocates, and community stakeholders. An essential part of person-centered planning is that the person drives the process. They are the experts of their own lives and are at the center of the "person-centered planning" process. It is essential to gather their input, hear their voice and choice of treatment/services, who they want involved in their treatment planning process, and ensure access to care is timely and efficient.
Arizona's model is based upon the premise that people want and deserve dignity, respect, inclusion, and safety. Based on four elements:
1. Affording people dignity, compassion and respect
2. Offering coordinated care, support or treatment
3. Offering personalized care, support or treatment
4. Supporting people to recognize, as well as develop their strengths and abilities in order to enable them to live a fulfilling and independent life.

Person-Centered Planning is based upon a foundation of Person-Centered Thinking (PCT), which inspires and guides respectful listening leading to actions, resulting in individuals who:
1. Have positive control over the life they desire and find satisfying
2. Are recognized and valued for their contributions to their journey toward recovery and to their families, people of support and their communities
3. Are supported by a network of relationships, both natural and paid, within their community
4. Are offered employment opportunities, education, vocational training, and opportunities to work/not work depending on an individual's unique needs and choices.

Person-centered planning includes a description of how care and services are delivered in a culturally competent, family/member centered manner and are responsive to diverse cultural and ethnic backgrounds. The AHCCCS Medical Policy Manual (AMPM) Policy 320-O: Behavioral Health Assessments and Treatment Service Planning (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320-O.pdf) specifies provisions for Behavioral health assessment, services and/or treatment planning for individuals we serve, including outlining additional requirements for individuals with SMI designations. Provider case managers are responsible for monitoring the member's current needs, services, and progress through regular and ongoing contact. Treatment plans are to be reviewed and updated annually at a minimum or based on individual wants, needs, strengths and desires.

The person-centered planning process ensures that cultural and linguistic needs are identified and addressed. Linguistic needs

are defined as providing services in a person's primary or preferred language, including sign language, and the provision of interpretation and translation services. Written materials are critical to obtaining services and the conversion of written materials from English into the person's preferred language while maintaining the original intent also occurs; examples include: Treatment Planning Documents, Member Handbooks, Provider Directories, Consent Forms, Appeal and Grievance Notices, and Denial and Termination Notices.

4. Describe the person-centered planning process in your state.

AHCCCS fosters an environment of person-centered planning that prioritizes and respects the voice and choice of the person being served, their family, identified persons of support, advocates (as designated) and service providers, as identified. The planning process is transparent and fluid; the Individual Service Plan (ISP) is a living document that can be updated or changed at any time based on the wants, needs, and strengths of the person served.

AHCCCS' Integrated System of Care (ISOC) is a continuum of coordinated community and facility-based services and supports for individuals with, or at risk for, behavioral health challenges. The ISOC is organized into a comprehensive network to create opportunities to foster recovery and improve health outcomes by:
1. Building meaningful partnerships with individuals served
2. Addressing the individuals' cultural and linguistic needs and preferences
3. Assisting the individual in identifying and achieving personal and recovery goals.

Arizona/AHCCCS developed the following Nine Guiding Principles to promote recovery in the adult behavioral health system and for engaging with adults who have a serious mental illness (SMI):
1. RESPECT: Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.
2. PERSONS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND PROGRAM DEVELOPMENT EFFORTS: A person in recovery has choice and a voice. Their self-determination in driving services, program decisions, and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the "informed consumer" and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
3. FOCUS ON INDIVIDUAL AS A WHOLE PERSON, WHILE INCLUDING AND/OR DEVELOPING NATURAL SUPPORTS: A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.
4. EMPOWER INDIVIDUALS TAKING STEPS TOWARDS INDEPENDENCE AND ALLOWING RISK TAKING WITHOUT FEAR OF FAILURE: A person in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.
5. INTEGRATION, COLLABORATION, AND PARTICIPATION WITH THE COMMUNITY OF ONE'S CHOICE: A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.
6. PARTNERSHIP BETWEEN INDIVIDUALS, STAFF, AND FAMILY MEMBERS/NATURAL SUPPORTS FOR SHARED DECISION MAKING WITH A FOUNDATION OF TRUST: A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.
7. PERSONS IN RECOVERY DEFINE THEIR OWN SUCCESS: A person in recovery – by their own declaration – discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.
8. STRENGTHS-BASED, FLEXIBLE, RESPONSIVE SERVICES REFLECTIVE OF AN INDIVIDUAL'S CULTURAL PREFERENCES: A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and more. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.
9. HOPE IS THE FOUNDATION FOR THE JOURNEY TOWARDS RECOVERY: A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

Arizona/AHCCCS collaborated with the child, family, and others to provide services that are tailored to meet the needs of children with serious emotional disturbances and their caregivers. The goal is to ensure that services are provided to the child and family in the most appropriate setting, in a timely manner, in accordance with the best practices and respecting the child, family and their cultural heritage. Arizona/AHCCCS developed The Twelve (12) Principles for Children's in the Behavioral Health Service Delivery System:
1. COLLABORATION WITH THE CHILD AND FAMILY: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment

process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. FUNCTIONAL OUTCOMES: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
3. COLLABORATION WITH OTHERS: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, DCS and/or DDD caseworker, and the child's probation officer. The team (a) develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan, and (d) makes adjustments in the plan if it is not succeeding.
4. ACCESSIBLE SERVICES: Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.
5. BEST PRACTICES: Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.
6. MOST APPROPRIATE SETTING: ?Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.
7. TIMELINESS: Children identified as needing behavioral health services are assessed and served promptly.
8. SERVICES TAILORED TO THE CHILD AND FAMILY: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.
9. STABILITY: Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.
10. RESPECT FOR THE CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.
11. INDEPENDENCE: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.
12. CONNECTION TO NATURAL SUPPORTS: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.
Overall, the Person-Centered Planning and Service Plan reflects the individuals' strengths and preferences that meet the persons' social, cultural, and linguistic needs and includes individualized goals and desired outcomes.? Additionally, the planning process also identifies risk factors (includes risks to member rights) and puts measures in place to minimize them with individual back-up plans and other strategies as needed.

Person-centered service planning supports the aging population via the AHCCCS Arizona Long-Term Care Services (ALTCS) division. ALTCS members are actively engaged in planning and creating the life they want through services and supports to ensure all members are integrated into their communities and have full access to the benefits of community living. ALTCS case managers play a significant role in assessing needs and addressing barriers and challenges that our members face, through a person-centered approach. The AHCCCS Person-Centered Service Plan (PCSP) is a requirement for the ALTCS population and is a written plan developed through an assessment of functional need that reflects the services and supports (paid and unpaid, including behavioral health) that are important to and important for the member in meeting the identified needs and preferences for the delivery of such services and supports. The PCSP also reflects the member's strengths and preferences that meet the member's social, cultural, and linguistic needs, individually identified goals and desired outcomes, and reflect risk factors (including risks to member rights) and measures in place to minimize risk, including the development of individualized back-up/ contingency plans and other strategies as needed. The person-centered service planning process ensures a standardized method for assessing and documenting discussions with members during assessment and service planning meetings for all ALTCS members; promotes and

support discussions with members around key indicators that help assess an individual's integration experience and access to rights afforded to them; and helps to document information shared during conversations with the members, which help to inform personal goal development and service planning.

Support Coordinators utilize person-centered service planning when assisting individuals who receive services within the Arizona Division of Developmental Disabilities (DDD) as well. Person-centered service planning ensures that the voice and choice of the member is heard and respected, leading to greater independence and input regarding the services that they will utilize. DDD Support Coordinators have been trained in person-centered service planning and use this approach to help the person achieve their goals, ensure their needs are met and live the way they choose to live.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

AHCCCS Medical Policy Manual (AMPM) Policy 640 - Advanced Directives (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/600/640.pdf) outlines that adult members, when incapacitated or unable to receive information, the member's family or surrogate as defined in A.R.S. §36-3231, shall be provided written information regarding Advance Directives as delineated in 42 CFR 489.102(e) concerning:
1. The member's rights, regarding Advance Directives under Arizona State law.
2. The organization's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
3. A description of the applicable state law and information regarding the implementation of these rights.
4. The member's right to file complaints with ADHS Division of Licensing Services, and
5. Written policies including a clear and precise statement of limitations if the provider cannot implement an Advance Directive as a matter of conscience.
This statement, at a minimum, shall:
a. Clarify institution-wide conscientious objections and those of individual physicians,
b. Identify state legal authority permitting such objections, and
c. Describe the range of medical conditions or procedures affected by the conscience objection.

The provider is not relieved of its obligation to provide the above information to the member once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures are in place to provide the information to the member directly at the appropriate time. The above information is provided to a member upon each admission to a hospital or nursing facility and each time the member comes under the care of a home health agency, hospice or personal care provider. [42 U.S.C. § 1396a (w)(2)]

In addition to the AHCCCS Medical Policy Manual (AMPM) Chapter 640, each RHBA provides additional resources and information on Advance Directives and each provider is required to provide information on advanced directives at the time of enrollment.

The Wellness, Recovery, Action Plan (WRAP) is another evidence-based tool utilized by providers throughout Arizona. The WRAP is a proactive plan developed by the individual and allows the person to self-direct and maintain control of their treatment and processes in the event they become unable to do so as the result of their symptomatology. The WRAP guides the person in creating an individualized "Wellness Toolbox," daily maintenance plan, identification of triggers, early warning signs, and signs things are "breaking down" with action plan(s) utilizing the Wellness Toolbox. Section 5 of the WRAP is a Crisis Plan or Advance Directive assisting the person to identify and communicate the signs that let others know they need to take over responsibility for their care and decision making, who they want to take over and support them in this time, health care information, a plan for staying home, things others can do that would help and things that others might choose to do that would not be helpful to the person. The WRAP provides the person with a sense of control, the ability to communicate their wishes, and guide their own treatment in times they are unable to do so.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? (●) Yes ( ) No

3. Does the state have any activities related to this section that you would like to highlight?

Within AHCCCS, many divisions collaborate to ensure compliance with block grant program integrity responsibilities. The Division of Grants and Innovation (DGI) provides ultimate oversight and management of evidence-based, person-centered programming and service delivery in addition to fiscal responsibility of MHBG and SABG grant dollars. The Division of Health Care Management (DHCM), the Office of the Director (OOD), the Division of Community Advocacy & Intergovernmental Relations (DCAIR), and the Division of Fee for Service Management (DFSM) also play an integral role in the ongoing monitoring for programmatic compliance, including promoting the proper expenditure of block grant funds, improving block grant program compliance, and demonstrating the overall effective use of block grant funds. ACC-RBHAs and TRBHAs are required to ensure they and their subcontractors are fulfilling all reporting requirements and deliverables outlined in their contract/IGA.

AHCCCS contracts with three AHCCCS Complete Care Contractors with a Regional Behavioral Health Agreement (ACC-RBHAs): Mercy Care, Care 1st, and Arizona Complete Health, for the provision of SAMHSA Mental Health Block Grant (MHBG) and Substance Abuse Block Grant (SABG) services and funding. These Contracts delineate the requirements of the ACC-RBHAs, including their responsibilities for implementing and monitoring subcontractors who are the providers of direct care services and treatment. Notwithstanding any relationship(s) the ACC-RBHA may have with any subcontractor, the ACC-RBHA maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. ACC-RBHAs

subcontract with providers in their Geographic Service Area (GSA)to ensure members may access services within their communities. Provider networks must meet access-to-care standards for the populations served. The AHCCCS Division of Grants and Innovation meets with ACC-RBHAs every other month and on an as needed basis. These meetings are called by AHCCCS DGI, and facilitated by the AHCCCS DGI Compliance Manager who coordinates agenda needs from all DGI units (such as SABG, MHBG, SOR crisis, etc.) as well as from the ACC-RBHAs. Both the MHBG and SABG teams meet with the ACC-RBHAs on a monthly and/or as-needed basis. Necessary updates and/or technical assistance are provided within these meetings.

AHCCCS additionally holds Intergovernmental Agreements (IGAs) with four (4) Tribal Regional Behavioral Health Authorities (TRBHAs): Gila River, Navajo Nation, White Mountain Apache, and Pascua Yaqui, for the provision of MHBG and SABG services and funding. The IGAs ensure that services and treatment funded under the federal block grants meet the legal requirements of the respective block grant. The TRBHAs are responsible for implementing and monitoring direct care services and treatment and for the development and implementation of primary substance abuse prevention services. Both the MHBG and SABG teams meet with the ACC-RBHA's on a monthly and as-needed basis and either AHCCCS or the ACC-RBHA's/TRBHA's can request to convene a meeting. Necessary updates and/or technical assistance are provided within these meetings.

Contracts/IGAs are updated and amendments are executed on a scheduled and as needed basis to revise and implement reporting, monitoring, evaluation, and compliance requirements. The Non-Title XIX/XXI contracts with the ACC-RBHAs are updated annually, amendments executed by October 1 each year. This contract amendment is facilitated by the AHCCCS Division of Health Care Services, Contracts Unit, reviewed and revised by all pertinent AHCCCS divisions and subject matter experts. Once suggested contract revisions are completed by AHCCCS, they are posted for public comment opportunity. Public comments are received, reviewed, and addressed by AHCCCS prior to contract execution. The IGAs are updated on a 5-year cadence. The IGA updates are negotiated between the AHCCCS Division for Fee for Service Management (DFSM) and the TRBHAs. The latest update occurred in 2021 and DGI provided requested revisions related to SABG and MHBG. NTXIX/XXI Contracts and IGAs are posted on the AHCCCS website at the links below.
ACC-RBHA NTXIX/XXII Contracts
https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/contracts.html
AHCCCS-TRBHA IGAs
https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/TRBHA.html

ACC-RBHAs are required to align their programs and activities with the following AHCCCS System Values:
1. Timely access to care
2. Culturally competent and linguistically appropriate care
3. Identification of the need for and the provision of comprehensive care coordination for physical and behavioral health service delivery
4. Integration of clinical and non-clinical health care related services
5. Education and guidance to providers on service integration and care coordination
6. Provision of disease/chronic care management including self-management support
7. Provision of preventive and health promotion and wellness services
8. Adherence with the Adult Behavioral Health Service Delivery System Nine Guiding Principles and the Arizona Vision and 12 Principles for Children Behavioral Health Service Delivery
9. Promotion of evidence-based practices through innovation
10. Expectation for continuous quality improvement
11. Improvement of health outcomes
12. Containment and/or reduction of health care costs without compromising quality
13. Engagement of member and family members at all system levels
14. Collaboration with the greater community
15. Maintenance, rather than delegation of, key operational functions to ensure integrated service delivery
16. Commitment to system transformation
17. Implementation of health information technology to link services and facilitate improved communication between treating professionals, and between the health team, the member, and member caregivers
18. Integration of the delivery of physical and behavioral health care as an essential part of improving the overall health of members.

AHCCCS ACOM Policy 103 - 'Fraud, Waste, and Abuse'
https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/100/103.pdf outlines the corporate compliance requirements including the reporting responsibilities for alleged fraud, waste and/or abuse involving AHCCCS program funds regardless of the source. This Policy also addresses additional responsibilities regarding compliance with broader program integrity regulatory and programmatic requirements. AHCCCS has a comprehensive Corporate Compliance Program to achieve the goals of preventing and detecting fraud, waste, and abuse of the program. The program ensures Contractor compliance with applicable laws, rules, regulations, and contract requirements. Continued collaboration efforts include regularly scheduled meetings held to share information with RBHAs and TRBHAs regarding their Corporate Compliance Program that includes all program integrity activities. The Office of Inspector General (OIG) is responsible for program integrity for the Arizona Health Care Cost Containment System (AHCCCS). It exists to prevent, detect, and recover improper payments due to Medicaid fraud, waste, and abuse. OIG works closely with federal and state partners, including the Medicaid Fraud Control Unity (MFCU) of the Arizona Attorney General, the Federal Bureau of Investigations (FBI), Drug Enforcement Agency (DEA), Health and Human Services (HHS) OIG, local police and law

enforcement agencies, county prosecutors, contracted health plans, and other state agencies. All suspected fraud, waste, or abuse must be reported to the AHCCCS OIG. The OIG is responsible for handling all reports of fraud, waste, and abuse of the AHCCCS program. Absolutely anyone can report Arizona Medicaid fraud, waste, or abuse without restrictions and reporters may remain anonymous. Information regarding OIG and how to report suspected fraud is available at: https://www.azahcccs.gov/Fraud/ReportFraud/

Operational Reviews

AHCCCS conducts annual MHBG/SABG Operational Reviews of ACC-RBHAs to determine if the Contractors satisfactorily meet AHCCCS's requirements as specified in Contract, AHCCCS policies, Arizona Revised Statute, the Arizona Administrative Code and 42 CFR Part 438, Managed Care; Increase AHCCCS knowledge of the Contractors' operational encounter processing procedures; provide technical assistance and identify areas where improvements can be made, as well as identifying areas of noteworthy performance and accomplishments; review progress in implementing recommendations made during prior reviews; determine if the Contractor is in compliance with its own policies and to evaluate the effectiveness of those policies and procedures; perform Contractor oversight as required by the CMS in accordance with AHCCCS' 1115 Waiver; and Provide information to an External Quality Review Organization (EQRO) for its use as described in 42 CFR 438.364. Operational Reviews can be found on the AHCCCS website: https://www.azahcccs.gov/Resources/OversightOfHealthPlans/OpReviews.html

AHCCCS conducts biennial Operational Reviews (OR) with the TRBHAs block grant services. Block grant requirements, prohibitions, and deliverables are outlined in the TRBHA Intergovernmental Agreements (IGA). During the OR, records of members who received block grant services are reviewed according to the prospective grant requirements to ensure the expenditure of funds on services for the priority population and intervention and prevention services, that the services meet the legal requirements of the grant, and that they are being utilized as the payor of last resort. Findings are discussed, plans are put in place if needed, and AHCCCS provides regular technical assistance to ensure regulatory utilization of grant dollars including reviewing reports and deliverables, monitoring and reviewing spend, providing technical assistance and training to the TRBHAs as needed, and conducting routine finance meetings.

Reporting Requirements

Regular deliverable submissions to AHCCCS by each ACC-RBHA and TRBHA are required and analyzed to ensure program integrity efforts are met. These include at a minimum: annual Independent Case Reviews; annual MHBG and SABG Activities and Expenditures Plans and Reports; quarterly Grievance and Appeal reporting; and annual/quarterly/monthly Financial Reporting. A brief description of each is provided below:

1. AHCCCS oversees the Independent Case Reviews (ICRs) to meet the Peer Review requirement of the block grant to ensure the quality and appropriateness of treatment services and indications of treatment outcomes. An ICR interdisciplinary team from an independent agency completes case reviews.
2. ACC-RBHAs and TRBHAs must provide information regarding MBHG and SABG activities and expenditures outlining use of funds, strategies for monitoring expenditures, and make adjustments in a timely manner to best meet the needs of the community.
3. ACC-RBHAs and TRBHAs must for all members, subcontractors, and providers administer all Grievances and Appeal System processes competently, expeditiously, and equitably. ACC-RBHAs and TRBHAs are required to report provider claim disputes, member grievances, SMI Grievances and SMI Appeals as delineated in Arizona Administrative Code Title 9, Chapter 21, Article 4.
4. ACC-RBHAs and TRBHAs are required to submit financial statements and reporting packages, which must comply with contractual requirements for management of federal block grant funds.

Policies and Procedures

In addition to the Contracts/IGAs, multiple policies and procedures are developed and implemented for ACC-RBHAs and TRBHAs to ensure operational and programmatic compliance and appropriate service delivery. Two priority manuals are the AHCCCS Contractor Operations Manual (ACOM) and the AHCCCS Medical Policy Manual (AMPM). Policies within these manuals are written in collaboration within multiple divisions at AHCCCS with revisions completed as needed due to Federal or State legislation, contractual requirements, operational changes, monitoring requirements, benefit coverage, etc. All applicable policies are incorporated by reference in the Contracts/IGAs.

Several noteworthy policies are outlined below which relate to ACC-RBHA grant services and funding; member and provider notifications; and access to care requirements (this is not an all-inclusive list):

ACOM Policy 103, Fraud, Waste, and Abuse
ACOM Policy 323, RBHAs Title XIX/XXI Reconciliation and Non-Title XIX/XXI Profit Limit
ACOM Policy 404, Contractor Website and Member Information
ACOM Policy 406, Member Handbook and Provider Directory
ACOM Policy 416, Provider Information
ACOM Policy 436, Provider Network Requirements
ACOM Policy 444, Notice of Appeal Requirements (SMI Appeals)
ACOM Policy 446, Grievances and Investigations Concerning Persons with Serious Mental Illness
ACOM Policy 448, Housing
AMPM Policy 310-B, Title XIX/XXI Behavioral Health Services Benefit
AMPM 310-V, Prescription Medications-Pharmacy Services

AMPM 320-V, Behavioral Health Residential Facilities
AMPM Policy 320-T1, Block Grants and Discretionary Grants
AMPM Policy 580, Behavioral Health Referral and Intake Process
AMPM Policy 650, Behavioral Health Provider Requirements for Assisting Individuals with Eligibility Verification and Screening, Application for Public Health Benefits Provider Eligibility
AMPM Policy 960, Quality of Care Concerns
AMPM Policy 961, Incident, Accident, and Death Reporting
AMPM Policy 962, Reporting and Monitoring of Seclusion and Restraint
AMPM Policy 963, Peer and Recovery Support Service Provision Requirements
AMPM Policy 964, Credentialed Parent Family Support Requirements
AMPM Policy 1040, Outreach, Engagement, Re-Engagement and Closure for Behavioral Health

Contractors, providers, and members have full access to the ACOM, AMPM, and other Guides and Resources via the AHCCCS website https://www.azahcccs.gov. Policies are made available to stakeholders for a 45-day Tribal Consultation/Public Comment period. Revision memos that accompany each policy revision explain the changes and notification of changes is sent via email. AHCCCS additionally hosts the AHCCCS Managed Care Organization (MCO) Update Meetings with contracted health plans, state agencies, and TRBHAs every other month or as needed. AHCCCS also conducts quarterly Tribal Consultation meetings to consult with tribes, Indian Health Service, tribal health programs operated under P.L. 93-638, and urban Indian health programs in Arizona regarding policy and programmatic changes that may significantly impact members. Individualized communication with each ACC-RBHA formally occurs during regular meetings with AHCCCS to review issues, concerns, and new information. If an improvement plan is established, oversight and communication between AHCCCS and the perspective ACC-RBHA or TRBHA occurs more frequently.

ACC-RBHAs and TRBHAs are responsible for ensuring that its subcontractors are notified when modifications are made to AHCCCS guidelines, policies, and manuals. In the event of a modification to AHCCCS Policy, guidelines, and manuals and are required to issue a notification of the change to its affected subcontractors within 30 calendar days of the published change and ensure amendment of any affected subcontracts. ACC-RHBAs are also contractually required to hold semi-annual provider forums to improve communication between the Contractor and providers and to provide such general information, technical assistance, and/or address issues.

Please indicate areas of technical assistance needed related to this section

None at this time.

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

AHCCCS has conducted 15 total Tribal Consultations between July 1, 2021 - June 1, 2023: 7 Quarterly Tribal Consultations and 8 Special Tribal Consultations. Those sessions can be accessed at the following AHCCCS website: https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html. In addition to quarterly Tribal Consultations, AHCCCS Division of Fee-For-Service Management (DFSM) held 7 quarterly meetings with Arizona's Tribal Regional Behavioral Health Authorities (TRBHAs). TRBHAs are tribal entities that have an Intergovernmental Agreement (IGA) with the AHCCCS administration, the primary purpose of which is to coordinate the delivery of comprehensive mental health services to all eligible persons assigned by the administration to the tribal entity. AHCCCS Division of Grants and Innovation (DGI) also conducts monthly meetings with TRBHA's specific to SABG and MHBG funding that started in 2022 and collaboration efforts will continue on a monthly basis. Tribes in Arizona continue to actively engage the Arizona Health Care Cost Containment System (AHCCCS) and the Centers for Medicare and Medicaid Services (CMS) to seek policies and other measures that address health care disparities in the American Indian population served by Indian Health Care Providers (IHCPs) and/or the provider networks under the AHCCCS Health Plan. Tribal Consultation meetings hosted by the AHCCCS provides the opportunity for Tribes in Arizona to bring forth their challenges and issues, as well as policy recommendations, utilizing the AHCCCS healthcare system.

2. What specific concerns were raised during the consultation session(s) noted above?

Consultation sessions with Tribal Regional Behavioral Health Authorities (TRBHAs) focused on AHCCCS presentations regarding the following array of topics: the physical and behavioral health care coordination for tribal members; non-emergency transportation services; pharmacy benefits; State Plan Amendments, including traditional healing, dental benefits, and differential adjusted payments; 1115 waivers, including AHCCCS Works/community engagement requirement and prior quarter coverage ; housing; funding and payment details; Indian Health Services (IHS) 638 funding; Value Based Purchasing; legislative actions; best practices; and policy implications. Through these sessions, two main areas of concern have emerged as significant priorities for action: Behavioral Health Residential Facilities (BHRFs) and Sober Living Homes (SLHs) related issues, as well as the need for

improvements in the tribal consultation process itself. The first area of concern revolves around BHRFs and SLHs, which have raised significant issues impacting tribal communities. It has become evident that these facilities, intended to support individuals dealing with behavioral health challenges and substance use disorders, have been a source of maltreatment, abuse, and fraudulent activities. Secondly, the impact of these harmful practices has been disproportionately felt by American Indian and Alaska Native communities, exacerbating the ongoing crisis of Missing and Murdered Indigenous People (MMIP). The need to address these issues and ensure the safety and well-being of tribal members accessing these facilities is of utmost importance. To that end, AHCCCS is committed to conducting additional tribal consultation with the 22 Arizona-based Indian Tribes as part of our ongoing efforts to address the challenges related to the BHRF/SLH. It is recognized that the tribal perspective is essential in shaping effective strategies and policies that meet the specific needs of tribal communities. By engaging in open and meaningful dialogue through these consultations, the aim is to ensure that the response efforts are inclusive, respectful, and informed by the tribal voice.

In addition to Tribal Consultations, AHCCCS holds quarterly meetings with the Tribal Regional Behavioral Health Authorities (TRBHAs). TRBHAs are tribal entities that have an Intergovernmental Agreement (IGA) with the AHCCCS administration, the primary purpose of which is to coordinate the delivery of comprehensive mental health services to all eligible persons assigned by the administration to the tribal entity. The Tribal Regional Behavioral Health Authorities (TRBHAs) continue to be actively involved in partnering with AHCCCS programmatic staff in regular meetings and conference calls to coordinate the efforts of substance use disorder prevention and treatment services, and to receive technical assistance related to the block grant reporting requirements. The State has identified a process for which the TRBHAs can request additional block grant dollars, if needed. Various TA sessions have also been conducted through monthly MHBG and SABG specific meetings to assure collaboration and education of block grant funding opportunities and utilization parameters are presented.

3. Does the state have any activities related to this section that you would like to highlight?

AHCCCS would like to highlight the meaningful collaborations conducted between TRBHA's and block grant staff as integrated cultural awareness is being discussed and how tribal initiatives can be utilized with block grant funds. Both MHBG and SABG conduct regularly scheduled (generally monthly) meetings with the TRBHA's to review budgets/revisions, discuss trends, challenges and barriers, and have meaningful interactions regarding the unique needs and ways in which the grants can best support their efforts. This has assisted with enhancing understanding and allowable utilization of funds in addition to providing TRBHA's with detailed grant opportunities for which they qualify. AHCCCS has also implemented its American Indian Medical Home Program (AIMH) for IHS/638 facilities for enhanced primary care case management and care coordination, as well as the implementation of Care Coordination Agreements between IHS/638 facilities and non-IHS/638 facilities to improve the delivery system for American Indians by increasing access to care and strengthening the continuity of care. The American Indian Medical Home (AIMH) Program is for American Indian/Alaska Native (AI/AN) members enrolled in the American Indian Health Program (AIHP). The AIMH Program is the first of its kind in the nation and was brought to fruition through a robust partnership between AHCCCS and tribal leadership. The AIMH Program supports Primary Care Case Management (PCCM), diabetes education, and care coordination for its AIHP enrolled members.
AHCCCS is deeply committed to continually improving its tribal consultation process, especially in a post-pandemic world. Recognizing the unique needs and perspectives of tribal communities, AHCCCS understands the importance of meaningful engagement and collaboration with tribal partners. To further enhance the tribal consultation process, AHCCCS has initiated a formal review of its existing practices. This review aims to assess and strengthen the effectiveness of tribal consultation in addressing the healthcare needs of tribal communities. One of the key components of this review involves conducting one-on-one sessions with all 22 Arizona-based Indian Tribes. These sessions will serve as dedicated platforms for open and constructive discussions, enabling AHCCCS and tribal representatives to exchange views, address concerns, and share recommendations. Importantly, AHCCCS views these sessions as true consultations with tribal partners. The agency recognizes the significance of actively listening to tribal perspectives and integrating them into decision-making processes. By fostering a collaborative environment, AHCCCS aims to ensure that tribal communities have a voice in shaping healthcare policies and programs that directly impact their well-being.
AHCCCS acknowledges the unique challenges that the COVID-19 pandemic has posed for tribal communities and understands that the post-pandemic landscape requires tailored approaches to address the evolving healthcare needs. Through this formal review and comprehensive consultation process, AHCCCS seeks to gather insights and input directly from tribal partners to inform the development of policies and initiatives that are responsive to their specific circumstances. By prioritizing the voices and experiences of tribal communities, AHCCCS is committed to forging stronger relationships and promoting health equity for all. This commitment to continuous improvement in tribal consultation reflects AHCCCS's dedication to ensuring that healthcare services are culturally appropriate, accessible, and responsive to the diverse needs of Arizona's tribal populations.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☑ Other (please list)

Perspectives on the following:
Major substance use issues in the community
Substances causing the most harm
Causes of substance use
Effectiveness of prevention efforts
Recommendations for prevention approaches
Gaps in prevention efforts
Community strengths that prevent substance use
Subgroup differences
Medical profession changes that reduce risk for prescription drug misuse
Types of access to substances
Types of substance use prevention efforts
Challenges on implementation
Training access/availability by county
Training needs
Efforts to evaluate impact

Demographics/information on communities served
Evaluation methods used
Evaluation needs
Resource adequacy
Addressing root causes
Efforts to consider special populations
Challenges

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- **a)** ☑ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☐ Adults (ages 27-54)
- **e)** ☑ Older adults (age 55 and above)
- **f)** ☑ Cultural/ethnic minorities
- **g)** ☑ Sexual/gender minorities
- **h)** ☑ Rural communities
- **i)** ☑ Others (please list)

LGBTQ+

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- **a)** ☐ Archival indicators (Please list)
- **b)** ☑ National survey on Drug Use and Health (NSDUH)
- **c)** ☑ Behavioral Risk Factor Surveillance System (BRFSS)
- **d)** ☑ Youth Risk Behavioral Surveillance System (YRBS)
- **e)** ☑ Monitoring the Future
- **f)** ☐ Communities that Care
- **g)** ☑ State - developed survey instrument
- **h)** ☐ Others (please list)

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ◉ Yes ○ No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

AHCCCS SUBG prevention staff make decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds, with assistance from state, regional, and local partners and existing evidence-based registries or guides, and through the use of contract-required deliverables.

AHCCCS values the implementation of evidence-based practices and also affords prevention providers with the flexibility to implement evidence-based programs, research-based programs, promising practices/programs, and innovative programs, within certain contract limitations. The Culture as Prevention model is considered by AHCCCS to be evidence-based for tribal/indigenous communities.

For example, contracts for directly-contracted providers requires the implementation of evidence based, research based, and/or promising practices according to peer reviewed journals as defined by current SAMHSA guidance in Selecting Best-fit Programs and Practices. AHCCCS is aware that every community is unique and there may be situations when there is not an appropriate evidence-based program to meet the needs of the community. AHCCCS has developed parameters regarding the use of innovative interventions. If a contractor wishes to implement an innovative program, they are required to submit an AHCCCS Innovative Prevention Program Intervention Protocol for any prevention program/intervention intended to be implemented under SABG that is not designated as evidence-based. Innovative prevention interventions are to be administered at a ratio of one innovative intervention per every one evidence-based, research-based, or promising practice. The Protocol, developed by AHCCCS staff, requires the prevention providers to formally submit documentation related to the intervention they are proposing to use, prior to the use of the intervention, for review and approval by AHCCCS. This protocol includes pertinent intervention information, including but not limited to:?

Program outcomes,??
Program setting,??
Intervention length,??
Description of the "conceptual" and "practical" fit of the proposed intervention,?
Explanation of how the proposed intervention is the best choice over other Evidence and/or Research Based and Promising interventions available for use in the community,?
Current Intervention Evaluation Methodology, and;?
Protocol to mitigate/remove risks of innovative program/practice implementation on the priority population, including a process for referral to appropriate services as needed.?

Evidence-based programs or practices are interventions that fall into one or more of the following categories:

1. The intervention is included in a federal registry of evidence based interventions, or
2. The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer reviewed journal, or
3. The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which shall be followed. These guidelines require interventions to be:
a. Based on a theory of change that is documented in a clear logic or conceptual mode,
b. Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals,
c. Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects, and
d. Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review; local prevention professionals; and key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

Depending on the contract-specific language, Contractors may also be required to utilize all 6 Center for Substance Abuse Prevention (CSAP) strategies, and serve each Institute of Medicine (IOM) Category per community need. This promotes comprehensive programming that is more likely to be evidence-based and effective than implementing only a few CSAP strategies.

The AZ National Prevention Network (NPN) representative also participates in many collaborative efforts with the Pacific Southwest Prevention Technology Transfer Center (PTTC), which is a great partner and resources for inquiries related to evidence-based practices. AHCCCS also participates in and collaborates with other state, federal, and community entities through the Arizona Substance Abuse Partnership (ASAP), which is the single statewide council on substance abuse prevention, treatment and recovery efforts. The previous Program Inventory Workgroup has transitioned into the AZ Prevention Workgroup Meeting, where evidence-based practices are discussed and highlighted. For example, the Communities that Care (CTC) model was presented and the workgroup discussed potential opportunities to support further implementation of the CTC in Arizona.

b) If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The State is committed to advancing health equity, including through the use of culturally and linguistically appropriate services and efforts to reach and serve all eligible individuals, particularly those who are historically disadvantaged, underserved, or experience other elevated risk factors for substance use. The integration of CLAS standards into the needs assessment step of the SPF may be done in a number of ways.

The AHCCCS SUBG team works to hire individuals who are familiar with and employ a health equity lens, and trains staff accordingly. AHCCCS also values this quality in hired vendors, such as Lecroy & Milligan Associates (LMA) who last completed the needs assessment process on behalf of AHCCCS. AHCCCS seeks to ensure that CLAS considerations are present through processes such as the needs assessment by use of contract language requirements around CLAS and related items, deliverable reviews by AHCCCS staff, technical assistance efforts, etc. AHCCCS works with Contractors to ensure that services are planned in accordance to the needs and preferences of the people that the program serves.

The 2018 AZ prevention needs assessment addressed demographic characteristics in various ways. For example, LMA coordinated a steering committee for the needs assessment process that ensured regional and local level stakeholders

were involved in the needs assessment process. One benefit of this steering committee is that these partners could provide guidance on how CLAS standards are or should be applied for the communities they serve. Additionally, as part of the needs assessment process, LMA assessed and underlying causes of substance use by asking "How does your substance use prevention program take into consideration demographic characteristics of the participants of your program (race/ethnicity, urban/rural, veterans, LGBTQ, youth, seniors, foreign language users, etc.)?" Responses were outlined in the needs assessment itself, including:

"Before implementing program or PSAs for a target population we will talk to our target population to receive feedback. In all of our prevention activities, we ask for feedback and speak with our target population to learn if it is culturally competent for that population."

"CLAS standards are in force, and each contracted program has guidelines on each standard. These include making program tools accessible, making adaptations to reading level, language, font size, method of dissemination, etc. For example, our LGBTQ program uses tools to capture a variety of gender identification options, and our older Arizona Statewide Substance Use Prevention Needs Assessment 2018 122 adult program uses large font on their evaluation and program materials."

"One has to be aware and willing to adapt to the needs of the ones you are trying to help. If poverty is huge with a specific group, having food anytime you work with them (and maybe some left over for them to take home is important)." "We are required to complete an educational program aimed at increasing understanding and awareness around how to foster and inclusive and welcoming climate for the LGBTQ community."

CLAS standards are further integrated into the needs assessment process by AHCCCS requiring needs assessments and strategic plans by prevention provider staff. Through this, AHCCCS may review and better understand the local demographics and needs served by the community-based providers, and provide feedback on best practices and CLAS standards based on the population being served.

AHCCCS is committed to the application of CLAS standards as an agency and may either require or promote the application of CLAS standards. Resources that can ensure CLAS standards are followed include AHCCCS Division of Grants and Innovation (DGI) review of materials, partnering with the AHCCCS Health Equity Committee, Communications team including Public Information Officers, Office of Individual and Family Affairs, and the Behavioral Health Planning Council.

b) If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The 2018 statewide prevention strategic plan utilized the SAMHSA Strategic Prevention Framework (SPF), including the guiding principle of sustainability. The needs assessment included a workforce survey, which collected information about the substance use prevention workforce in AZ, including demographics, length of time working in prevention, counties served, whether they serve rural/urban/suburban, workforce qualifications, trainings received, certifications held, among other measures. One result of this survey informs us that 33% of the survey respondents had received training on the SPF specific to evaluation/sustainability. This report also highlights sustainability strategies that participants reported.

Additionally, AHCCCS requires SUBG prevention contractors to conduct and submit to AHCCCS a regional prevention needs assessment utilizing the AHCCCS template. The template includes a requirement for Sustainability of local data collection methods and efforts. AHCCCS staff reviews these deliverable submissions against the requirements for the deliverable and provides feedback and TTA as needed to ensure these elements are addressed.

The assessment can be found here
https://www.azahcccs.gov/Resources/Downloads/Grants/ArizonaSubstanceAbusePreventionNeedsAssessment.pdf

b) If no, please explain in the box below.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce? ○ Yes ◉ No

a) If yes, please describe.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce? ◉ Yes ○ No

a) If yes, please describe mechanism used.

AHCCCS is committed to advancing Arizona's prevention system and has several mechanisms for either providing or promoting training and technical assistance (TTA), including providing TTA directly to the field of subrecipients and partners, or through hired vendors.

Direct TTA from AHCCCS includes meeting with all prevention contractors once every 2 months at the Statewide Prevention Systems Meeting to provide and request updates, which is a platform by which AHCCCS staff may learn about TTA needs or provide TTA. Among other purposes, this platform is used for AHCCCS to deliver technical assistance directly, and AHCCCS often coordinates training opportunities to occur during this meeting. Examples include contract requirement reminders, TA on deliverables, Wellington TTA on evaluation services, Bloom 365 presentation, PAXIS presentation, and a Project AWARE and school-based referral presentation.

AHCCCS Grant Coordinators also meet regularly with individual contractors and partners. This may be every 2 weeks, monthly, bi-monthly, quarterly, or ad hoc based on need. For example, prevention providers that are directly contracted with AHCCCS through the 2020 RFP which awarded 19 contracts in 2021, are required to meet regularly with AHCCCS and most occur monthly, though some may need more frequent or less frequent touch bases. AHCCCS meets with the TRBHAs regularly as well, with monthly meetings established, but flexible based on the needs and preferences of the TRBHA.

In addition to requests for TTA that may come up through platforms described above, AHCCCS also supports the directly-contracted providers through their required monthly data reporting, or through provider submissions of the required annual Workforce Development Plan deliverable.

AHCCCS also utilizes existing and free resources for TTA. The Arizona High Intensity Drug Trafficking Area (AZHIDTA) has provided twice yearly no cost SAPST trainings, and AHCCCS ensures contractors are aware of this resource and AHCCCS is able to for contracted providers to travel to attend the trainings, in accordance with the contractor approved budget.

The Prevention Technology Transfer Center (PTTC) is a leading resource for substance use prevention professionals in Arizona. In addition to the regular TTA offerings that put forth by the Pacific Southwest PTTC and available to AZ prevention professionals (which PTTC staff at times shares directly with AHCCCS, or is otherwise promoted by AHCCCS), AHCCCS also collaborates with the PTTC to explore unmet AZ prevention training needs and develop a plan together to meet the need. TTA examples that AHCCCS provided through collaboration with the PTTC include Screening Brief Intervention and Referral to Treatment (SBIRT) for prevention professionals, and the Brief Risk Reduction Interview and Intervention Model (BRRIIM) Model.

AHCCCS also contracts with vendors on occasion to offer TTA opportunities.
AHCCCS has contracted with Wellington to provide prevention evaluation technical assistance to contractors related to the activities within the SUBG.

Since 2019, Wellington has provided AHCCCS and its prevention contractors assistance collecting and reporting data regarding their prevention efforts. Wellington hosted a three-hour technical assistance training on 6/16/22 to teach contractors how to utilize their developed data portal for inputting and tracking outcome data. Wellington provides ongoing individualized contractor technical assistance when needed. A Wellington representative most often attends the AHCCCS Statewide Prevention Meetings to provide additional assistance.

AHCCCS recently contracted with the Arizona State University (ASU) to expand the scope and utilization of the Arizona Youth Survey (AYS) to be implemented in Arizona schools. The survey is administered biennially to a statewide sample of 8th, 10th, and 12th grade youth under the direction of the Arizona Criminal Justice Commission. The survey is designed to assess risk and protective factors associated with the development of problem behaviors to provide data drive guidance for prevention efforts. The ASU consultants provide technical assistance for statewide and local primary prevention service implementation. The project is designed to expand and enhance the AYS and provide training that will support local primary prevention providers by better equipping them to utilize evidence-based risk and protective factor data collected from the survey. ASU facilitated two daylong hybrid workshops on how to use the AYS data can be used to select best fit evidence-based substance use prevention programs using the Communities That Care (CTC) model. The hybrid technical assistance workshops occurred on 11/29/22 and 12/8/22 and featured a keynote speaker.

In summary, AHCCCS provides regular and ad hoc TTA by either offering it directly in an individual or group manner, promoting existing trainings, coordinating with partners, or by hiring contractors to conduct trainings that have been identified as a need by prevention stakeholders.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

a) If yes, please describe mechanism used.

At the state level, the AHCCCS SABG-funded prevention system follows and implements the Strategic Prevention Framework (SPF) model, which includes the development and implementation of a statewide needs assessment at least every 3-5 years. The most recent Needs Assessment, finalized in September 2018, included a community readiness assessment that allowed AHCCCS to see the state's capacity to address current prevention needs on a large scale. A statewide Prevention Strategic Plan was developed in 2020. Because of the significant changes to public health and the implementation of prevention services due to COVID-19, additional data was collected, analyzed, and reported on in the Strategic Plan. Capacity building including readiness and a resource assessment were features of the Strategic Plan. A Steering Committee of state and tribal agencies, coalitions, universities and Regional Behavioral Health Authorities was established to help guide the strategic planning process. Findings from the additional data collection indicates that resource availability is impacted by several factors at the time: changing dynamics of the pandemic, regional and local variation in resource availability, and the types of resources available. A major impact on readiness and resources during the pandemic was the virtual-only nature of many resources, while in-person services were less available. The report also indicates community readiness to address substance use had decreased slightly between a pre-COVID survey vs post-COVID survey, and most participants saw their communities as somewhere in the middle on a scale of not ready to very ready.

At the community level, readiness assessments should be conducted as a part of the required needs assessment process, which requires an updated needs assessment every 3 years. AHCCCS provides a template for the needs assessment to ensure prevention contractors are including the necessary assessment components. AHCCCS also reviews and approves the submitted needs assessments and provides technical assistance as needed. The TRBHAs who receive SABG Prevention funds are also required to conduct regular substance use prevention needs assessments. These assessments at the community level are intended to be used to identify and address those factors contributing to substance use problems. Prevention efforts should be intentionally designed to meet the communities' needs, as well as increase community readiness and capacity to provide prevention activities and services.

Another related deliverable for the directly-contracted primary prevention contractors is a workforce development plan.

Required annually, providers plan their staff development and trainings to ensure, at minimum, that they meet the contract requirements for trainings for prevention providers. Providers often choose to bolster their readiness and capacity by adding optional trainings, or trainings that are required or promoted by their agency. Since there is often turnover in the behavioral health field, including prevention, these are critical plans to ensure that new staff are supported in their development and readiness to deliver prevention services.

Coalitions are diligent in their work to improve community readiness through community outreach and education, training, information dissemination, coalition development, and more.

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

AHCCCS tends to utilize existing and no cost resources, and in those cases does not have the authority to make adaptations to the curriculum or implementation plan to integrate National CLAS Standards. Examples include the PTTC and the Arizona High Intensity Drug Trafficking Area (AZ HIDTA).

However, when hiring vendors for capacity building, AHCCCS seeks to ensure that the resources to be developed are done so in accordance with a health equity lens and are culturally relevant. We may do this by requiring that the vendor collaborates with local providers to receive input prior to resource development, requiring or assisting the vendor to ensure a representative group of stakeholder informants is involved in planning, having native speakers of non-English languages review content, promote that the individual delivering a service is of a same or similar demographic as the intended audience, collaborate with the AHCCCS Divison for Fee for Service Management (DFSM) who oversees the American Indian Health Plan and Intergovernmental Agreements with TRBHAs, collaborate with the AHCCCS tribal liaison, etc.

AHCCCS also promotes the use of the SAMHSA Tribal TTA Center, National Hispanic and Latino PTTC, which provides culturally relevant capacity building materials for those groups.

5. Does your state integrate sustainability into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

AHCCCS values and consider sustainability in SUBG primary prevention efforts regarding capacity building.

AHCCCS first seeks to utilize existing resources. AZ coordinates with and promotes existing resources for capacity building, such as the PTTC and the AZ HIDTA, which provide prevention trainings at no cost.

When coordinating prevention capacity building efforts and activities through AHCCCS or contracted vendors, we have conversations and put mechanisms into place such as contract requirements and deliverable requirements that seek to sustain efforts over time. This may be done through recording trainings, PowerPoint slide decks, etc. and making these recorded resources available online through the AHCCCS grants webpage, or internally in the AHCCCS SharePoint site and re-shared as needed with prevention stakeholders, such as when new prevention staff are hired. For example, AHCCCS has utilized vendors to conduct trainings on developing logic models and evaluation tools. The SUBG Prevention Kick Off Meeting for the RFP new contractors and the logic model training is available on the AHCCCS webpage and a training on the use of the SUBG prevention evaluation web portal is recorded and available for sharing upon need/request.

https://www.azahcccs.gov/Resources/Grants/SABG/
https://www.youtube.com/watch?v=e-MZGznhUII

b) If no, please explain in the box below.

Narratve Question

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Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG? (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [x] Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds
- **b)** [ ] Timelines
- **c)** [ ] Roles and responsibilities
- **d)** [x] Process indicators
- **e)** [x] Outcome indicators
- **f)** [x] Cultural competence component (i.e., National CLAS Standards)
- **g)** [x] Sustainability component
- **h)** [ ] Other (please list):
- **i)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

AHCCCS SUBG prevention staff make decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds, with assistance from state, regional, and local partners and existing evidence-based registries or guides,

and through the use of contract-required deliverables.

AHCCCS values the implementation of evidence-based practices and also affords prevention providers with the flexibility to implement evidence-based programs, research-based programs, promising practices/programs, and innovative programs, within certain contract limitations. The Culture as Prevention model is considered by AHCCCS to be evidence-based for tribal/indigenous communities.

For example, contracts for directly-contracted providers requires the implementation of evidence based, research based, and/or promising practices according to peer reviewed journals as defined by current SAMHSA guidance in Selecting Best-fit Programs and Practices. AHCCCS is aware that every community is unique and there may be situations when there is not an appropriate evidence-based program to meet the needs of the community. AHCCCS has developed parameters regarding the use of innovative interventions. If a contractor wishes to implement an innovative program, they are required to submit an AHCCCS Innovative Prevention Program Intervention Protocol for any prevention program/intervention intended to be implemented under SABG that is not designated as evidence-based. Innovative prevention interventions are to be administered at a ratio of one innovative intervention per every one evidence-based, research-based, or promising practice. The Protocol, developed by AHCCCS staff, requires the prevention providers to formally submit documentation related to the intervention they are proposing to use, prior to the use of the intervention, for review and approval by AHCCCS. This protocol includes pertinent intervention information, including but not limited to:?
Program outcomes,??
Program setting,??
Intervention length,??
Description of the “conceptual” and “practical” fit of the proposed intervention,?
Explanation of how the proposed intervention is the best choice over other Evidence and/or Research Based and Promising interventions available for use in the community,?
Current Intervention Evaluation Methodology, and;?
Protocol to mitigate/remove risks of innovative program/practice implementation on the priority population, including a process for referral to appropriate services as needed.?

Evidence-based programs or practices are interventions that fall into one or more of the following categories:

1. The intervention is included in a federal registry of evidence based interventions, or
2. The intervention produced positive effects on the primary targeted outcome, and these findings are reported in a peer reviewed journal, or
3. The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which shall be followed. These guidelines require interventions to be:
a. Based on a theory of change that is documented in a clear logic or conceptual mode,
b. Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals,
c. Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects, and
d. Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review; local prevention professionals; and key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

Depending on the contract-specific language, Contractors may also be required to utilize all 6 Center for Substance Abuse Prevention (CSAP) strategies, and serve each Institute of Medicine (IOM) Category per community need. This promotes comprehensive programming that is more likely to be evidence-based and effective than implementing only a few CSAP strategies.

The AZ National Prevention Network (NPN) representative also participates in many collaborative efforts with the Pacific Southwest Prevention Technology Transfer Center (PTTC), which is a great partner and resources for inquiries related to evidence-based practices. AHCCCS also participates in and collaborates with other state, federal, and community entities through the Arizona Substance Abuse Partnership (ASAP), which is the single statewide council on substance abuse prevention, treatment and recovery efforts. The previous Program Inventory Workgroup has transitioned into the AZ Prevention Workgroup Meeting, where evidence-based practices are discussed and highlighted. For example, the Communities that Care (CTC) model was presented and the workgroup discussed potential opportunities to support further implementation of the CTC in Arizona.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

AHCCCS SUBG prevention staff make decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds, with assistance from state, regional, and local partners and existing evidence-based registries or guides, and through the use of contract-required deliverables.

AHCCCS values the implementation of evidence-based practices and also affords prevention providers with the flexibility to implement evidence-based programs, research-based programs, promising practices/programs, and innovative programs, within certain contract limitations. The Culture as Prevention model is considered by AHCCCS to be evidence-based for tribal/indigenous communities.

For example, contracts for directly-contracted providers requires the implementation of evidence based, research based, and/or promising practices according to peer reviewed journals as defined by current SAMHSA guidance in Selecting Best-fit Programs and Practices. AHCCCS is aware that every community is unique and there may be situations when there is not an appropriate evidence-based program to meet the needs of the community. AHCCCS has developed parameters regarding the use of innovative interventions. If a contractor wishes to implement an innovative program, they are required to submit an AHCCCS Innovative Prevention Program Intervention Protocol for any prevention program/intervention intended to be implemented under SABG that is not designated as evidence-based. Innovative prevention interventions are to be administered at a ratio of one innovative intervention per every one evidence-based, research-based, or promising practice. The Protocol, developed by AHCCCS staff, requires the prevention providers to formally submit documentation related to the intervention they are proposing to use, prior to the use of the intervention, for review and approval by AHCCCS. This protocol includes pertinent intervention information, including but not limited to:?
Program outcomes,??
Program setting,??
Intervention length,??
Description of the “conceptual” and “practical” fit of the proposed intervention,?
Explanation of how the proposed intervention is the best choice over other Evidence and/or Research Based and Promising interventions available for use in the community,?
Current Intervention Evaluation Methodology, and;?
Protocol to mitigate/remove risks of innovative program/practice implementation on the priority population, including a process for referral to appropriate services as needed.?

Evidence-based programs or practices are interventions that fall into one or more of the following categories:

1. The intervention is included in a federal registry of evidence based interventions, or
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3. The intervention has documented evidence of effectiveness, based on guidelines developed by the Center for Substance Abuse Prevention and/or the state, tribe, or jurisdiction in which the intervention took place. Documented evidence should be implemented under four recommended guidelines, all of which shall be followed. These guidelines require interventions to be:
a. Based on a theory of change that is documented in a clear logic or conceptual mode,
b. Similar in content and structure to interventions that appear in federal registries of evidence-based interventions and/or peer-reviewed journals,
c. Supported by documentation showing it has been effectively implemented in the past, multiple times, and in a manner attentive to scientific standards of evidence. The intervention results should show a consistent pattern of credible and positive effects, and
d. Reviewed and deemed appropriate by a panel of informed prevention experts that includes qualified prevention researchers experienced in evaluating prevention interventions similar to those under review; local prevention professionals; and key community leaders, as appropriate (for example, law enforcement officials, educators, or elders within indigenous cultures).

Depending on the contract-specific language, Contractors may also be required to utilize all 6 Center for Substance Abuse Prevention (CSAP) strategies, and serve each Institute of Medicine (IOM) Category per community need. This promotes comprehensive programming that is more likely to be evidence-based and effective than implementing only a few CSAP strategies.

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prevention, treatment and recovery efforts. The previous Program Inventory Workgroup has transitioned into the AZ Prevention Workgroup Meeting, where evidence-based practices are discussed and highlighted. For example, the Communities that Care (CTC) model was presented and the workgroup discussed potential opportunities to support further implementation of the CTC in Arizona.

8. Does your state integrate the National CLAS Standards into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

The State is committed to advancing health equity, including through the use of culturally and linguistically appropriate services and efforts to reach and serve all eligible individuals, particularly those who are historically disadvantaged, underserved, or experience other elevated risk factors for substance use. The integration of CLAS standards into the planning step of the SPF may be done in a number of ways, including in the AHCCCS staff TA to contractors and vendors, contractor requirements, the Statewide Substance Abuse Prevention Strategic Plan, requirements and AHCCCS review and approval of regional strategic plans submitted by subrecipients.

The AHCCCS SUBG team works to hire individuals who are familiar with and employ a health equity lens, and trains staff accordingly. AHCCCS also values this quality in hired vendors, such as Lecroy & Milligan Associates (LMA) who last completed the strategic plan process on behalf of AHCCCS in 2020. AHCCCS seeks to ensure that CLAS considerations are present through mechanisms such as contract language requirements around CLAS and related items, deliverable reviews by AHCCCS staff, technical assistance efforts, etc. AHCCCS works with Contractors to ensure that services are planned in accordance to the needs and preferences of the people that the program serves.

The AHCCCS Statewide Substance Abuse Prevention Strategic Plan utilized the SAMHSA SPF for its structure. The plan states “Through the five-step planing process, cultural competency and sustainability were prioritized, and there is commitment among stakeholders to continue prioritizing cultural competence and sustainability throughout the plan’s implementation and evaluation.” Further, the plan guides the prevention field to follow the SAMHSA identified cultural competence principles for prevention planners:

Include the target population in all aspects of prevention planning.
Use a population-based definition of community (i.e., let the community define itself).
Stress the importance of relevant, culturally appropriate prevention approaches.
Employ culturally competent evaluators.
Promote cultural competence among program staff, reflecting the communities they serve.

The strategic planning process itself followed these principles. LMA as the contracted vendor for the process coordinated a steering committee for the strategic plan that ensured regional and local level stakeholders were involved in the planning process. One benefit of this steering committee is that these partners could provide guidance on how CLAS standards are or should be applied for the communities they serve. LMA and AHCCCS reviewed the demographics of the steering committee and worked to ensure a diverse array of stakeholders were represented by region, rural/urban/suburban, priority populations served, etc. The planning process was intended to reflect the diverse opinions and perspectives of Native American, African American and Hispanic populations; rural and urban communities; counties statewide; and specific groups such as LGBTQ+ and other community and faith-based organizations.

CLAS recommendations were provided throughout the plan such as for each CSAP strategy, the strategic plan indicates ways to promote linguistically and culturally relevant services for the priority populations.

The plan is located here
https://www.azahcccs.gov/Resources/Downloads/Grants/SABG/AHCCCS_StatewideSubstanceAbuseStrategicPlan.pdf

CLAS standards are further integrated into the planning process by AHCCCS requiring strategic plans by prevention contractors. Through this, AHCCCS may review and better understand the planned strategies to be implemented, among who, by who, where, and why and provides AHCCCS the opportunity to provide feedback and TTA. Cultural responsiveness is a required element of the strategic plan. Subrecipients should include information as follows:

Include information about how the agency and/or coalition will ensure all prevention activities are inclusive and regionally/locally representative of the community of focus.
Identify key partnerships and stakeholders to be involved in achieving cultural responsiveness.
Identify any barriers in existence that will impede the agency/coalition’s ability to provide culturally responsive services and

a plan to address said barriers, as needed.

AHCCCS also ensures CLAS standards are integrated when working with hired vendors. For example, AHCCCS worked with Riester, a media company, to plan and implement a primary prevention media campaign called Talk Heals, which can be seen at https://talkheals.org/. AHCCCS specifically worked with Riester to ensure that the language used in the campaign was relevant to the priority populations, by age, education level, and language.
AHCCCS provided feedback to ensure that the language, graphics, and strategies used were appropriate for segmented age populations from 12-14, 15-17, 18-21, etc. Spanish content was developed by a Spanish speaker at Riester, and also reviewed by a native Spanish speaking AHCCCS SUBG Grant Coordinator. The staff member provided feedback on how to better phrase Spanish language materials for the audience. Finally, parent materials were intentionally written at a 6th grade reading level or below to ensure parents could read and understand the materials.

Finally, AHCCCS may utilize resources and partnerships to CLAS standards are followed. For example, AHCCCS Division of Grants and Innovation (DGI) Grant Coordinator staff review of materials, partnering with the AHCCCS Health Equity Committee, Communications team including Public Information Officers, Office of Individual and Family Affairs, and the Behavioral Health Planning Council.

b) If no, please explain in the box below.

NA

9. Does your state integrate sustainability into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Sustainability is integrated into the planning for SUBG prevention through mechanisms such as the AHCCCS Statewide Substance Abuse Prevention Strategic Plan, subrecipients regional strategic plans, and other efforts at AHCCCS when making decisions about funding of prevention activities.

The AHCCCS strategic plan utilized the SPF model for its format. The sustainability section of the plan guides the AZ prevention field on enhancing sustainability: having a robust strategic plan, maintaining and improving community capacity, identifying effective programs, measuring outcomes, adapting to change as priorities shift, and commitment from a diverse group of collaborative stakeholders.

Additionally, subrecipients are required to submit local/regional strategic plans. AHCCCS puts mechanisms into place such as contract requirements and deliverable requirements that seek to sustain efforts over time. The strategic plan deliverable requires subrecipients to include a sustainability plan for identified prevention services, including the location of additional funding sources to address community needs. The required action plan included in this deliverable also requires subrecipients to list out all of their efforts not limited to SUBG to show how programs/activities, funding, and priority populations are served to meet the subrecipients goals and objectives. AHCCCS reviews these deliverables and provides feedback and TA prior to approving the deliverable.

Finally, sustainability is also integrated into planning through various efforts regarding allocating funds, approving programs, and developing contracts. When making funding decisions, AHCCCS considers how the program will continue if SUBG funding is not provided. AHCCCS SUBG staff may collaborate with partners on other grants at AHCCCS and with SAMHSA to learn about other opportunities, provides TTA to subrecipients to assist them with sustainability planning such as building partnerships, grant writing knowledge and skills development, how to set up and use data and evaluation to demonstrate program effectiveness that can be used in grant applications or other requests for funding, and coalition building to enhance community capacity to implement sustainable programming.

b) If no, please explain in the box below.

NA

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☑ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

This strategy provides awareness and knowledge of the nature and extent of substance use, abuse, and addiction and their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two.??
Tabling/Booth events at Health Fairs, School Parent Nights, and local community events?
Dissemination of prevention flyers, posters, brochures, and other informational media at local grocery stores, doctor's offices, schools, etc.??
Media campaigns aimed at increasing knowledge of local substance use and abuse trends and data, as well as focusing on risk and protective factors to reduce substance use and abuse within high-risk populations.??

· Social media campaigns
· Printed material dissemination

· Radio advertising
· Billboards
· Newsletters
· Resource fairs
· Speaking engagements

b) Education:

This strategy involves two-way communication and is distinguished from the information dissemination strategy by the fact that interaction between the educator/ facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g., of media messages), and systematic judgment abilities.?
Parenting/Family Education curriculum, such as Strengthening Families, Guiding Good Choices, and Triple P. These programs aim to enhance parenting behaviors and skills, enhance effective child management behaviors and parent-child interactions and bonding, to teach children skills to resist peer influence, and reduce adolescent problem behaviors.??
Curriculum that teaches youth life skills, such as LifeSkills, which are designed to prevent teenage drug and alcohol abuse, tobacco use, violence and other risk behaviors by teaching students self-management skills, social skills, and drug awareness and resistance skills.??

· Evidence-based and promising practice curriculum administered in schools and summer camps.
· Community prevention education workshops for youth and adults.
· Mentors

c) Alternatives:

This strategy provides for the participation of target populations in activities that exclude substance use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by, alcohol and drugs and would, therefore, minimize or obviate resort to the latter.??
Drug-free community and/or youth events, including drug-free dances, sports tournaments, after-school youth groups/programs/clubs, etc.??
Connection and engagement in cultural activities, tribal practices, and learning cultural and/or tribal ways.??

· Substance free community events for youth and families.
· Red ribbon week activities
· Youth summer camps
· Cultural programs
· Youth and adult leadership activities
. On campus Sober nights (IHEs)

d) Problem Identification and Referral:

This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment.?
Programs/classes for youth who have broken school campus rules regarding alcohol, tobacco, and other drugs (ATOD), such as being in possession of ATOD or related paraphernalia. Classes aim to educate youth about the dangers of ATOD use, offer alternatives to substance use, and prevent future infractions.??

· Collaborative partnerships with direct service agencies.
· Drug and alcohol impact panels

e) Community-Based Processes:

This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration, coalition building, and networking.?
Building and sustaining of community-based coalitions (there are currently 20 SABG Prevention-funded coalitions within the state).??
Strategic planning at state and local levels, which includes bringing together key stakeholders from the following sectors to the table to engage in effective planning:?
Youth,?
Parents,?
Law enforcement,?
Schools,?
Businesses,?
Media,?
Youth-serving organizations,?
Religious and fraternal organizations,?
Civic and volunteer groups,?

Healthcare professionals,?
State, local, and tribal agencies with expertise in substance abuse, and;?
Other organizations involved in reducing substance abuse.?

· Monthly coalition meetings
· Youth leadership committees
· Community and volunteer training
· Systematic planning

f) Environmental:

This strategy establishes, or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two subcategories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.?
The passing of local ordinances that affect the sale, manufacturing, or availability of ATODs, including alcohol tax increases, moratoriums on alcohol/marijuana advertising around schools, parks, or places where youth are present, and moratoriums on the establishment or placement of medical marijuana stores in local areas.?
The review of current ATOD policies within schools and/or communities, including the review of policies related to prevention of ATOD use amongst youth, review of policies regarding "punishment" of youth who use or are caught, what prevention strategies are used to decrease repeat behavior, and the eventual revision of policies to be prevention focused, rather than punishment focused.?

· Collaboration with schools and community stakeholders.
· Community drug take back events
· Council meetings
· Review board participation
· Distribution of medication lock boxes
· Promoting/reviewing alcohol, tobacco, and drug use policies in schools

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means? (●) Yes ( ) No

a) If yes, please describe.

AHCCCS is committed to administering the SABG primary prevention funds in a manner that is data-driven, cost effective, and enhances service provision across the state in communities in need, aiming to fill gaps and reduce duplication. AHCCCS does this in a number of ways.

One of the first steps to developing a scope of work and an agreement with a potential prevention partner is the submission of a budget. All contracted primary prevention providers submit budgets to AHCCCS for review and approval before work begins. This allows AHCCCS to review planned activities and planned expenditures to ensure that they meet the requirements of the SABG primary prevention set aside. During this review, AHCCCS program and finance staff look for duplication with other SABG budgets, other funding sources that AHCCCS may manage such as the SOR funds, and other prevention efforts that AHCCCS is aware of generally. AHCCCS staff actively looks for duplication, and provides feedback to the contractor/partner if there are concerns such as supplanting of funds or the need for cost allocation of funds.

AHCCCS participates in a number of collaborative efforts with other state, regional, tribal, and local entities that allows for system communication regarding which primary prevention services are being funded and implemented throughout the state. Examples include AHCCCS' work with Substance Abuse Coalition Leaders of Arizona (SACLAz), the Arizona Substance Abuse Partnership (ASAP), Governor's Office of Youth Faith and Family (GOYFF), PTTC, Wellington, and AHCCCS staff overseeing other prevention initiatives. These collaborations allow AHCCCS to ensure there is no service duplication, and for AHCCCS to gather information regarding any gaps and additional needs in services throughout the state, and coordinate additional support to communities in need of prevention services.

Further, AHCCCS implements additional contracting and policy mechanisms as well as oversight and monitoring efforts with all contracted prevention partners to review planned and actual activities and provide feedback on service gaps and duplication. Contract deliverable requirements ensure contractors submit information to AHCCCS that allows AHCCCS to assess the use of SABG dollars and may seek to review this information against other funds. These deliverables include planning deliverables such as provider budgets, logic models, strategic plans, action plans, and evaluation plans as well as Contractor Expenditure Reports (CERs) showing actual expenditures under SABG prevention. AHCCCS staff reviews CERs from a programmatic and fiscal lens to ensure appropriateness and allowability under the grant.

AHCCCS prevention staff who provide this oversight and monitoring are trained in prevention basics at minimum such as the SAPST, as well as prevention ethics. AHCCCS staff also are provided ongoing training to ensure that they are knowledgeable and competent to support prevention contractors in their primary prevention work. Examples of additional training provided to AHCCCS prevention staff includes the PTTC Prevention Academy, CADCA Annual Leadership Forum, CADCA Mid-Year Forum, NPN Conference, and the AZ Drug Summit, among others.

Since GOYFF administers a large portion of the SABG prevention funds, AHCCCS works closely with GOYFF to ensure both parties are aware of which providers are funded and what programs/activities are funded under the SABG. AHCCCS and GOYFF are increasing this effort in 2023, as GOYFF released a Request for Grant Applications (RFGA) to establish updated agreements with prevention providers. The two agencies seek to work together to reduce duplication and cover gaps in the prevention field in AZ. In 2023, AHCCCS also developed a document to compare prevention grant subrecipients under AHCCCS prevention funding and shared information with GOYFF to offer transparency in funded subrecipients through AHCCCS for enhanced decision making under the RFGA.

Additionally, AHCCCS previously collaborated with ASAP and the AZ National Guard Counter Drug Task Force on a review of prevention funding in AZ, recipients and their activities under each funding source.

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

AHCCCS works with internal staff as well as Contractors to ensure that services are implemented in accordance to the needs and preferences of the people that the program serves.

The AHCCCS Statewide Substance Abuse Prevention Strategic Plan utilized the SAMHSA SPF for its structure. The plan states "Through the five-step planing process, cultural competency and sustainability were prioritized, and there is commitment among stakeholders to continue prioritizing cultural competence and sustainability throughout the plan's implementation and evaluation."

Promote cultural competence among program staff, reflecting the communities they serve.
Examples - CBI's promotora program implemented in Mesa serving Hispanic/Latino/Spanish-speaking populations, served by a staff member who is a native Spanish-speaker and utilizes a program build for Spanish-speaking populations. Phoenix Indian Center implements cultural-specific programming for and by Indigenous peoples, with programming developed specifically for the priority population.

AHCCCS also requires that Coalition Coordinators under the grant reside in the jurisdiction that they serve, to promote services being planned and implemented by their own community members. AHCCCS provided a flexibility to this requirement for one contractor in a rural/remote tribal community who required to be relocated. This allowed for the contractor to maintain staff who is a part of the community to serve the community, in an effort to promote and maintain CLAS standards, and to avoid staffing concerns.

Another example is the PAXIS program implementation of trainings among juvenile corrections staff. PAXIS strategically utilized a trainer who had worked in corrections to better connect with the specific culture and needs of those being served for effective program implementation.

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

Sustainability is integrated into the implementation step by ensuring that the program maintains at least 1 full time equivalent (FTE) Coalition Coordinator. The AHCCCS required workforce development plan deliverables for subrecipients ensures sustainability and capacity of the program through all required contract process, including implementation.

If there is a funding need to continue an effective program, AHCCCS staff may with with other grant partners, state agencies, and SAMHSA to identify how to maintain a program that is needed.

b) If no, please explain in the box below

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [x] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [x] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** [ ] Other (please list:)
- **g)** [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** [x] Numbers served
- **b)** [x] Implementation fidelity
- **c)** [ ] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [x] Attendance
- **f)** [x] Demographic information
- **g)** [x] Other (please describe):

narrative reports are optional, requesting subrecipients to provide a brief narrative to report on items that are not otherwise captured.

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

- **a)** [x] 30-day use of alcohol, tobacco, prescription drugs, etc

b) ☑ Heavy use

c) ☑ Binge use

d) ☑ Perception of harm

e) ☑ Disapproval of use

f) ☑ Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

g) ☐ Other (please describe):

AHCCCS worked with a contracted evaluation consultant to develop pre- and post-survey tools for SABG subrecipients to administer as part of prevention direct service education programming. The tool is based off of National Outcome Measures (NOMs) and also includes additional optional measures for prevention programs to choose from. The pre- and post-surveys are to be customized to the program being implemented to measure the most appropriate outcomes being targeted by the programming.

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

a) If yes, please explain in the box below.

AHCCCS integrates CLAS standards in evaluation through contracting with a professional vendor, outlining requirements, collaborating, and providing TA to the vendor as well as subrecipients as needed.

For example, Wellington, the current hired evaluation vendor, provides all materials in English and Spanish and ensures language is appropriate to the age and reading level of the intended audience. Wellington has worked with multiple SUBG prevention subrecipients to adapt evaluation tools to be more appropriate for the intended population, such as adapting surveys intended for youth to interviews to assess impacts of programming on kindergarten age children, and working with tribal or Spanish-speaking partners to adapt the survey questions in a way that is more appropriate for the population served while maintaining survey tool validity.

One of the SUBG prevention subrecipients serves immigrants and refugee communities, thereby serving a wide array of cultural and linguistic needs. AHCCCS, Wellington, and the contractor may collaborate to ensure CLAS standards are integrated into the evaluation for this subrecipient. Just as with any other subrecipients, we will collaborate to meet the CLAS standard needs for evaluation.

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ◉ Yes ○ No

a) If yes, please describe in the box below.

AHCCCS and Wellington efforts for building sustainability into the evaluation step involves recorded, posted and shared evaluation training resources. This includes but is not limited to the online SUBG prevention evaluation portal recently developed, recorded evaluation trainings, evaluation portal user guides, and planning future funding for continued evaluation services under the grant.

b) If no, please explain in the box below.

Footnotes:

AHCCCS SUBSTANCE ABUSE PRIMARY PREVENTION PROGRAMS

PROVIDER DATA MANAGEMENT SYSTEM USER

June 2022

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CHAPTER 1: INTRODUCTION TO THE AHCCCS PRIMARY PREVENTION DATA MANAGEMENT SYSTEM

AHCCCS Primary Prevention Grant Programs

AHCCCS is the awardee of the Substance Abuse Prevention and Treatment Block Grant (hereinafter "SABG") in the State of Arizona. This funding is administered by the federal agency Substance Abuse Mental Health Services Administration (SAMHSA). AHCCCS uses the SABG program for prevention, treatment, recovery support, and other services to supplement Medicaid, Medicare, and private insurance services. Adhering to funding guidelines, AHCCCS uses block grant funds for the following purposes:

1. **Fund primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment.**
2. Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
3. Fund those priority treatment and support services that demonstrate success in improving outcomes and/or supporting recovery that are not covered by Medicaid, Medicare, or private insurance.
4. Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, prevention, treatment, and recovery support services.

Specific to the Arizona Substance Abuse Primary Prevention Services grant which falls under purpose #1 above, Providers are funded to oversee and implement comprehensive primary prevention interventions that are Evidence-Based (EBP), Research Based (RBP), Promising Practices (PP) or Innovative Programs (IP) according to peer reviewed journals as defined by current SAMHSA guidance in Selecting Best-fit Programs and Practices. The comprehensive primary prevention interventions serve Institute of Medicine (IOM) populations as identified by community need and must include the six Center for Substance Abuse Prevention (CSAP) prevention strategies.

About the Data Management System

The purpose of the AHCCCS Primary Prevention Data Management System is to collect Provider data on several data points that must be reported by AHCCCS to SAMHSA on a monthly, quarterly, and annual basis. These data points include aspects of program implementation (strategies and activities implemented, service locations, tracking evidence-based programs, etc.), participants served (demographics, IOM categories, special populations served, etc.), and program expenditures (by strategy categories).

Data Management System Help Desk

A **Help Desk** is provided by Wellington Consulting Group and is available for the Arizona AHCCCS Substance Abuse Primary Prevention Services Providers and users of the AHCCCS Primary Prevention Data Management System. All inquiries are responded to within 24 hours. The Help Desk can be contacted by email.

Samantha Martin
samantha@wellingtongroupconsulting.com

Lyra Contreras
lyra@wellingtongroupconsulting.com

CHAPTER 2: ACCESSING THE DATA MANAGEMENT SYSTEM & BASIC NAVIGATION

Instructions on How to Access the Data Management System

A username and password are required to access the data management system. Users should contact tech support to reset passwords. No guest access is allowed. You must have a username and password to obtain access to the system.

Each Provider agency's main point of contact should notify their AHCCCS Contract Manager when new staff need access to and training on the system. Wellington will coordinate with each Provider agency to schedule refresher and new staff training on the AHCCCS Primary Prevention Data Management System.

Accessing the Data Management System from the Internet

Once you have a username and password, you will be able to access the Data Management System through the Internet. Use any of the following internet browsers: Internet Explorer, Google Chrome, Safari, or Microsoft Edge. Do not use Mozilla Firefox.

Step 1: Open Internet Explorer, Google Chrome, Safari, or Microsoft Edge.

Step 2: In the address bar (not the search bar), type in the following address:

www.azpreventionsabg.org

Step 3: Log in using your assigned Username and password and click "Submit".

No guest access is allowed. You must have a username and password to obtain access.

***Do not use** the **Back** button on the Internet browser to return to the previous page. The **Back** button will cause you to exit the data system.*

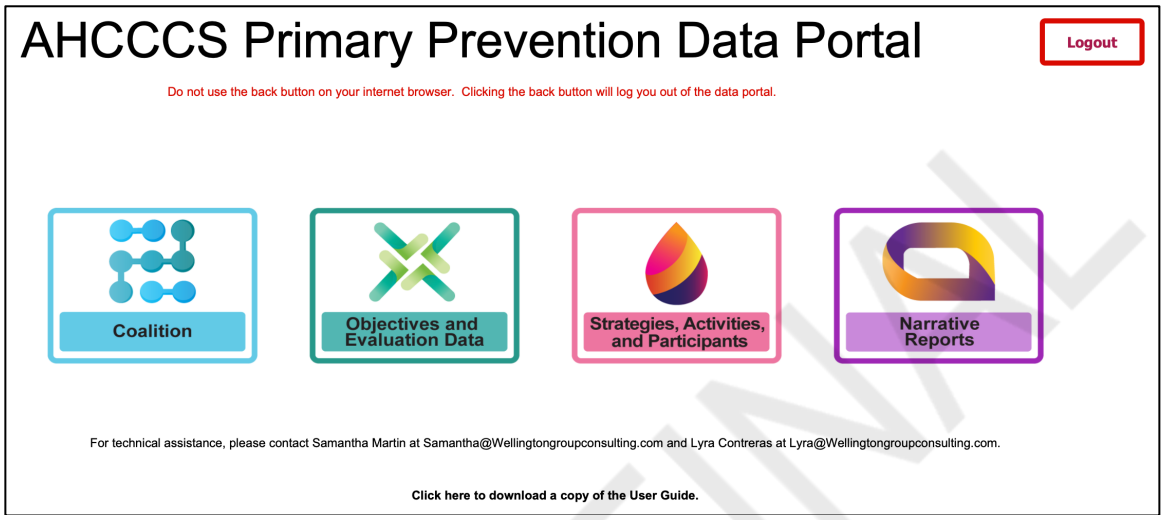
If data is entered incorrectly or if you need assistance with the Data Management System, click on the Tech Support link on the main website page or send a direct email to contact the AHCCCS Data Management System support team listed on page 1 of this user guide.

NOTE: The Data Management System will automatically sign the user out after 20 minutes of inactivity. Completing one of the following actions will restart the 20 minute clock and allow you to remain logged in:

- Change the page or form
- Leave the current field and move to another field
- Click the Save button associated with recently entered data

Main Menu Layout

The first page in the Data Management System is the *Main Menu* page. Navigate from the Main Menu to windows to enter and report data. Click on the button of the desired data section to gain access. Users of the AHCCCS Primary Prevention Data Management System will be assigned a "level of access" when they receive their username and password. Access to various data sections will be based on the assigned level of access.



Navigation of each button on the Main Menu is discussed in this User Guide in detail. To exit the Data Management System at any time, close the application or web page.

Basic Navigation Buttons

Use the icons on the Main Menu and in the Navigation Bar to navigate through the AHCCCS Data Management System. Buttons will appear across the top of each screen to assist in navigation of the system:

The Home button  returns to the Main Menu page.

allows for searching data.

The 

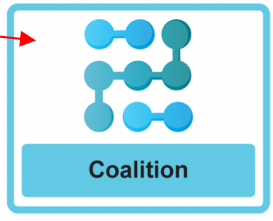
button goes to the previously accessed page.

The 

button saves the record or screen being viewed in PDF format.

CHAPTER 3: COALITION DATA AND TRACKING

Data pertaining to your substance abuse prevention coalition is tracked in this section of the data management system. Click the **Coalition** button to begin.



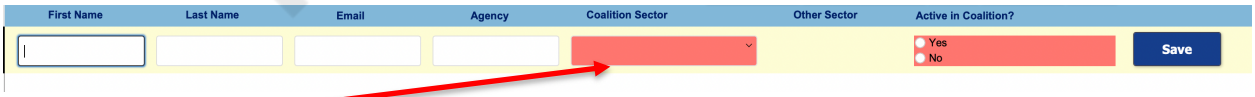
The Coalition Resource Menu includes the following sections:

Enter and Review Coalition Members

This section of the Data Management System is designed to record your coalition membership.

Once you click on the "Enter and Review Coalition Members" button, you will see the main navigation buttons as follows:

1. Add New Member: Enter the names and contact information for each member of the coalition. Fields to be completed include Coalition member's first name, last name, email address and agency or profession. NOTE: Coalition Members need to be entered annually at the start of each new grant year.



A dropdown menu is available for selecting one of the SAMHSA recognized sectors for each coalition member.

Select whether the member is active or not active in the coalition by clicking Yes or No under that heading.

Click on the "save" button to save the record. 

Once saved, you can enter another coalition member by clicking the Add New Member button, click the Back button to return to the Coalition Resource Menu, or click the Home button to return to the Main Menu.

2. Find: Once coalition members are entered, you are able to search the coalition roster for an existing member. Click the "Find" button then enter information pertaining to the record or records you are seeking. Searches can be conducted on any of the membership roster fields including first name, last name, email address, agency, coalition sector or coalition membership status. After entering the criteria, click the "search" button to display the list of records relevant to the search criteria that was entered.

Coalition Meeting Attendance

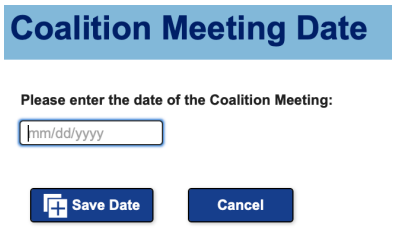
AHCCCS requires that at least nine (9) formal coalition meetings take place each year. Monthly formal coalition meetings shall be attended by at least eight (8) sector representatives at least nine (9) months of the calendar year from the mandated sectors. A formal coalition meeting does not include workgroups, subcommittee, or ad hoc meetings.

After each meeting of the substance abuse coalition, click on the "Coalition Meeting Attendance" button on the Coalition Resource Menu, then click on the 

button to begin.

(**NOTE**: Coalition Members must be entered in the Data Management System as described above prior to entering Coalition Meeting Attendance.)

You will be prompted to enter the coalition meeting date, then click the Save Date button.



After clicking the Save Date button, a list of all coalition members entered to date will appear with radial buttons to select whether or not each particular member attended the Coalition meeting on that particular date.

After recording the attendance for each member, click on the 

button to refresh the page and complete the attendance record for that meeting.

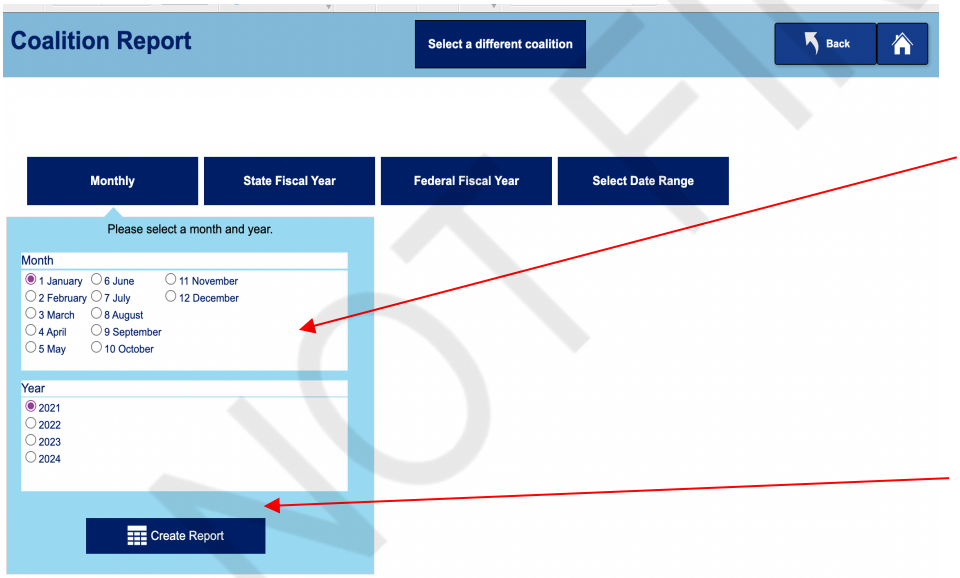
Coalition Sector Report

Once coalition meetings and member attendance have been entered into the Data Management System, this menu option allows the user to run a report that shows the number of coalition members in attendance at any given meeting or over a specified timeframe and also provides a count of the number of member sectors represented. **NOTE**: This report is for the main coalition meetings and does not include subcommittee meetings.

The following date filters are available for specifying the date range to be included in the report:

- Monthly
- State Fiscal Year Quarters
- Federal Fiscal Year Quarters
- State Fiscal Year
- Federal Fiscal Year
- Select Date Range

To begin, select the report type based on the timeframe you would like to see:



Under each report type, the user is able to select the appropriate month, quarter or annual fiscal year for the desired data report. If a different timeframe is desired, the Select Date Range button allows you to choose specific dates. Once the timeframe is chosen, click on the Create Report button to run the report.

The result will provide the user with the number of coalition meetings, number of participants in attendance, and the total number of sectors represented at the coalition meeting held during that specified timeframe.

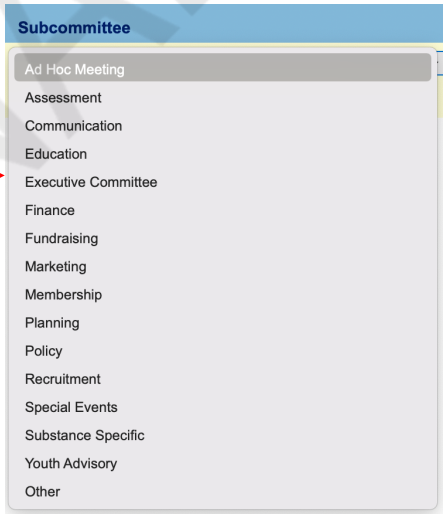
Once the report has been created, the user has the option to save the report as PDF by using the navigation buttons at the top of the screen, return back to the Coalition Resource Menu, or return to the Data Management System Main Menu.

Subcommittee Meeting Attendance

In addition to tracking formal coalition meetings, attendance at workgroups, subcommittees or ad hoc meetings should be tracked. After each meeting of the subcommittees of the substance abuse coalition, the click on the "**Subcommittee Meeting Attendance**" button on the Coalition Resource Menu, then click on the

button to begin. You will be prompted to enter the Subcommittee meeting date, the type of subcommittee, the Number in Attendance and any Notes pertaining to the particular Subcommittee meeting; then click the **Save** button.

After clicking the **Save Date** button, a list of all coalition members entered to date will appear with radial buttons to select whether or not each particular member attended the Coalition meeting on that particular date. The Subcommittee types available include the following:

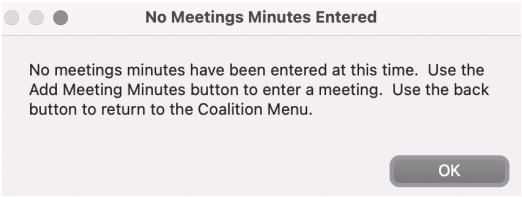


Note, if "Other" is selected, enter the Subcommittee Type in the text box. After recording the Coalition Subcommittee meeting information, click the **Save** button.

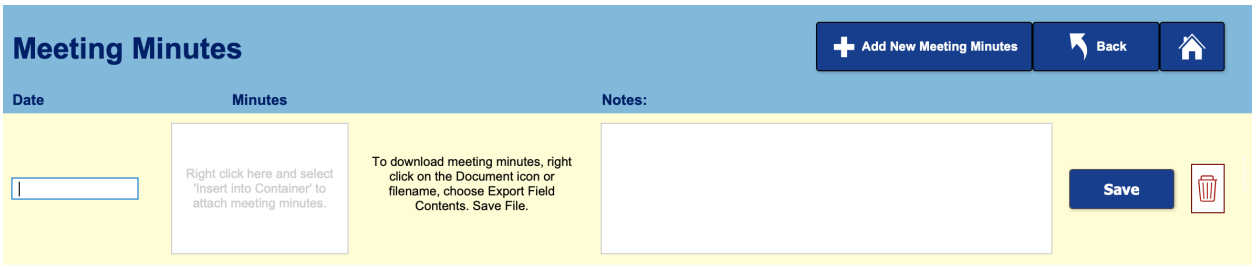
If an error is made when entering Subcommittee Meeting information, clicking the 'trash' button will remove that Subcommittee meeting from the data management system. Once Coalition Subcommittee Meeting information is complete, you can select a button to **Add A New Subcommittee Meeting**, go **Back** to the Coalition Resource Menu or go **Home** (to the Main Menu).

Meeting Minutes (Optional)

If the user chooses to enter Coalition Meeting Minutes to the SABG Data Management System, click the **Meeting Minutes (Optional)** button. If no meeting minutes have been added, the following message will appear.



To add minutes, click the **Add New Meeting Minutes** button. The user will be prompted to enter the meeting date, upload a file containing the meeting minutes and to enter any notes regarding the meeting and/or minutes.



To upload a document containing meeting minutes, right click the container field under Minutes and select "Upload Document" (On an iMac or if using a mouse without a right click button, hit the "control" button while clicking the mouse in the container field under the Minutes heading).

After the Meeting Minutes details are entered, click the **Save** button. If an error is made when uploading Meeting Minutes, clicking the button will remove those meeting minutes from the Data Management System.

CHAPTER 4: OBJECTIVES AND EVALUATION DATA

Adhering to funding guidelines, AHCCCS uses a portion of the block grant funds to support primary prevention by providing universal, selective, and indicated prevention activities and services for persons not identified as needing treatment and to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion and prevention services.

Various theories are used to try to understand and predict how and why people change their unhealthy behaviors to healthier ones. For example, to understand behavioral intent (a plan or likelihood that someone will behave in a particular way in specific situations), a person's attitudes toward that behavior as well as external factors (such as influence from peers or parents) are examined. All of the prevention programs link key intervention components and activities to key determinants of important behaviors. The purpose of the AHCCCS Primary Prevention evaluation is to assess whether critical program components or activities were implemented and whether they had an impact upon determinants, important behaviors, and overall health goals.

Purpose of the AHCCCS Primary Prevention Evaluation

The AHCCCS Primary Prevention evaluation focuses on determining the impact of the prevention programs on key risk and protective factors for certain target populations. In the design, it is hypothesized that the more informed youth are about the risk/harm of underage drinking, marijuana use and misuse and abuse or prescription medication, the more unfavorable their attitudes toward underage drinking, marijuana use, and misuse/abuse of prescription drugs will become. It is also hypothesized that the better the interpersonal relationships and positive perception of school safety, the more likely youth will seek help at school from a counselor, teacher, or other adult. And thirdly, it is hypothesized that the more parents and youth engage in communication around resistance strategies to reduce underage

drinking, marijuana use and misuse and abuse of prescription medication, the less likely they are to report 30-day use.

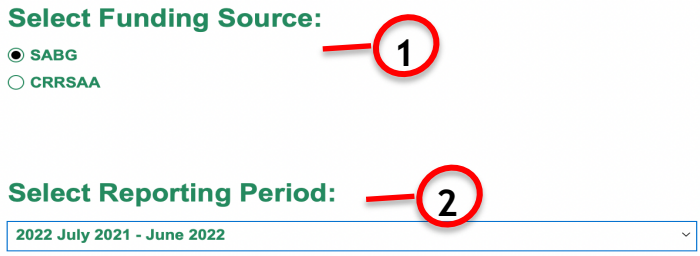
The following performance measures are required for Federal reporting. The Statewide Evaluation of the AHCCCS Primary Prevention programs collects the following data to meet those reporting requirements:

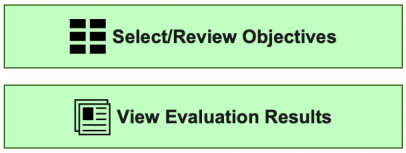
1. Reduced Morbidity Abstinence from Drug Use/Alcohol Use
    a. 30-day Use (Alcohol, Cigarette, Other Tobacco Products, Marijuana, Illegal drugs other than Marijuana)
    b. Perception of Risk/Harm of Use (Risk from Alcohol, Cigarettes, Marijuana)
    c. Age of First Use (Alcohol, Cigarette, Other Tobacco Products, Marijuana, Illegal drugs other than Marijuana)
    d. Perception of Disapproval/Attitudes (self/peers) (Cigarettes, Marijuana, Alcohol)
2. Employment/Education
    a. Perception of Workplace Policy (re: random drug and alcohol tests)
    b. Average Daily School Attendance Rate
3. Family Communications Around Drug and Alcohol Use
    a. Youth self-report
    b. Parent self-report
4. Social Connectedness
    a. Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

The selection of outcome objectives and the evaluation data obtained from participant surveys are both housed under the **Objectives and Evaluation Data** tab of the data management system. Click this button to begin.

NOTE: Outcome objectives and evaluation data must be collected and recorded for each funding source.

To begin (1), select the funding source that you are reporting under. Once a funding source is selected, the drop down menu for selecting a reporting period will appear. Select the current funding period (2) then click continue (3):





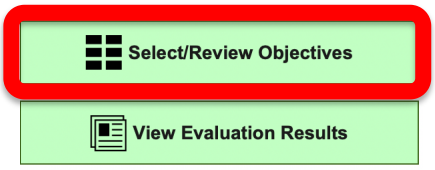
The following pages cover each section of the Objectives and Evaluation Data menu.

Primary Prevention Program Outcome Objectives

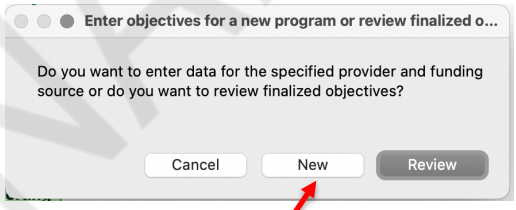
SAMHSA has identified ten domains for National Outcome Measures (NOMs). The domains embody meaningful, real-life outcomes for people who are striving to attain and sustain recovery, build resilience, and work, learn, live, and participate fully in their communities. All recipients of funding from the Substance Abuse Block Grant (SABG) must report on National Outcome Measures. The NOMs matrix represents the beginning of a state-level reporting system that, in turn, will create an accurate and current national picture of substance-abuse and mental-health services. See Appendix A for the Evaluation Questions and Objectives for the required National Outcome Measures

Select/Review Objectives

At the start of EACH Primary Prevention grant funding year, each Provider must select and enter the outcome objectives that pertain to each funding source received from AHCCCS.

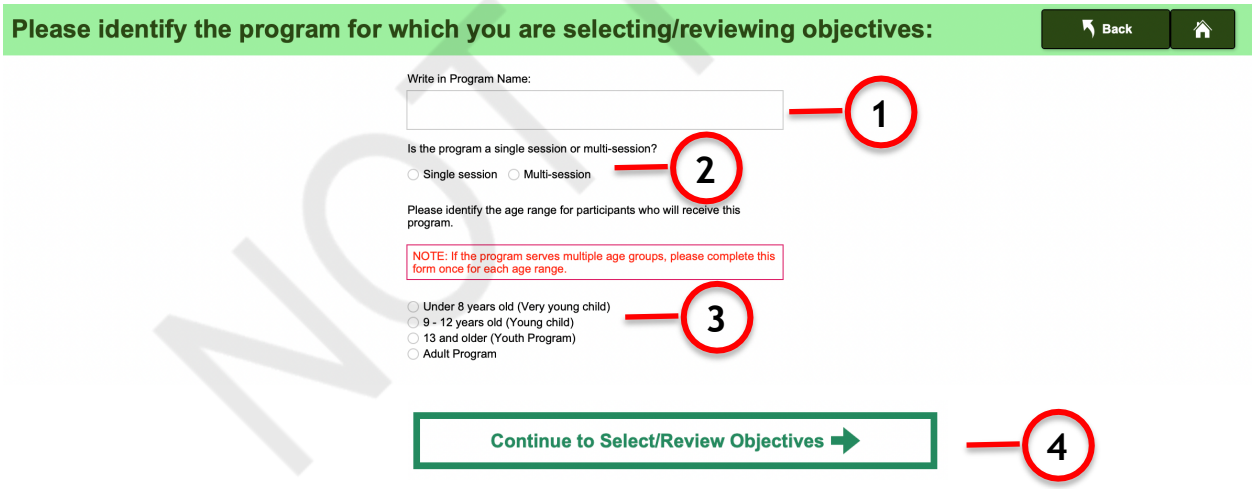


When you click the Select/Review Objectives button, you will be prompted to select whether you want to enter "new" objectives or "review" objectives previously selected.



NOTE: Once objectives have been selected for a particular funding source and grant year, you are NOT able to remove those objectives from the Data Management System.

To begin selecting objectives, click the "new" button. You will see the following screen:



1. To begin, fill in the program name.
2. Select whether the program is single session or multi-session
3. Identify the age range of participants to be served with the program. **NOTE**: If the program serves multiple age groups, you should repeat the process for identifying objectives for each age range served. Once the age range of participants is selected, the continue button will appear.
4. Click the button to Continue to Select/Review Objectives

All of the possible outcome objectives are listed. For a complete list of objectives, see Appendix A. Providers must choose at least one objective, and may select multiple objectives, that align with the

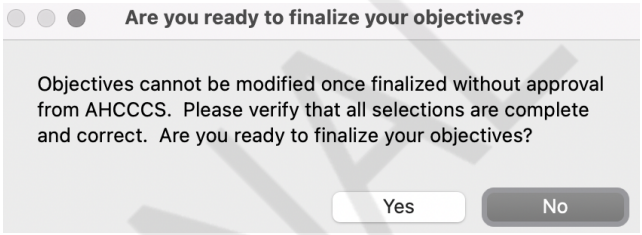
program focus, goals, and projected outcomes. At least one NOMs objective must be selected under the category of participants to be served (young child, youth, adult, etc.). In addition to the NOMs objectives, there are optional objectives for both youth and adults that may also be selected.

NOTE: Once objectives are selected and saved, Providers will not be able to modify those objectives without written approval from the AHCCCS Contract Manager.

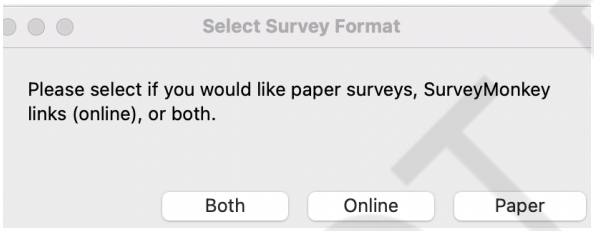
Once all applicable objectives have been selected, click the 

button to save and continue. You will be prompted to verify that you are ready to finalize the objectives specific to the funding source, contract year, program and target population selected.

To continue, click 'yes' or if modifications are needed, click 'no' to return to the objective selection tables.



Once the objectives are finalized, you will be asked to choose if you will be administering surveys 1) In person (paper surveys), 2) online or electronically or 3) using both paper and online versions.

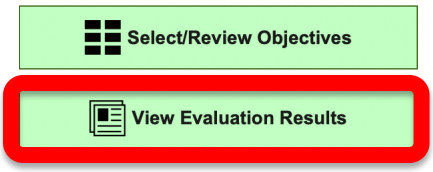


Once you select the type of survey to be administered, the page will refresh and show the final chosen objectives.

View Evaluation Results

Survey tools have been designed to be used to collect data on the Primary Prevention programs in order to provide an assessment of the impact of the programs on the target populations participating in the programs. Three types of survey tools have been developed: Pre/Post, Post Only, and Retrospective Pre. The type of survey used will depend upon the length and type of program being evaluated. See Appendix B. The survey items created will increase our understanding of how or why the prevention strategy(ies) either did or did not work and this assessment can typically guide subsequent program improvement. The survey items can also increase our understanding of the relationships among the determinants, behaviors, and health goals. By identifying and targeting those factors that both affect adolescents' decisions about substance use and can be changed by certain prevention strategies, the chances of reducing underage drinking and substance use among youth are greatly improved. This information can then lead to the implementation of more effective program models. The tables in Appendix C provide an overview of the AHCCCS Primary Prevention evaluation tool items, what's being evaluated and why it is being evaluated (i.e., what research studies say about "it" and the impact on prevention of substance

use.) The Wellington Group will design program surveys for each Provider based on the program, objectives chosen and target audience of each program.

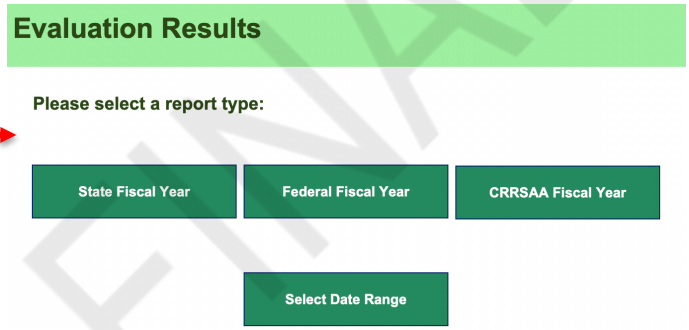


When "paper" surveys are administered to adult or youth participants, Providers should scan and email completed surveys to the Wellington Group staff within 48 hours of survey administration. Upon receipt, data entry staff will enter data into the Data Management System.

If online surveys are collected through Survey Monkey, data will be downloaded directly by Wellington Consulting Group each month and uploaded into the Data Management System.

Once data has been entered into the system, users can access the raw data by selecting the **View Evaluation Results** button.

Users have a variety of date options for viewing the evaluation data by selecting one of the date specific buttons as shown here.

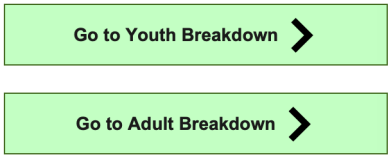


Once a date range button is selected, choose the desired fiscal year or other date range (month, quarter, etc.) then click the 

button to view the data.

Evaluation Results Filters

After selecting the **Create Report** button and running the evaluation results, a set of additional filters appear to the right of the evaluation results table. These options allow the user to filter the evaluation data to view only youth or only adult data and includes demographic data for each population age group.



CHAPTER 5: STRATEGIES, ACTIVITIES, AND PARTICIPANTS

This section of the Data Management System is designed to capture, track, and report on several aspects of primary prevention funded programs that must be reported by AHCCCS to SAMHSA on a quarterly and annual basis. These data points include aspects of program implementation (strategies and activities implemented, service locations, tracking evidence-based programs, etc.), participants served (demographics, IOM categories, special populations served, etc.), and program expenditures (by budget and strategy categories).

The following paragraphs contain important information regarding the data that must be entered and the definitions that are used by SAMHSA to determine the categories of service. Please read this section prior to entering data.

Definitions and Reporting Due Dates

The **Provider Profile** and the **Activities List** should be completed upon grant award and must be updated when new program delivery sites and activities are added to the program.

Direct Service Participants are defined as recipients of direct service activities and are tracked through the enrollment information. The participant demographic data must be collected and entered in the Data Management System as enrollment takes place. Each individual participant should be entered only once. AHCCCS reviews and aggregates this data monthly. The participant data must be updated each month no later than the 15th of the month following the reporting month (For example, October report information must be completed by November 15h).

NOTE: Individual Direct Service Participants within a particular direct service activity should only be counted once.

Individual Based Activities (Direct Service)

Individual counts of participants should be **unduplicated** within a direct service activity. However, there may be instances where a participant is counted more than once IF that individual participates in **more than one** individual-based activity. In that case, the individual will be recorded under each activity (however, each participant is entered only once on the **Direct Service Participants** section of the Data Management System. For example, a young person may receive a prevention curriculum in his/her health class and also participate in an after-school tutoring program. This individual would be reported twice.

Population Based Activities (Indirect Service)

The **Indirect Services** data may be provided as a duplicate count; that is, an individual who participates in population-based activities may be recorded multiple times. For example, a young person may attend a high school assembly on substance abuse, attend a health fair, and receive a brochure as part of the implementation dissemination strategy. This individual would be reported three times, under three different activities. The following month, the same individual might attend the same or different population-based activities and he/she would be counted again. These types of activities address a broad audience and implementation does not typically involve formal enrollment of the participants. Therefore, the demographic data that is reported may be an estimation of the characteristics of the participants.

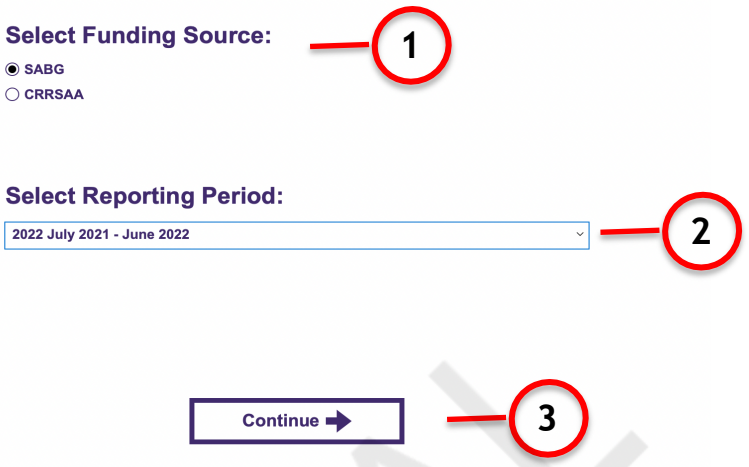
The **Expenditures** report must be completed once per month; report on monthly expenditures by strategy and monthly expenditures on evidence-based programs. This report must be completed by the 15th of the month following the reporting period.

Accessing the Strategies, Activities and Participants Section of the Data Management System

Click the **Strategies, Activities and Participants** button to begin.

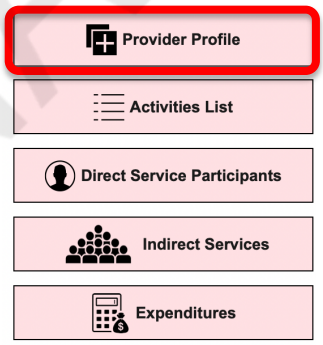
Next, select the Funding Source and Reporting Period to continue.
NOTE: Strategies, activities, and participants must be tracked separately for EACH funding source.

To begin (1), select the funding source under which you are reporting. Once a funding source is selected, the drop down menu for selecting a reporting period will appear. Select the current funding period (2) then click 'continue' (3).



Provider Profile

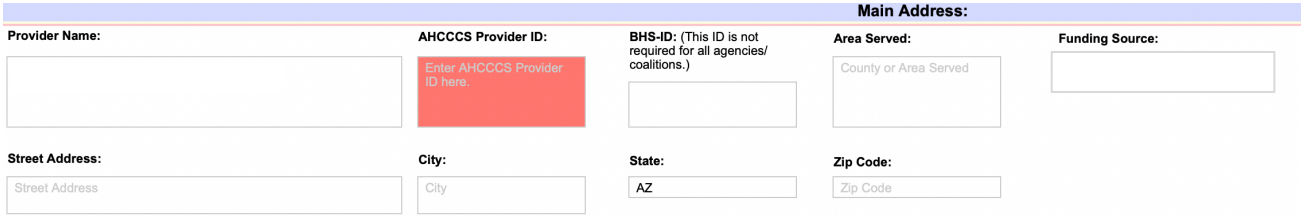
Data collected in the Provider Profile:



- Provider Name
- AHCCCS Provider ID
- I-BHS ID (Optional)
- Area(s) Served
- Funding Source
- Provider's Main Street Address
- Targeted Substances Addressed
- Targeted Populations
- Risk Categories of Populations served by your grant funding
- Charitable Choice Questions
- Additional Program Address(es) and data specific to those program addresses

At the start of the grant program, Providers should complete all applicable sections of the Provider Profile. The first section, **Main Street Address**, is to be completed with the following information:

- Provider Name – once entered, the name will automatically populate after login to the AHCCCS Primary Prevention Data Management System
- AHCCCS assigned Provider ID
- I-BHS ID, a unique ID for each Provider assigned by SAMHSA; this is optional and only assigned to those agencies offering both prevention and treatment services
- Area served (county, town, school, or specific community being served by the funded Provider)
- Funding Source - this will automatically populate with the funding source selection made in the previous screen
- **Main Street Address** of the Funded Provider
- City of the Funded Provider
- State of Funded Provider
- Zip Code of Funded Provider



In the next section, Providers should indicate which substances are being targeted by the programming of the selected funding source for the **Main Street Address**. Select one or multiple substances targeted. Substance choices include the following:

- ☐ Alcohol
- ☐ Cocaine
- ☐ Heroin
- ☐ Inhalants
- ☐ Marijuana
- ☐ Methamphetamines
- ☐ Prescription Drugs
- ☐ Synthetic Drugs
- ☐ Tobacco

In the third section, select the target category or categories of populations being served at the **Main Street Address. NOTE**: Although different populations may be served, the Provider should only mark the target populations that are intentionally recruited for the program. The target categories include:

- ☐ African American
- ☐ American Indian/Alaskan Natives
- ☐ Asian
- ☐ Hispanic
- ☐ Homeless
- ☐ LGBTQ
- ☐ Military Families
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ Rural
- ☐ Students in College
- ☐ Underserved Racial and Ethnic Minorities

For the **Main Street Address** of program implementation, select the category or categories of high-risk populations being served at the program implementation site. **NOTE**: Only high risk populations being targeted and intentionally recruited for program participation at that location should be counted. The categories of high risk participants include:

- ☐ Abuse Victims
- ☐ Already Using Substances
- ☐ Child of Substance Abusers
- ☐ Drop-outs
- ☐ Economically Disadvantaged
- ☐ Homeless or Runaway Youth
- ☐ Mental Health Problems
- ☐ Physically Disabled
- ☐ Pregnant Women/Pregnant Teens

☐ Violent and Delinquent Behavior
☐ Other, Please Specify Other

The **Charitable Choice** questions are required by SAMHSA and are included in Section 5 of the Provider Profile. Under Charitable Choice Provisions; Final Rule (42 CFR Part 54), SAMHSA grant recipients must:

1. Ensure that religious organizations that are Providers provide to all potential and actual program beneficiaries (services recipients) notice of their right to alternative services;
2. Ensure that religious organizations that are Providers refer program beneficiaries to alternative services; and
3. Fund and/or provide alternative services. The term "alternative services" means services determined by the state to be accessible and comparable and provided within a reasonable period of time from another substance abuse Provider ("alternative Provider") to which the program beneficiary (services recipient) has no religious objection. The purpose of this table is to document how the state is complying with these provisions.

Providers should select each category that applies to show how the Provider will notify program beneficiaries about the Charitable Choice options (check all that apply).

- Used model notice provided in final regulation.
- Used notice development by provider (email a copy to your AHCCCS Contract Manager).
- Provider has disseminated notice to religious organizations that are service Providers.

Providers should select each category that applies to the methods for referrals to alternative services being used by the specific location (check all that apply).

- Provider has developed specific referral system for this requirement.
- Provider has incorporated this requirement into existing referral system(s).
- Other networks and information systems are used to help identify Providers.

The Provider should enter the total number of referrals made to other substance abuse Providers ("alternative Providers") that were necessitated by religious objection, as defined previously. **NOTE**: This field should be updated monthly to include any additional referrals made during the reporting month from a specific service delivery location.

The final section should be filled in as needed with notes from the Provider related to any **Main** location services listed in the Provider Profile.

Be sure to click the **Save** button once you have finished completing the Provider Profile.

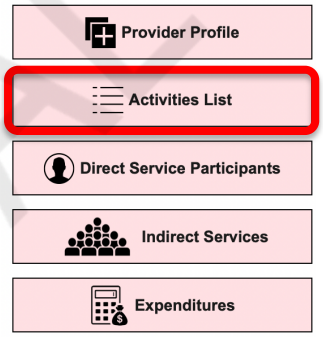
Adding Additional Administrative Locations

For those Primary Prevention Providers operating prevention programming from an Administrative office location that is NOT the MAIN Street Address, it is necessary to complete the Provider Profile information detailed above pertaining to the additional Administrative address. **NOTE:** Administrative addresses do not include partner, community or school organizations that are hosting prevention classes or activities.

For each Administrative location operating programs under the selected funding source, click the **+ Add New Administrative Location** button and complete all of the sections of the Provider Profile for EACH Administrative location including the following:
Section 1: Administrative location address
Section 2: Substances targeted by programs at that Administrative location
Section 3: Priority populations targeted by programs at that Administrative location
Section 4: High risk target populations targeted by programs at that Administrative location
Section 5: Charitable Choice notices and referral methods specific to services provided at that Administrative location
Section 6: Notes related to the Administrative location services and programs

Activities List

Prior to entering any data pertaining to program participants, the Provider must enter Strategies and Activities. The Activities List is used to record all of the strategies and activities being implemented under the selected funding and to indicate the type of each activity (evidence-based, promising or innovative). To begin this task, click the **Activities List** button.



Information collected in this form include the following:

- Funding Source (automatically populated once funding source is selected)
- Prevention Strategy
- Activity Category
- Activity Description/Curriculum Name
- Type of Program

Strategy and Activity Definitions

All funded programs should fit into one of the Center for Substance Abuse Prevention (CSAP) defined strategy and activity categories. Below is a list of the six strategies and corresponding activities.

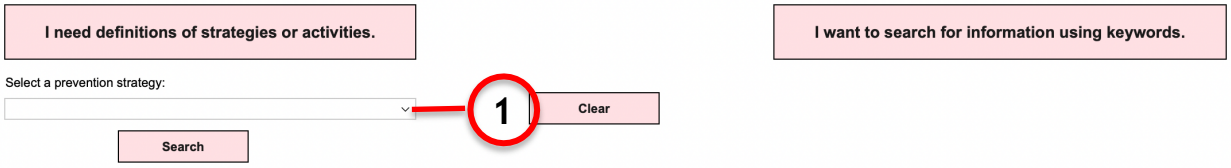
STRATEGY CATEGORIES	ACTIVITIES
INFORMATION DISSEMINATION	Clearinghouse/Information Resource Centers
	Resource Directories
	Media Campaigns
	Brochures
	Radio And TV
	Speaking Engagements
	Health Fairs And Other Health Promotion Activity
	Information Lines/Hot Lines
	Other Information Dissemination Activity*
EDUCATION	Parenting and Family Management
	Ongoing Classroom and/or Small Group Sessions
	Peer Leader/Helper Programs
	Education Programs for Youth Groups

	Mentors
	Preschool ATOD Prevention Programs
	Other Education Activity*
ALTERNATIVES	Drug Free Dances and Parties
	Youth/Adult Leadership Activity
	Community Drop-in Centers
	Community Service Activity
	Outward Bound
	Recreation Activity
	Other Alternative Activity*
PROBLEM IDENTIFICATION AND REFERRAL	Employee Assistance Programs
	Student Assistance Programs
	Driving While Under the Influence/Driving While Intoxicated Education Programs
	Other Problem Identification and Referral Activity*
COMMUNITY BASED PROCESS	Community and Volunteer Training
	Systematic Planning
	Multi-agency Coordination and Collaboration/Coalition
	Community Team-Building
	Accessing Services and Funding
	Other Community-Based Process Activity*
ENVIRONMENTAL	Promoting the Establishment or Review of Alcohol, Tobacco, and Drug Use Policies in Schools
	Guidance and Technical Assistance on Monitoring, Enforcement, Governing, Availability and Distribution of Alcohol, Tobacco and Other Drugs
	Modifying Alcohol and Tobacco Advertising Practices
	Product Pricing Strategies
	Other Environmental Activities*

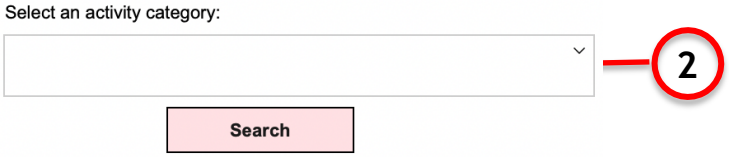
NOTE: *Providers should attempt to classify program services under one of the available activity categories rather than using the "Other" category under each strategy whenever possible. Use the help section or keyword process described below to help classify an activity.

At the top of the Activities List form is a button to offer assistance in classifying a strategy and/or activity. Click the **I need help classifying an activity!** button.

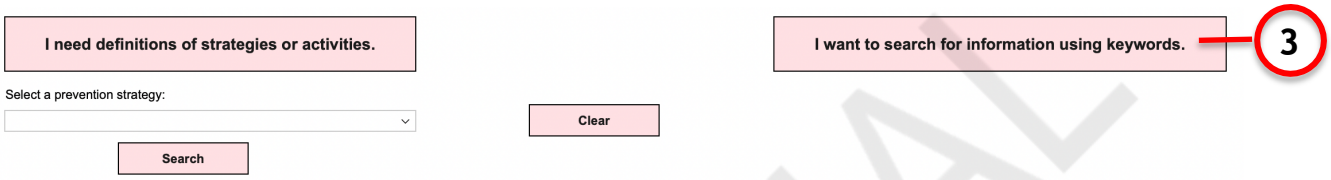
1) From this help screen, you can select a prevention strategy from the dropdown list, click the **Search** button and view the definition of that strategy.



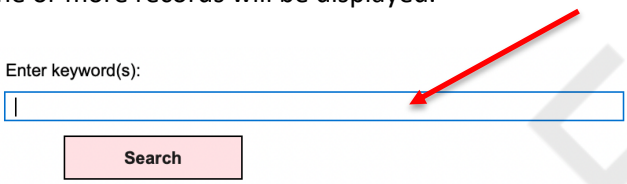
2) After viewing the strategy definition, you are able to select one of the activity categories listed under that strategy from the dropdown menu and view the definition by clicking the **Search** button.



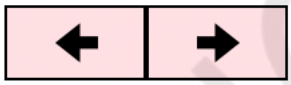
3) A third option for help in classifying a strategy or activity is to enter a keyword. Begin by selecting the **I want to search for information using keywords** button.



Once the user enters a keyword or several keywords separated by commas, click the search button and one or more records will be displayed.



One or more strategies and activities containing the keyword/s listed will be displayed. The display will show the Prevention Strategy, Prevention Strategy Definition, Activity Category as well as a definition of the Activity. Use the arrows to scroll through the strategies and activities to determine which category best fits the funded strategy and activity being implemented.

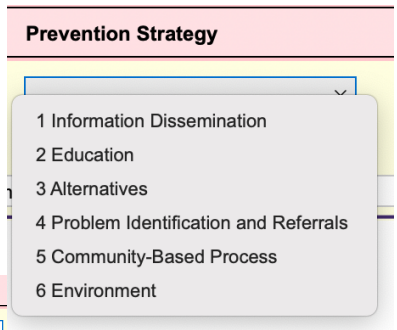


Once help is no longer needed, click on the 

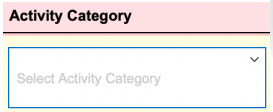
button to return to entering activities in the Activities List.

Completing the Activities List

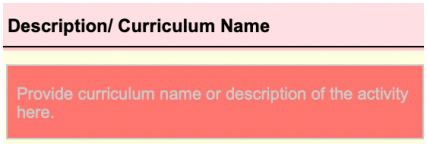
Once you have determined the appropriate strategy and activity categories for your funded programs, you can enter each into the Activities list. To begin entering a funded activity, select from one of the six CSAP Prevention Strategies as represented in the dropdown menu.

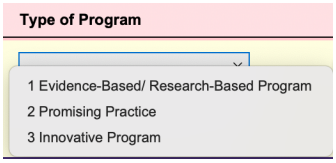


After choosing the strategy, the list of corresponding activities become available in a dropdown list under the Activity Category heading.

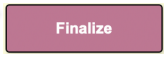


In the next section, provide a written description of the activity or the curriculum name in the text box.

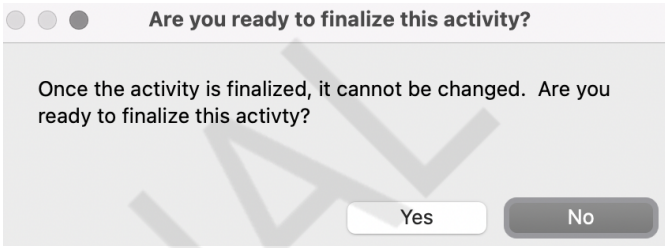




Finally, from the dropdown menu under the Type of Program heading, indicate whether the activity is 1) Evidence-Based/Research-Based, 2) a Promising Program or 3) an Innovative Program. To complete the entry, click on the button.



NOTE: Once you enter and finalize an activity, the activity **cannot** be changed. Be sure that you enter all the information correctly and thoroughly prior to finalizing the entry. Once the information is entered and correct, select **Yes** to save the entry.



Continue entering each strategy and activity to be implemented under the funding source, both direct and indirect service activities must be listed. If you have multiple events/activities taking place in a particular month under the same Activity Category, you can create separate descriptions of these events in the Activity List.
Click the 

button at the top of the page to restart the activity entry process.

NOTE: The **Activities List** must be completed for EACH funding source received for Primary Prevention services from AHCCCS. If more than one funding source is being utilized by the Provider, return to the **Home** screen, enter the **Strategies, Activities and Participants** section of the Data Management System then select the next funding source and Reporting Period, then enter all Activities being funded by the other funding source/s. In addition, activities will need to be entered EACH funding year of the grant.

Once the complete list of activities has been entered, options are available at the top of the page to **1)** filter the Activities List by strategy type or **2)** view the full list of activities.

To filter, select a strategy category from the drop down menu and click the **Go** button.

Direct Versus Indirect Services and Activities

All activities implemented under Primary Prevention funding fall into one of two categories: Direct Service Activities or Indirect Service Activities. To determine where a specific activity should be recorded, Data Management System users should follow these guidelines:

Direct Services: Interactive prevention interventions that require personal contact with small groups to influence individual-level change *(i.e. classroom-based programs, parenting programs, community training, etc.).*

Indirect Services: Population-based prevention interventions that require sharing resources and collaborating to contribute to community-level change *(i.e. compliance checks, media campaigns, information dissemination, recreational activities, large group/assembly-style presentations, advocacy, etc.).*

To identify direct service activities, answer the following questions:

1) Does your training, curriculum, or program, etc. involve two-way interaction between the presenter/facilitator and participant(s)?
2) Is there a level of interaction with participants that allows you to collect their demographic data?
3) Is your activity multi-session? And if your activity is one session, does it last for one hour or more?
4) Are you using a pre/post or retrospective survey with participants at this activity?

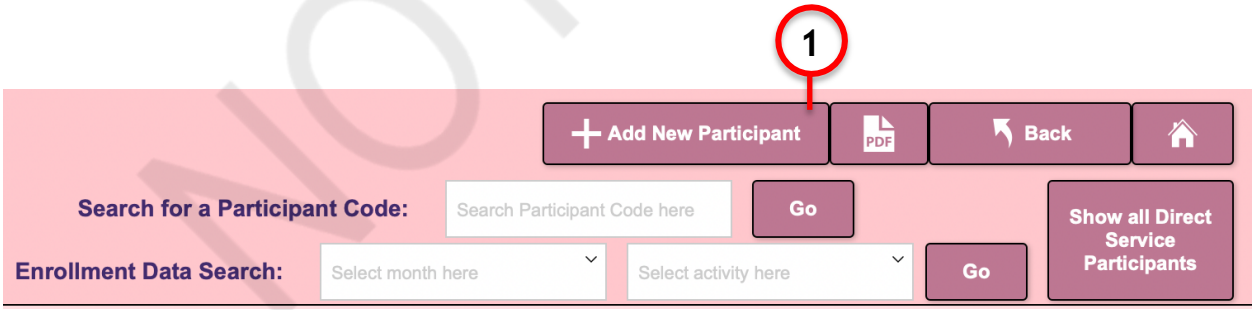
If your answer to any of these questions is "NO", the activity is most likely an indirect service. Please contact your AHCCCS Program Administrator if you have further questions about a specific activity.

Direct Service Participants

Each participant enrolled in and served by Direct Services under AHCCCS Primary Prevention funding must be entered into the Data Management System. The menu at the top of the Direct Service Participants page contains the features needed to add new participants, search for, and sort existing participants, and view and print lists of participants.

NOTE: Prior to entering any Direct Service Participants, the Activities List must be finalized and contain individual-based, direct service activities/programs.

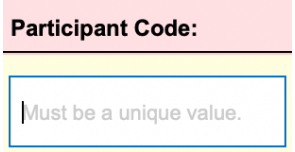
To begin entering a Direct Service Participant (1), click the **+Add New Participant** button at the top of the page.



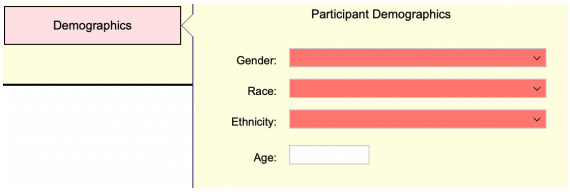
Participant Codes

A unique participant code must be assigned to each direct service participant and filled into the first field. To protect the confidentiality of program participants, it is preferred that you use a unique identifier rather than the participants' names. Providers may choose their own method of selecting a participant code or may use one of the example methods. Whichever method is selected to codify direct service participants, the code must be used consistently throughout the life of the grant funding and program implementation. Examples:

a) First Name Initial, Last Name Initial, Date of Birth (ex. JS10181995)
b) Location Abbreviation, First Name Initial, Last Name Initial, Date of Birth (ex. CVHSJS10181995)



Demographics

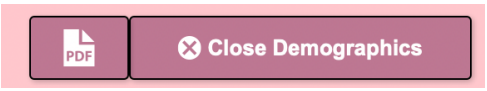


Click on each of the demographic categories to select the demographic information for the participant. The demographic categories include the following:

- **Gender – response required**
  - Male
  - Female
  - Gender Unknown or participant identifies as gender other than Male or Female
- **Race – response required**
  - American Indian/Alaskan Native
  - Asian
  - Black or African American
  - Native Hawaiian/Other Pacific Islander
  - White
  - More Than One Race
  - Race Unknown
- **Ethnicity – response required**
  - Hispanic/Latino
  - Not Hispanic/Latino
  - Ethnicity Unknown
- **Age – maybe be left blank if unknown**
  - Enter the participant's age at the time of enrollment

At any time, users of the Data Management System are able to retrieve a summary report of all participants entered to date. Simply click on the **Demographic Summary** button at the top of the Direct Service Participants page and a summary report will generate listing the age gender, race and ethnicity of direct service participants entered to date.

Once you run the Demographic Summary report, you can either save your report as a **PDF** or **Close Demographics** report by selecting the appropriate button at the top of the report.

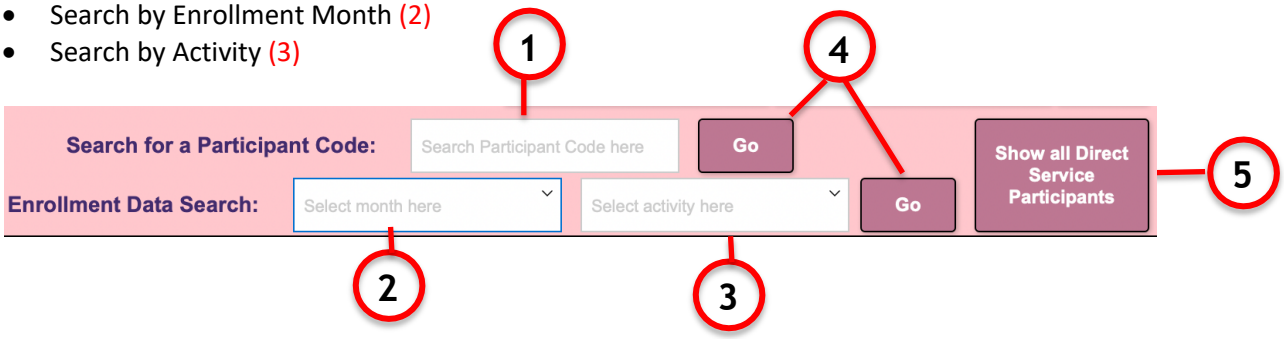


Participant Searches and Filters

Once all of the Direct Service participants have been entered into the Data Management System, the user can filter the complete list of participants using one of three search fields:

- Search for a Participant Code (1)

- Search by Enrollment Month (2)
- Search by Activity (3)



Once a search field has been selected, click one of the **Go** buttons (4) to view participants matching the search criteria entered. To return to a view of the full list of participants, click the **Show all Direct Service Participants** button (5).

NOTE: The search filters work two ways.

1. Identifying the first part of the field. Take for example the Participant Code, "AA0322TOLLESON". Search for this Participant Code by typing the first few characters of the Participant Code "AA032". If you type in "Toll", the search command looks for that combination of letters/numbers at the start of any word. You would not find the Participant Code "AA0322TOLLESON" because "Toll" is not at the beginning of the word.

2. Searching for a combination of letters/numbers positioned anywhere within the Participant Code (like "Toll") can be done using the following method: Type an asterisk "*" before and after the text you want to search for. To find "Toll" anywhere in the Participant ID, you need to type in "*toll*".

Activity/Activities

The Direct Service activities entered earlier into the Activities List section specific to the selected funding source will appear under one of the strategy buttons.

Education	Alternatives	Problem ID and Referrals	Community-Based Process

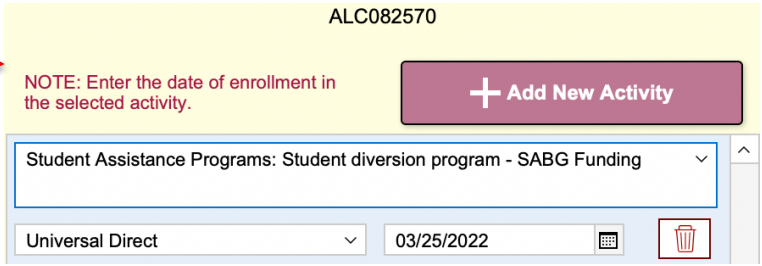
NOTE: Activities implemented under the Information Dissemination and Environmental strategies are all **Indirect** Services and will not appear as one of the **Direct** Service strategy options. Only Strategy categories added under the Activities List section for the selected funding source will appear (and may not look the same as this example).

If there are no strategy buttons as shown, the following error message will be displayed:

No buttons here? Use the pink Back button to return to the menu and finalize your Activity List.

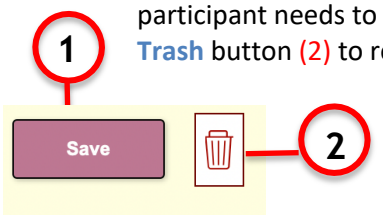
Select the Strategy category (pink button), then the Activity from the drop down list in which the new participant has enrolled. Choose the IOM Category that best describes the participant as related to their enrollment in the selected activity. Choose from the categories of Universal, Selective or Indicated. Finally, select the date that the participant enrolled in the selected activity.

See the example

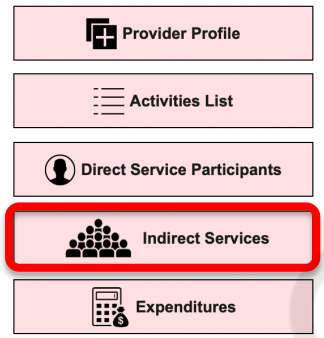


If the participant is enrolled in a second activity under the same Strategy category, select the + Add New Activity Button, select the activity and the IOM category then enter the enrollment date for that activity. If an activity needs to be removed, click the Trash button to remove the activity.

Once the activity enrollment information is entered and completed, click the **Save** button (1). If the participant needs to be deleted or removed from the Data Management System, click the **Trash** button (2) to remove that participant.

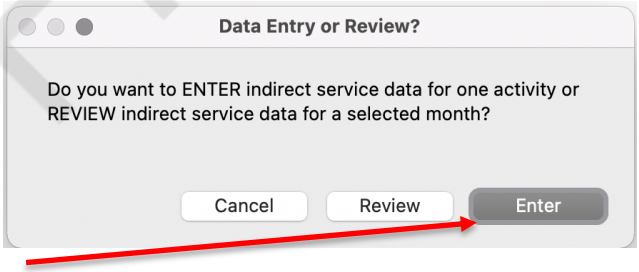


Indirect Services

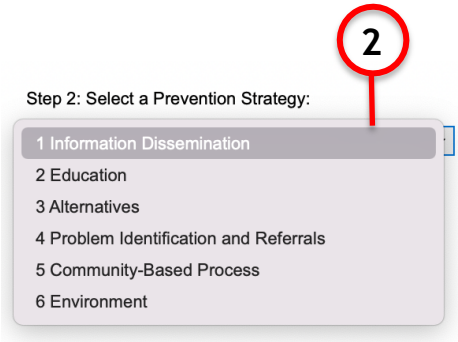


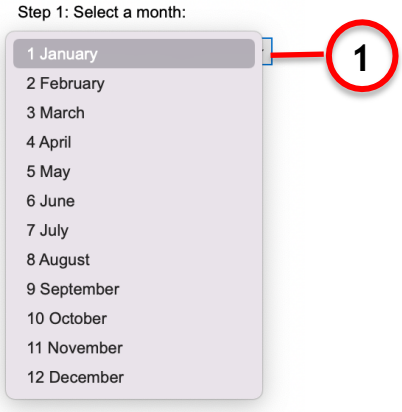
Prior to reporting on Indirect Services, be sure all activities, including Indirect Services, have been entered on the **Activities List**.

After clicking on the Indirect Services button, you will be asked if you would like to **Review** existing Indirect Services or **Enter** new Indirect Services.



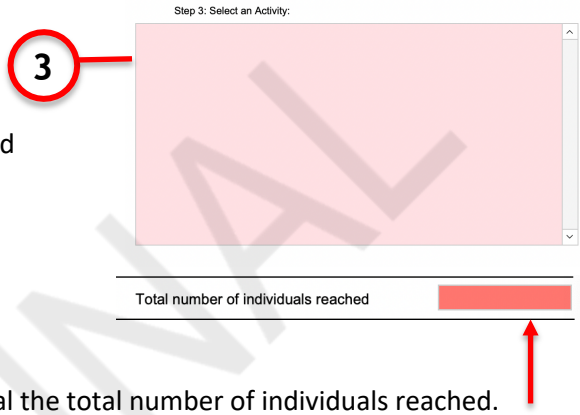
To begin entering Indirect Services, click the **Enter** button. For one time or time limited services, select the month that the Indirect Service took place from the dropdown menu. (1) For on-going activities, the Indirect Services record should be completed each month. Provide the details on how many participants were indirectly served that month.





Next, select the Prevention Strategy category (2). Once you choose a Prevention Strategy category, all of the Activities entered in the Activities List under that Strategy category will appear to the right of the Strategies. To finalize the Indirect Services entry, select the Activity from the populated list (3).

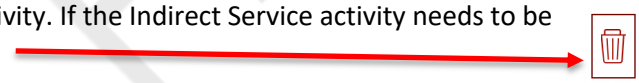
After selecting the appropriate Activity, you will be prompted to enter new participant data for that activity. In addition to entering the total number of individuals indirectly served, demographic data for the indirect service populations must be reported including the following:



- Age Ranges
- Gender
- Race Categories
- Ethnicity Categories

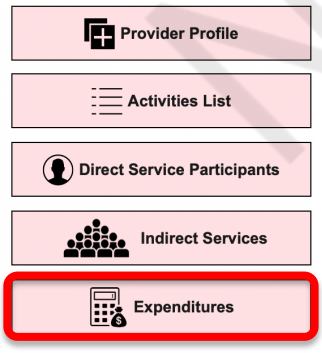
NOTE: The sum of each demographic category must equal the total number of individuals reached.

Be sure to click the **Save** button after the demographic data has been entered for the Indirect Services in this Activity. If the Indirect Service activity needs to be removed, click the Trash button.

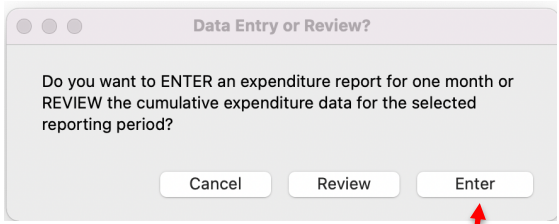


To continue entering additional Indirect Services, click the **+ Add Another Indirect Service Form** button at the top of the page. If you have multiple events/activities taking place in a particular month under the same Activity Category, you can create separate descriptions of these events in the Activity List.

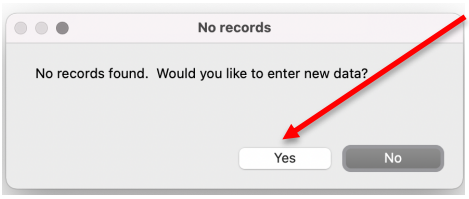
Expenditures



The Expenditure Report is **due by the 15th of the month** following the reporting period. Click the **Expenditures** tab. You will be asked if you choose to **Review** or **Enter** expenditure data; to begin a new Expenditure Report, select **Enter.**

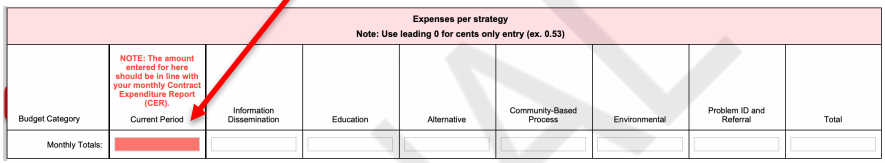


Next, select an Expenditure reporting month from the drop down menu. Then click here to continue:



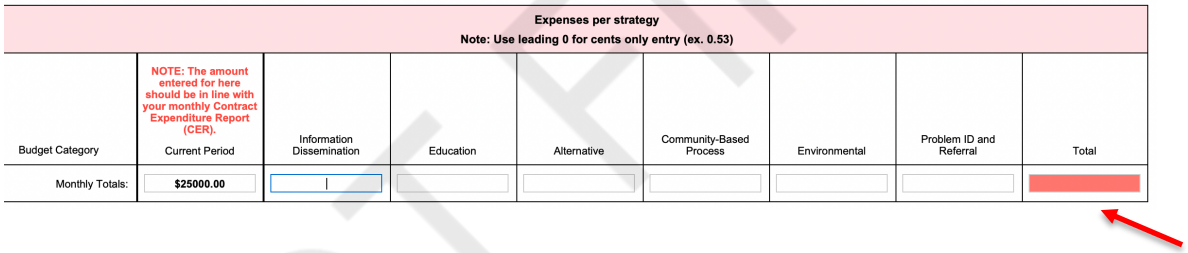
When entering a new Expenditure Report for a particular month, you will receive a message indicating that no data is found. Would you like to enter new data? Select **Yes** to continue entering Expenditure data.

The monthly total in the first column (Current Period) must equal the Contract Expenditure Report (CER) total submitted to AHCCCS for that month.



Expenses per strategy Note: Use leading 0 for cents only entry (ex. 0.53)								
Budget Category	NOTE: The amount entered for here should be in line with your monthly Contract Expenditure Report (CER). Current Period	Information Dissemination	Education	Alternative	Community-Based Process	Environmental	Problem ID and Referral	Total
Monthly Totals:								

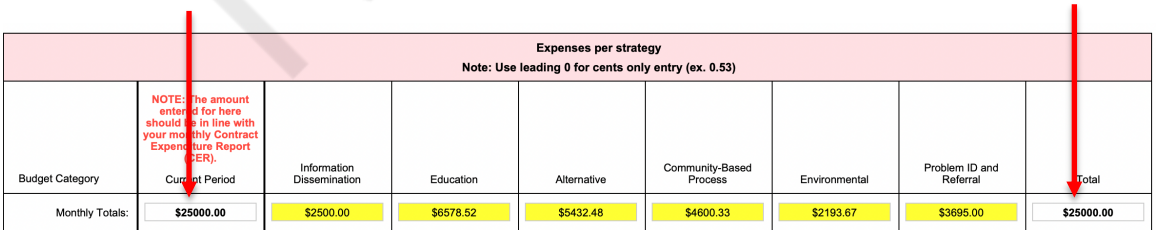
SAMHSA requires all Primary Prevention grant recipients to track and report expenditures by strategy. The sum of all of the strategies combined must add up to the total expenditures for that month (Current Period).



Expenses per strategy Note: Use leading 0 for cents only entry (ex. 0.53)								
Budget Category	NOTE: The amount entered for here should be in line with your monthly Contract Expenditure Report (CER). Current Period	Information Dissemination	Education	Alternative	Community-Based Process	Environmental	Problem ID and Referral	Total
Monthly Totals:	$25000.00							

For each of the strategy columns, enter the dollar amount expended on each of the six strategies for the reporting period. **NOTE:** Enter the dollar amounts using only numbers and decimal points (no commas). In the last column, the totals of the amounts entered into each strategy line item will automatically calculate. **NOTE:** The total of the Current Period line items and the total of all the Strategy line items **must match**. If these numbers do not match, you will see a red box in the TOTAL column.

Once the sum of all strategies match the Current Period, the red cell will disappear.



Expenses per strategy Note: Use leading 0 for cents only entry (ex. 0.53)								
Budget Category	NOTE: The amount entered for here should be in line with your monthly Contract Expenditure Report (CER). Current Period	Information Dissemination	Education	Alternative	Community-Based Process	Environmental	Problem ID and Referral	Total
Monthly Totals:	$25000.00	$2500.00	$6578.52	$5432.48	$4600.33	$2193.67	$3695.00	$25000.00

NOTE:
Red cells indicate required data is missing or totals do not match.
Yellow cells indicate money was entered but there are no participants in the specified prevention strategy. If no direct participants are enrolled in activities or services under the specified prevention strategy during the month, please document one (1) participant under indirect services. **This allows the expenditures per strategy category data required by SAMSHA to calculate correctly.**

After completing the monthly expenditures and expenditures by Strategy columns, be sure the expenditure categories mirror the participants served under those categories each month. If there are no Direct Service or Indirect Service participants entered in a Strategy category that month, the field under the Strategy category will be yellow.

If funds were expended under a Strategy but no participants were enrolled that month (for example, time was spent planning, purchasing, hiring, etc.), enter at least one indirect participant under the appropriate activity under that Strategy category to allow the expenditure per Strategy category data to calculate correctly.

The second table of the Expenditures tab collects information on **Additional Expenditure Allocation Categories.**

Percent Allocated to:				
Prevention (other than primary prevention) and Treatment Services	Pregnant Women and Women with Dependent Children	Primary Prevention	Early Intervention Services for HIV	Syringe Service Programs
%	%	%	%	%
Total:	%			

In this table, enter the percentage of each month's expenditures allocated to the following categories:

- Prevention (other than primary prevention) and Treatment Services
- Pregnant Women and Women with Dependent Children
- Primary Prevention
- Early Intervention Services for HIV
- Syringe Service Programs

The total of these category allocations (percentages) should be 100%. **NOTE**: This table must be completed each month. The table will turn red if data is not entered into the table.

The final question on the Expenditure form pertains to Administrative Expenditures. If Administrative costs were expended during the reporting month, select **Yes**.

Did this coalition have Indirect or Administrative Expenditures this month? (•) Yes ( ) No

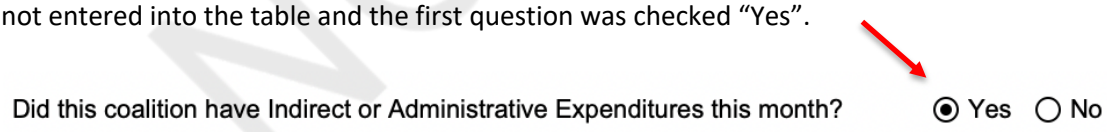
For the month, what was the total for Indirect or Administrative expenditures?

Percent of Expenditure Allocated to Resource Development:						
Planning, Coordination, and Needs Assessment	Quality Assurance	Training (Post-employment)	Education (Pre-employment)	Program Development	Research and Evaluation	Information Systems
%	%	%	%	%	%	%
Total:	%					

Next, enter the dollar amount expended on Administrative costs. Finally, fill in the percent of Administrative Expenditures allocated to each of the following Administrative Expense Categories in the table.

- **Planning, Coordination, and Needs Assessment** - Any funding mechanism with community-based organizations or local governments for planning and coordination fall into this category. Needs assessment projects to identify the scope and magnitude of the problem, resources available, gaps in services, and strategies to close those gaps should also be included in this category. Expenditures for activities such as planning meetings, data collection, analysis, and writing are allowed.
- **Quality Assurance** – This category includes activities at any level (state, region, Provider) to assure conformity to acceptable professional standards and to identify problems that need to be remedied.
- **Training (post-employment)** – This category includes expenditures for staff development and continuing education for personnel employed in local programs as well as support and coordination agencies, as long as the training relates to substance abuse services delivery. Typical costs include course fees, tuition and expense reimbursements to employees, trainer(s) and support staff salaries, and certification expenditures.
- **Education (pre-employment)** – This category includes support for students and fellows in vocational, undergraduate, graduate, or postgraduate programs who have not yet begun working in substance abuse programs. Costs might include scholarship and fellowship stipends, instructor(s) and support staff salaries, and operating expenses.
- **Program Development** – This category includes consultation, technical assistance, and material support to local Providers and planning groups. Generally, these activities are carried out by state level agencies.
- **Research and Evaluation** – This category includes program performance measurement, evaluation, and research, such as clinical trials and demonstration projects to test feasibility and effectiveness of a new approach. These activities may have been carried out by the principal agency of the state or an independent organization.
- **Information Systems** – This includes collecting and analyzing treatment and prevention data to monitor performance and outcomes. These activities might be carried out by the principal agency of the state or an independent organization.

The total of these category allocations (percentages) should add up to 100%. **NOTE**: This table must be completed if Indirect or Administrative Costs were expended that month. The table will turn red if data is not entered into the table and the first question was checked “Yes”.



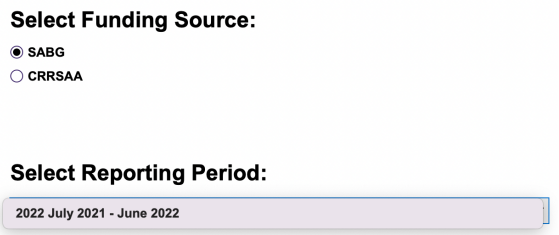
Be sure to click the Save button after the Expenditures data has been entered for the month. If the Expenditure report needs to be removed, click the Trash button.

CHAPTER 6: NARRATIVE REPORTS (OPTIONAL)

Each month of the contract year, providers are able enter a narrative report by selecting this button from the Main Menu of the Data Management System.

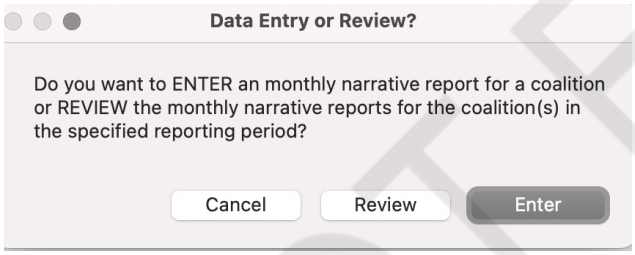
NOTE: The completion of the monthly narrative report is OPTIONAL. Providers can use this form to provide further narrative information to support the direct and indirect participant service numbers and expenditure reports.

Select the funding source and grant year (reporting period) for the report you wish to enter. **NOTE**: As with all of the previously described reports, a separate monthly narrative report must be completed for each funding source.



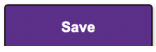
After the funding source and reporting period are selected, select the month for which you are completing the report then click **Continue**.

Indicate whether you are entering a new report (**Enter**), reviewing an already submitted report (**Review**), or exiting the screen (**Cancel**).



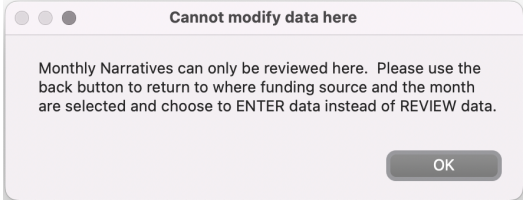
Click **Enter** to start a new monthly narrative report. The top of the page will indicate the Coalition name and the selected month. Providers will enter a text response to the following question:

Please provide a brief narrative to report on items that are not otherwise captured in the coalition's process and outcomes measures (items to consider include, but are not limited to: successes, challenges, best practices identified, EBP fidelity and/or adaptations considerations, workforce development, and technical assistance needs).

Once the response has been typed into the space provided, click 

to keep or  to delete the report.

To review an already submitted report, select the funding source, reporting period and month as described above then click **Review.** The previously saved report for the month selected will be displayed. **NOTE:** This does not allow the Provider to edit an existing report. If the user clicks inside the text box, the following message will be displayed.



To edit an existing Narrative Report, select the **ENTER** button rather than the **Review** button.

APPENDIX A: NOMS EVALUATION QUESTIONS AND OBJECTIVES

Table 1

NOMs Domain: Youth	Evaluation Questions	Objectives
Abstinence from drug use/alcohol use – 30-day use (alcohol, cigarette, other tobacco products, marijuana, illegal drugs other than marijuana)	Does the implementation of the PPP decrease 30-day use among youth participants?	**Objective 1a**: By (insert date), there will be a 1% increase in the percentage of youth who report NO use of alcohol in past 30 days as measured by the Youth Primary Prevention Survey. **Objective 1b**: By (insert date), there will be a 1% increase in the percentage of youth who report NO use of cigarette in past 30 days as measured by the Youth Primary Prevention Survey. **Objective 1c**: By (insert date), there will be a 1% increase in the percentage of youth who report NO use of other tobacco products in past 30 days as measured by the Youth Primary Prevention Survey. **Objective 1d**: By (insert date), there will be a 1% increase in the percentage of youth who report NO use of e-cigarettes/vaping in past 30 days as measured by the Primary Prevention Survey. **Objective 1e:** By (insert date), there will be a 1% increase in the percentage of youth who report NO vaping of marijuana in past 30 days as measured by the Primary Prevention Survey. **Objective 1f**: By (insert date), there will be a 1% increase in the percentage of youth who report NO use of marijuana (smoke or edibles) in past 30 days as measured by the Primary Prevention Survey. **Objective 1g**: By (insert date), there will be a 2% increase in the percentage of youth who report NO use of prescription drugs in past 30 days as measured by the Primary Prevention Survey. **Objective 1h**: By (insert date), there will be a 1% increase in the percentage of youth who report NO use of other illegal drugs in past 30 days as measured by the Primary Prevention Survey. **Objective 1i**: By (insert date), there will be a 2% increase in the percentage of youth who report NO use of prescription pain relievers in past 30 days as measured by the Primary Prevention Survey. **Objective 1j**: By (insert date), there will be a 2% increase in the percentage of youth who report NO use of prescription stimulants in past 30 days as measured by the Primary Prevention Survey. **Objective 1k**: By (insert date), there will be a 2% increase in the percentage of youth who report NO use of multiple drugs at the same time in past 30 days as measured by the Primary Prevention Survey.

NOMs Domain: Youth	Evaluation Questions	Objectives
Abstinence from drug use/alcohol use – Perception of Risk/Harm of Use (alcohol, cigarettes, marijuana)	Does the implementation of the PPP increase youth perception of risk / harm of ATOD use?	**Objective 2a**: By (insert date), youth participants will show at least a 4% increase in their perception of risk/harm of smoking cigarettes as measured by the Primary Prevention Survey. **Objective 2b**: By (insert date), youth participants will show at least a 4% increase in their perception of risk/harm of using e-cigarettes/vaping as measured by the Primary Prevention Survey. **Objective 2c**: By (insert date), youth participants will show at least a 4% increase in their perception of risk/harm of vaping marijuana as measured by the Primary Prevention Survey. **Objective 2d**: By (insert date), youth participants will show at least a 4% increase in their perception of risk/harm of using marijuana (smoke/edibles) as measured by the Primary Prevention Survey. **Objective 2e**: By (insert date), youth participants will show at least a 4% increase in their perception of risk/harm of using marijuana concentrates as measured by the Primary Prevention Survey. **Objective 2f**: By (insert date), youth participants will show at least a 4% increase in their perception of risk/harm of underage drinking as measured by the Primary Prevention Survey. **Objective 2g**: By (insert date), youth participants will show at least a 4% increase in their perception of risk/harm of binge drinking as measured by the Primary Prevention Survey. **Objective 2h**: By (insert date), youth participants will show at least a 4% increase in their perception of risk/harm of using prescription drugs such as OxyContin, Percocet, Vicodin, Adderall, Ritalin, or Xanax as measured by the Primary Prevention Survey. **Objective 2i**: By (insert date), youth participants will show at least a 4% increase in their perception of risk/harm of using prescription drugs such as Adderall, Ritalin, Concerta, Vyvanse, Dexedrine as measured by the Primary Prevention Survey. **Objective 2j**: By (insert date), youth participants will show at least a 4% increase in their perception of risk/harm of using other illegal drugs as measured by the Primary Prevention Survey.
Abstinence from drug use/alcohol use – Age of First Use (alcohol, cigarettes, other tobacco products, marijuana or hashish,	Does the implementation of the PPP decrease the age of first use reported by youth? (comparison over 3 year periods)	**Objective 3a:** By (3-year date), there will be a 10% increase in the percentage of high school students (grades 9-12) who report they never tried alcohol as measured by the Primary Prevention Survey. **Objective 3b:** By (3-year date), there will be a 10% increase in the percentage of high school students (grades 9-12) who report they never tried

NOMs Domain: Youth	Evaluation Questions	Objectives
heroin, Rx pain relievers)		cigarettes/other tobacco products as measured by the Primary Prevention Survey. **Objective 3c:** By (3-year date), there will be a 10% increase in the percentage of high school students (grades 9-12) who report they never tried e-cigarettes/vaping as measured by the Primary Prevention Survey. **Objective 3d:** By (3-year date), there will be a 10% increase in the percentage of high school students (grades 9-12) who report they never tried marijuana as measured by the Primary Prevention Survey. **Objective 3e:** By (3-year date), there will be a 10% increase in the percentage of high school students (grades 9-12) who report they never tried prescription drugs as measured by the Primary Prevention Survey. **Objective 3f:** By (3-year date), there will be a 10% increase in the percentage of high school students (grades 9-12) who report they never tried other illegal drugs as measured by the Primary Prevention Survey.
Abstinence from drug use/alcohol use – Perception of disapproval/attitudes (cigarettes, marijuana experimentally, regularly, alcohol, peer disapproval of cigarettes)	Does the implementation of the PPP increase youth perception of disapproval/attitudes toward ATOD use?	**Objective 4a:** By (insert date), youth participants will show at least a 5% increase in their unfavorable attitudes toward use of cigarettes/tobacco products as measured by the Primary Prevention Survey. **Objective 4b:** By (insert date), youth participants will show at least a 5% increase in their unfavorable attitudes toward use of e-cigarettes/vaping as measured by the Primary Prevention Survey. **Objective 4c:** By (insert date), youth participants will show at least a 5% increase in their unfavorable attitudes toward vaping marijuana as measured by the Primary Prevention Survey. **Objective 4d:** By (insert date), youth participants will show at least a 5% increase in their unfavorable attitudes toward use of marijuana as measured by the Primary Prevention Survey. **Objective 4e:** By (insert date), youth participants will show at least a 5% increase in their unfavorable attitudes toward use of marijuana concentrates as measured by the Primary Prevention Survey. **Objective 4f:** By (insert date), youth participants will show at least a 5% increase in their unfavorable attitudes toward underage drinking as measured by the Primary Prevention Survey. **Objective 4g:** By (insert date), youth participants will show at least a 5% increase in their unfavorable attitudes toward binge drinking as measured by the Primary Prevention Survey.

NOMs Domain: Youth	Evaluation Questions	Objectives
		Objective 4h: By (insert date), youth participants will show at least a 5% increase in their unfavorable attitudes toward use of Rx pain relievers drugs as measured by the Primary Prevention Survey. **Objective 4i:** By (insert date), youth participants will show at least a 5% increase in their unfavorable attitudes toward use of Rx stimulant drugs as measured by the Primary Prevention Survey. **Objective 4j:** By (insert date), youth participants will show at least a 5% increase in their unfavorable attitudes toward use of other illegal drugs as measured by the Primary Prevention Survey. **Objective 4k:** By (insert date), youth participants will show at least a 5% increase in their perception of their friends' unfavorable attitudes toward smoking one or more packs of cigarettes a day as measured by the Primary Prevention Survey.
Employment/Education: Perception of Workplace Policy	Does the implementation of the PPP increase youth perception of workplace policy around random drug and alcohol tests?	**Objective 5:** By (insert date), youth participants will show a least a 5% increase in their positive perception regarding workplace policy of random drug and alcohol tests.
Family Communications Around Drug and Alcohol Use (Youth)	Does the implementation of the PPP increase youth communications around drug and alcohol use?	**Objective 6**: By (insert date), youth participants will show at least a 5% increase in the number of times they have talked to their parents/caregiver about ATOD in the past 12 months.
Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	Does the implementation of the PPP increase parent communications around drug and alcohol use?	**Objective 7**: By (insert date), adult participants will show at least a 5% increase in the number of times they have talked to their youth about ATOD in the past 12 months.
Retention: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message.	Does the implementation of the PPP increase youth exposure to prevention messages?	**Objective 8:** By (insert date), youth participants will show at least a 10% increase in their exposure to prevention messages (seeing, reading, watching or listening) in the past 12 months as measured by the Primary Prevention Survey.

Table 2 provides the Evaluation Questions and Objectives for the measurement of optional risk and protective factors for youth.

Table 2

YOUTH Risk/Protective Factors & Domain (Optional)	Evaluation Questions	Objectives
School/Community Factor: School Engagement / Physical and Psychological Safety – **Youth** Perception of School Climate	Does the implementation of the PPP increase youth perception of school climate?	**Objective**: By (insert date), there will be a 4% increase in the ratings of school climate by youth as measured by the School Climate survey addendum.
Individual Factor: Good Goal Setting Skills and Problem Solving - **Youth** Perception of Goal Setting and Problem-Solving Skills.	Does the implementation of the PPP increase youth perception of their goal setting and problem solving skills?	**Objective:** By (insert date) there will be a 4% increase in youth rating of their goal setting and problem solving skills as measured by the Problem Solving/Goal Setting survey addendum.
Individual Factor: Perceived Stress: **Youth** Self-Report of Perceived Stress	Does the implementation of the PPP decrease youth self-report of stress?	**Objective:** By (insert date) there will be a 5% decrease in youth perceived stress as measured by the Perceived Stress Scale addendum.
Individual Factor: Self-efficacy: **Youth** Perception of Self-efficacy	Does the implementation of the PPP increase youth rating of their ability to implement those behaviors needed to produce a desired effect?	**Objective:** By (insert date) there will be a 5% increase in youth rating of self-efficacy on the Self-Efficacy survey addendum.
Individual Factor: Social Connectedness: **Youth** Perception of Sense of Belonging	Does the implementation of the PPP increase youth sense of belonging?	**Objective:** By (insert date) there will be a 3% increase in youth rating of social connectedness as measured by the Belonging Scale survey addendum.

Table 3 provides evaluation questions and objectives for the measurement of optional risk and protective factors for adults.

Table 3

ADULT Risk/Protective Factors & Domain (Optional)	Evaluation Questions	Objectives
Family Factor: Family provides structure, limits, rules, monitoring, and predictability: Frequency of Parent communication with children regarding alcohol or other substance use.	Does the implementation of PPP activities increase the number of times parent talk to their children about alcohol and/or other substance use in the past 30 days?	**Objective:** By (insert date) there will be a 5% increase in the number of times parents report talking to their youth in the past 30 days about alcohol and/or other substance use as measured by the Adult PPP Survey: Family-child Communication Section.
Community Factor: Societal/ community norms about alcohol and drug use: Adult Perception of Risk/Harm of Substance Misuse.	Does the implementation of PPP activities increase adult perception of the risk/harm of substance misuse among the elderly or other adult populations?	**Objective**: By (insert date) there will be a 5% increase in adult perception of risk/harm of substance misuse among the elderly or other adult populations as measured by the Adult PPP Survey: Perception of Risk/Harm of Substance Misuse section.

Community Factor: Societal/ community norms about alcohol and drug use: Adult Perception of Laws and Norms Favorable to Drug Use	Does the implementation of PPP activities designed to impact laws and norms favorable to drug use have an impact on community attitudes perception of community norms?	**Objective**: By (insert date) there will be a 2% increase in adult perception of community norms about alcohol and drug use among youth as measured by the Adult PPP Survey: Perception of Community Norms section.
Community Factor: Adult Knowledge of Substance Use (Marijuana, Rx, Alcohol, Vaping)	Do the PPP 360 Presentations on key substances (Marijuana, Rx, Alcohol, and Vaping) increase adult knowledge of each substance?	**Objective**: By (insert date) there will be a 5% increase in adult knowledge of (insert substance) as measured by the Adult PPP Survey: 360 Substance section.
Community Factor: Community Mobilization: Adult Involvement in Community Action/ Knowledge of Issues/Resources	Does participation in PPP community mobilization change adult involvement, concern, and knowledge for the prevention of alcohol and other substance use?	**Objective**: By (insert date) at least 70% of the participants in the community mobilization activity will indicate an increase in involvement, concern, and knowledge as measured by the post only Community Mobilization Survey.
Family Factor: Clear expectations for behavior and values: Adult attitude toward youth substance use.	Does the implementation of PPP activities increase adult unfavorable attitudes toward youth substance use?	**Objective**: By (insert date) there will be a 5% increase in adult unfavorable attitudes toward youth substance use as measured by the Adult PPP Survey: Attitude toward Youth Substance Use section.
Family Factor: Clear expectations for behavior and values: Adult perception of risk/harm of youth substance use.	Does the implementation of PPP activities increase adult perception of risk/harm of youth substance use.	**Objective:** By (insert date) there will be a 5% increase in adult perception of risk/harm of youth substance use as measured by the Adult PPP Survey: Perception of Risk/Harm of Youth Substance Use section.
Family Factor: Family provides structure, limits, rules, monitoring, and predictability: Frequency of parent/child communication regarding alcohol or other substance use.	Does the implementation of PPP activities increase the number of times parent talk to their children about alcohol and/or other substance use in the past 30 days?	**Objective:** By (insert date) there will be a 5% increase in the number of times parents report talking to their youth in the past 30 days about alcohol and/or other substance use as measured by the Adult PPP Survey: Family-child Communication Section.
Community Factor: Societal/ community norms about alcohol and drug use: Adult perception of risk/harm of substance misuse.	Does the implementation of PPP activities increase adult perception of the risk/harm of substance misuse among the elderly or other adult populations?	**Objective**: By (insert date) there will be a 5% increase in adult perception of risk/harm of substance misuse among the elderly or other adult populations as measured by the Adult PPP Survey: Perception of Risk/Harm of Substance Misuse section.

Community Factor: Societal/ community norms about alcohol and drug use: Adult Perception of Laws and Norms Favorable to Drug Use	Does the implementation of PPP activities designed to impact laws and norms favorable to drug use have an impact on community attitudes perception of community norms?	**Objective**: By (insert date) there will be a 2% increase in adult perception of community norms about alcohol and drug use among youth as measured by the Adult PPP Survey: Perception of Community Norms section.
Community Factor: Adult Knowledge of Substance Use (Marijuana, Rx, Alcohol, Vaping)	Do the PPP 360 Presentations on key substances (Marijuana, Rx, Alcohol, and Vaping) increase adult knowledge of each substance?	**Objective**: By (insert date) there will be a 5% increase in adult knowledge of (insert substance) as measured by the Adult PPP Survey: 360 Substance section.
Community Factor: Community Mobilization: Adult Involvement in Community Action/ Knowledge of Issues/Resources	Does participation in PPP community mobilization change adult involvement, concern, and knowledge for the prevention of alcohol and other substance use?	**Objective**: By (insert date) at least 70% of the participants in the community mobilization activity will indicate an increase in involvement, concern and knowledge as measured by the post only Community Mobilization Survey.

Table 4 provides an Evaluation Question and Objective for the measurement of collaboration among coalition members.

Table 4

COALITION Risk/Protective Factors & Domain (Optional)	**Evaluation Questions**	**Objectives**
Community Factor: Collaboration, Coordination, Cooperation among nonprofit organizations, government agencies and other organizations with common prevention goals	Does the implementation of PPP coalition activities increase collaboration among the group membership?	**Objective:** By (insert date) there will be a 5% increase in readiness to collaborate among the group membership as measured by the Wilder Collaboration Factors Inventory.

APPENDIX B: PRIMARY PREVENTION EVALUATION TOOLS

Youth Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
In the past 30 days, how many days did you: 1. Drink one or more drinks of an alcoholic beverage? 2. Smoke part or all of a cigarette? 3. Use other tobacco products? 4. Use electronic cigarettes (e-cigarettes, vapes) 5. Vaped marijuana? 6. Smoked marijuana or had edibles? 7. Use prescription drugs to get high? 8. Use any other illegal drugs such as heroin, cocaine or crack, methamphetamines? 9. Use prescription pain relievers without a doctor telling you to take them (OxyContin, Vicodin, Percocet, Fentanyl) 10. Use prescription stimulants without a doctor telling you to take them (Adderall, Ritalin, Concerta, Vyvanse, Dexedrine) 11. Use multiple drugs at the same time (including alcohol, prescription drugs, marijuana, and other illegal drugs)	Past 30-Day Use (NOMS)	Indicate how many days they had used specific substances in the past 30 days	Drug use is implicated in a number of developmental problems in adolescence: poor academic performance sexual precocity, aggression and violence, gang involvement, and mental distress and disorder. Although substance use is not thought to *cause* all of these problems, it is empirically *associated* with a number of problem behaviors and with adolescent delinquency in general.
How much do you think people risk harming themselves (physically & in other ways) if they: 1. Smoke one or more packs of cigarettes per day? (NOT including e-cigarettes) 2. Use e-cigarettes or vape? 3. Vape marijuana? 4. Use marijuana? (smoke or edibles) 5. Use marijuana concentrates? (honey oil, wax, crumble, shatter, budder) 6. Have one or two drinks of an alcoholic beverage (beer, wine, liquor) nearly every day? 7. Have five or more drinks of an alcoholic beverage in a row once or twice a week? 8. Use prescription pain relievers such as OxyContin, Percocet,	Perception of Risk/Harm of Use (NOMS)	A 4-point scale with 1 being "no risk" and 4 being "great risk".	Perceived risks or beliefs about the harmful effects of alcohol or drugs are strongly associated with substance use. According to The National Center on Addiction and Substance Abuse at Columbia University, Fact Sheets, teens 15 and older who drink are seven times (drug use – five times) more likely to have sexual intercourse and twice as likely to have it with four or more partners than non-drinking teens. At-risk clusters occur when drugs and alcohol are used, meaning that at-risk behaviors tend to cluster together – smoking, drug and alcohol abuse and sexual activity. Attitudes about the risks associated with substance use have historically been closely related to their use. Examining youths' attitudes about the risks associated with using substances and their perception of

Youth Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
Vicodin, Adderall, Ritalin, or Xanax without a doctor telling them to take them? 9. Use prescription drug stimulants such as Adderall, Ritalin, Concerta, Vyvanse, Dexedrine without a doctor telling them to take them? 10. Use other illegal drugs such as heroin, cocaine or crack, methamphetamines?			the availability of substances provides needed prevention information.
How old were you when you first: 1. Had a drink of an alcoholic beverage? 2. Smoked part or all of a cigarette? 3. Used electronic cigarettes (e-cigs, vapes)? 4. Used marijuana or hashish? 5. Used prescription drugs to get high? 6. Used other illegal drugs?	Age of First Use (NOMS)	Asked to give the age when they first used specific substances (more than a few sips)	Initiating substance use during childhood or adolescence is linked to substantial long-term health risks. Early (aged 12 to 14) to late (aged 15 to 17) adolescence is generally regarded as a critical risk period for the initiation of alcohol use with multiple studies showing associations between age at first alcohol use and the occurrence of alcohol abuse or dependence. Moreover, there is evidence across a range of other substances—including marijuana, cocaine, other psychostimulants, and inhalants—that the risk of developing dependence or abuse is greater for individuals who initiate use of these substances in adolescence or early adolescence than for those who initiate use during adulthood.

Youth Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
How do you feel about someone your age 1. Smokes one or more packs of cigarettes per day? (NOT including e-cigarettes) 2. Uses e-cigarettes **regularly**? (e-cigs, vaping) 3. Vape marijuana? 4. Use marijuana **once or twice a week**? (smoke or edibles) 5. Smokes or vapes marijuana concentrates (honey oil, wax, crumble, shatter, budder) 6. Takes one or two drinks of an alcoholic beverage (beer, wine, liquor) **nearly every day**? 7. Has **five or more drinks** of an alcoholic beverage, **in a row**, once or twice a week? 8. Uses prescription drugs such as OxyContin, Percocet, Vicodin, Adderall, Ritalin, or Xanax? 9. Uses prescription stimulants (Adderall, Ritalin, Concerta, Vyvanse, Dexedrine)? 10. Uses other illegal drugs such as heroin, cocaine or crack, methamphetamines? 11. How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?	Perception of Disapproval/ Attitudes (self/peers) (NOMS)	5-point scale with "1" being Strongly Approve and "5" being Strongly Disapprove	Having attitudes favorable to tobacco, alcohol, or drugs is associated with increased risk of using substances in adolescence (Hawkins, Catalano, & Miller, 1992). Data suggest that attitudes toward substance use tend to be substance-specific. Youth-directed substance use prevention programs seeking to affect this outcome should expect the percent of youth with unfavorable attitudes toward substance use to increase before finding reduced levels of substance use.
Think about if you were going to work for an employer and answer the following questions. 1. How likely is it that you would work for an employer that conducts random **alcohol and drug** tests?	Employment/ Education: Perception of Workplace Policy (NOMS)	3-point scale with 1 being "More likely" and 3 being "Would make no difference".	One measure requested for this grant funded program is the perception of drug testing in the work environment. The ultimate objectives are to increase or retain employment, reduce workplace AOD use, and increase positive perception of workplace policy regarding random drug and alcohol tests.
In the past 12 months, how often have you: PARENT 1. Talked to your youth about alcohol, tobacco, and or other drugs?	Parent/ child communication in the past 12 months about ATOD	4-point scale from 1 = Never to 4 = More than 5 times	Parent/child communication has been found to have statistically significant inverse associations with youth substance use. Parent-child communication is a potentially modifiable protective factor of adolescent substance use. Substantial literature indicates that

Youth Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
YOUTH 1. Talked to your parents/caregivers about alcohol, tobacco, and or other drugs? 2. Talked to at least one adult (not your parents) about alcohol, tobacco, and or other drugs?	(NOMS)		greater frequency and quality of general parent-child communication are negatively associated with adolescent substance use. For instance, one study found that perceived difficulty talking to parents about problems is associated with increased risk of substance use in both boys and girls. Based on children's self-reports, the amount of time parents spend with their children and the frequency of parent-child communication are both associated with reduced risks for tobacco onset and alcohol use in the past month. Consistent with these findings, enhancing parent-child communication is a common target in substance use interventions for adolescents.
In the past 12 months, how often have you: 1. Seen or heard an ad, message, or presentation about "not" smoking, "not" vaping, "not" drinking, "not" using drugs? 2. Received written information or materials like brochures, flyer, booklet, picture about risks of alcohol or drug use? 3. Attended a presentation or class on risk of alcohol or illegal drug use or on how to say "no". 4. Attended a health fair, assembly, family night or event where information on risk of alcohol or illegal drug use was presented.	Exposure to media around "not using" a substance. (NOMS)	4-point scale from 1 = Never to 4 = Many Times.	Media exposure to anti-drug campaigns is showing promising findings showing significantly more negative beliefs and attitudes, lower intentions to use and lower receptivity to pro-substance ads and marketing practices. Normative education approaches include content and activities to correct inaccurate perceptions regarding the high prevalence of substance use. Many adolescents overestimate the prevalence of smoking, drinking, and the use of certain drugs, which can make substance use seem to be normative behavior. Educating youth about actual rates of use, which are almost always lower than the perceived rates of use, can reduce perceptions regarding the social acceptability of drug use. One way to present this information would be to collect and provide findings from classroom, school, or local community survey data that show actual prevalence rates of substance use in the immediate social environment. Otherwise, this can be taught using national survey data which typically show prevalence rates that are considerably lower than what teens believe. Additionally, normative education attempts to undermine popular but inaccurate beliefs that substance use is considered acceptable and not particularly

Youth Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
			dangerous. This can be done by highlighting evidence from national studies that shows strong anti-drug social norms and generally high perceived risks of drug use in the population. Normative education materials are often included in social resistance programs.
Think about your school and indicate how much you agree with these statements. 1. Teachers and staff seem to take a real interest in my future. 2. Teachers or another adult in my school are available when I need to talk to them. 3. It is easy to talk with teachers or other staff in my school. 4. At my school, there is a teacher or some other adult who notices when I'm not there. 5. Teachers or some other adult at my school help us students with our problems. 6. Problems in this school are solved by students and staff. 7. School rules are enforced consistently and fairly. 8. My teachers believe that I can do well in my school. 9. I feel close to people at this school.	Youth perception of school climate	4-point scale with 1 being "strongly disagree" and 4 being "strongly agree".	There is extensive research that shows school climate having a profound impact on students' mental and physical health. School climate has been shown to affect middle school students' self-esteem, mitigate the negative effects of self-criticism, and affect a wide range of emotional and mental health outcomes. Research has also revealed a positive correlation between school climate and student self-concept. A positive and sound socio-emotional climate of a school is also related to the frequency of its students' substance abuse and psychiatric problems. More specifically, a positive school climate is linked to lower levels of drug use as well as less self-reports of psychiatric problems among high school students. In early adolescence, a positive school climate is predictive of better psychological well-being. Research findings indicate that the lack of enforcement of school rules and the presence of unsafe places in and around the school influence adolescent drug use directly and indirectly through their effects on violence victimization. Experimental research shows that an improved school social environment—including student participation in school, relationships, and a positive school ethos—predicts reductions in student substance use. They also found that school-level and individual-level observational studies consistently reported that disengagement and poor teacher–student relationships were associated with drug use and other risky health behaviors.

Youth Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
1. I can work out my problems if I try hard enough. 2. It's easy for me to stick to my plans and accomplish my goals. 3. I can usually handle whatever comes my way.	Problem solving & goal setting skills	5-point scale with 1 being "strongly disagree" and 5 being "strongly agree".	The importance of understanding how adolescents make decisions lies in the challenging and difficult problems they face today. If we as adults are to guide adolescents in making decisions, we need to know what information they possess, what information they choose to use, and their cognitive ability. Personal resilience strengths consist of cooperation and communication, empathy, problem–solving, self–efficacy, self–awareness, and goals and aspirations.
Fill in ● indicating how often in the last month you felt: **1.** That you were unable to control the important things in your life? **2.** Confident about your ability to handle your personal problems? **3.** That things were going your way? **4.** That difficulties were piling up so high that you could not overcome them?	Youth Stress	5-point scale where 1 = Never and 5=Always	Stress is an inevitable, normal experience that is felt when an individual is unsure if she can meet the demands of her environment. Depending on the context, stress can be one of three things: 1) positive and conducive to healthy development, 2) simply tolerable with no strong effects, or 3) toxic and conducive to physical, emotional, and mental impairment (Center on the Developing Child, 2015). Adolescence is a period marked by physical and psychological changes such as greater involvement in peer relationships and increased autonomy. Some of these changes likely contribute to the increase in exposure to stressors that is typically seen after the transition from childhood to adulthood. Although some increase in exposure to stressors during this time is expected, particularly high levels of stress during adolescence have been associated with increased depressive symptoms and externalizing symptoms. Adolescence is a time of significant and rapid change that is associated with increases in both exposure to stressors and likelihood of alcohol and drug use. As a result, stressors occurring during early- to mid-adolescence may contribute uniquely to the development of substance use. In particular, stressors during this time may relate to early-onset substance use (i.e., prior to age 15), which has been related to the development of substance use disorders. Several theories have been developed to explain how exposure to

Youth Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
			stressors may specifically relate to substance use. The stress-coping model and self-medication model of substance abuse suggest that substance use increases as users attempt to regulate their emotions and manage reactions to negative or stressful experiences. Cross-sectional research has found that both severe stressors, such as experiencing or witnessing violence or being abused, as well as more moderate stressors, such as problems at school, work-related stress, and family conflict are more common among substance-using adolescents and young adults.
Fill in ● indicating how much you agree with the following statements. 1. I can always manage to solve difficult problems if I try hard enough 2. If someone does not agree with me, I can find means and ways to get what I want 3. It is easy for me to stick to my aims and accomplish my goals 4. I am confident that I could deal efficiently with unexpected events 5. Thanks to my resourcefulness, I know how to handle unforeseen situations 6. I can remain calm when facing difficulties because I rely on my coping abilities 7. When I am confronted with a problem, I can usually find several solutions 8. If I am in a bind, I can usually think of something to do 9. No matter what comes my way, I'm usually able to handle it	Self-Efficacy	5-point scale where 1 = Strongly disagree to 5=Strongly agree	Self-efficacy is the belief that one has the ability to implement the behaviors needed to produce a desired effect. There has been growing interest in the role of self-efficacy as a predictor and/or mediator of treatment outcome in a number of domains. In numerous studies of substance abuse treatment, self-efficacy has emerged as an important predictor of outcome, or as a mediator of treatment effects. Other studies found that self-efficacy was related to the occurrence or frequency of drinking or drug use. It has been found that self-efficacy was a relatively strong predictor of post-treatment abstinence and the frequency of marijuana use reported a significant relationship between self-efficacy expectancies during inpatient alcohol dependence treatment and several frequency-related outcome variables: the likelihood of drinking; time to first drink; and time to relapse during the year following treatment. In the substance abuse field, it has been postulated, and generally accepted, that if clients are taught coping skills (e.g., problem-solving, social skills, communication skills) and they subsequently experience success as a result of implementing those skills in lieu of using substances, this mastery experience is likely to enhance their efficacy beliefs.

Youth Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
1. I feel disconnected from the world around me. 2. Even around people I know, I don't feel that I really belong. 3. I feel so distant from people. 4. I have no sense of togetherness with my peers. 5. I don't feel related to anyone. 6. I catch myself losing all sense of connectedness with society. 7. Even among my friends, there is no sense of brother/sisterhood. 8. I don't feel that I participate with anyone or any group.	Social Connectedness / Sense of Belonging	5-point scale where 1 = Strongly disagree to 5=Strongly agree	The concept of sense of belonging as connectedness is an abstract dimension of relatedness. Gaining an understanding of this concept within a cultural worldview has the potential to positively impact the mental health of ethnic minority populations. Sense of belonging as connectedness portrays the dynamic nature of human existence. It is a dynamic phenomenon of social significance. Belonging scores were positively related to actual program attendance over a 6-month period, self-reported attendance in the last week, and protective factors found in communities. Belonging scores were moderately and negatively related to community-based risk factors. **Connectedness** reflects actions, which can be increased or decreased through intervention and attitudes which can be shaped or developed through intervention. Thus, connectedness may be more amenable to intervention than is resiliency, and its predictors and consequences are thoroughly studied in the literature on adolescent risk-taking and social development.
1. Did you feel interested in the program sessions and classes? 2. Did you feel the material presented was clear? 3. Did discussions or activities help you to learn program lessons? 4. Did you feel respected as a person? 5. Did you have a chance to ask questions about topics or issues that came up in the program? 6. Have you ever taken a class that talked about the same information as this class?	Program satisfaction	4-point Likert-type scale (NO! = 1, no = 2, yes = 3, and YES! = 4)	Assess whether youth are receptive to programs being delivered, and that facilitators are offering a physical and emotionally safe environment for learning.

ADULT Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
How do you feel about YOUTH: 1. Drinking alcohol? 2. Drinking alcohol at parties or events where there are adults? 3. Smoking cigarettes? 4. Using e-cigarettes/vaping? 5. Using marijuana? 6. Using prescription drugs to get high? 7. Using over the counter drugs like cough syrup, sinus medication, or cold medicine to get high? 8. Using other illegal drugs such as heroin, cocaine or crack, methamphetamines?	Adult/Parent attitude toward ATOD use among youth	5-point scale with 1 being Approve to 5 being Strongly Disapprove	Research shows that teens and young adults do believe their parents should have a say in whether they drink alcohol. Parenting styles are important — teens raised with a combination of encouragement, warmth, and appropriate discipline are more likely to respect their parents' boundaries. Understanding parental influence on children through conscious and unconscious efforts, as well as when and how to talk with children about alcohol, can help parents have more influence than they might think on a child's alcohol use. Parents can play an important role in helping their children develop healthy attitudes toward drinking while minimizing its risk.
How much do you think youth risk harming themselves (physically & in other ways) if they: 1. Try cigarettes **once or twice**? 2. Use cigarettes **regularly***?* 3. Using e-cigarettes or vaping. 4. Try marijuana **once or twice**? 5. Use marijuana **regularly**? 6. Take one or two drinks of an alcoholic beverage **once or twice**? 7. Use alcohol (beer, wine, liquor) **regularly**? 8. Have five or more drinks of an alcoholic beverage in a row **once or twice a week**? 9. Use prescription drugs **regularly** for the purposes of getting high? 10. Uses other illegal drugs such as heroin, cocaine or crack, methamphetamines?	Adult/Parent perception of the serious risk and health problems of alcohol and substance use	Scale of 1 to 4 where 1 = No Risk and 4 = Great Risk.	Similar to parental attitudes toward underage drinking and substance use by youth, parental perception of risk and health problems impacts on youth perception of risk/harm. Research has shown that dialogue between parents and young people can influence teen drug use.
In the past 12 months, how often have you: 1. Talked to your children about alcohol, tobacco, and or other drugs?	Adult/Parent – Child Communication about alcohol and drug use	Scale of 1 to 4 with the following values: 1 = 0 times; 2 = 1 to 2 times; 3 = 3 to 5	Parent-child communication and connectedness appear to be protective against substance use during adolescence. Substantial literature indicates that greater frequency and quality of general parent–child communication are negatively associated with adolescent substance use.

ADULT Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
		times; and 4 = More than 5 times.	
Read each statement below and mark your opinion. 1. It is dangerous to take someone else's prescription medicine. 2. It is OK to share prescription medicine with my friends. 3. Taking prescription medicine together with over-the-counter medicine is always safe. 4. A person could have a seizure if they take more than the recommended amount of certain prescription medicines. 5. Taking prescription pain pills and drinking alcohol is risky. 6. It is OK to throw the pills in the trash when they get old. 7. It is OK to mix medicines without talking to a doctor or pharmacist. 8. Taking some supplements (like vitamin pills, herbal remedies, and other over-the-counter supplements) can be risky if you are taking certain prescription medications. 9. When I get a prescription filled, it is important to talk to the pharmacist and ask questions about interactions with other medications or supplements I am taking. 10. It is important to take a list of all the medications that I am taking and all the over-the-counter medicines and supplements that I am taking to all my visits with the doctor. 11. I know where there are permanent drop box locations in my county where I can dispose of old, unused or unneeded prescription drugs. 12. Older individuals should not drink any alcohol if they have medical conditions that can be made worse by alcohol, for example, diabetes, heart disease. 13. The recommended limit of drinks for men and women over ages of 60 is 1 standard drink per day and no more than 7 drinks a week. 14. One standard drink is equal to a can of beer or a glass of wine.	Elderly Adult Knowledge / Awareness of Risk/Harm of substance misuse (alcohol & Rx drugs)	Scale: 1=Yes 2=No 3=I Don't Know	Alcohol and prescription drug abuse affects up to 17% of adults over the age of 60 as per the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Due to insufficient knowledge, limited research data, and hurried office visits, health care providers often overlook substance abuse among the elderly. This is made worse by the fact that the elderly often have medical or behavioral disorders that mimic symptoms of substance abuse, such as depression, diabetes, or dementia. At-risk drinking is more prevalent among older adults than AUD and is likely responsible for a larger share of the harm to the health and well-being of older adults. Guidelines provided by the American Geriatrics Society and the National Institute for Alcohol Abuse and Alcoholism recommend that older adults drink no more than 7 standard drinks (12-oz beer, 4- to 5-oz glass of wine, 1.5 oz of 80-proof liquor) per week. Prevalence rates for older-adult at-risk drinking (defined as more than 3 drinks on one occasion or more than 7 drinks per week) are estimated to be 16.0% for men and 10.9% for women. There is also a substantial proportion of the older-adult population who are binge drinkers (generally defined as 5 or more standard drinks in one drinking episode, though definitions vary for older adults). In a study of community-based older adults who reported drinking one or more drinks in the previous 3

ADULT Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
15. As one ages, lean body mass and the ability of the liver to process alcohol is diminished.			months, 67% reported binge drinking in the last year. Older adults take more prescribed and over-the-counter medications than younger adults, increasing the risk for harmful drug interactions, misuse, and abuse. A cross-sectional community-based study of 3005 individuals aged 57 to 85 years found that 37.1% of men and 36.0% of women used at least 5 prescription medications concurrently. The study also found that about 1 in 25 of the participants were at risk for a major drug interaction, and half of these situations involved nonprescription medications. Research has shown a strong association between depression and alcohol use disorders that continues into later life. In addition, a number of older adults also suffer from increased anxiety. Depression and alcohol use are the most commonly cited co-occurring disorders in older adults. Among those aged 65 and older, over 13% of those with lifetime major depression also met criteria for a lifetime alcohol use disorder. Twenty percent of older adults with depression have a co-occurring alcohol use disorder. At-risk and problem drinking among the elderly is likely to increase existing feeling of depression. Older adults with this comorbidity can be more difficult to diagnose and treat because each of these problems may complicate the other. It is important from a clinical standpoint to assess depressive symptoms in addition to assessing for alcohol and psychoactive medication misuse.
1. If a kid drank some beer, wine or hard liquor (for example, vodka, whiskey or gin) in your neighborhood would he or she be caught by the police?	Laws and Norms Favorable to Drug Use	4-point scale 1=YES!	Community norms are the attitudes and policies a community holds about drug use and crime. When these norms and community laws are favorable

ADULT Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
2. If a kid smoked marijuana in your neighborhood, would he or she be caught by the police? 3. If a kid carried a handgun in your neighborhood, would he or she be caught by the police?		2=yes 3=no 4=NO!	towards substance use or crime or if they are unclear, children are at higher risk. It is well documented that social norms predict a range of health behaviors, including exercise, tobacco, alcohol, and illicit drug use.
MARIJUANA For the following questions, please indicate how much you agree BEFORE you heard the presentation. Then, think about NOW and how much you agree now AFTER the presentation. *For each item, mark (X) one response for BEFORE the program and one response for AFTER the program.* 1. The potency of marijuana has increased since the 1970s. 2. Students who use marijuana tend to get lower grades and are more likely to drop out of high school. 3. A new trend in marijuana use is smoking liquid or wax marijuana in an e-cigarette, known as vaping. 4. Repeated marijuana use can lead to addiction. 5. Early first use of marijuana is associated with the most significant impairment. 6. Marijuana can reduce inhibition, which can lead to risky behaviors. 7. Kids who are regular users of marijuana are more likely to use other drugs. 8. Adolescence is a critical period for brain development. 9. I know how to talk to my children about marijuana use. 10. I know what to do if I spot drug or alcohol use in any of my children. **VAPING** For the following statements, please indicate how much you agree with the statement BEFORE you heard the presentation. Then, think about NOW and how much you agree NOW, AFTER the presentation.	Adult Knowledge of Substance Use 360 Presentations (Marijuana, Rx, Alcohol, Vaping) Pregnant Women Knowledge	Retrospective Pre Scale: 1=Strongly Disagree to 4=Strongly Agree	The Arizona Rx Drug Initiative model was designed to be a coordinated effort between action items implemented at the state and policy level, in conjunction with corresponding action items implemented at the local community level. This approach tapped into an existing community-based substance abuse infrastructure and the social capital it represents and allows for new and innovative community-based initiatives to be implemented without the immediate need for a large upfront investment of cash resources. Instead, the focus is placed on leveraging existing community-based networks and the strategic infusion of additional resources to support emerging community needs. The community coalitions, their task groups, and local champions serve as the primary vehicle of change responsible for spearheading and driving all local efforts across the five strategies. By taking an approach that relies on the leadership and involvement of community members, the Arizona Rx Drug Initiative has leveraged the passion and energy of those who are directly impacted by, and have a vested interest in, the problem of prescription drug misuse and abuse in "their own backyards."

ADULT Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
For each item, mark one response for BEFORE the program and one response for AFTER the program. 1. E-cigs/E-juice contains nicotine, flavorings, and harmful carcinogens once it is heated. 2. E-cigs create a vapor from the addictive liquid nicotine (juice) and is bad for your health. 3. Nicotine can act as a neurotoxin and impair development of the pre-frontal cortex (area for decision making, judgment, and planning). 4. A bottle of e-juice contains enough nicotine to kill an adult. 5. Each pod is the equivalent of a pack of cigarettes. 6. I feel like I know enough about specific resistance strategies to help my kids say "no" to vaping. 7. Tobacco companies intentionally use cartoons and flavorings that are sweet and appealing to youth. 8. E-cigs are not a safe alternative to cigarettes. 9. JUULs contain nicotine and are just as addictive as cigarettes. 10. Users inhale a lot of chemicals, especially if the vapor is flavored and can exacerbate asthma and other lung conditions. 11. Nicotine is a highly addictive substance and acts as a gateway drug with the effect of addiction, especially in adolescents. 12. Nicotine changes the way synapses are formed which can alter the way the brain controls attention and learning. **ALCOHOL** For the following statements, please indicate how much you agree with the statement BEFORE you heard the presentation. Then, think about NOW and how much you agree NOW, AFTER the presentation. *For each item, mark one response for BEFORE the program and one response for AFTER the program.*			The other 360 presentations are modeled after the Rx360 model.

ADULT Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
1. Youth who start drinking before the age of 15 are five times more likely to develop a problem than those who start drinking at 21. 2. Underage drinking among youth in our community is a problem. 3. Short term or moderate drinking impacts learning and memory much more in youth than in adults. 4. Drinking is more harmful to youth than adults because their brains are still developing. 5. Damage to the brain from alcohol in the teen years can be long-term and irreversible 6. I feel like I know enough about specific resistance strategies to say "no" to drinking. 7. The amount of alcohol you drink in a can of beer is the same amount as in a shot of liquor or a glass of wine 8. Drinking alcohol while pregnant can damage a developing fetus causing a baby brain damage 9. When someone is passed out from alcohol, the alcohol in the blood can continue to rise. 10. Long term use and/or heavy drinking can cause cancer of the mouth, esophagus, throat, liver, colon and breast. It can also cause stroke and liver disease. **PRESCRIPTION DRUGS** For the following statements, please indicate how much you agree with the statement BEFORE you heard the presentation. Then, think about NOW and how much you agree NOW, AFTER the presentation. *For each item, mark one response for BEFORE the program and one response for AFTER the program.* 1. It is dangerous to take someone else's prescription medicine. 2. It is NOT OK to share prescription medicine with my friends 3. Taking prescription medicine together with over-the-counter medicine is not always safe			

ADULT Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
4. A person could have a seizure if they take more than the recommended amount of certain prescription medicines 5. Taking prescription pain pills and drinking alcohol is risky 6. It is NOT OK to throw the pills in the trash when they get old 7. It is dangerous to mix medicines without talking to a doctor or pharmacist 8. Taking some supplements (like vitamin pills, herbal remedies, and other over-the-counter supplements) can be risky if you are taking certain prescription medications 9. When I get a prescription filled, it is important to talk to the pharmacist and ask questions about interactions with other medications or supplements I am taking 10. It is important to take a list of all the medications that I am taking and all the over-the-counter medicines and supplements that I am taking to all my visits with the doctor. 11. I know where there are permanent drop box locations in my county where I can dispose of old, unused or unneeded prescription drugs.			
Post Only Survey **Fill in ● to indicate how much your participation has changed your involvement, concern, and knowledge** 1. Since my participation in (fill in name of program), my personal involvement in organized activities for the prevention of alcohol and other drug abuse has… 2. Since my involvement in (fill in name of program), my personal concern for preventing alcohol and other drug abuse in my community has… 3. Since my involvement in (fill in name of program), my personal knowledge of the risk factors that contribute to alcohol and other drug abuse has… 4. Since my involvement in (fill in name of program), my personal knowledge of community programs and community resources that address alcohol and drug abuse has… 5. Since my involvement in (fill in name of program), my personal knowledge of community Drop Box locations has…	Adult Involvement in Community Action / Community Mobilization/ Knowledge of Issues/Resources	4-point scale: 1=Decreased, 2=Not changed, 3=Increased a little, 4=Increased a lot	Community mobilization is designed to increase community readiness and engage communities in prevention activities and actions to reduce use of harmful legal products among youth. For example, one study demonstrated via efforts to prevent alcohol abuse that effective community mobilization can support prevention actions and engage more community members. Effective community mobilization is essential to implementing a mutually supportive mix of prevention approaches, i.e., environmental strategies and a school-based prevention curriculum. Coalitions or partnerships consisting of key leaders, agencies, and organizations provide a substantial base to mobilize the entire community to address a health or social problem. Coalition capacity-building training and technical assistance should also be provided to

ADULT Primary Prevention Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
6. Since my involvement in (fill in name of program), my belief that I have the ability to influence change in my community around alcohol and drug abuse prevention 7. Since my involvement in (fill in name of program), my personal knowledge of youth substance use has… 8. Since my involvement in (fill in name of program), my personal knowledge of mental health and mental illness has…			strengthen or build coalitions where they are in the early stages of organizing or reorganizing.

Coalition Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
Wilder Collaboration Inventory 1. Agencies in our community have a history of working together. 2. Trying to solve problems through collaboration has been common in this community. It's been done a lot before. 3. Leaders in this community who are not part of our collaborative group seem hopeful about what we can accomplish. 4. Others (in this community) who are not a part of this collaboration would generally agree that the organizations involved in this collaborative project are the "right" organizations to make this work. 5. The political and social climate seems to be "right" for starting a collaborative project like this one. 6. The time is right for this collaborative project. 7. People involved in our collaboration always trust one another. 8. I have a lot of respect for the other people involved in this collaboration. 9. The people involved in our collaboration represent a cross section of those who have a stake in what we are trying to accomplish. 10. All the organizations that we need to be members of this collaborative group have become members of the group. 11. My organization will benefit from being involved in this collaboration. 12. People involved in our collaboration are willing to compromise on important aspects for our project. 13. The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts.	Coalition Effectiveness	5-point scale: 1=Strongly Disagree to 5=Strongly Agree	Community coalitions are often formed to help communities mobilize resources and coordinate activities that improve the public's health. Conceivably, coalitions may contribute to all phases of health program delivery, from planning to implementation and sustainability. Most important, however, may be the role of coalitions in assisting communities with identifying, planning, and subsequently adopting effective health programs. In this regard, community coalitions may be best served by the promotion of evidence-based programs—those that have been systematically evaluated and shown to be effective in changing health-related behavior. One area in which evidence-based standards and programs have been well articulated is drug abuse prevention. Coalitions are particularly important to the delivery of drug abuse prevention programs because coalitions include constituents and prevention stakeholders from many perspectives. By bringing together representatives from local government, law enforcement, education, media, parent groups, health agencies,

Coalition Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
14. Everyone who is a member of our collaborative group wants this project to succeed. 15. The level of commitment among the collaboration participants is high. 16. When the collaborative group makes major decisions, there is always enough time for members to take information back to their organizations to confer with colleagues about what the decision should be. 17. Each of the people who participate in decisions in this collaborative group can speak for the entire organization they represent, not just a part. 18. There is a lot of flexibility when decisions are made; people are open to discussing different options. 19. People in this collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working. 20. People in this collaborative group have a clear sense of their roles and responsibilities. 21. There is a clear process for making decisions among the partners in this collaboration. 22. This collaboration is able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or change in leadership. 23. This group has the ability to survive even if it had to make major changes in its plans or add some new members in order to reach its goals. 24. This collaborative group has tried to take on the right amount of work at the right pace. 25. We are currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project. 26. People in this collaboration communicate openly with one another. 27. I am informed as often as I should be about what goes on in this collaboration. 28. The people who lead this collaborative group communicate well with the members. 29. Communication among the people in this collaborative group happens both at formal meetings and in informal ways. 30. I personally have informal conversations about the project with others who are involved in this collaborative group.			and businesses, coalitions can provide a community forum for identifying, planning, and adopting prevention programs that would not otherwise be possible through the efforts of a single agency.

Coalition Evaluation Tool Question #/Question	What's Being Evaluated	Scale	Why is it being Evaluated
31. I have a clear understanding of what our collaboration is trying to accomplish. 32. People in our collaborative group know and understand our goals. 33. People in our collaborative group have established reasonable goals. 34. The people in this collaborative group are dedicated to the idea that we can make this project work. 35. My ideas about what we want to accomplish with this collaboration seem to be the same as the ideas of others. 36. What we are trying to accomplish with our collaborative project would be difficult for any single organization to accomplish by itself. 37. No other organization in the community is trying to do exactly what we are trying to do. 38. Our collaborative group had adequate funds to do what it wants to accomplish. 39. Our collaborative group has adequate "people power" to do what it wants to accomplish. 40. The people in leadership positions for this collaboration have good skills for working with other people and organizations.			

APPENDIX C: EVALUATION REQUIREMENTS

Evaluation Tools

Participation in the statewide evaluation of the Primary Prevention grant is required for Primary Prevention programs funded under AHCCCS' SABG, CRRSAA and other grant funding. Providers may **not** conduct pre or post evaluation activities in addition to these requirements.

Providers will be provided with the various surveys and are able to select administration of either paper surveys, electronic surveys, or both. For surveys administered online, Providers will be provided with a personalized survey link and data will automatically be sent to the statewide evaluation team, Wellington Consulting Group, for data analysis. For paper surveys that are administered in-person, Providers are required to **scan the surveys and email them** to the Evaluation Team staff **within 48 hours of administration**. Once survey data is received, the survey data is viewable from the View Evaluation Results button of the Objectives and Evaluation tab on the Main Menu.

The collection of the following Outcome Data is required.

REQUIRED FOR SAMHSA PERFORMANCE MEASURES		
Domain: Reduced Morbidity Abstinence from Drug Use/Alcohol Use		
Measure **30-Day Use**	**Measure Calculation**	**Data Collection Tools**
30-Day Use: Alcohol	# and % who reported having used alcohol during the past 30 days; percent change between pre/post.	Youth Primary Prevention Survey
30-Day Use: Cigarette	# and % who reported having smoked cigarettes during the past 30 days; percent change between pre/post.	Youth Primary Prevention Survey
30-Day Use: Other Tobacco Products	# and % who reported having used other tobacco products during the past 30 days; percent change between pre/post.	Youth Primary Prevention Survey
30-Day Use: Marijuana	# and % who reported having used marijuana or hashish during the past 30 days; percent change between pre/post.	Youth Primary Prevention Survey
30-Day Use: Other Illegal drugs	# and % who reported having used other illegal drugs during the past 30 days; percent change between pre/post.	Youth Primary Prevention Survey
Measure **Perception of Risk/Harm**	**Measure Calculation**	**Data Collection Tools**
Alcohol	# and % reporting moderate or great risk; percent change between pre/post.	Youth Primary Prevention Survey
Cigarettes	# and % reporting moderate or great risk; percent change between pre/post.	Youth Primary Prevention Survey
Marijuana	# and % reporting moderate or great risk; percent change between pre/post.	Youth Primary Prevention Survey
Measure **Age of First Use**	**Measure Calculation**	**Data Collection Tools**
Alcohol	Average age of first use; percent change between cohorts over specified time period.	Youth Primary Prevention Survey
Cigarettes	Average age of first use; percent change between cohorts over specified time period.	Youth Primary Prevention Survey

Other Tobacco Products	Average age of first use; percent change between cohorts over specified time period.	Youth Primary Prevention Survey
Marijuana	Average age of first use; percent change between cohorts over specified time period.	Youth Primary Prevention Survey
Other Illegal drugs	Average age of first use; percent change between cohorts over specified time period.	Youth Primary Prevention Survey
Measure Perception of Disapproval/ Attitudes	**Measure Calculation**	**Data Collection Tools**
Disapproval of Cigarettes	# and % somewhat or strongly disapproving; percent change between pre/post.	Youth Primary Prevention Survey
Perception of Peer Disapproval of Cigarettes	# and % reporting their friends would somewhat or strongly disapprove; percent change between pre/post.	Youth Primary Prevention Survey
Disapproval of Using Marijuana Experimentally	# and % somewhat or strongly disapproving; percent change between pre/post.	Youth Primary Prevention Survey
Disapproval of Using Marijuana Regularly	# and % somewhat or strongly disapproving; percent change between pre/post.	Youth Primary Prevention Survey
Disapproval of Alcohol	# and % somewhat or strongly disapproving; percent change between pre/post.	Youth Primary Prevention Survey
Domain: Employment/Education		
Measure	**Measure Calculation**	**Data Collection Tools**
Perception of Workplace Policy	# and % reporting that they would be more likely to work for an employer conducting random drug and alcohol tests; percent change between pre/post.	Youth Primary Prevention Survey
Average Daily School Attendance Rate	ADA divided by total enrollment and multiplied by 100; percent change over specified time period.	Monthly Report of Average Daily School Attendance
Domain: Crime and Criminal Justice		
Measure	**Measure Calculation**	**Data Collection Tools**
Alcohol Related Traffic Fatalities (ARTF)	Number of ARTF divided by total # of traffic fatalities and multiplied by 100; percent change over specified time period.	US Department of Transportation, National Highway Traffic Safety Administration Data
Alcohol and Drug Related Arrests (ADRA)	# of ADRA divided by total # of arrests and multiplied by 100; percent change over specified time period.	Bureau of Justice Statistics
Domain: Social Connectedness		
Measure	**Measure Calculation**	**Data Collection Tools**
Family Communications around Drug and Alcohol Use (Youth)	# and % of youth reporting having talked with a parent; percent change over specified time period between pre/post.	Youth Primary Prevention Survey
Family Communications around Drug and Alcohol Use (Parents of Youth)	# and % of parents reporting they have talked to their youth; percent change over specified time period between pre/post.	Adult Primary Prevention Survey
Domain: Retention		
Measure	**Measure Calculation**	**Data Collection Tools**
Exposure to Prevention Messages	# and % of youth reporting having been exposed to prevention message; percent change between pre/post.	Youth Primary Prevention Survey

The collection of the following performance measures is optional.

OPTIONAL PERFORMANCE MEASURES		
Measure	**Measure Calculation**	**Data Collection Tools**
Youth Perception of School Climate	# and % of youth reporting how well each of the school climate items describes their school; percent change between pre/post.	Youth Primary Prevention Survey: Addendum

OPTIONAL PERFORMANCE MEASURES		
Measure	**Measure Calculation**	**Data Collection Tools**
Youth Perception of Goal Setting and Problem Solving	# and % of youth reporting using goal setting and problem solving skills; percent change between pre/post.	Youth Primary Prevention Survey: Addendum
Youth Self Report of Perceived Stress	# and % of youth reporting decrease in perceived stress; percent change between pre/post.	Youth Primary Prevention Survey: Addendum
Youth Perception of Self-Efficacy	# and % of youth reporting increase in belief in how much they can achieve their goals; percent change between pre/post.	Youth Primary Prevention Survey: Addendum
Youth Perception of Sense of Belonging	# and % of youth reporting increase in their sense of belonging; percent change between pre/post.	Youth Primary Prevention Survey: Addendum
Adult Attitude toward Youth Substance Use	# and % of adults somewhat or strongly disapproving; percent change between pre/post.	Adult Primary Prevention Survey
Adult Perception of Risk/ Harm of Youth Substance Use	# and % of adults reporting moderate or great risk; percent change between pre/post.	Adult Primary Prevention Survey
Frequency of Parent/ Child Communication regarding Alcohol or Other Substance Use	# and % of adults reporting they have talked to their youth; percent change over specified time period.	Adult Primary Prevention Survey
Adult Perception of Risk/ Harm of Substance Misuse	# and % of adults reporting increase in knowledge; percent change between pre/post.	Adult Primary Prevention Survey
Adult Perception of Laws and Norms Favorable to Drug Use	# and % of adults reporting change in laws and norms favorable to drug use; percent change between pre/ post.	Adult Primary Prevention Survey
Adult Knowledge of Substance Use (Marijuana, Rx, Alcohol, Vaping)	# and % of adults reporting increase in knowledge after presentation; percent change between pre/post.	Adult Primary Prevention Survey
Adult Involvement in Community Action/ Knowledge of Issues/ Resources	# and % of adults reporting an increase in involvement / knowledge after participation in the program.	Adult Primary Prevention Survey

Administering the Evaluation Tools

Pre/Post Tools

The **Pre** tools should be administered to program participants who are:

- Enrolled in evidence-based or evidence-informed programs with multiple sessions.
- The tool should be administered during the first session; if someone enrolls during the second session, the tool should also be administered to that person.
- The pre survey should **not** be administered to any participant starting a program after the third lesson of any session has been delivered.

The **Post** tools should be administered to program participants who have completed the program:

- The tool should be administered during the last session of the program.
- The length of the last session should be planned in order to provide sufficient time for completion of the evaluation tool.
- If a participant is leaving the program with more than two lessons left in a session, they would **not** be given the post evaluation.

Post Only Tool & Retrospective Pre Tool

The Post Only and Retrospective Pre tools are used for one-time only sessions. The length of the session or presentation should be planned in order to provide sufficient time for completion of the evaluation tool.

- The **Post Only** tool includes items that measure self-report of increase in knowledge or awareness as well as self-report of intention to do something after receiving the program information or training. It should be noted that percent gain cannot be measured when using a Post Only measure.
- The **Retrospective Pre** tool is a way to assess participants' self-reported changes in knowledge, awareness, skills, confidence, or attitudes. The Retrospective Pre Tool can be used with one-time only programs such as Rx360. The tool is administered after the program, and participants are asked:
    - To rate their current knowledge, skill, attitude, behavior ***Now*** or ***After*** as a result of the program.
    - Then, to reflect back and rate that same knowledge, skill, attitude, behavior ***Before*** participating in the program.

Timeframe for Data Collection

The evaluation tools will be administered according to each Provider's internal program implementation timeline. Data from pre/post evaluation tools will be organized by "program participation year." The program participation year has been designed to maximize the number of sessions from which pre and post data will be available, especially for programs that operate in schools. Each program participation year runs from July 1 thru June 30, unless otherwise specified (i.e. CRRSAA funding).

Parental Consent Forms

If required, active parental consent must be obtained for any and all youth participants **prior** to participating in the program and/or completing the evaluation. An "active consent" requires a parent or legal guardian to sign and return a form if they consent for their child to participate in the program and in the evaluation. Parents may consent to allowing their child to participate in the program and not the evaluation without consequence.

Parental consent forms must be kept by the individual Provider for a period of five years and then destroyed according to the individual organization's records retention policy. The contractor should keep the consent forms in a locked cabinet in a secured area.

Programs should use the AHCCCS provided consent form, but may add any additional topics to the forms such as, emergency contact information, allergies, t-shirt sizes, etc.

Youth Assent

At the time the evaluation tool is handed out to the youth, the facilitator should read to the youth the evaluation script designated for the tool that is being completed. The scripts provide the youth with the assent information letting them know they can opt out of answering certain questions on the evaluation or opt out entirely from taking the evaluation. The scripts also provide information on how to complete the survey.

NOTE: *If a youth opts out entirely from taking the pre or post evaluation, please indicate it on the attendance record.*

Attendance Records

AHCCCS requires that attendance records be kept on every participant attending a curricula session. With the new evaluation process, attendance sheets should include a checklist indicating if each participating youth received active parental consent to participate in the program and another column indicating if the youth has received parental consent to participate in the evaluation. If the consent forms were not required, the checklist should be marked "NA". A standard attendance sheet has been developed for Provider use. Programs should use the AHCCCS attendance sheet as this documentation will be reviewed during site visits for verification that evaluation tools were administered.

Talking Points for Evaluation of Programs

When reviewing the evaluation tool with the participants, schools, parents, etc. the following points may be helpful for program staff:

- The purpose of the Primary Prevention evaluation is to assess whether critical program components or activities were implemented and whether they had an impact upon determinants, important behaviors and overall prevention goals.
- Only aggregate data is being reported so there is nothing to identify an individual who completes the survey.
- The evaluation tools ask participants to provide their opinions based on the information they learned during their attendance in the program.
- Parents or legal guardians may be required to give active parental consent for their youth to participate in the evaluation. Although parental consent is given, the youth still have the option to opt out of answering any questions, which may make them feel uncomfortable or may opt out of participating in the evaluation at all.
- Parents or legal guardians may request a copy of the evaluation tools at any time.

To assist with explaining why the questions on the tools are being asked, refer to the chart provided under the section "Purpose of the Primary Prevention Evaluation Tool."

Spanish-language Documents

The evaluation tools have been translated into Spanish. The facilitator scripts for each evaluation tool have been translated and can be given to or read to those youth who are Spanish dominant and may not understand it read in English. The Parental Consent form has also been translated. The translations follow the English version of the document.

AHCCCS SABG/CRRSAA FUNDING OF PRIMARY PREVENTION PROGRAMS

IHE EVALUATION PLAN

Process			
Evaluation Question	**Measurement/Variable**	**Data Source/ Method for Collecting**	**Analysis**
Primary Prevention Priorities and Special Populations What are the population groups on which grantees are focusing their prevention efforts? What are the targeted substances on which grants are focusing their efforts?	1. Number of people reached by population of focus category (Students in college, military families, LGBTQ, American Indians, African American, Hispanic, Homeless, Native Hawaiian, Asian, Rural) 2. Number and type of substance being targeted (Alcohol, Tobacco, Marijuana, Rx Drugs, Cocaine, Heroin, Inhalants, Methamphetamine, Synthetic Drugs) 3. Perception of successes, challenges, & barriers by key stakeholders	• Target population data collected at enrollment in primary prevention programs • Participant-level service encounter records • Challenges/barriers and successes collected from optional monthly narrative reports	• Frequency Analysis • Content Analysis
What strategies and services are planned and delivered to these populations?	1. Number and type of direct and indirect prevention strategies and activities per strategy (Information Dissemination, Education, Alternative Activities, Problem Identification and Referral, Community-based Process, Environmental) 2. Number of evidence-based, promising practice programs and strategies being offered	• Strategy and activity reports collected through portal on monthly basis	• Frequency Analysis • # of evidence-based funded • Total # of programs • % of evidence-based programs
How many people were served through direct services and reached through indirect strategies	1. Number of people served and reached – direct services 2. Number of people reached – indirect services 3. Number of people reached – universal direct, universal indirect, selective, indicated.	• Enrollment in direct services collected at intake • Number attending indirect services collected at event	• Frequency Analysis
What are the demographic characteristics of the participants who enrolled in direct services	1. Number of people reached by demographic category in direct services (race/ethnicity, gender, age).	• Demographic characteristics collected at enrollment	• Frequency Analysis
What are the challenges with data collection	1. Types of challenges with data collection that impact on analysis and reporting	• List of challenges	• Content Analysis

Outcomes			
Evaluation Question	**Measurement/Variable**	**Data Source/ Method for Collecting**	**Analysis**
Abstinence How did participants' knowledge, attitudes, behaviors, and awareness of resources change during participation in direct services?	**Change in Behavior** 1. Number and percent of participants who report no use of targeted substances in past 30 days 2. Number and percent of participants who report a reduction in use of targeted substances from baseline to exit.	• Young Adult Prevention Survey (Pre/Post) for evidence-based programs • UofA H&W Survey	• Frequency Analysis • Descriptive Analysis • Percent Change
Perception of Risk/Harm: Marijuana Use Does the implementation of the PPP have a positive impact in marijuana perceptions of harm?	1. Number and percent of young adults participating in direct services who report a positive impact in marijuana perceptions of harm from baseline to exit. 2.	• Young Adult Prevention Survey (Pre/Post) for evidence-based programs	• Frequency Analysis • Descriptive Analysis • Percent Change
Perception of Risk/Harm: Binge Drinking Does the implementation of the PPP have a positive impact in binge drinking perceptions of harm?	1. Number and percent of young adults participating in direct services who report a positive impact in marijuana perceptions of harm from baseline to exit.	• Young Adult Prevention Survey (Pre/Post) for evidence-based programs	• Frequency Analysis • Descriptive Analysis • Percent Change
Optional Risk/Protective Factor (Goal Setting/Problem Solving) Does the implementation of the PPP increase young adult perception of their goal setting and problem-solving skills?	1. Number and percent of young adults reporting an increase in their ratings of goal setting and problem-solving skills from baseline to exit.	• Young Adult Prevention Survey (Pre/Post) for evidence-based programs with goal setting and problem-solving items.	• Frequency Analysis • Descriptive Analysis • Percent Change
Optional Risk/Protective Factor (Perceived Stress) Does the implementation of the PPP decrease young adult self-report of stress?	1. Number and percent of young adults reporting a decrease in their ratings of perceived stress from baseline to exit.	• Young Adult Prevention Survey (Pre/Post) for evidence-based programs with perceived stress items.	• Frequency Analysis • Descriptive Analysis • Percent Change
Optional Risk/Protective Factor (Social Connectedness) Does the implementation of the PPP increase young adult sense of belonging?	1. Number and percent of young adults reporting an increase in their ratings of social connectedness from baseline to exit.	• Young Adult Prevention Survey (Pre/Post) for evidence-based programs with social connectedness items.	• Frequency Analysis • Descriptive Analysis • Percent Change

Arizona Statewide Prevention Needs Assessment

September 2018

LeCroy & Milligan ASSOCIATES, INC.

Arizona Statewide Prevention Needs Assessment

September 2018

Submitted to:
AHCCCS
801 E. Jefferson St
Phoenix, AZ, 85034
Ph: (602) 417-4760
https://www.azahcccs.gov/

Submitted by:
LeCroy & Milligan Associates, Inc.
2002 N. Forbes Blvd. Suite 108
Tucson, AZ 85745
Ph: (520) 326-5154
Fax: (520) 326-5155
www.lecroymilligan.com

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The evaluation team thanks The Arizona Health Care Cost Containment System (hereafter referenced as AHCCCS) Office of Grant and Project Management Team, Division of Health Care and Management, for their efforts and guidance with this evaluation.

About AHCCCS:

Founded in 1982, AHCCCS (pronounced 'access') is Arizona's Medicaid program. Medicaid is a federal healthcare program jointly funded by the federal and state governments for individuals and families who may qualify for acute or long-term services.

Built on a system of competition and choice, AHCCCS is a $12 billion program that operates under an integrated managed care model, through a Research and Demonstration 1115 Waiver. Contracted health plans coordinate and pay for medical services delivered by more than 70,000 health care providers for 1.9 million individuals and families in Arizona.

- **Mission:** Reaching across Arizona to provide comprehensive, quality health care to those in need.
- **Vision:** Shaping tomorrow's managed care...from today's experience, quality and innovation.
- **Values:** Passion, Community, Quality, Respect, Accountability, Innovation, Teamwork, Leadership
- **Credo:** Our first care is your health care.

About LeCroy & Milligan Associates, Inc.:

Founded in 1991, LeCroy & Milligan Associates, Inc. (hereafter referenced as LMA) is a consulting firm specializing in social services and education program evaluation and training that is comprehensive, research-driven and useful. Our goal is to provide effective program evaluation and training that enables stakeholders to document outcomes, provide accountability, and engage in continuous program improvement. With central offices located in Tucson, Arizona, LMA has worked at the local, state and national level with a broad spectrum of social services, criminal justice, education and behavioral health programs.

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Acknowledgements

The Substance Abuse Block Grant (hereafter referenced as SABG) Program was authorized by US Congress to provide funds to States, Territories, and American Indian Tribes for the purpose of planning, implementing, and evaluating activities to prevent and treat substance use and/or misuse and is the largest Federal program dedicated to improving publicly-funded substance use prevention and treatment systems. On July 1, 2016, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) the former designated State agency to administer the SABG Block Grant, merged with AHCCCS. This merger was passed by the legislature at the recommendation of the Governor and consolidated the administration of physical and behavioral health services under one agency. As a result, AHCCCS became the Single State Authority (SSA) in the administration for the SABG Blog Grant. This report represents the first AHCCCS Statewide Prevention Needs Assessment after this merging.

AHCCCS contracted with LMA to conduct a comprehensive statewide prevention needs assessment to better understand the current substance use prevention activities occurring in Arizona, as well as identify the totality of the State's prevention needs.
The Needs Assessment workplan included the following components (See Exhibit 1):

- Develop and Implementing the Needs Assessment Approach and Evaluation Plan
- Generate a Community Prevention Inventory
- Conduct Focus Groups throughout Arizona
- Conduct Key Informant Interviews throughout Arizona
- Conduct an Online Survey for the Substance Use Prevention Workforce
- Synthesize Secondary Data Analysis for a multitude of Data Sources

LMA engaged seven team members to complete this comprehensive Statewide Needs Assessment:

Katie Haverly, M.S. – Project Lead
Kate McDonald, PhD – Quantitative Analysis
Sonia Cota-Robles, PhD, JD – Qualitative Data Collection and Analysis
Steven Wind, PhD – Qualitative Data Collection and Analysis
Debby Urken, MSW - Qualitative Data Collection and Analysis
Pamela Hill, MPH - Qualitative Data Collection and Analysis
Frankie Valenzuela – Data Management

The State Needs Assessment process was successfully completed with the assistance and coordination of a Steering Committee which included AHCCCS and the AHCCCS' SABG Block Grant funded partners also known as the Regional Behavioral Health Authorities (hereafter referenced as RBHAs) including the Cenpatico Integrated Care (CIC) which serves Southern

Arizona, Mercy Maricopa Integrated Care (MMIC) which serves Central Arizona, and Health Choice Integrated Care (HCIC) which serves Northern Arizona; and the Tribal Regional Behavioral Health Authorities (TRBHA) including Pascua Yaqui and Gila River Health Care (which are unique and not synonymous with RBHAs); and the Governor's Office of Youth, Faith, and Family hereafter (GOYFF).

In addition, AHCCCS and LMA would like to thank the following organizations and community members for their support, data and/or resources to make the needs assessment process possible:

- The Administrative Office of the Courts/Arizona Supreme Court Juvenile Justice Services Division and Adult Probation Services Division
- The Arizona Alliance for Community Health Centers (AACHC)
- The Arizona Center for Rural Health (AzCRH)
- The Arizona Criminal Justice Commission
- The Arizona Department of Health Services (ADHS)
- The Arizona Suicide Prevention Coalition (AZSPC)
- The Arizona Prevention Workforce participants
- The Community Prevention Coalitions and other prevention programs for providing information for the Community Prevention Inventory.
- The Focus Groups' participants across the State
- The Inter-Tribal Council of Arizona (ITCA),
- The Key Informant Interviews' participants across the State
- The Prevention Specialists Workforce
- The Substance Abuse Coalition Leaders in Arizona (SACLA)
- The University of Arizona, Arizona State University and Northern Arizona University
- The LGBTQ/GSM (Gender and Sexual Minority) Statewide Advisory Committee
- The communities and other participants that supported and contributed with additional resources

Data Limitations

There were considerable data limitations in the development of this report. The time frame for the evaluation team to complete the Statewide Needs Assessment was limited to three months during the summer of 2018. Due to this short time frame, primary data collection for focus groups and interviews were conducted with those groups and individuals that responded quickly to requests from the evaluation team. Although an enormous amount of support and requests were made, due to scheduling concerns, travel coordination, resource availability, and willingness to participate, the reader should interpret qualitative findings as a sampling of perspectives in Arizona and should not consider the findings to be a statistically significant representation for the State. There may also be selection bias involved in the reporting on those groups and interviews because of the criteria mentioned above. In addition, it is important that the reflections of those members from the Pascua Yaqui Tribe and Gila River Indian Community focus groups and interviews not be generalized to each other or to other Tribes in Arizona. Of Arizona's 22 Federally recognized Tribes, these were the only two Tribes the evaluation team were able to connect with as part of this assessment. Finally, the inventory of prevention programs identified in this document do not reflect all of the prevention programs and activities currently being implemented in the State.

Executive Summary

The 2018 Statewide Prevention Needs Assessment was a systematic process to collect and analyze information to describe the prevention needs of Arizona. This assessment is a practical tool that will allow community planners, stakeholders and coalitions, in collaboration with local and State governments, to identify the levels of risk and protective factors operating in their communities that are predictive of substance use and/or misuse and related behaviors. This information can then be utilized by these groups to assist with reducing substance use and misuse risk factors, while enhancing protective factors to positively affect behavior(s). This information can be utilized to inform policy and program planning, allocation of funding, and guide the statewide strategic prevention plan. In addition, this assessment can provide clarity on current prevention programs across the State to better identify the gaps in available services and resources. The needs assessment included a four-pronged evaluation initiative divided in secondary data analyses, primary data collection and analyses, the collation of a community substance use prevention inventory, and the conduction of a statewide substance use prevention workforce survey. The overall purpose of the needs assessment was to explore the following four main questions:

1. *What are the current substance use issues in Arizona by region and subpopulation?*
2. *What substance use prevention programs are active in Arizona?*
3. *What are the causes for using and/or abusing substances in Arizona?*
4. *What are the recommendations for the future of substance use prevention in Arizona?*

The secondary data analyses included the gathering, review and summation of statewide and national data sources. Data for the secondary analysis originated from both statistical surveys and administrative sources. The primary data collection activities included conducting focus groups and interviews with key informants throughout Arizona. Nineteen focus groups comprised of 172 individuals were conducted throughout the three main regions of Arizona (north, central and south) with a mix of urban and rural communities. Four subpopulations of interest (Youth, Veterans, Elderly, and those that identify as Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ) guided the majority of the scheduling of these groups. In addition, one focus group was conducted with the Pascua Yaqui TRBHA, and one focus group was conducted with *Promotores* serving the Phoenix (Central) area. Participants of all focus groups included active members of the populations or individuals involved with the populations. Eighteen key informant interviews were conducted on a one-on-one basis with persons who could provide access to specific information about a population, and/or who understood the risk factors or substance use problem behaviors of that population. These included community leaders, coalition leaders, RBHA administrators, medical health

professionals, school principals, refugee prevention specialists, superintendents, related school staff, Tribal elders, Tribal council members and university prevention specialists.
A variety of sources were utilized to develop the Community Prevention Inventory. Many known programs and coalitions were invited to participate in a digital survey. Additional information about coalitions was obtained at Substance Abuse Coalition of Leaders in Arizona (SACLA) meetings and through phone contact. The project team also obtained information about prevention efforts at the State's three public universities directly from the university staff responsible for coordinating such efforts. Online research was also utilized to source information for the inventory. The Substance Use Prevention Workforce Survey was a digital survey shared with individuals affiliated with organizations and coalitions that focused on substance use prevention. LMA distributed survey invitations through primary agencies and key contacts, to complete the surveys and/or forward them to secondary contacts in the target populations. The survey was completed by 142 individuals who self-identified as working or volunteering in substance use and/or misuse prevention.

The analysis and summation across all evaluation components contributed to 10 major findings:

1) An increasing number of Arizonans of all ages and in all regions are suffering from untreated mental health issues that are leading to substance use and/or misuse.
2) LGBTQ identified individuals in all regions are experiencing significantly more risk factors for, consequences of, and issues with substance use and/or misuse as compared to non-LGBTQ identified individuals.
3) Vaping (e-cigarettes, etc.) is increasing in Arizona for youth in middle and high schools and is significantly higher than national averages.
4) The Counties that are experiencing the most severe consequences of substance use in Arizona are: (1) Gila County, (2) Navajo County, (3) Mohave County, and (4) Pima County.
5) A lack of social support and/or someone to turn to/talk to is a protective factor for substance use and/or misuse to which many Arizonans do not have access.
6) The normalization of marijuana and other substances may be leading to increased substance use.
7) Reductions in funding and resources for schools prohibit effective prevention programs from being delivered to high needs communities.
8) Recent efforts to combat the prescription drug opioid crisis in Arizona are leading to increased street drug use.
9) Prevention programs that are culturally competent, engaging and up to date are more effective and should be prioritized.
10) If basic needs are not being met (e.g. shelter, food, safety, physical health, mental health, social support) then prevention programs and efforts often fail.

For more information about the Arizona Statewide Prevention Needs Assessment, please contact Gabrielle Richard at Gabrielle.Richard@azahcccs.gov and/or Katie Haverly at katie@lecroymilligan.com.

Introduction

A Needs Assessment is a systematic process for collecting and analyzing information to describe the needs of a population. For substance use prevention, it allows community planners in collaboration with local and state governments to identify the levels of risk and protective factors operating in a given community that are predictive of substance use and related problem behaviors which can then inform policy and program planning. This process can also identify current prevention programs that are occurring across the State to better understand where gaps may exist, as well as what programming is most effective to help improve prevention activities statewide.

Needs Assessment Approach

This assessment was done utilizing the SAMHSA's Strategic Prevention Framework (SPF) (https://www.samhsa.gov/capt/applying-strategic-prevention-framework). The SPF is a planning process for preventing substance use and misuse. The five steps and two guiding principles of the SPF offer prevention professionals a comprehensive framework for addressing the substance misuse and related behavioral health problems facing their communities. The effectiveness of the SPF begins with a clear understanding of community needs and engages community members in all stages of the planning process. The steps are as follow:

Step 1: Assess Needs

Step 2: Build Capacity

Step 3: Plan

Step 4: Implement

Step 5: Evaluate

The SPF also includes two guiding principles:

Cultural competence: The ability to interact effectively with members of a diverse population.

Sustainability: The process of achieving and maintaining long-term results.

Strategic Prevention Framework Diagram- Partnership for Success

The Arizona Statewide Prevention Needs Assessment is related to the critical first step of this process and will feed into and support each of the subsequent four steps.

The SPF planning process has five distinctive features according to SAMHSA. The SPF model is:

1. **Data-driven**: Quality decisions require quality data. The SPF is designed to help practitioners gather and use data to guide all prevention decisions—from ranking the community impact of each substance misuse issue, to choosing the most appropriate methods to address those problems. Data also helps practitioners determine whether communities are making progress in meeting their prevention needs.

2. **Dynamic**: Assessment is more than just a starting point. Practitioners will perform frequent ongoing assessments as the prevention needs of their communities change, and as community capacity to address these needs evolve. Communities may also simultaneously engage in activities categorized in different steps. For example, practitioners may need to find and mobilize additional capacity to support implementation once an intervention is underway. For these reasons, the SPF is a circular, rather than a linear, model.

3. **Focused on population-level change**: Earlier prevention models often measured success by evaluating individual program outcomes or changes among small groups. But effective prevention means implementing multiple strategies that address the constellation of risk and protective factors associated with substance misuse in a given community. This macro-oriented thinking is more likely to create an environment that helps people support healthy decision-making.

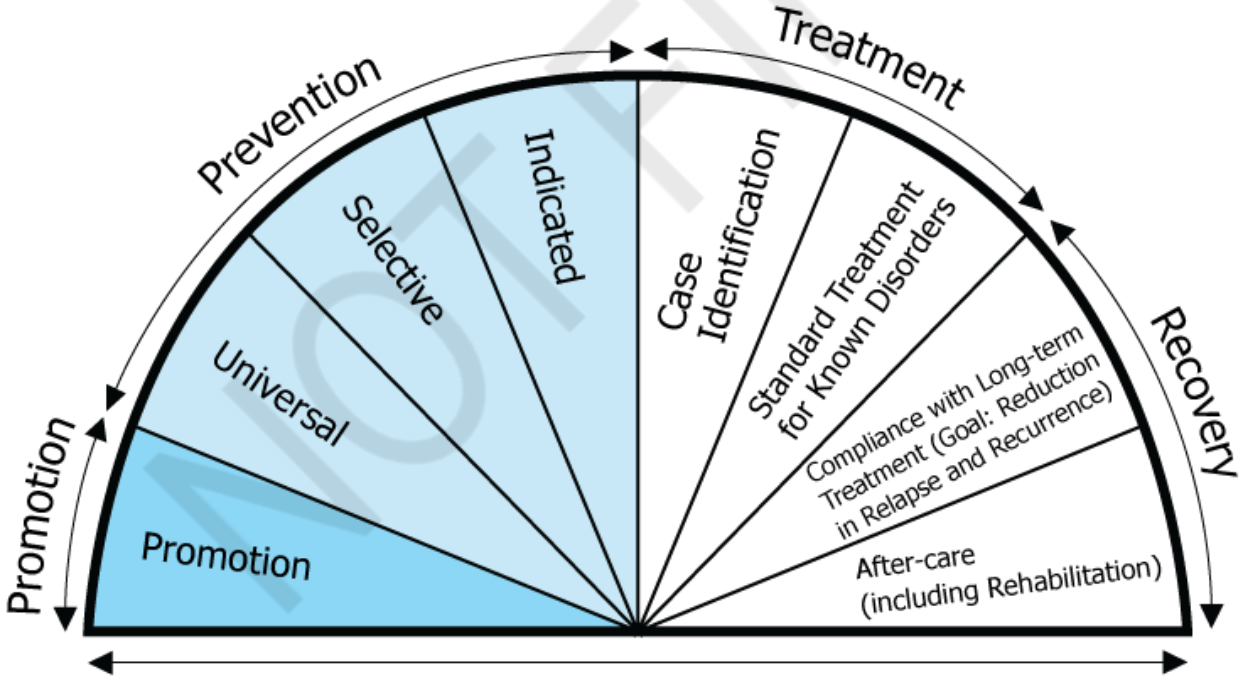
4. **Intended to guide prevention efforts for people of all ages:** The SPF challenges prevention professionals to look at substance misuse among populations that are often overlooked but at significant risk, such as young adults ages 18 to 25 and adults age 65 and older.

5. **Reliant on a team approach:** Each step of the SPF requires—and greatly benefits from—the participation of diverse community partners.

To apply the SPF, a data-driven, outcomes-based approach is used to identify those substance misuse and behavioral outcomes that warrant the most immediate attention. This data is then used to identify risk and protective factors related to these outcomes and craft strategies to impact these factors. (https://www.samhsa.gov/capt/tools-learning-resources/data-prevention-planning-seow).

Substance Use Prevention

Prevention is part of a continuum of behavioral health programs and services that include treatment and recovery support.



Source: https://www.samhsa.gov/prevention

In 1994, The Institute of Medicine proposed a framework to classify prevention interventions according to their target population as Universal, Selective or Indicated (IOM, 1994). Universal interventions target the general population and are not directed at a specific risk group. Selective interventions target those at higher-than-average risk for substance abuse and Indicated interventions target those already using or engaged in higher risk behaviors.

Research national studies confirm the cost benefit of prevention programs. In a longitudinal, randomized control trial, Kuklinkski et al (2015) were able to calculate a benefit cost ratio of $8.22 for every dollar invested in the Communities That Care (CTC) prevention system; a community-based approach to prevent initiation of delinquency, alcohol use and tobacco use. Additionally, a longitudinal prevention trial conducted in Iowa (Spoth, Guyll & Day, 2002) explored the cost benefit/cost-effectiveness of a family centered program to strengthen families (ISFP) and delay or prevent onset of drug and alcohol use (Preparing for the Drug Free Years - PDFY). Conservative estimates for the ISFP intervention were a cost-effectiveness figure of $12,459 per case prevented, a benefit-cost ratio of S9.60 per $1 invested, and a net benefit of $5,923 per family. For PDFY, estimates were a cost effectiveness of $20,439 per case prevented, a benefit-cost ratio of $5.85 per $12 invested, and a net benefit of $2,697 per family.

In the most recent cost benefit analysis conducted by SAMHSA (Miller & Hendrie 2008), the total annual costs to society (including resource costs and productivity costs) for substance use and/or misuse were calculated to be **$510.8 billion**. This same report concluded that if effective school-based prevention programs were to be implemented nationwide, these programs could save an estimated **$18** per **$1** invested in prevention.

It is clear that the societal cost of substance use is staggering, and that the savings generated from effective prevention programs often are well worth the investment.

The objective of SABG funded AHCCCS Primary Prevention Services' is to help plan, implement, and evaluate activities that prevent and treat substance use and/or misuse at the state level. SAMHSA requires that grantees spend no less than 20% of their SABG allotment on substance use primary prevention strategies. These Primary Prevention Strategies are directed towards at-risk individuals not yet identified to be in need of treatment. The strategies include:

1. Information Dissemination
2. Education
3. Alternatives
4. Problem Identification and Referral
5. Community-Based Process
6. Environmental

Primary Prevention programs funded through AHCCCS SABG Block Grant are intended to decrease the prevalence and severity of substance use and misuse problems among populations

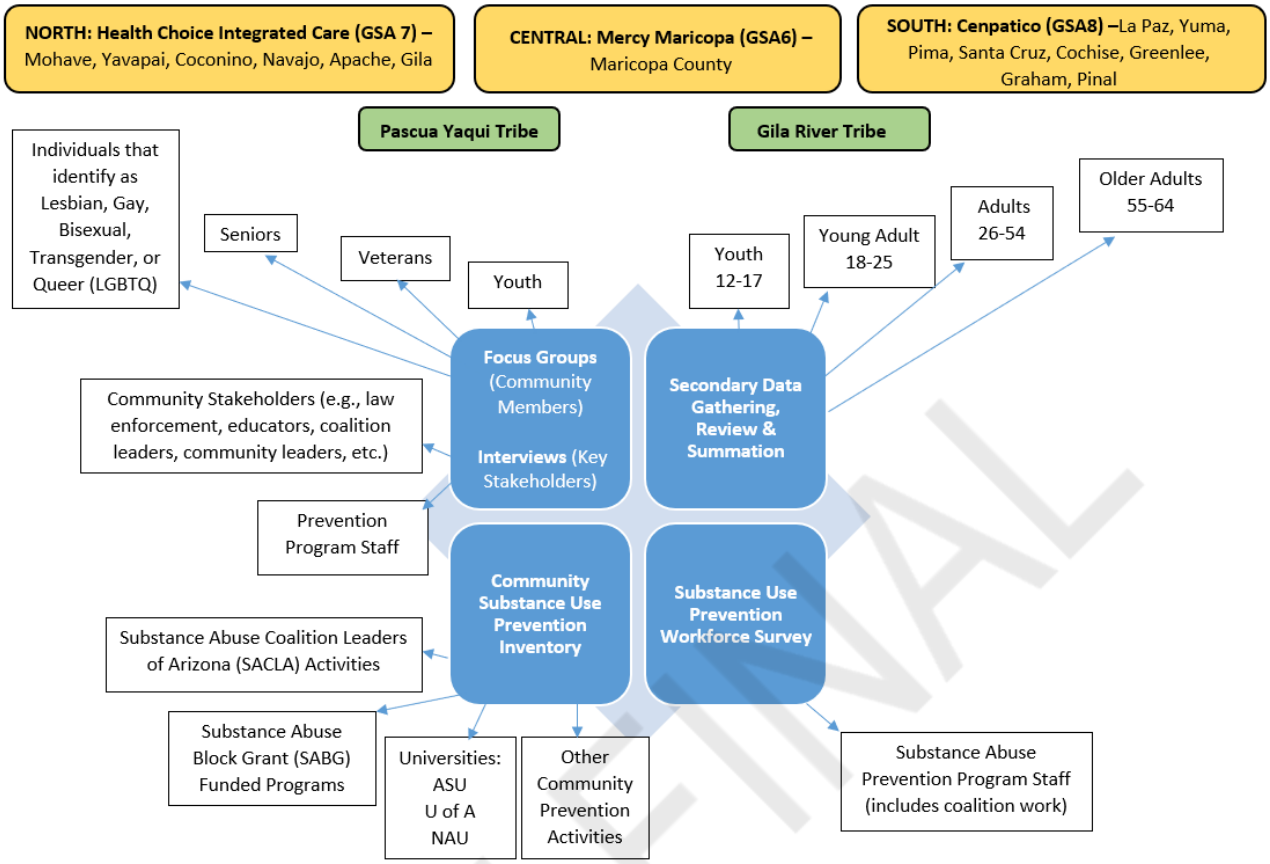
that do not have a diagnose of a mental or behavioral health disorder, including Substance Use Disorder (SUD). Prevention is accomplished by developing the system infrastructure and identify the strengths of individuals, families, and communities.

Project Overview

On June 6, 2018, the research team met with the Steering Committee for the Statewide Prevention Needs Assessment which included AHCCCS and other State government staff, representatives from the three RBHAs (Health Choice Integrated Care, Mercy Maricopa, and Cenpatico), The Governor's Office of Youth, Faith, and Family (GOYFF), and two TRBHAs (The Pascua Yaqui Tribe and Gila River Health Care). As part of this discussion, the committee agreed upon four subpopulations of interest for the needs assessment: (1) Youth, (2) Veterans, (3) Seniors, and (4) those that identify as Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ). These subpopulations guided the scheduling and conduct of focus groups and interviews across the three regions of RBHAs (North, Central and South) as well as the two TRBHAs. Four short reports are also available that summarize the findings for each of these subpopulations. (See Appendices G, H, I, J)

In order to conduct a comprehensive prevention needs assessment for Arizona, four main areas of assessment were implemented: (1) conducting qualitative primary data collection including focus groups and interviews, (2) quantitative secondary data compilation, review and summation, (3) organizing a comprehensive Community Substance Use Prevention Inventory, and (4) conducting a statewide Prevention Workforce Survey (See Exhibit 1).

Exhibit 1. Overview of the Arizona Statewide Substance Use Prevention Needs Assessment



The structure of this needs assessment report will assist the reader in understanding:

1) Current substance use issues in Arizona by region and subpopulation.
2) Current prevention programs that are occurring in Arizona.
3) The causes and risk/protective factors for using and misusing substances in Arizona.
4) Data-driven recommendations, ideas and innovations for future prevention program development in Arizona.

Methodology

Secondary Data Analysis

The goals of the secondary data analysis for the Arizona Statewide Prevention Needs Assessment are to provide a comprehensive picture of:

- The prevalence of substance use in Arizona,
- The consequences of substance use, and
- The risk and protective factors associated with substance use.

Data for the secondary analysis was drawn from two general sources: statistical surveys and administrative sources. For some analyses, online data portals generated real time descriptive data summaries and cross-tabular analyses. Depending on variable and sample characteristics, other analyses included cross tabulation, chi square tests, means comparison and t-tests/ANOVAs. For all analyses, results were deemed significant if the p value is .05 or less, indicating that the possibility of the relationship occurring by chance is less than 5%. The specific data sources and their relative strengths and limitations are reviewed briefly below.

Statistical Surveys

In survey research, respondents are sampled from a target population, then data is collected and analyzed using statistical procedures. Because error is unavoidable in survey research, there is always some level of uncertainty with regard to survey estimates. Statisticians employ techniques to interpret survey data accurately given this uncertainty. Two techniques referenced in this report are 95% confidence intervals (95% CIs) and p-values.

- *A 95% confidence interval* is an upper and lower bound around a survey estimate. For example, the 2016 Behavioral Risk Factor Surveillance Survey (BRFSS) estimated that the prevalence of binge drinking among Arizona adults was 15.6%, with a 95% CI of 14.3% to 16.9%. This means there is a 95% chance that the true prevalence of binge drinking in Arizona falls between 14.3% and 16.9%. Larger confidence intervals suggest less-precision, or more uncertainty in the data. In this report, the 95%CI is indicated in the bar charts through the use of error lines.

- *P-values, or probability values,* are used in hypothesis testing to determine whether differences between estimates are statistically meaningful. For instance, the prevalence of binge drinking among adult males in Arizona according to the 2016 BRFSS was 21.3%, but only 10.1% for females. In order to test the hypothesis that the prevalence of binge drinking differs between males and females, the two estimates are statistically compared and a p-value is generated. If the p-value is less than .05, there is strong evidence that the two estimates are meaningfully different after accounting for the uncertainty in each estimate. The commonly accepted threshold is $p<.05$ for

determining statistical significance; p-values of <.10 are considered marginally significant. These thresholds are applied in this report.

The primary surveys referenced for the secondary data analysis include the:

- **National Survey on Drug Use and Health (NSDUH):** The NSDUH is an annual, national survey of the non-institutionalized population aged 12 or older directed by the Substance Abuse and Mental Health Services Administration (SAMHSA). The goal of the NSDUH is to provide national and state level data on key substance use and mental health indicators in order to inform prevention and treatment efforts and monitor changes overtime. Because of sample size limitations, state level estimates are based on two or three years of combined data, with the most recent data drawn from the 2016 survey. Online analysis tools are still being developed for the NSDUH and are not currently functional. As a result, the secondary analysis relied on data already published in NSDUH reports. Data were not available to investigate disparities in indicators by key sociodemographic characteristics. Additionally, data were not available for finite age categories of adults over 25.

- **Behavioral Risk Factor Surveillance System (BRFSS):** The BRFSS is an annual state-based survey of non-institutionalized adults 18 or older coordinated by the Centers for Disease Control (CDC). The goal of the BRFSS is to monitor health risk behaviors and while it does not focus specifically on substance use, it does collect data on cigarette and alcohol use. Arizona sample sizes are larger for the BRFSS than the NSDUH, and there are online analysis tools available that permit statistical analyses of disparities, risks and more detailed age groupings than those allowed by the NSDUH. Data for this report were drawn from the 2016 BRFSS, which was the most recent year of data available at the time. Results from the 2017 BRFSS were released September 2018 and can be accessed online through the CDC maintained website: "BRFSS Prevalence Data and Data Analysis Tools."

- **Youth Risk Behavior Surveillance System (YRBSS):** The YRBSS is administered every two years to a representative sample of 9th through 12th grade students in the United States. The YRBSS is coordinated by the CDC with the goal of providing national, state and Tribal government estimates of youth risk behaviors, health conditions, and social problems. Data are available for a number of substance use indicators for 2017, and the online analysis tools permit statistical analyses of disparities and risks.

- **American Community Survey (ACS):** The ACS is an ongoing survey conducted by the U.S. Census Bureau to provide updated estimates of key socioeconomic and demographic indicators (e.g., educational attainment, income, veteran status, employment, etc.). Demographic data in this report are from five years of aggregated

ACS data (2012-2016). The 5-year aggregated data were used because the larger sample sizes enhance precision and enable functional estimates for small geographic areas, including small counties.

- **Arizona Youth Survey (AYS):** The AYS is conducted by the Arizona Criminal Justice Commission every two years among 8th, 10th and 12th graders in all 15 counties in Arizona. The AYS collects data about youth substance use and risk behaviors. Data are available at the state, county and zip-code level. Limitations of the AYS include that the survey does not randomly sample schools for inclusion in the study; rather all Arizona schools are invited to participate. In addition, the number and percentage of schools that participate in the survey can vary from year to year depending on the school's decision to participate in the survey.

Administrative Data Sources

Unlike survey data, which sample a subset of the population, administrative data aim to track every relevant case or event. These data are often collected for administrative purposes, such as tracking participants in a program, making decisions about funding, monitoring services, or tracking vital events (e.g., births, deaths, etc.). The secondary data analysis utilized numerous administrative data sources, including:

- **Arizona Vital Statistics Data:** The Bureau of Public Health Statistics in the Arizona Department of Health Services (ADHS) maintains Arizona's health and vital data. The secondary data analysis accessed mortality data in addition to hospital and emergency department discharge data related to drugs, alcohol and intentional self-harm (suicide).

- **The Treatment Episode Data Set (TEDS):** TEDS is maintained by the Center for Behavioral Health Statistics and Quality and SAMHSA. It tracks substance use and/or misuse admissions annually at the state and national level.

- **The Arizona Crime Report:** The Arizona Crime Report is compiled by the Arizona Department of Public Safety and includes annual data on arrests in the State, including arrests for drugs and alcohol.

- **The Arizona Motor Vehicle Crash Facts, 2017:** These data are compiled annually from Arizona's motor vehicle crashes for the Arizona Department of Transportation and provides data on drug and alcohol related crashes.

- **Fatality Analysis Reporting System (FARS):** FARS is a nationwide census maintained by the National Highway Traffic Safety Administration that tracks fatal injuries from motor vehicle traffic crashes, including fatal crashes involving drugs and alcohol.

- **U.S. 2010 Census Data:** The U.S. census is completed every ten years by the U.S. Census Bureau in order to enumerate the U.S. population and collect important demographic information.

Data Limitations and Challenges

There are a number of limitations to the secondary data analysis that are common when conducting comprehensive needs assessments with large surveillance datasets that should be considered when interpreting findings. LMA utilized the triangulation of multiple data sources where possible to mitigate some of these challenges.

Error, Chance and Bias

Survey samples may not be representative of the target population, either because of chance, low response rates, or some error in survey methodology. Survey respondents may answer survey questions inaccurately, either because they cannot recall the event correctly, did not understand the question, or because they want to provide a more socially desirable response. Social response bias can be especially problematic when survey questions ask about something illegal, like drug use. As a result, survey data may under-estimate the true prevalence of an event. Additionally, when sample sizes are small, it is more difficult to make accurate estimates or detect true differences between estimates. All data were also cross-sectional in nature, making it difficult to evaluate causality. Finally, administrative data sources are prone to error, especially due to mistakes or inconsistencies in mortality coding or disease classification. Errors in administrative data sources are difficult to identify and evaluate.

Data Inconsistencies

Most indicator data were compiled from multiple data sources. Users are cautioned not to directly compare prevalence estimates from different data sources. For instance, in 2016 the BRFSS estimated that the prevalence of adult binge drinking in Arizona was 15.6%, while the NSDUH estimated the prevalence was 24.5%. This significant difference was attributed to differences in survey administration techniques and other methodological inconsistences, including slight differences in question wording between the two surveys (Center for Behavioral Health Statistics and Quality, 2017).

Another limitation is that changes to survey methodology that occur overtime can compromise trend analyses. Two changes occurred in 2015 that impacted the secondary data analysis. First, the NSDUH sample and survey instrument were redesigned which limits the timeframe that can be utilized for trend analyses. Additionally, the Department of Health and Human Services mandated a coding transition from International Classification of Diseases 9th revision (ICD-9) to ICD-10 for many administrative data sources. The ICD codes are utilized for mortality coding and disease classification. Both the NSDUH revisions and ICD revisions impacted numerous indicators investigated in the secondary analysis. In these instances, data prior to 2015 were not

a practical comparison to future data; users are cautioned not to examine trends across the baseline established in 2015.

Limited Data for Priority Populations

Another challenge to providing a comprehensive secondary data analysis was the unavailability of statistically relevant samples for several key indicators and priority populations. Quantitative data were consistently limited for the following Arizona sub-populations:

- American Indian/Alaska Native populations, especially at the Tribal level.
- LGBTQ adults: Data on substance use risks among LGBTQ adults are limited for Arizona. However, results from a 2018 survey may help shed some light on the problem. The Shout Out survey was funded by the Maricopa County Department of Public Health and conducted by the Southwest Center for HIV/AIDS in partnership with the Health Management Associated Community Strategies and other groups. The goals of the survey were to learn more about the health needs of Arizona's LGBTQ populations in order to plan initiatives to better meet their needs. The survey asked specifically about substance use. The data are currently being analyzed and a public report is forthcoming.
- Veterans
- Older adults, especially substance use consumption patterns for finite categories of adults over 25.
- Specific geographic levels (e.g., communities, zip codes, TRBHAs, etc.)

To bolster information about these priority populations in Arizona, the majority of qualitative data collection was focused on these populations.

Additionally, the availability and utility of online analytical tools were limited in the statistical analyses they could perform making it difficult to completely assess disparities and test hypotheses. Finally, due to lags in data collection and processing, the most recent data for many indicators were from 2016. These data may not accurately reflect current substance use patterns, risks and consequences in Arizona. In the future, targeted data collection and analytical efforts could help improve information about substance use in Arizona.

Qualitative Data Analysis

Primary data collection is an important component of a comprehensive needs assessment. Real time insights about needs and issues can bolster quantitative data that may not be current, or that does not capture information about specific communities and populations. The statewide qualitative data collection plan sourced insights from one-on-one key informant interviews and focus groups comprised of qualifying individuals. Two evaluators were present at each focus group, one to facilitate the group and one to take detailed notes, with groups lasting on average for 90 minutes. Interviews were conducted in person or over the phone and lasted on average 30 minutes. Both focus groups and interviews were recorded in order to corroborate findings

after these sessions. Recordings, notes, and transcripts were then reviewed for emergent common key themes that arose by subgroup, and for the State as a whole. It is important to caution the reader that these focus groups and interviews should not be generalized to represent the viewpoints of entire regions or subpopulations. The insights gathered from these sessions are representative of the individuals who share them and need to be contextualized within the larger framework of further education regarding these communities and populations. In addition, some subpopulations had very few respondent perspectives and should be recognized as such. For example, two prevention specialists were interviewed to learn more about the refugee population in the Tucson area. One focus group was conducted with *Promotores* in the Phoenix area, and when discussing Tribal communities, only one focus group and one interview with a Tribal elder was conducted with the Pascua Yaqui Tribe, and one interview was conducted with a community key informant in Gila River Indian Community. When reading summaries of findings about these three groups, the reader should be cautioned that these perspectives are based on a handful of individuals.

18 Key informant interviews were conducted on a one-on-one basis with community leaders, coalition leaders, RBHA administrators, medical health professionals, school principals, superintendents and other school staff, Tribal elders and council members and University prevention specialists. Key informants were selected based on the following criteria: (1) Individuals who had key insights about a community and/or population, (2) Individuals who had key insights about a community and/or population where there was a dearth of quantitative data available to understand the issues and needs of that community, and /or (3) Individuals who had key insights about a community and/or population that were recommended to the research team by a variety of sources. The interview guide (Appendix A) was developed (with feedback from the Steering Committee) to ensure cultural competency, understandability, and relevance to the key questions of the needs assessment.

19 Focus groups were conducted with 172 individuals and were interactive, small group discussions conducted in a controlled environment, where a selected group of people discussed specific topics related to substance use prevention. The focus group protocol guide was developed (with feedback from the Steering Committee) to ensure cultural competency, clarity, and relevance to the key questions of the prevention needs assessment (Appendix B). Focus groups were convened for the four subpopulations of interest (youth and those serving youth, veterans, seniors and those that identify as LGBTQ) spread evenly over the three main regions of Arizona (North, Central, South) with a mix of urban and rural communities. Youth have traditionally been the focus of many primary prevention efforts due to the potential of delaying or preventing the onset of substance use and/or misuse. A series of focus groups were conducted with youth as well as individuals that serve or are connected to youth (educators, prevention specialists, teachers, law enforcement, parents, etc.) to generate a comprehensive understanding of the current substance use issues and prevention needs for Arizona. In addition, one focus group was conducted with Pascua Yaqui Tribe, and one focus group was

conducted with *promotores* serving the Phoenix (Central) area. A *Promotora* is a Hispanic/Latino community member who receives specialized training to provide basic health education in the community without being a professional health care worker. *Promotores* serve as liaisons between their community, health professionals, and human and social service organizations. Participants of all focus groups included active members of the population or persons involved with the populations. These conversations were led by a moderator whose role was to foster interaction, keep the group on task, and encourage participation.

Community Prevention Inventory

The project team used a variety of sources to develop the Community Prevention Inventory. To initially obtain data about community prevention coalitions, the team invited coalition leaders included on a list provided by the Substance Abuse Coalition Leaders of Arizona (SACLA) to complete a survey posted on SurveyMonkey. Additional information about coalitions was obtained at a SACLA meeting and through phone contact. The Governor's Office of Youth, Faith and Family also provided information about current prevention activities occurring throughout the State. The project team also obtained information about prevention efforts at the State's three public universities directly from university staff responsible for coordinating such efforts. Information on the AHCCCS SABG Block Grant funded programs were obtained from the RBHAs contacts, TRBHA programs were obtained via phone and e-mail, and online research also contributed information for the inventory. It is important to note that despite all of these efforts there are likely programs and efforts that were unable to be identified due to lack of response to surveys, little to no marketing or online information about programs, etc.

Workforce Survey

Instruments and Measures

The implemented survey was developed to collect information from statewide members of the substance use prevention workforce. The survey was anonymous to collect information about the types of substance use prevention efforts the respondents were engaged in, challenges on implementation, training access, training needs, efforts to evaluate impact, as well as demographics and information about the types of communities they serve. A screening question confirmed that respondents were working or volunteering in substance use prevention.

Data Collection

The Substance Use Prevention Workforce Survey was developed in an online format using Qualtrics and shared with individuals affiliated with organizations and coalitions that focus on substance use prevention. In collaboration with AHCCCS and to promote participation, it was determined that the invitation could reach the target populations in either of two ways: (1) agencies and key contacts could provide LMA with a list of staff and LMA team would be responsible for sending out an invitation to complete the survey that included the survey link, or (2) agencies and key contacts could forward the invitation and survey link to their own

contacts in the target population. This decision maximized participation, though it was not possible to track the response rate in the latter case because agencies and key contacts did not share the lists of those to whom they sent the invitation. The survey was completed by 142 individuals who self-identified as working or volunteering in substance use and/or misuse prevention. Not all respondents answered all questions; findings disseminated total response numbers to each question.

Geographic Areas and Demographics

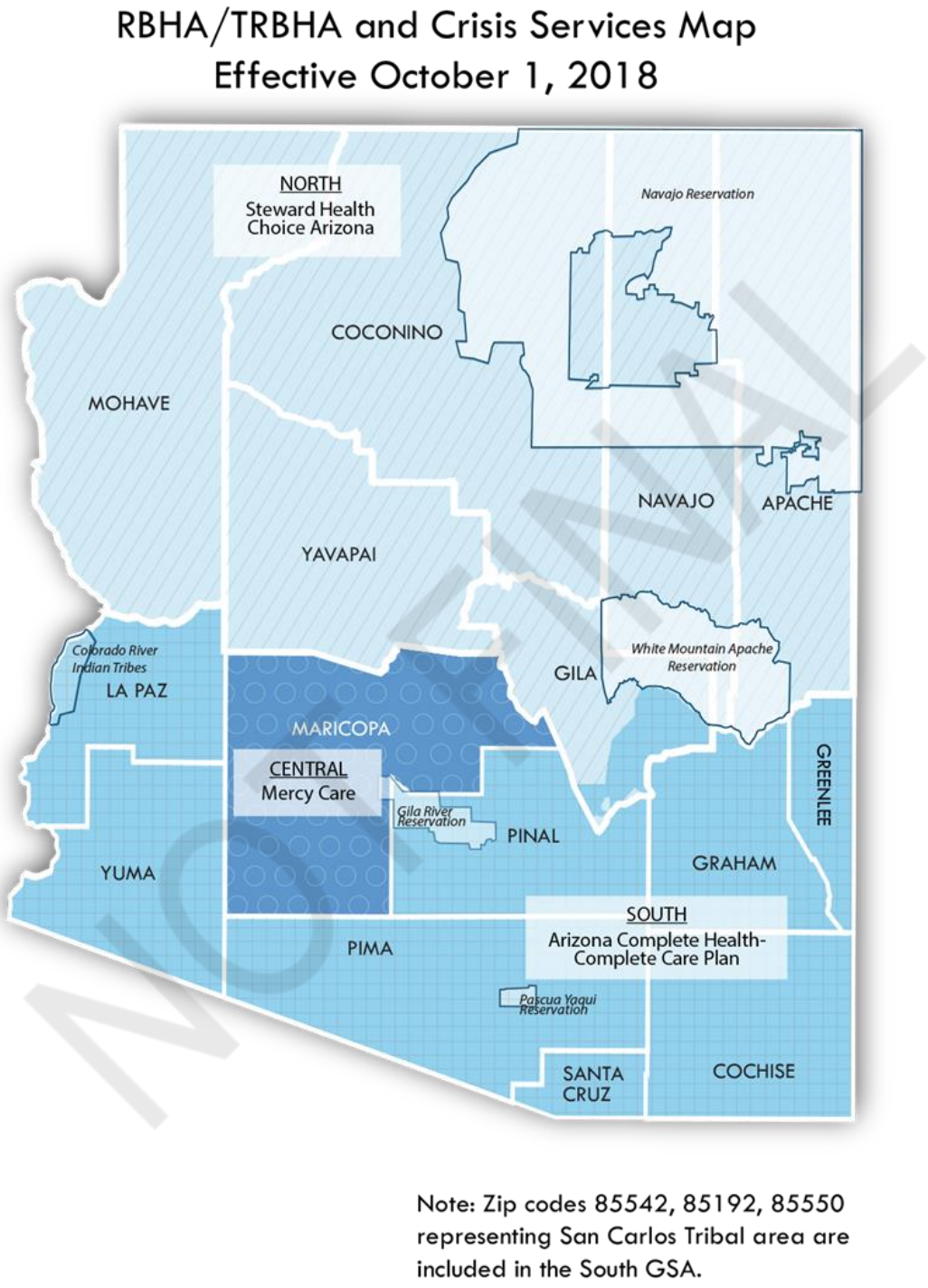
Tribal and Regional Behavioral Health Authorities (TRBHAs)

The Arizona Health Care Cost Containment System (AHCCCS) is the Single State Agency (SSA) that contracts with the Regional Behavioral Health Authorities (RBHAs), the Tribal Regional Behavioral Health Authorities (TRBHAs), and the Governor's Office of Youth, Faith and Families (GOYFF) to provide prevention and behavioral health services throughout Arizona. Eligible AHCCCS members are assigned to a TRBHA based on their zip code, geographic service area (GSA) or the Tribal community in which they reside. Exhibit 2 maps the location of each of Arizona's RBHAs and TRBHAs. It is important to note that AHCCCS has an Inter-Governmental Agreement (IGA) contract for Procurement requirements for the allocation of SABG Block Grant primary prevention funding with two TRBHAs to the Gila River Health Care and the Pascua Yaqui Tribe.

County and zip code designations for each RBHA at the time of the needs assessment are as follows:

- North RBHA (Health Choice Integrated Care) includes Apache, Coconino, Gila, Mohave, Navajo and Yavapai, counties with the exception of zip codes 85542, 85192, and 85550 representing the San Carlos Tribal area. These zip codes are served by the South RBHA.
- Central RBHA (Mercy Maricopa), includes Maricopa County and five zip codes in neighboring Pinal County: 85120, 85140, 85142, 85143, and 85220.
- South RBHA (Cenpatico Integrated Care) includes Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz, and Yuma, and zip codes 85542, 85192, and 85550. Zip codes covered by the Central region are excluded: 85120, 85140, 85142, 85143, and 85220.

Exhibit 2. Location of Arizona's Counties and Tribal and Regional Behavioral Health Authorities (TRBHAs)*



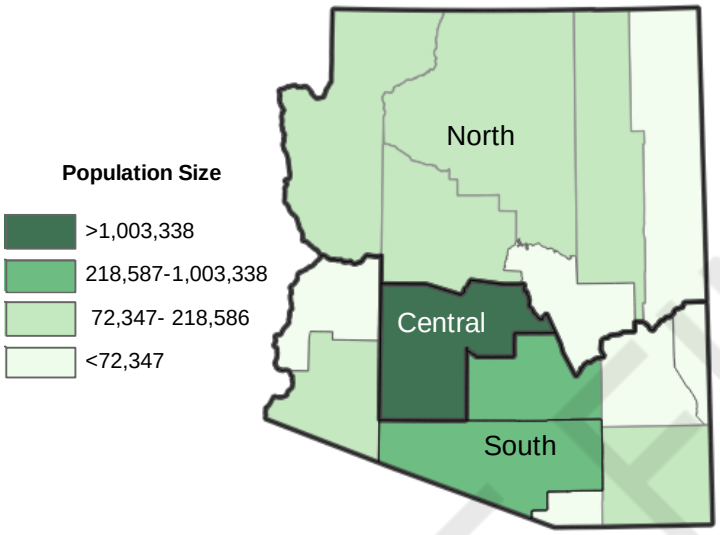
Source: Map provided by AHCCCS 02/22/19; Produced by AHCCCS October, 2018.

**This updated map is not reflective of the RBHA/TRBHAs that were providing services during the time of the needs assessment data collection. Since the assessment took place during a time of transition to AHCCCS Complete Care Plans, this map should be used going forward when determining RBHA/TRBHA designations and service areas.*

Population

Arizona is divided into 15 counties, with 22 sovereign American Indian Tribes and a population of over 6.7 million. Most of the population of Arizona is concentrated in Maricopa and Pima counties, specifically the urban areas in and around Phoenix and Tucson. Maricopa County is the largest county with a population of nearly 4.1 million, followed by Pima County (1.0 million; Exhibit 3)[1].

Exhibit 3. Population Estimates by Arizona County, 5-Year Estimates from 2012-2016[2]



Rank	County	Population
1	Maricopa	4,088,549
2	Pima	1,003,338
3	Pinal	397,604
4	Yavapai	218,586
5	Mohave	203,629
6	Yuma	203,292
7	Coconino	138,064
8	Cochise	128,177
9	Navajo	108,209
10	Apache	72,346
11	Gila	53,179
12	Santa Cruz	46,547
13	Graham	37,529
14	La Paz	20,304
15	Greenlee	9,224

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year

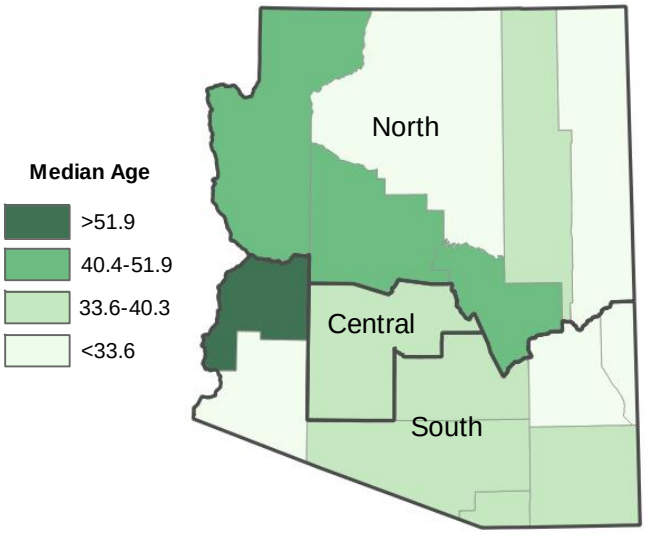
The seven least populated counties in Arizona are the rural counties of Navajo, Apache, Gila, Santa Cruz, Graham, La Paz and Greenlee (See Exhibit 3). Although Arizona's rural population comprises only 5% of the State's total population, nearly one-third of the rural population identify as American Indian/Alaska Native (Rural Health Quarterly, 2017).

Age

The median age in Arizona is 37.1 years, compared to 37.7 years nationally. The age profile differs by County (See Exhibit 4). La Paz, Yavapai and Mohave counties have the oldest populations. Over one-third of residents in La Paz (36.1%), and more than one-quarter of residents in Yavapai (28.3%) and Mohave (26.9%) are 65 and older. Coconino, Graham, Greenlee and Apache counties have among the youngest populations.

[1] Please note, except where indicated, demographic data are based on five years of aggregated data from the U.S. Census Bureau's American Community Survey, 2012-2016.
[2] Counts and rates for all maps are classified into four groups by the Jenks natural breaks classification.

Exhibit 4. Median Age by Arizona County, 5-Year Estimates from 2012-2016



Rank	County	Age
1	La Paz	55.1
2	Yavapai	51.9
3	Mohave	49.7
4	Gila	48.9
5	Cochise	40.3
6	Pinal	38.3
7	Pima	38.1
8	Santa Cruz	36.4
9	Maricopa	35.8
9	Navajo	35.8
12	Apache	33.5
12	Apache	33.5
13	Greenlee	33.3
14	Graham	32.4
15	Coconino	30.7

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates

Race/Ethnicity

In Arizona, the majority of residents identify as white only (56.1%; See Exhibit 5). Approximately 4.0% of the population identifies as black only, and another 4.0% identify as American Indian/Alaska Native only. Only 3.0% identify as Asian only, and fewer than 3% identify as multiracial or some other race. Nearly one-third of residents in Arizona identify as Hispanic/Latino of any race (30.5%; ACS, 2012-2016).

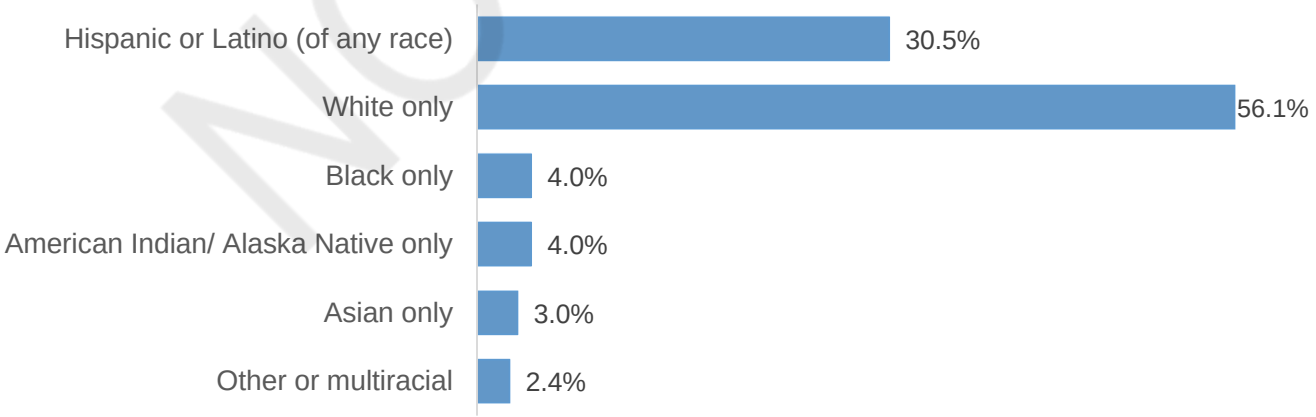
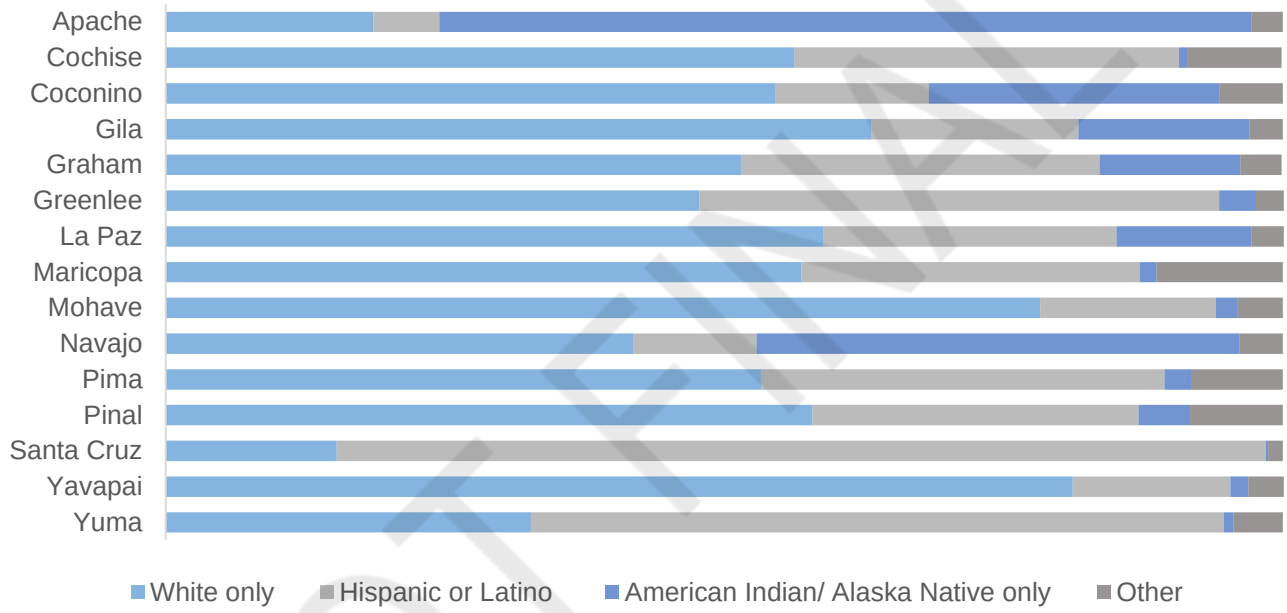


Exhibit 5. Race/Ethnicity in Arizona, 5-Year Estimates from 2012-2016
Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates

Arizona's racial and ethnic profile differs significantly by county (See Exhibit 6). Approximately 81% of residents in Yavapai County identify as white only, while a minority of Santa Cruz County residents (15%) identify as white only. In Apache County nearly 73% of residents identify as American Indian/Alaska Native while fewer than 1% of residents in Cochise, Santa Cruz, and Yuma counties identify as American Indian/Alaska Native. Santa Cruz County has the highest proportion of residents identifying as Hispanic/Latino ethnicity (83%); Apache County has the smallest Hispanic/Latino population (6%). Detailed data on race and ethnicity by county are located in Appendix C.

Exhibit 6. Race/Ethnicity by Arizona County, 5-Year Estimates from 2012-2016

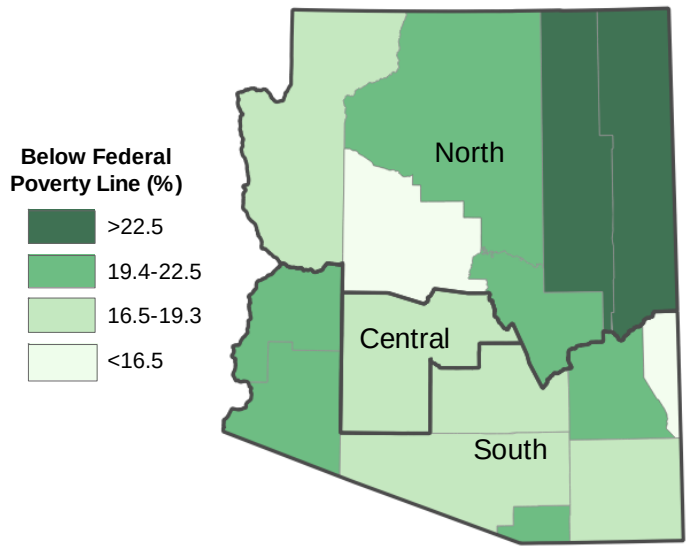


Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates

Poverty

In 2016, the poverty threshold for a family of four in Arizona was $24,300. Estimates from the 2012-2016 ACS indicate nearly 18% of Arizonans live below 100% of the federal poverty line, compared to 15% of the population nationally. The prevalence of poverty varies by Arizona county. Navajo and Apache counties report the highest percentage of residents living below 100% of the federal poverty line (36.2% and 29.9%, respectively). Greenlee and Yavapai counties have the fewest residents living below 100% of the federal poverty line (13.4% and 14.7%, respectively) (See Exhibit 7).

Exhibit 7. Percentage of Individuals Living Below 100% of the Federal Poverty Line by Arizona County, 5-Year Estimates from 2012-2016



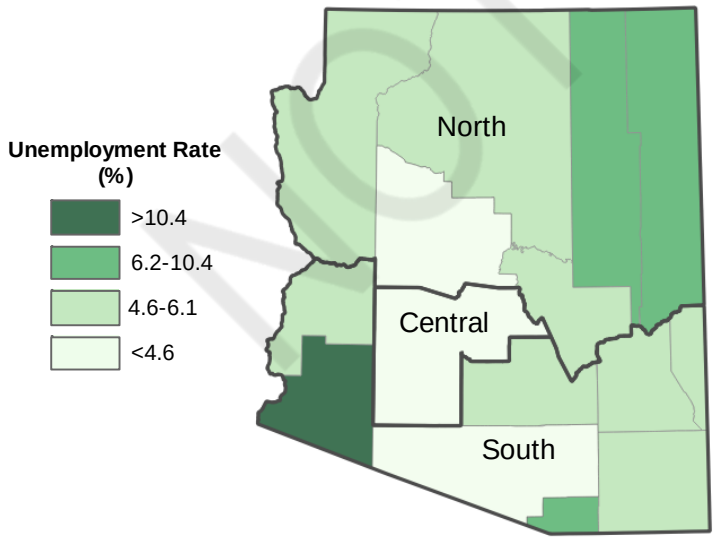
Rank	County	%
1	Apache	36.2
2	Navajo	29.9
3	Graham	22.5
4	Coconino	22.2
5	Santa Cruz	21.9
6	Gila	21.2
7	La Paz	21.1
8	Yuma	20.5
9	Mohave	19.3
10	Pima	19.1
11	Cochise	18.9
12	Maricopa	16.5
12	Pinal	16.5
14	Yavapai	14.7
15	Greenlee	13.4

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates

Unemployment

The Bureau of Labor Statistic's Community Population Survey (2018) estimated Arizona's seasonally adjusted unemployment rate to be 4.7 per 100 in May 2018, which is higher than the rate nationally (3.8). Annually, the highest unemployment rates in Arizona are reported in Yuma (17.0), Apache (10.4) and Santa Cruz (9.5) counties. The lowest unemployment rates are reported in Maricopa (4.2), Pima (4.5) and Yavapai (4.5) counties (See Exhibit 8).

Exhibit 8. Annual Average Unemployment Rate (%) by Arizona County, 2017



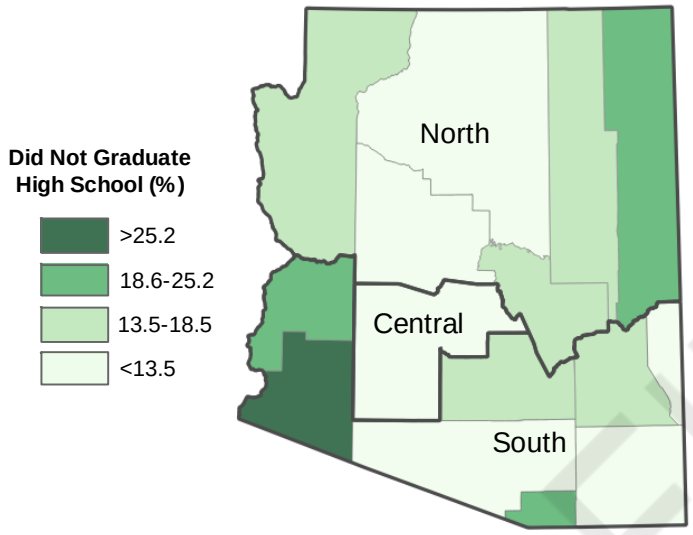
Rank	County	Rate
1	Yuma	17.0
2	Apache	10.4
3	Santa Cruz	9.5
4	Navajo	7.6
5	Gila	6.1
6	Mohave	5.9
7	Cochise	5.6
7	Coconino	5.6
9	Graham	5.4
9	La Paz	5.4
11	Greenlee	5.1
12	Pinal	5.0
13	Pima	4.5
13	Yavapai	4.5
15	Maricopa	4.2

Source: Bureau of Labor Statistics, Current Population Survey, 2017

High School Graduation Rate

High school graduation rates vary across Arizona Counties, with an estimated 13.8% of individuals 25 and older not graduating statewide, compared to 13.0% nationally. In Yuma County, an estimated 28.3% of residents 25 and older did not graduate from high school, while only 9.8% of Yavapai County residents did not graduate from high school (See Exhibit 9).

Exhibit 9. Percentage of Individuals 25 and Older who Did Not Graduate From High School by Arizona County, 5-Year Estimate 2012-2016



Rank	County	%
1	Yuma	28.3
2	Santa Cruz	25.2
3	La Paz	24.8
4	Apache	21.8
5	Navajo	18.5
6	Mohave	16.1
7	Gila	15.7
8	Pinal	15.1
9	Graham	14.6
10	Cochise	13.4
11	Maricopa	13.1
12	Pima	12.3
13	Greenlee	12.1
14	Coconino	11.1
15	Yavapai	9.8

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates

High Risk Counties: Summary

These data indicate that a subset of Arizona counties share a disproportionate amount of socioeconomic burden. Apache, Yuma, Santa Cruz, Navajo, La Paz, Graham and Coconino counties rank among the top five in the indicators of unemployment, poverty and low educational attainment. These counties also have among the highest proportion of racial/ethnic minorities. Specifically, Navajo and Apache counties have the highest proportion of American Indian/Alaska Native residents and Santa Cruz County has the highest proportion of Hispanic/Latino residents.

Findings

Substance Use

Secondary Data Analysis

Prevalence estimates of substance use in Arizona are based on pooled data from the National Survey of Drug Use and Health (NSDUH), with the most recent year of data sourced from 2016[3]. The NSDUH prevalence estimates are supplemented with data from the 2017 Youth Risk Behavior Survey (YRBS) and the 2016 Behavioral Risk Factor Surveillance System Survey (BRFSS). Specifically, YRBS data are used to investigate substance use patterns and disparities specific to high school youth and is stratified by race/ethnicity, sexual identity, gender and high school grade. BRFSS data are used to estimate adult disparities for alcohol and tobacco use.

Data permitting, the following estimates are presented for each indicator:

- prevalence by age group,
- prevalence overtime (e.g., annually since 2009),
- prevalence by RBHA or county, and
- disparities in prevalence by available sociodemographic indicators (e.g., gender, race/ethnicity, sexual identity, etc.)

Primary Substance Use Indicators:

The primary indicators of past month (i.e., current) substance use includes:

- any alcohol use,
- binge alcohol use (defined as drinking five or more drinks for males, or four or more drinks for females, on the same occasion on at least one day in the past 30 days),
- use of any tobacco products or cigarettes,
- marijuana use, and
- any illicit drug use (defined as use in the month before the survey for any of the following 10 drugs: marijuana, cocaine/crack, heroin, hallucinogens, inhalants, and methamphetamine, as well as the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives.)

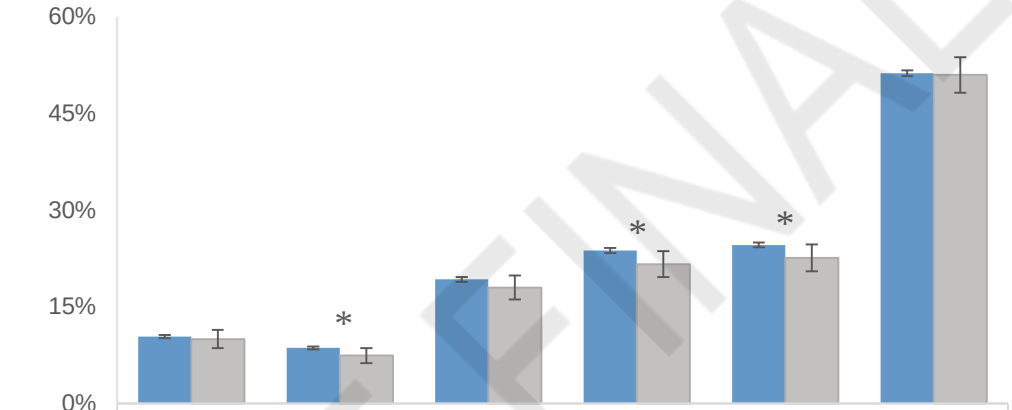
Exhibit 10 displays prevalence estimates of past month substance use in Arizona and the United States for the population aged 12 and older. The 95% Bayesian confidence interval for each estimate is indicated with error bars (SAMHSA, 2017). Data from the 2015-2016 NSDUH

[3] State-level prevalence estimates are based on two years of combined NSDUH data (2015,2016); estimates by RBHA are based on three years of combined NSDUH data (2014, 2015, 2016). NSDUH data are pooled in order to increase the precision of state and regional estimates, and to detect changes overtime more accurately given the small sample size (SAMHSA, 2017).

indicate that for the 12 and older population, alcohol was the most commonly used substance, both in Arizona and nationally.

Arizona's estimates were slightly lower than nationwide estimates for all indicators of past month use, but the differences were not statistically significant at p<.05. However, when the more lenient p-value threshold of p<.10 was used, prevalence estimates of past month marijuana, tobacco product, and binge alcohol use in Arizona were marginally lower than national estimate.

Exhibit 10. Prevalence of Past Month Substance Use Among those 12 and Older in the U.S. and Arizona, 2015-2016



	Any illicit drug use	Marijuana	Cigarette	Any Tobacco Product	Binge Alcohol Use	Any Alcohol Use
U.S.	10.4%	8.6%	19.2%	23.7%	24.6%	51.2%
Arizona	10.0%	7.4%	18.0%	21.6%	22.6%	50.9%

* Difference between the prevalence estimate for the total U.S. and Arizona is marginally significant at p<.10
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015-2016

Past Year Substance Use

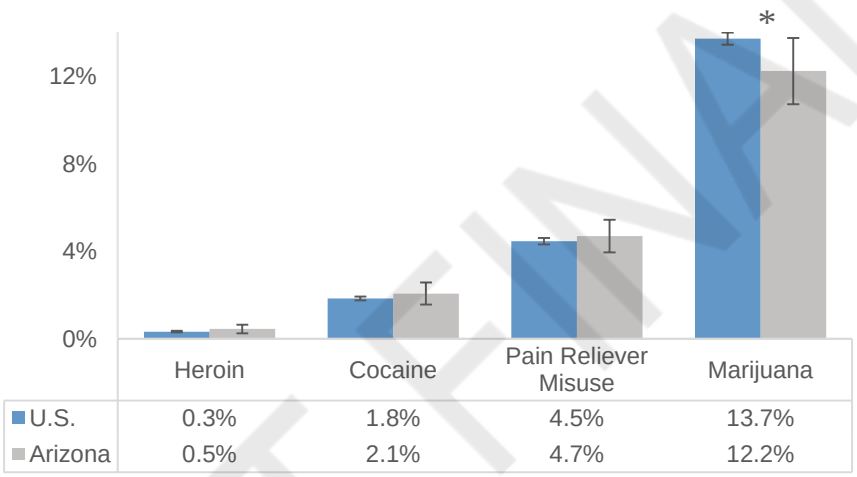
The NSDUH also collects data on past year substance use including:

- marijuana,
- heroin,
- cocaine, and
- pain reliever misuse, which includes misuse of opioid pain relievers such as hydrocodone (e.g., Vicodin®), oxycodone (e.g., OxyContin® and Percocet®), and morphine. This misuse is defined as "use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told to take a drug; or use in any other way not directed by a doctor.

Misuse of over-the-counter drugs is not included" (SAMHSA, 2017)

Nearly one in eight, or 12.2% of Arizonans reported marijuana use in the past year, while 1 in 200 reported past year heroin use (0.5%). Arizonans reported marginally less past year marijuana use than the total U.S. population (12.2% vs 13.7%, p=0.07), however Arizonans reported slightly higher rates of past year heroin, cocaine and pain reliever misuse than national estimates. None of these differences were statistically significant (See Exhibit 11).

Exhibit 11. Prevalence of Past Year Drug Use Among those 12 and Older in the U.S. and Arizona, 2015-2016



* Difference between the prevalence estimate for the total U.S. and Arizona is marginally significant at p<.10
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

More detailed information about each indicator of substance use is presented in the remaining section of this report.

Alcohol Use

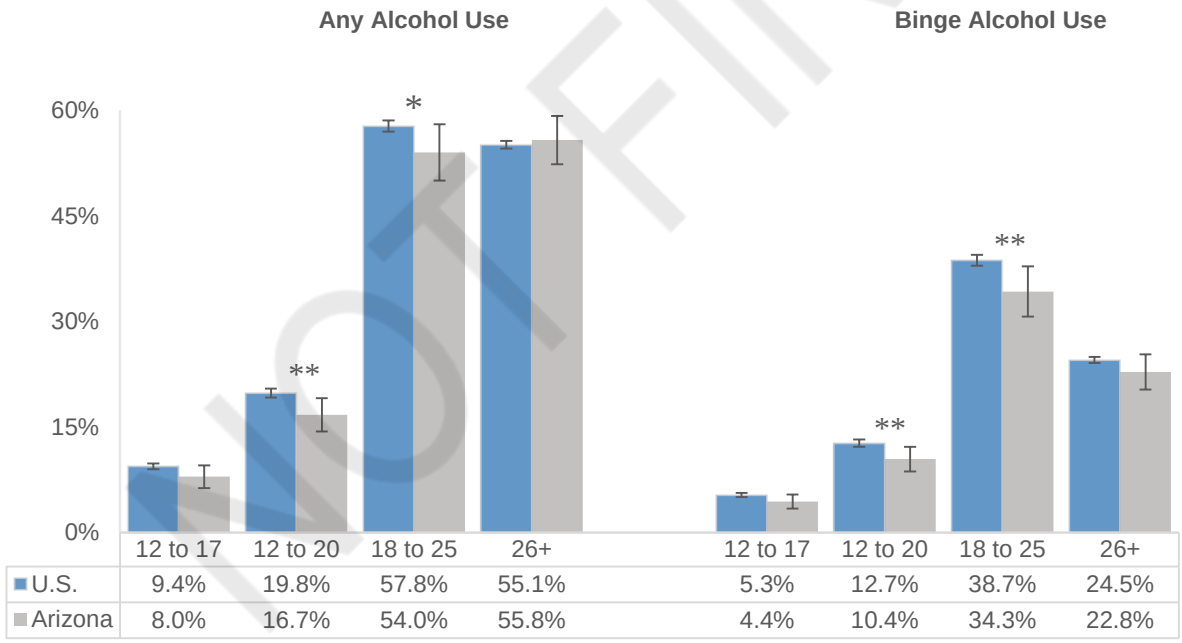
Alcohol is the most commonly used substance for youth and adults in Arizona. Data from the 2015-2016 NSDUH estimate that 2.90 million Arizonans, or 50.9% of the 12 or older population used any alcohol in the past month (i.e., qualified as current users). Nearly half of current alcohol users (44.3%) reported binge drinking, defined as drinking five or more drinks for males, or four or more drinks for females, on the same occasion on at least one day in the past 30 days (SAMHSA, 2017). This means that 1.29 million Arizonans, or 22.6% of the 12 or older population, met the criteria for current binge drinking. The prevalence of current alcohol use and binge drinking for Arizonans did not differ significantly from national estimates.

Youth Prevalence

NSDUH calculates underage drinking as alcohol use among those aged 12 to 20. Data from the 2015-2016 NSDUH indicate underage drinking was significantly lower in Arizona than nationally for both any alcohol use (16.7% vs 19.8%, p=0.021), and past month binge alcohol use (10.4% vs 12.7%, p=0.02; See Exhibit 12).

NSDUH data suggest youth 12 to 20 had lower rates of past month and binge alcohol use than youth nationally, though data from the 2017 YRBS indicates that the prevalence of binge drinking among high school students in Arizona was significantly *higher* than the national estimates (17.9% vs 13.2%, p=0.02). The estimate of any alcohol use was also higher for Arizona high school students based on YRBS data, although the difference was not significant as compared to national estimates at p<.05 (33.1% vs 29.8%, p=0.15).

Exhibit 12. Prevalence of Past Month Alcohol Use and Binge Alcohol Use by Age Group in the U.S. and Arizona, 2015-2016



	Any Alcohol Use				Binge Alcohol Use			
	12 to 17	12 to 20	18 to 25	26+	12 to 17	12 to 20	18 to 25	26+
U.S.	9.4%	19.8%	57.8%	55.1%	5.3%	12.7%	38.7%	24.5%
Arizona	8.0%	16.7%	54.0%	55.8%	4.4%	10.4%	34.3%	22.8%

Difference between the prevalence estimate for the total U.S. and Arizona is marginally significant at p<.10, or significant at p<.05**
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Adult Prevalence

Data from the 2015-2016 NSDUH estimates that approximately 2.86 million, or 55.5% of adults aged 18 or older in Arizona used any alcohol in the past month, and 1.26 million (24.5%)

reported past month binge drinking. Binge alcohol use peaked for those aged 18 to 25 (See Exhibit 12), tapering off for individuals over 25. Past month alcohol use in Arizona was marginally lower than national estimates for those 18 to 25 (54.0% vs 57.8, p=0.06). Binge alcohol use in Arizona was significantly lower than national estimates for those 18 to 25 (34.3% vs 38.7%, p=0.02).

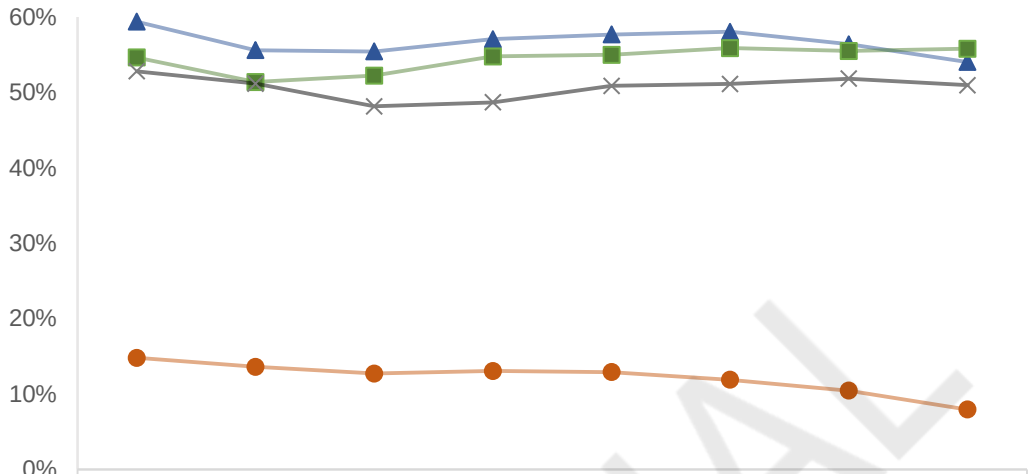
NSDUH data were not publicly available for finite age categories of adult alcohol use, however, the 2016 BRFSS showed that alcohol consumption for both binge drinking and current alcohol use peaked for those aged 25 to 44, and then declined with increasing age. Those 65 or older had the lowest prevalence of alcohol use. Please note, because of methodological differences between the two surveys, caution should be taken when directly comparing prevalence estimates from the NSDUH and BRFSS.

Youth Trends

Between 2008 and 2016, past month alcohol use in Arizona did not significantly change for the population overall (i.e., those aged 12 or older); however, there were significant decreases for youth. Arizona youth aged 12 to 17 reported substantial decreases in current alcohol use between 2008 and 2016, with the prevalence falling from 14.8% to 8.0% (p= <.001; See Exhibit 13). Drastic declines in current alcohol use were also reported between 2014 and 2016, falling from 10.5% to 8.0% (p=0.004). These data suggest current alcohol use among youth may have declined further in the last two years. National estimates of current alcohol use for youth 12 to 20 declined similarly over this time period.

Binge drinking data from the 2015-2016 NSDUH could not be compared with prior estimates because of a change in the definition of binge drinking for females from five to four drinks that occurred in 2015. However, data from 2008 to 2014 indicate the age trends for binge alcohol use mirrored the trends for past month alcohol use. Among those 12 to 17, past month binge alcohol use decreased from 8.8% in 2008 to 6.4% in 2014, although p-values were not available to assess statistical significance (See Exhibit 14).

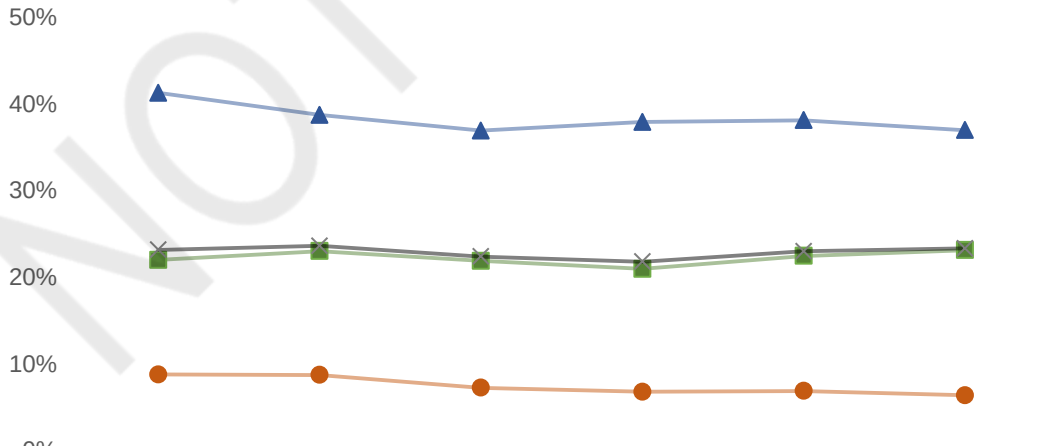
Exhibit 13. Trends in Prevalence of Past Month Alcohol Use in Arizona by Age Group, 2008-2016



	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
12 to 17	14.8%	13.6%	12.7%	13.1%	12.9%	11.9%	10.4%	8.0%
18 to 25	59.3%	55.6%	55.4%	57.1%	57.7%	58.0%	56.4%	54.0%
26 or older	54.6%	51.4%	52.2%	54.7%	55.0%	55.9%	55.5%	55.8%
12 or older	52.8%	51.2%	48.1%	48.7%	50.9%	51.1%	51.8%	50.9%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Exhibit 14. Trends in Prevalence of Past Month Binge Drinking in Arizona by Age Group, 2008-2014

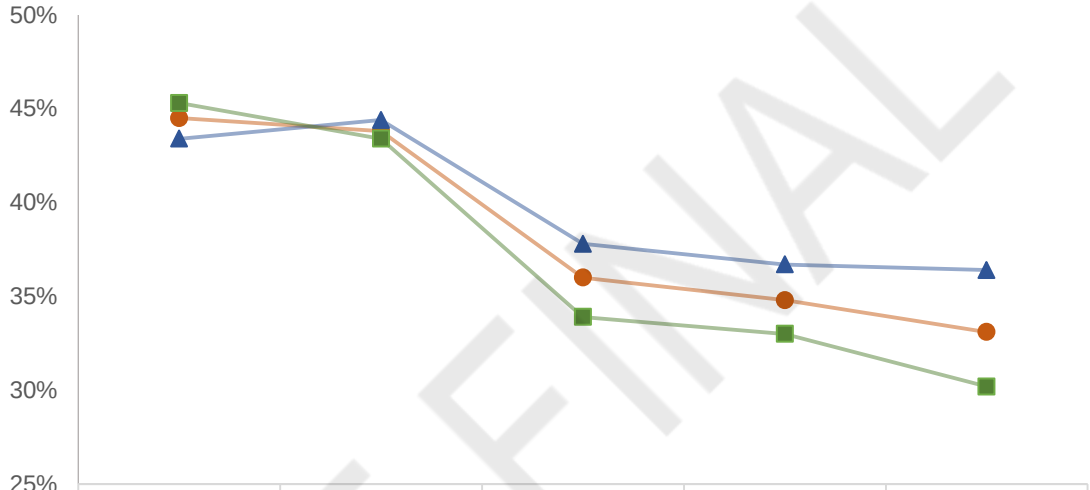


	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14
12 to 17	8.8%	8.7%	7.2%	6.8%	6.9%	6.4%
18 to 25	41.3%	38.7%	36.9%	37.9%	38.1%	37.0%
26 and older	22.0%	23.0%	21.9%	21.0%	22.5%	23.1%
12 or older	23.2%	23.6%	22.4%	21.8%	23.0%	23.3%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Data from the YRBS also show significant declines in current alcohol use among Arizona high school students between 2009 and 2017 (44.5% versus 33.1%, p<.001) (Exhibit 15). Although declines were significant for both males and females, males experienced a greater decrease than females (males: 45.3% vs 30.2%; p=<.001 | females: 43.4% vs 36.4%; p<0.02). Again, because of the change in the definition, trends could not be assessed for binge drinking.

Exhibit 15. Trends in Prevalence of Past Month Alcohol Use Among Arizona High School Students by Gender, 2009-2017



	2009	2011	2013	2015	2017
Total	44.5%	43.8%	36.0%	34.8%	33.1%
Females	43.4%	44.4%	37.8%	36.7%	36.4%
Males	45.3%	43.4%	33.9%	33.0%	30.2%

Source: CDC, High School Youth Risk Behavior Survey (YRBS), 2017

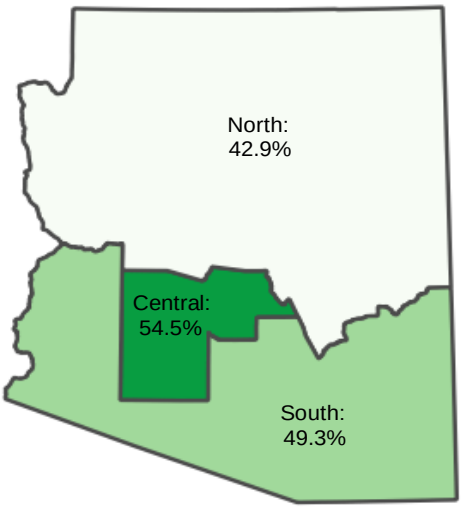
Adult Trends

There were also significant decreases in alcohol use for those aged 18 to 25, falling from 59.3% in 2008 to 54.0% in 2016 (p=0.045; See Exhibit 13). For those aged 18 to 25 binge alcohol use also decreased from 41.3% in 2008 to 37.0% in 2014, although p-values were not available to assess statistical significance (See Exhibit 14). There were no changes in the prevalence of past month alcohol use or binge alcohol use for those aged 26 or older.

Prevalence by RBHA

Exhibit 16. Prevalence of Any Alcohol Use in the Past Month Among those 12 and Older by Arizona's RBHA, 2014 - 2016

Combined NSDUH data from 2014, 2015 and 2016 demonstrate significant differences in alcohol use in the past month by Arizona's RBHA among those 12 and older (See Exhibit 16). The North Region had significantly less alcohol use than the Central (42.9% vs 54.5%; p<.001) or South Region (42.9% vs 49.3%, p=0.029). The South Region had moderate use, with significantly more alcohol use than the North Region and less alcohol use than the Central Region.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015-2016

Data were not available for binge alcohol use in the past month because of changes to the definition of this measure that occurred in 2015, however, the data on alcohol use disorder indicated that there were no significant regional differences in alcohol use disorder in the past year by Arizona RBHAs. These findings could suggest that those who drank any alcohol in the North Region were more likely to engage in high risk drinking behaviors than those who drank alcohol in the Central and South regions. This is also supported by data presented later in the report, which indicate that some of the highest rates of alcohol related morbidity and mortality are in counties in Arizona's Northern Region.

Youth Disparities

The 2017 YRBS data revealed important disparities in alcohol use among sub-populations of Arizona's high school students (9th-12th grades).

- Gender: Female high school students in Arizona were significantly more likely than males to report any past month alcohol use (36.4% vs 30.2%, p=0.04), and marginally more likely to report binge alcohol use in the past month (20.7% vs 15.4%, p=0.06). At the national level, female high school students were also slightly more likely than males to report both past month alcohol use (31.8% vs 27.6%, p<.001), and binge alcohol use (14.1% vs 12.8%, p=0.10). It is noteworthy that the gender differences were not as pronounced nationally, and females in Arizona were significantly more likely to report binge drinking than females nationally (20.7% vs 14.1%, p=0.02). Differences between male students in Arizona and nationally were not statistically significant.

- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual had a significant increased risk of any alcohol use in the past month (52.7% vs 30.8%, p<.001), and binge alcohol use in the past month (31.9% vs 16.5%, p<.001). Females identifying as gay, lesbian, or bisexual were

significantly more likely to report binge alcohol use than males (37.4% vs 21.6%, p=0.03).

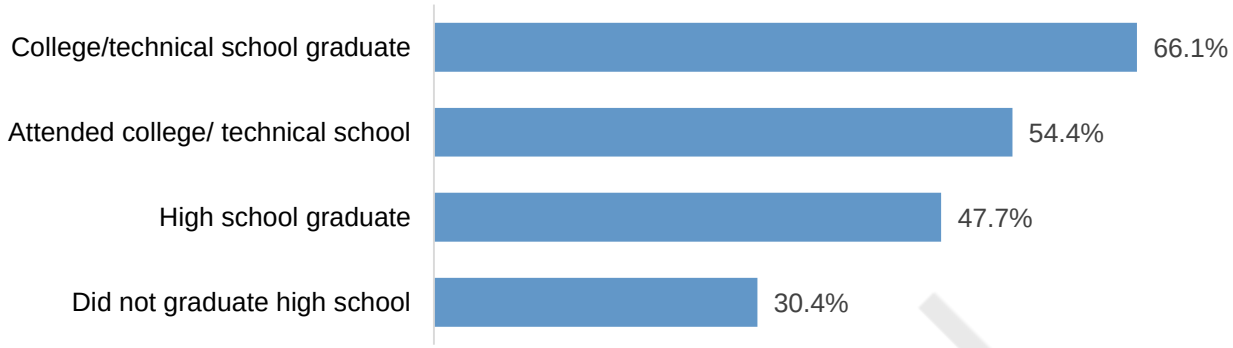
- Grade Level: Compared to 9th graders, 12th graders reported more alcohol use (21.3% vs 47.8%, p<.001), and binge alcohol use (11.6% vs. 25.7%, p=0.06).
- Race/Ethnicity: There were no significant differences in alcohol consumption indicators between non-Hispanic White and Hispanic high school students. Prevalence estimates for other racial and ethnic groups were not available for YRBS data.

Adult Disparities

The BRFSS 2016 highlights significant disparities in the prevalence of alcohol use among sub-populations of Arizona adults 18 or older.

- Gender: Although female high school students in Arizona reported significantly more alcohol use than their male peers, the gender risk profile for adults was reversed. Compared to female adults, male adults had a significantly higher prevalence of past month alcohol use (58.6% vs 45.7%, p<.001), and binge alcohol use (21.3% vs 10.1%, p<.001)
- Race/Ethnicity: Compared to other racial/ethnic groups, white non-Hispanics had the highest prevalence of past month alcohol use (58.1%), and Hispanics had amongst the lowest prevalence (42.4%, p<.001). There were no significant racial/ethnic differences in binge alcohol use.
- Educational Attainment: The prevalence of alcohol use differed significantly by educational attainment, with use increasing for each level of education (p<.001; See Exhibit 17). Those with a college or technical school degree had the highest prevalence of alcohol use (66.1%) and those who had not graduated high school had the lowest prevalence of alcohol use (30.4%). Binge alcohol use did not differ by educational attainment.
- Veterans: Veterans reported significantly more alcohol use in the past month than non-veterans (58.8% vs 51.0%, p=<.001), but did not have a significantly different prevalence of binge drinking (14.1% vs 15.8%, p=0.35)

Exhibit 17. Prevalence of Past Month Alcohol Use among Individuals 18 and Older by Educational Attainment, 2016



Source: The Centers for Disease Control, Behavior Risk Factor Surveillance System (BRFSS), 2016

Tobacco Use

According to data from the 2015-2016 NSDUH, 1.2 million Arizonans, or 21.6% of the population aged 12 or older reported using any tobacco product in the past month, and 1.0 million (18.0%) reported cigarette use. As such, the findings indicate that 83% of tobacco users in Arizona smoked cigarettes. The prevalence of tobacco product use in the past month in Arizona was marginally lower than the national prevalence (21.6% vs 23.7%, p=0.05). The estimate for cigarette use in Arizona was also slightly lower, but did not differ significantly from the national estimate (18.0% vs 19.2%, p=0.21).

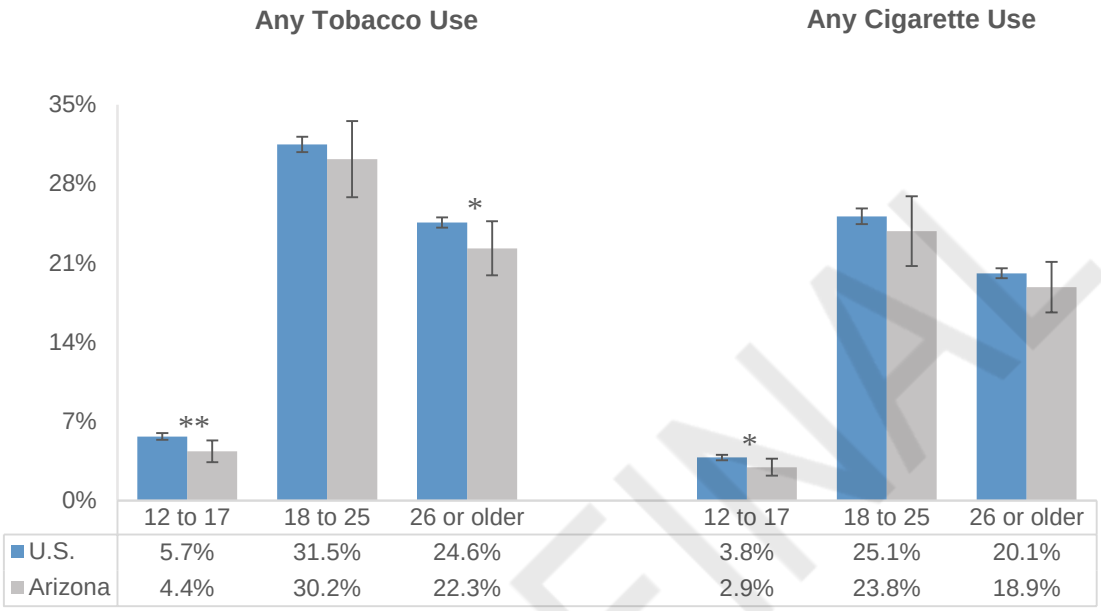
Youth Prevalence

Data from the 2015-2016 NSDUH estimated that 24,000 Arizona youth aged 12 to 17 actively used tobacco products, and 16,000 used cigarettes. Youth had the lowest prevalence of tobacco use of all age groups in Arizona (See Exhibit 18). Arizona youth reported significantly less tobacco use than youth nationally (4.4% vs 5.7%, p=0.026), and marginally less cigarette use than youth nationally (2.9% vs 3.8%, p=0.060). Only 69% of youth tobacco users in Arizona smoked cigarettes. YRBS data show no difference between Arizona high school students and national high school students use of cigarettes (AZ: 7.1% vs U.S.: 8.8%, p=0.21).

The NSDUH does not collect information on electronic vapor products, however, data from the 2017 YRBS indicated Arizona high school students were more likely to report that they had tried an electronic vapor product (including e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens) than youth nationally (51.0% vs 42.2%, p<.001). Current use of an electronic vapor product was also higher among Arizona's high school students than students nationally, but the differences were not significant (16.1% vs 13.2%, p=0.21). The full effects of e-cigarette use on adolescent health are still being researched, although the Office of the U.S. Surgeon General (2018) warns risks may include addiction, increased risk of other

tobacco use products, and negative effects on respiratory health and brain development.

Exhibit 18. Prevalence of Past Month Tobacco and Cigarette Use by Age Group in the U.S. and Arizona, 2015-2016



	Any Tobacco Use			Any Cigarette Use		
	12 to 17	18 to 25	26 or older	12 to 17	18 to 25	26 or older
U.S.	5.7%	31.5%	24.6%	3.8%	25.1%	20.1%
Arizona	4.4%	30.2%	22.3%	2.9%	23.8%	18.9%

Difference between the prevalence estimate for the total U.S. and Arizona is marginally significant at p<.10, or significant at p<.05**
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Adult Prevalence

NSDUH data from 2015-2016 estimated that approximately 1.2 million (23.4%) of adults aged 18 or older used tobacco products in Arizona, and 1.0 million (19.6%) smoked cigarettes (See Exhibit 18). The prevalence of tobacco and cigarette use in Arizona did not differ significantly from national estimates for individuals aged 18 to 25, but those over 25 reported marginally less tobacco use in Arizona (22.3% vs 24.6%, p=0.074).

NSDUH data were not available for finite age categories of adult tobacco use, but these data were provided by the 2016 BRFSS. Those data estimated that the prevalence of current smoking among adults in Arizona was lowest for young adults aged 18 to 24 and adults older than 65, with usage peaking for middle aged adults. Because of methodological differences between the two surveys, caution should be taken when directly comparing prevalence estimates from the NSDUH and BRFSS, although general trends should be comparable.

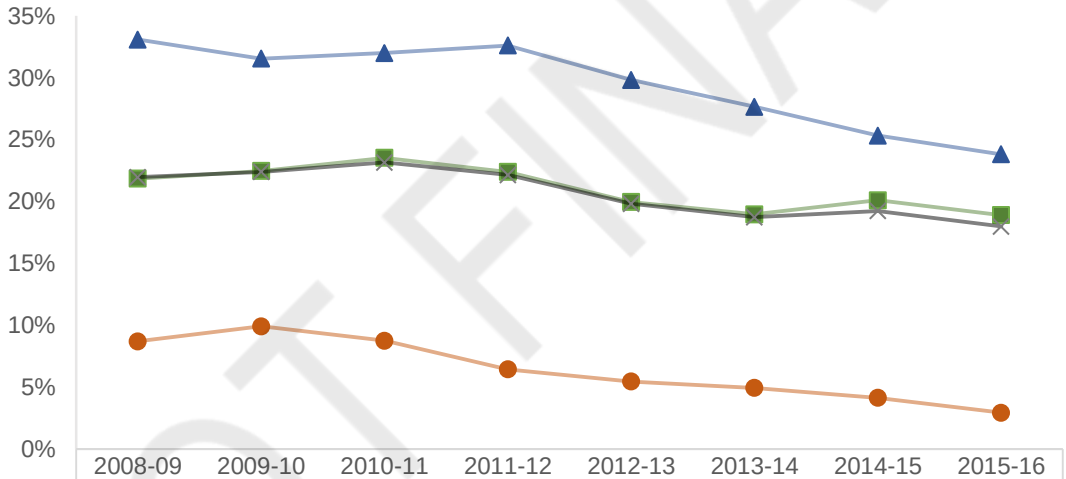
BRFSS 2016 data also show a significant inverse relationship between increasing age and active e-cigarette use, such that the prevalence of e-cigarette use decreased with each age group over 25. Most notably, the prevalence of e-cigarette use was 8.5% for those aged 18 to 24, but only

1.1% of those 65 or older (p<.001).

Youth Trends

NSDUH data indicate that past month tobacco use in Arizona for those 12 or older declined significantly between 2008 and 2016 (25.7% vs 21.6%, p=0.006), and past month cigarette use also declined (21.9% vs 18.0%, p=0.003; See Exhibit 19). Youth aged 12 to 17 had the most pronounced declines between 2008 and 2016 for tobacco use (10.2% vs 4.4%, p<.001) and past month cigarette use (8.7% vs 2.9%, p<.001). YRBS data also indicate significant declines in cigarette and tobacco use among Arizona high school students between 2009 and 2017 for the following survey questions: "ever tried cigarette smoking" (53.6% versus 29.9%, p<.001), and "currently smoked cigarettes" (19.7% versus 7.1%, p<.001).

Exhibit 19. Trends in the Prevalence of Past Month Cigarette Use in Arizona by Age Group, 2008-2016



	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
12 to 17	8.7%	9.9%	8.8%	6.4%	5.5%	4.9%	4.1%	2.9%
18 to 25	33.1%	31.5%	32.0%	32.6%	29.8%	27.6%	25.3%	23.8%
26 or older	21.8%	22.5%	23.5%	22.4%	20.0%	19.0%	20.1%	18.9%
12 or older	22.0%	22.4%	23.2%	22.1%	19.8%	18.7%	19.2%	18.0%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

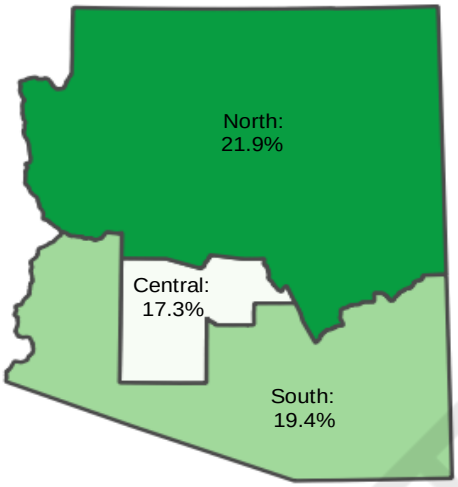
These declines in youth cigarette use should be contextualized by additional findings that approximately 16% of Arizona high school students reported that they currently used an electronic vapor product (YRBS, 2017). Data from the National Youth Tobacco Survey show the prevalence of e-cigarette use has increased significantly for adolescents across the U.S., and that e-cigarette use is higher among high school students than adults. Data on e-cigarette use in Arizona were first collected by the YRBS in 2015 making it difficult to assess trends, however preliminary indications suggest lifetime use of e-cigarettes did not change significantly from 2015 to 2017 among Arizona high school students (51.6% vs. 51.0%, p=0.84), but there were

significant declines in overall active e-cigarette use between 2015 and 2017 (27.5% versus 16.1%, p<.001). Trends in e-cigarette use should be assessed as more data are made available.

Adult Trends

NSDUH data also indicate significant decreases in tobacco use for those aged 18 to 25 from 2008 to 2016. Specifically, the prevalence of any tobacco use fell from 39.8% to 30.2%, (p<.001), and cigarette use fell from 21.8% to 18.9% (p=0.045; See Exhibit 19). There were only marginally significant changes in the prevalence of tobacco and cigarette use in the past month for those aged 26 or older.

Exhibit 20. Prevalence of Past Month Cigarette Use Among those 12 and Older by Arizona's RBHA, 2014 - 2016



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014- 2016

Prevalence by RBHA

Combined data from 2014, 2015 and 2016 NSDUH demonstrate substantial differences in tobacco and cigarette use in the past month by RBHA (See Exhibit 20). The North Region had significantly more past month tobacco use than the Central Region (26.5% vs 21.1%, p=0.011). The North Region also had significantly more past month cigarette use than the Central Region (21.9% vs 17.3%, p=0.027).

Youth Disparities

The 2017 YRBS data reveal important disparities in tobacco use among sub-populations of Arizona's high school students.

- Gender: Male high school students in Arizona were significantly more likely to use smokeless tobacco than females (6.9% vs 2.1%, p=<.001), and were more likely to report current use of an electronic vapor product (18.9% vs 13.1%, p=0.04). There were no other significant differences observed by gender.
- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual had a significant increased risk of having ever tried a cigarette (50.4% vs 26.9%, p<.001), of smoking in the past 30 days (19.4% vs 5.4%, p<.001), of having ever tried an electronic vapor product (64.4% vs 49.6%, p<.001), and of currently using an electronic cigarette (30.8% vs 14.3%, p<.001).
- Grade Level: Compared to 9th graders, 12th graders reported more current cigarette use (5.1% vs 10.9%, p<.001). Current electronic vapor products use also increased but was not statistically significant (14.4% vs. 22.3%, p=0.25).
- Race/Ethnicity: There were no significant differences in cigarette or tobacco use between non-Hispanic White and Hispanic high school students. However, non-Hispanic white

students reported significantly more current electronic vapor product use (21.7% vs 13.2%, p=0.042). Estimates for other racial and ethnic groups were not available.

Adult Disparities

The BRFSS 2016 highlighted significant sociodemographic disparities in the prevalence of cigarette use in Arizona among those 18 or older.

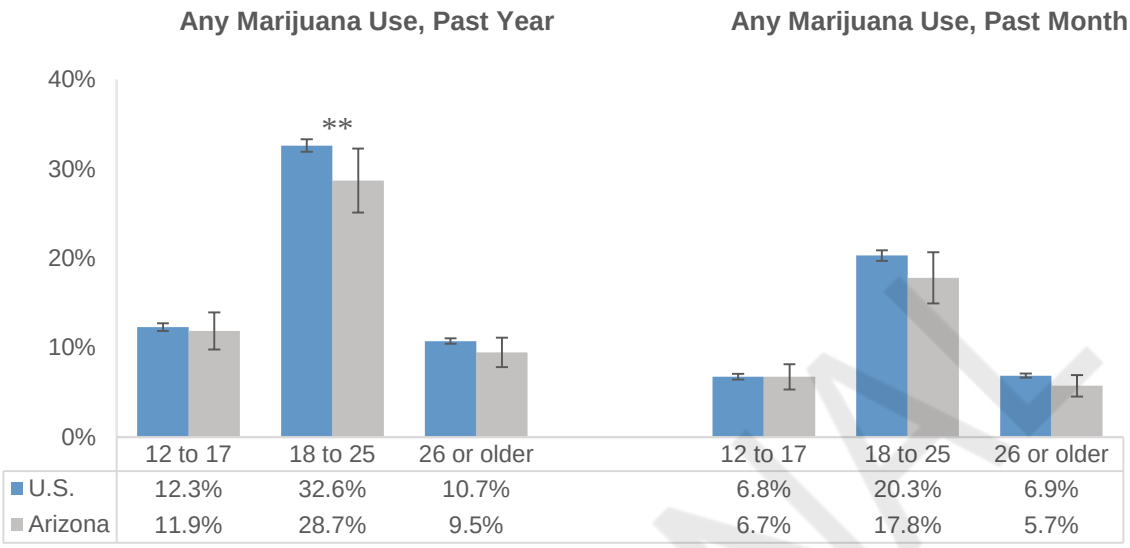
- Gender: Compared to female adults, male adults in Arizona had a significantly higher prevalence of current cigarette use (17.5% vs 12.1%, p<.001).
- Race/Ethnicity: Compared to other racial/ethnic groups, those identifying as multiracial had the highest prevalence of current cigarette use (29.8%), and Hispanics had the lowest prevalence of cigarette use (11.4%).
- Educational Attainment: Findings indicate the prevalence of cigarette use had a broadly inverse relationship with educational attainment. Those with a college or technical school degree had the lowest prevalence of cigarette use (6.7%). Those who had not graduated high school had the highest prevalence of cigarette use (20.2%).
- Veterans: Veterans reported significantly more current cigarette use in the past month than non-veterans (17.6% vs 14.2%, p=0.05).

Marijuana Use

According to data from the 2015-2016 NSDUH, 696,000 (12.2%) of Arizonans aged 12 or older used marijuana in the past year, and 422,000 (7.4%) reported past month marijuana use (See Exhibit 21). These estimates were marginally less than the national estimates of marijuana use (13.8% vs 12.2%, p=0.072).

Approximately 64,000 Arizonans 12 or older reported using marijuana for the first time in the 24 months leading up to the 2016 NSDUH. Of these 64,000 new users, approximately 39% were aged 12 to 17, 42% were aged 18 to 25, and 19% were older than 25. The percentage of recent marijuana initiates (overall and by age category) did not differ significantly between Arizona, the total U.S., or across Arizona's RBHAs. Although NSDUH collects initiation data for other drugs, these data were not included in the state level reports available from SAMHSA.

Exhibit 21. Prevalence of Past Year and Past Month Marijuana Use by Age Group for the U.S. and Arizona, 2015-2016



	12 to 17	18 to 25	26 or older	12 to 17	18 to 25	26 or older
U.S.	12.3%	32.6%	10.7%	6.8%	20.3%	6.9%
Arizona	11.9%	28.7%	9.5%	6.7%	17.8%	5.7%

** Difference between the prevalence estimate for the total U.S. and Arizona is significant at p<.05
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Youth Prevalence

Data from the 2015-2016 NSDUH estimated 65,000 (11.9%) of Arizona youth aged 12 to 17 used marijuana in the past year, and 37,000 (6.8%) used marijuana in the past month (See Exhibit 21). Data from the 2017 YRBS estimated that nearly one in five (19.5%) Arizona high school students used marijuana in the past month. None of the prevalence estimates for Arizona youth differed significantly from national estimates.

Adult Prevalence

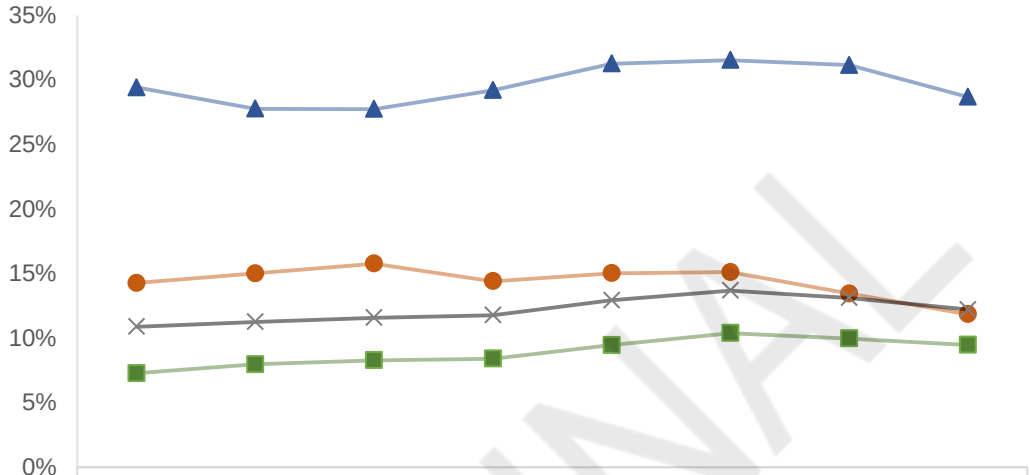
In Arizona, as nationally, the prevalence of past year and past month marijuana use peaked for those aged 18 to 25 (See Exhibit 21). Compared to young adults nationally, Arizonans aged 18 to 25 reported significantly less marijuana use in the past year (28.7% vs 32.6%, p=0.041), and less past month use (17.8% vs 20.3%, p=0.116), although past month use was not statistically significant. Estimates for older Arizonans 26 and over did not differ significantly from national estimates. Data were not available for more finite age categories.

Youth Trends

Data from the 2015-2016 NSDUH indicated marijuana use for those aged 12 or older increased slightly in the U.S. between 2008 and 2016 but the changes were not significant for either past year marijuana use (10.9% to 12.2%, p=0.147; See Exhibit 22), or past month marijuana use (6.7% to 7.4%, p=0.347). There were also no significant changes in past month or past year marijuana

use for youth aged 12 to 17 between 2008 and 2016. The YRBS similarly showed no significant changes in marijuana use for Arizona high school students between 2009 and 2017.

Exhibit 22. Trends in Prevalence of Past Year Marijuana Use in Arizona by Age Group, 2008-2016



	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
12 to 17	14.3%	15.0%	15.8%	14.4%	15.0%	15.1%	13.5%	11.9%
18 to 25	29.4%	27.8%	27.7%	29.2%	31.3%	31.5%	31.2%	28.7%
26 or older	7.3%	8.0%	8.3%	8.4%	9.5%	10.4%	10.0%	9.5%
12 or older	10.9%	11.3%	11.6%	11.8%	12.9%	13.7%	13.1%	12.2%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Adult Trends

No significant changes in past month or past year marijuana use were detected for young adults aged 18 to 25 between 2008 and 2016 (See Exhibit 22). However, there were significant increases in prevalence of past year marijuana use between 2008 and 2016 for adults aged 26 or older (7.3% to 9.5%, p=0.035). Increases in past month marijuana use were not significant for this age group. Nationally, past year and past month marijuana use increased significantly for adults 18 to 25 and 26 or older.

Prevalence by RBHA

Data from 2014, 2015, and 2016 NSDUH indicated that there were no significant differences in marijuana use in the past year, or past month, by RBHA in Arizona.

Youth Disparities

Disparities in high school marijuana consumption in Arizona were investigated by gender, sexual identity, grade level, and race/ethnicity using data from the 2017 YRBS. Significant differences were only detected for estimates by sexual identify. Specifically, the prevalence of past month marijuana use among gay, lesbian or bisexual students in Arizona was more than

twice the prevalence for heterosexual students (37.7% vs 17.2%, p<.001).

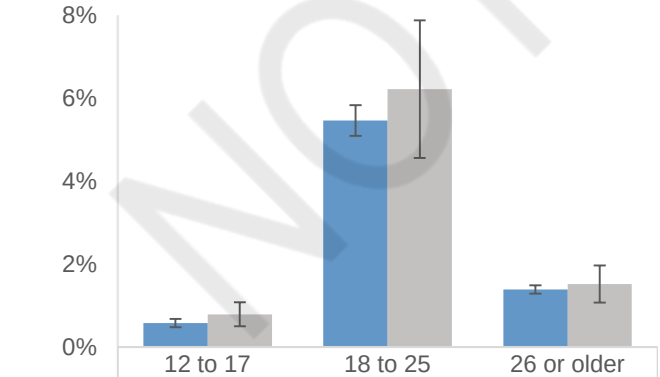
Adult Disparities:
No data were available to estimate disparities in marijuana use in Arizona for adult populations. Understanding what disparities may exist in adult marijuana usage should be considered as an important initiative moving forward to inform prevention priorities.

Cocaine Use

Data from 2015-2016 NSDUH estimated 118,000 (2.1%) of Arizonans 12 or older used cocaine, including crack cocaine, in the past year (See Exhibit 23). Although the estimate for past year cocaine use among those 12 or older was higher in Arizona than nationally, the difference was not statistically significant (2.1% versus 1.8%, p=0.454).

Youth Prevalence
Data from the 2015-2016 NSDUH estimated that fewer than 1% of Arizona youth aged 12 to 17 used cocaine in the past year (0.8%), which corresponds to approximately 4,000 youth across the State. Past year data were not collected by the YRBS, however, in 2017 a survey question was included pertaining to lifetime cocaine use. According to these data approximately 5.6% of Arizona high school youth reported ever using cocaine. None of the youth prevalence estimates differed significantly from national estimates.

Exhibit 23. Prevalence of Past Year Cocaine Use by Age Group for the U.S. and Arizona, 2015-2016



	12 to 17	18 to 25	26 or older
U.S.	0.6%	5.5%	1.4%
Arizona	0.8%	6.2%	1.5%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015-2016

Adult Prevalence
Data from the 2015-2016 NSDUH estimated that 113,000 (2.2%) of Arizona adults 18 or older used cocaine in the past year. Prevalence of cocaine use is over four times higher for young adults aged 18 to 25 than adults 26 or older (6.2% versus 1.5%). Adult estimates in Arizona did not differ significantly from national estimates.

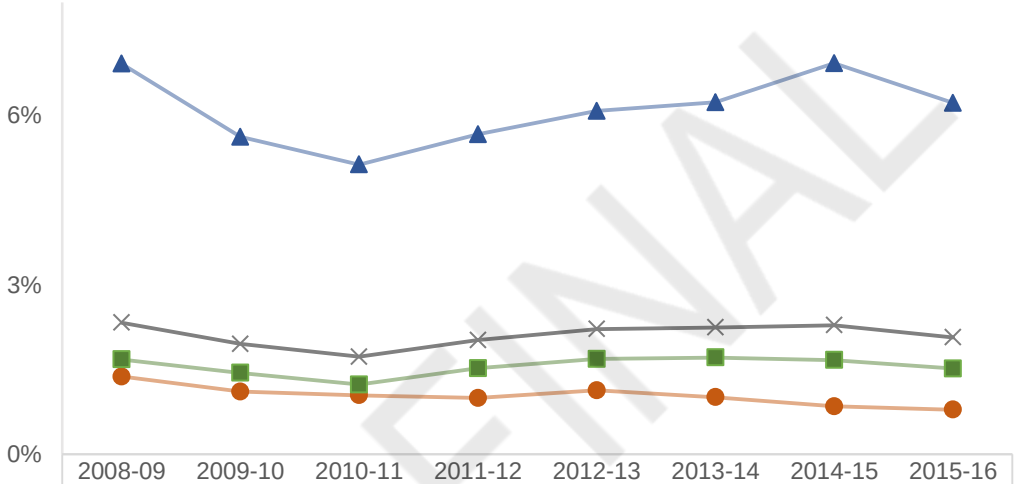
Youth Trends
Between 2008 and 2016, past year cocaine use for those aged 12 or older declined significantly in the U.S. (2.01% versus 1.84%, p=0.003), but did not change in Arizona (2.3% versus 2.1%, p=0.278) (See Exhibit 24). However, in Arizona there were significant declines in past year cocaine use for youth aged 12 to 17 between 2008 and 2016 (1.4% versus

0.8%, p=0.037). Data from the YRBS also indicated significant declines in "ever using cocaine" among Arizona high school students from 2009 to 2017 (11.5% versus 5.6%, p<0.001).

Adult Trends

There have been no significant declines in past year cocaine use among adults in Arizona. Nationally, prevalence rates remained unchanged among adults as well.

Exhibit 24. Trends in Prevalence of Past Year Cocaine Use in Arizona by Age Group, 2008-2016



	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
12 to 17	1.4%	1.1%	1.0%	1.0%	1.1%	1.0%	0.8%	0.8%
18 to 25	6.9%	5.6%	5.1%	5.7%	6.1%	6.2%	6.9%	6.2%
26 or older	1.7%	1.4%	1.2%	1.5%	1.7%	1.7%	1.7%	1.52%
12 or older	2.3%	2.0%	1.7%	2.0%	2.2%	2.2%	2.3%	2.1%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Prevalence by RBHA

Data from the 2014, 2015 and 2016 NSDUH found no significant differences in past year cocaine use between the State's RBHAs at the p<.05 level.

Youth Disparities

Disparities in "ever using cocaine" among high school students in Arizona were investigated by gender, sexual identity, grade level, and race/ethnicity using data from the 2017 YRBS. Significant differences were only detected by race/ethnicity. Specifically, the prevalence of lifetime cocaine use among Hispanic students in Arizona was higher than the prevalence for non-Hispanic white students (8.0% vs 3.8%, p=0.01). Estimates for other racial and ethnic groups were not available.

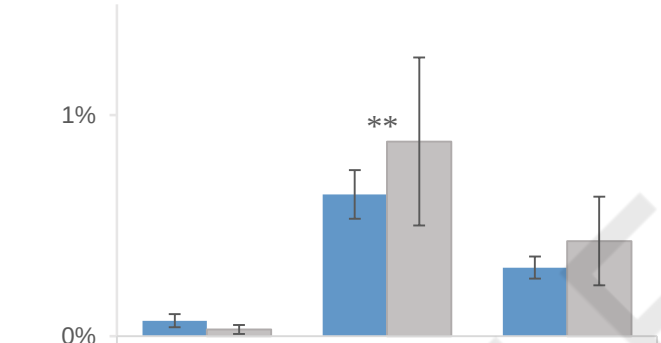
Adult Disparities

No data were available to estimate disparities in cocaine use in Arizona for adult populations. Understanding what disparities may exist in adult cocaine usage should be considered as an important initiative moving forward to inform prevention priorities.

Heroin Use

Data from the 2015-2016 NSDUH estimated 26,000 Arizonans 12 or older used heroin in the past year. This corresponds to a prevalence of less than half a percent (0.45%). Overall, the prevalence of heroin use in Arizona did not differ from national estimates.

Exhibit 25. Prevalence of Past Year Heroin Use by Age Group in the U.S. and Arizona, 2015-2016



	12 to 17	18 to 25	26 or older
U.S.	0.07%	0.64%	0.31%
Arizona	0.03%	0.88%	0.43%

U.S. and Arizona is marginally significant at p<.05
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Youth Prevalence

Youth aged 12 to 17 in Arizona had significantly lower rates of heroin use than youth nationally (0.03% versus 0.07%, p=0.026) (See Exhibit 25). Data from the 2017 YRBS indicated that 1.9% of Arizona high school students ever used heroin, compared to 1.7% nationally (p=0.76).

Adult Prevalence

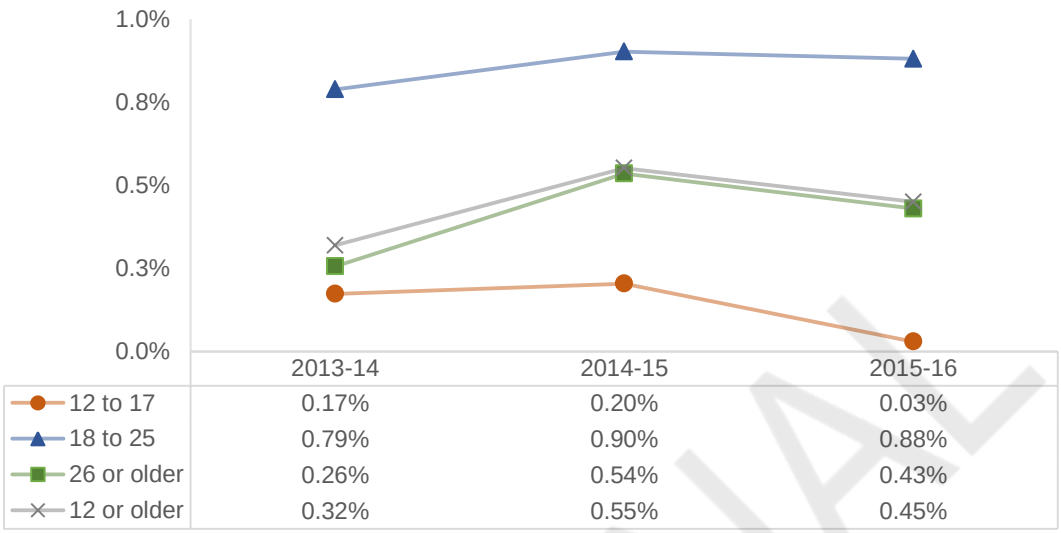
The prevalence of past year heroin use peaked for those 18 to 25 (0.88%), declining to 0.43% for those older than 25. The prevalence of heroin use among adults did not differ from national estimates.

Youth Trends

Data prior to 2013 were not available for heroin use in Arizona. Between 2014 and 2016 there were no significant changes in heroin use among those 12 and older, either nationally or in Arizona, but there were significant declines in the prevalence of heroin use for youth aged 12 to 17 (0.20% vs 0.03%, p=0.006) (See Exhibit 26). Data were not available to estimate the significance of changes between 2013 and 2016. Significant changes were not detected for youth nationally during this time.

Data from the YRBS comparing lifetime heroin use among Arizona high school students between 2009 and 2017 detected marginally significant declines (3.5% vs 1.9%, p=0.07).

Exhibit 26. Trends in the Prevalence of Past Year Heroin Use in Arizona by Age Group, 2013-2016



	2013-14	2014-15	2015-16
12 to 17	0.17%	0.20%	0.03%
18 to 25	0.79%	0.90%	0.88%
26 or older	0.26%	0.54%	0.43%
12 or older	0.32%	0.55%	0.45%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Adult Trends

Between 2013 and 2016 there were no significant declines in heroin use among Arizona adults. This lack of substantial change was also observed at the national-level.

Prevalence by RBHA

Data from the 2014, 2015 and 2016 NSDUH found no significant differences in heroin use by RBHA.

Youth Disparities

Disparities in "ever using heroin" among high school students in Arizona were investigated by gender, sexual identity, grade level, and race/ethnicity using data from the 2017 YRBS. Differences were detected by gender and sexual identity.

- Gender: Male high school students in Arizona were marginally more likely to report that they ever used heroin than females (2.6% vs 1.2%, p=0.05).
- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as lesbian, gay or bisexual were more likely to report that they had ever used heroin, although the difference was only marginally significant (0.9 vs 6.9; p=0.06). Most of the difference is due to the much higher prevalence of lifetime heroin use among gay and bisexual males. In fact, more than one in six (17.8%) male high school students in Arizona identifying as gay or bisexual reported that they had tried heroin in their lifetime. Males identifying as gay or bisexual were significantly more likely to report that they had ever used heroin when compared to females identifying as

lesbian, gay or bisexual (1.7% vs 17.8%, p=0.01), or heterosexual males (1.2 vs 17.8%, p=0.02).

Adult Disparities

No data were available to estimate disparities in heroin use in Arizona for adult populations. Understanding what disparities may exist in adult heroin usage should be considered as an important initiative moving forward to inform prevention priorities.

Pain Reliever Misuse

NSDUH defines pain reliever misuse as "use in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told to take a drug; or use in any other way not directed by a doctor. Misuse of over-the-counter drugs is not included" (SAMHSA, 2017). NSDUH asks specifically about the misuse of opioid pain relievers such as hydrocodone (e.g., Vicodin®), oxycodone (e.g., OxyContin® and Percocet®), and morphine, although respondents may specify that they misused other non-opioid pain relievers. Data reports from the 2015-2016 NSDUH estimated 267,000 (4.7%) of Arizonans 12 or older misused pain relievers in the past year. The prevalence estimates for Arizona, overall and by age group, did not differ from national estimates for pain reliever misuse.

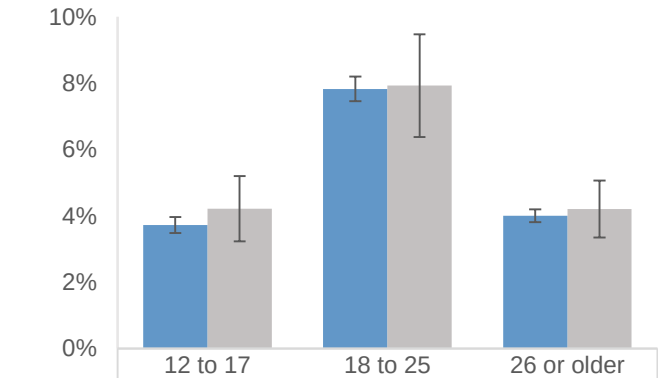
Youth Prevalence

The 2015-2016 NSDUH estimated that 23,000 (4.2%) youth aged 12 to 17 misused prescription pain relievers in the past year (See Exhibit 27). The 2017 YRBS also asked about prescription pain reliever misuse among high school students, however, the measure was slightly different from NSDUH's metric. YRBS measured if respondents ever took prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin®, OxyContin®, hydrocodone, and Percocet®, one or more times during their life). Based on this measure, approximately 15.4% of Arizona high school students reported ever misusing pain relievers.

Adult Prevalence

According to data from the 2015-2016 NSDUH, an estimated 244,000 (4.7%) Arizonans 18 or older misused prescription pain relievers in the past year. The prevalence of prescription pain reliever misuse use in Arizona was greatest for young adults, aged 18 to 25 (7.9%; See Exhibit 27). Arizona's estimates did not differ from national estimates.

Exhibit 27. Prevalence of Past Year Pain Reliever Misuse by Age Group for the U.S. and Arizona, 2015-2016



	12 to 17	18 to 25	26 or older
U.S.	3.72%	7.82%	4.00%
Arizona	4.21%	7.92%	4.20%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Trends

NSDUH redesigned their questionnaire in 2015, creating a new baseline for pain reliever misuse. As a result, trend data are not presented for this outcome.

Prevalence by RBHA

Data were not available to estimate pain reliever misuse by RBHA.

Youth Disparities:

Disparities in high school pain reliever misuse in Arizona were investigated by gender, sexual identity, grade level, and race/ethnicity using data from the 2017 YRBS. Significant differences were only detected for estimates by sexual identify. Specifically, the prevalence of lifetime pain reliever misuse among gay, lesbian or bisexual students in Arizona was more than twice the prevalence for heterosexual students (30.7% vs 13.3%, p<.001).

Adult Disparities:

No data were available to estimate disparities in pain reliever use in Arizona for adult populations. Understanding what disparities may exist in adult pain reliever usage should be considered as an important initiative moving forward to inform prevention priorities.

Past Month Illicit Drug Use

The NSDUH defined current illicit drug use as drug use in the month before the survey for any of the following 10 drugs: marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, and methamphetamine, as well as the misuse of prescription pain relievers, tranquilizers, stimulants, and sedatives. An estimated one in 10 Arizonans aged 12 or older reported current use of illicit drugs. This corresponds to approximately 568,000 Arizonans. The majority of illicit

drug use was marijuana use, with only 4% of Arizonans 12 or older (223,000) reporting illicit drug use other than marijuana.

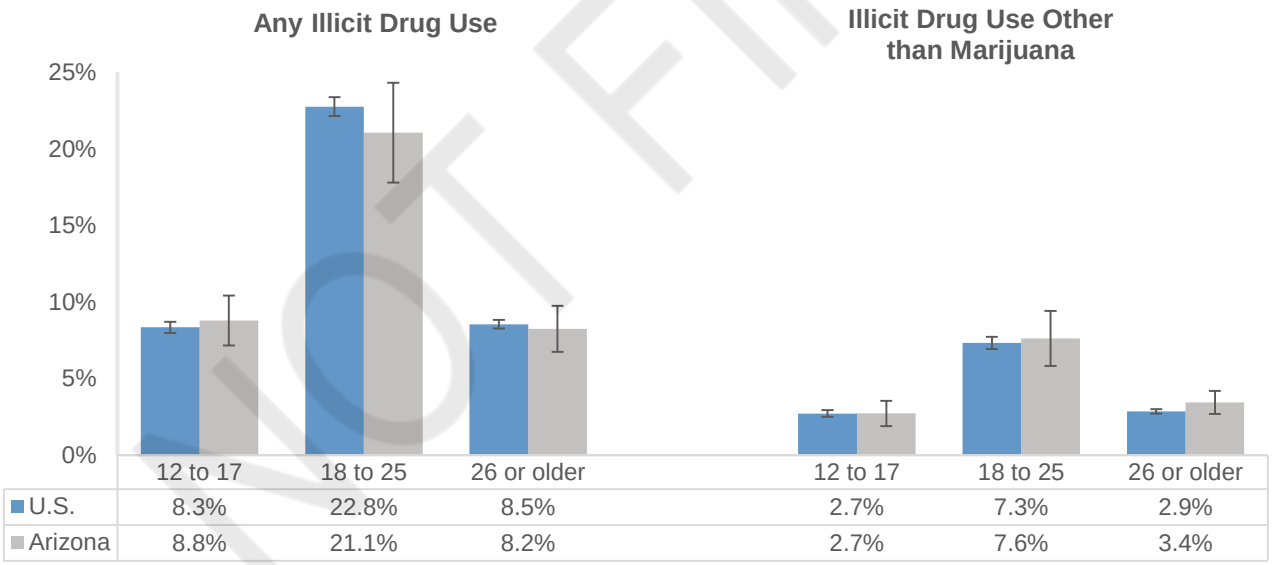
Youth Prevalence

In 2015-2016, an estimated 48,000 (8.8%) of Arizona youth aged 12 to 17 reported current illicit drug use, and 15,000 (2.7%) used illicit drugs other than marijuana (See Exhibit 28). Arizona prevalence estimates did not differ from national estimates.

Adult Prevalence

In 2015-2016, an estimated 520,000 (10.1%) of Arizona adults 18 or older were current illicit drug users, and 208,000 (4.1%) used illicit drugs other than marijuana. The prevalence of current illicit drug use peaked for those aged 18 to 25 (21.1%). Arizona's estimates of illicit drug use did not differ significantly from national estimates.

Exhibit 28. Prevalence of Past Month Illicit Drug Use and Illicit Drug Use Other than Marijuana by Age Group for the U.S. and Arizona, 2015-2016



	Any Illicit Drug Use			Illicit Drug Use Other than Marijuana		
	12 to 17	18 to 25	26 or older	12 to 17	18 to 25	26 or older
U.S.	8.3%	22.8%	8.5%	2.7%	7.3%	2.9%
Arizona	8.8%	21.1%	8.2%	2.7%	7.6%	3.4%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Trends

NSDUH redesigned their questionnaire in 2015, creating a new baseline for past month illicit drug use. As a result, trend data are not presented for this outcome.

Prevalence by RBHA

Data were not available to estimate past month illicit drug use by RBHA.

Disparities

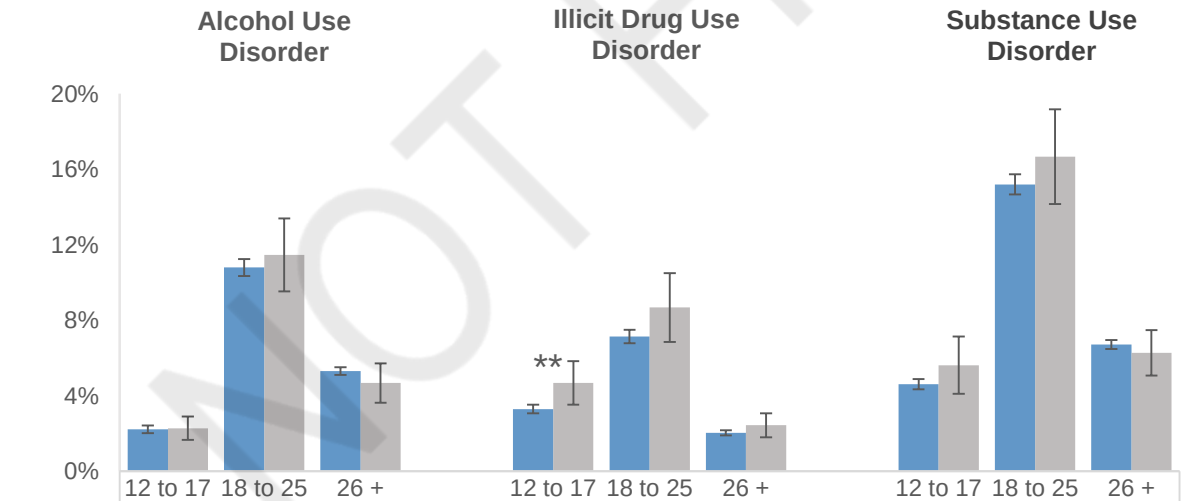
Data were not available to estimate disparities in past month illicit drug use for youth or adults.

Past Year Substance Use Disorders

Substance Use Disorders (SUDs) are defined as "clinically significant impairment due to recurrent use of alcohol or other drugs (or both), including health problems, disability, or failure to meet major responsibilities at work, school, home" (SAMHSA, 2017, p. 24). The 2015-2016 NSDUH estimated the prevalence of Substance Use Disorders (SUD) among respondents 12 or older using the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) criteria. The DSM 5 criteria were not included in this survey due to the time frame of the data collection. Respondents who reported alcohol or illicit drug use were screened for SUDs.

NSDUH estimated three categories of past year substance use disorder: alcohol use disorder, illicit drug use disorder, and substance use disorder (which was the combined estimate for those with either alcohol or illicit drug use disorder, or both conditions). Data on changes overtime and across RBHAs were only available for the measure of alcohol use disorder.

Exhibit 29. Prevalence of Past Year Alcohol, Illicit Drug Use and Substance Use Disorder by Age Group for the U.S. and Arizona, 2015-2016



	Alcohol Use Disorder			Illicit Drug Use Disorder			Substance Use Disorder		
	12 to 17	18 to 25	26 +	12 to 17	18 to 25	26 +	12 to 17	18 to 25	26 +
U.S.	2.2%	10.8%	5.3%	3.3%	7.1%	2.0%	4.6%	15.2%	6.7%
Arizona	2.3%	11.5%	4.7%	4.7%	8.7%	2.4%	5.6%	16.7%	6.3%

** Difference between the prevalence estimate for the total U.S. and Arizona is significant at p<.05
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Alcohol Use Disorder

Youth and Adult Prevalence

Alcohol use disorder was defined as dependence or abuse of alcohol based on DSM-IV criteria. An estimated 304,000 (5.3%) of Arizonans aged 12 or older met the criteria for past year alcohol

use disorder based on data from the 2015-2016 NSDUH (See Exhibit 29). The prevalence of alcohol use peaked for those aged 18 to 25 (11.5%). None of estimates for Arizona differed significantly from national estimates.

Youth and Adult Trends

Estimates of alcohol use disorder in Arizona declined significantly between 2008-2009 and 2015-2016 for the Arizona's 12 or older population (7.7% vs 5.3%, p=0.001), and for each age group as follows: 12 to 17 (5.4% vs 2.3%, p<0.001), 18 to 25 (18.2% vs 11.5%, p<0.001), and 26 or older (6.3% vs 4.7%, p=0.05). Similar declines in prevalence were observed nationally.

Prevalence by RBHA

There were no significant differences in alcohol use disorder by RBHA. As noted earlier, this is meaningful in light of the significant regional differences observed in the indicator of any alcohol use in the past month (i.e., the North Region had significantly less current alcohol use than the South or Central regions). These data suggest that although fewer residents 12 or older drink alcohol in the North Region, those who do may be more likely to engage in risky drinking behaviors.

Disparities in Alcohol Use Disorder

No data were available to estimate disparities in Alcohol Use Disorder.

Past Year Illicit Drug Use Disorder

Youth and Adult Prevalence

An estimated 198,000 (3.5%) Arizonans 12 or older met the criteria for illicit drug use disorder in the past year based on data from the 2015-2016 NSDUH. Prevalence of illicit drug use disorder peaked for those aged 18 to 25 (8.7%). The prevalence of illicit drug use disorder was significantly higher for Arizona youth aged 12 to 17 than youth nationally (4.7% vs 3.3%, p=0.013; See Exhibit 29). No other significant differences were detected between Arizona and national estimates of illicit drug use, and no other data were available for past year illicit drug use.

Past Year Substance Use Disorder

Youth and Adult Prevalence

NSDUH defines substance use disorder as those who met the DSM-IV criteria for either dependence or abuse of alcohol or illicit drugs in the past year. An estimated 431,000 (7.6%) Arizonans 12 or older met the criteria for substance use disorder in the past year based on data from the 2015-2016 NSDUH. NSDUH did not estimate the proportion of people in Arizona suffering from both alcohol and illicit drug use disorders, but nationally 11.6% of those with SUDs had both alcohol and illicit drug use disorder. The prevalence of substance use disorder peaked for those aged 18 to 25 (16.7%; See Exhibit 29). No significant differences were detected

between Arizona and national estimates of substance use disorder. Exhibit 30 provides a summary of youth and adult substance use prevalence across all above reported measures.

Summary of Substance Use Data

Exhibit 30 summarizes the substance use data presented in this section of the report. Prevalence estimates are included for each of the substance use indicators as reported by the NSDUH, YRBS and BRFSS surveys. Again, users are cautioned not to directly compare prevalence estimates across different surveys because of methodological differences. For each survey, prevalence estimates are presented for the sample overall, and for sub-populations where available.

Exhibit 30. Prevalence of Substance Use Indicators Available in the NSDUH, YRBS, and BRFSS

	Past Month Prevalence							Past Year Prevalence				Lifetime Prevalence			
Indicator	Alcohol	Binge Alcohol	Tobacco Product	Ciga-rette	Electronic Vapor	Mari-juana	Any Illicit Drug	Mari-juana	Cocaine	Heroin	Pain Reliever Misuse	Cocaine	Heroin	Metham-phetamine	Pain Reliver Misuse
National Survey of Drug Use and Health (NSDUH), 2015-2016															
Overall Prevalence (12 and older)	50.9	22.6	21.6	18.0	–	7.4	10.0	12.2	2.1	0.5	4.7	–	--	--	--
Age Categories															
12 to 17	8.0	4.4	4.4	2.9	–	6.7	8.8	11.9	0.8	0.0	4.2	–	--	--	--
12 to 20	16.7	10.4	--	--	–	–	--	--	--	--	--	–	--	--	--
18 to 25	54.0	34.3	30.2	23.8	–	17.8	21.1	28.7	6.2	0.9	7.9	–	--	--	--
18 and older	55.5	24.5	23.4	19.6	–	7.5	10.1	12.3	2.2	0.5	4.7	–	--	--	--
25 and older	55.8	22.8	22.3	18.9	–	5.7	8.2	9.5	1.5	0.4	4.2	–	--	--	--
RBHA															
North	42.9	--	26.5	21.9	–	7.1	--	11.0	2.2	0.5	--	–	--	--	--
Central	54.5	--	21.1	17.4	–	8.0	--	13.0	2.1	0.5	--	–	--	--	--
South	49.3	--	22.5	19.4	–	7.5	--	12.1	2.3	0.5	--	–	--	--	--
Youth Risk Factor Behavioral Surveillance System (YRBS), 2017															
Overall Prevalence (9th- 12th grades)	33.1	17.9	12.3	7.1	16.1	19.5	--	--	--	--	--	5.6	1.9	2.3	15.4
Gender															
Female	36.4	20.7	8.5	6.2	13.1	20.2	--	--	--	--	--	5.0	1.2	1.9	15.8
Male	30.2	15.4	15.7	7.5	18.9	18.7	--	--	--	--	--	6.0	2.6	2.5	14.7
Hispanic vs White															
Hispanic	35.2	19.4	12.0	7.3	13.2	21.0	--	--	--	--	--	8.0	2.8	3.7	15.6
Non-Hispanic white	35.0	20.0	13.9	7.4	21.7	18.2	--	--	--	--	--	3.8	1.3	1.1	15.3
Sexual Identity															
Heterosexual (straight)	30.8	16.5	10.4	5.4	14.3	17.2	--	--	--	--	--	5.0	0.9	1.4	13.3
Gay, lesbian or bisexual	52.7	31.9	24.9	19.4	30.8	37.7	--	--	--	--	--	9.2	6.9	7.2	30.7
Behavioral Risk Factor Surveillance System (BRFSS), 2016															
Overall Prevalence (18 and older)	52.1	15.6	--	14.7	–	–	--	--	--	--	--	–	--	--	--
Age Categories															
Age 18 to 24	48.2	21.8	--	9.0	–	–	--	--	--	--	--	–	--	--	--
Age 25 to 44	55.7	22.7	--	18.6	–	–	--	--	--	--	--	–	--	--	--
Age 45 to 64	52.8	13.2	--	17.2	–	–	--	--	--	--	--	–	--	--	--
Age 65 or older	47.9	4.4	--	8.7	–	–	--	--	--	--	--	–	--	--	--
Race/Ethnicity															
Non-Hispanic white, only	58.1	15.6	--	15.5	–	–	--	--	--	--	--	–	--	--	--
Non-Hispanic black, only	49.4	14.7	--	22.0	–	–	--	--	--	--	--	–	--	--	--
Non-Hispanic other race, only	40.3	13.6	--	15.6	–	–	--	--	--	--	--	–	--	--	--
Non-Hispanic, multiracial	52.5	24.1	--	29.8	–	–	--	--	--	--	--	–	--	--	--
Hispanic	42.4	16.1	--	11.4	–	–	--	--	--	--	--	–	--	--	--
Gender															
Male	58.6	21.3	--	17.5	–	–	--	--	--	--	--	–	--	--	--
Female	45.7	10.1	--	12.1	–	–	--	--	--	--	--	–	--	--	--
Educational Attainment															
Did not graduate high school	30.4	12.5	--	20.2	–	–	--	--	--	--	--	–	--	--	--
High school graduate	47.7	16.0	--	19.6	–	–	--	--	--	--	--	–	--	--	--
Attended college/ technical school	54.4	15.6	--	14.5	–	–	--	--	--	--	--	–	--	--	--
College/technical school graduate	66.1	17.0	--	6.7	–	–	--	--	--	--	--	–	--	--	--
Veteran Status															
Veteran	58.8	14.1	--	17.6	–	–	--	--	--	--	--	–	--	--	--
Not Veteran	51.0	15.8	--	14.2	–	–	--	--	--	--	--	–	--	--	--

-- Not Available
Binge alcohol use is defined as drinking five or more drinks (for males) or four or more drinks (for females) on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least one day in the past 30 days.
Electronic vapor product use includes using e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens, on at least one day during the 30 days.
Misuse of pain relievers is defined by NSDUH as use of prescription psychotherapeutics in any way not directed by a doctor, including use without a prescription of one's own; use in greater amounts, more often, or longer than told; or use in any other way not directed by a doctor. Prescription psychotherapeutics do not include over-the-counter drugs.
Misuse of pain relievers is defined by YRBSS as ever taking prescription pain medicine without a doctor's prescription or differently than how a doctor told them to use it (counting drugs such as codeine, Vicodin, Oxycontin, Hydrocodone, and Percocet, one or more times during their life).
Illicit Drug Use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.

Consequences of Substance Use

In addition to estimating the prevalence of substance use in Arizona, secondary data were also used to estimate the consequences of substance use. This section of the report presents data on the following consequences of substance use:

- discharge data on hospitalizations and emergency department visits for alcohol and drug use,
- drug and alcohol-induced mortality rates,
- treatment rates by substance use,
- suicides, and
- criminal activities related to impaired driving and drug possessions.

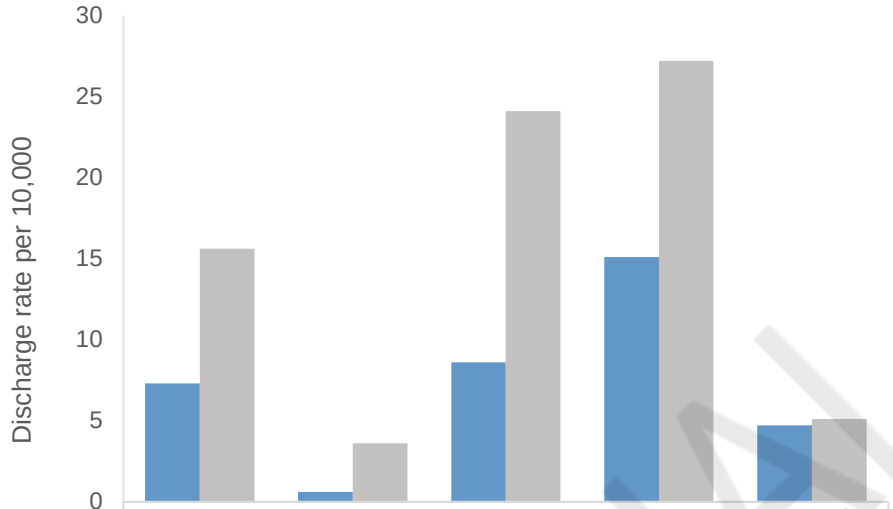
Hospitalizations and Emergency Department Discharges

The Arizona Department of Health Services publishes discharge data on alcohol and drug related hospitalizations and Emergency Department (ED) visits. For both inpatient and ED discharges, the unit of analysis is the discharge event (i.e., individuals with multiple discharges are enumerated more than once). Diagnostic categories for alcohol and drug conditions were based on ICD-10 codes beginning in 2016; prior years were coded from ICD-9 and are not directly comparable. Arizona data are only compared to national estimates when comparable sources could be located.

Discharge Rates for Alcohol Abuse

In 2016, in Arizona, the rate of ED discharges with alcohol abuse as the first-listed diagnosis was 15.6 per 10,000, and the rate of hospital discharges was 7.3 per 10,000. For both ED and hospital discharges the rates rose consistently with increasing age, peaking for those aged 45 to64, and then declining for those 65 and older (See Exhibit 31).

Exhibit 31. Hospital and ED Discharge Rates per 10,000 with Alcohol Abuse as First-Listed Diagnosis, by Age in Arizona, 2016



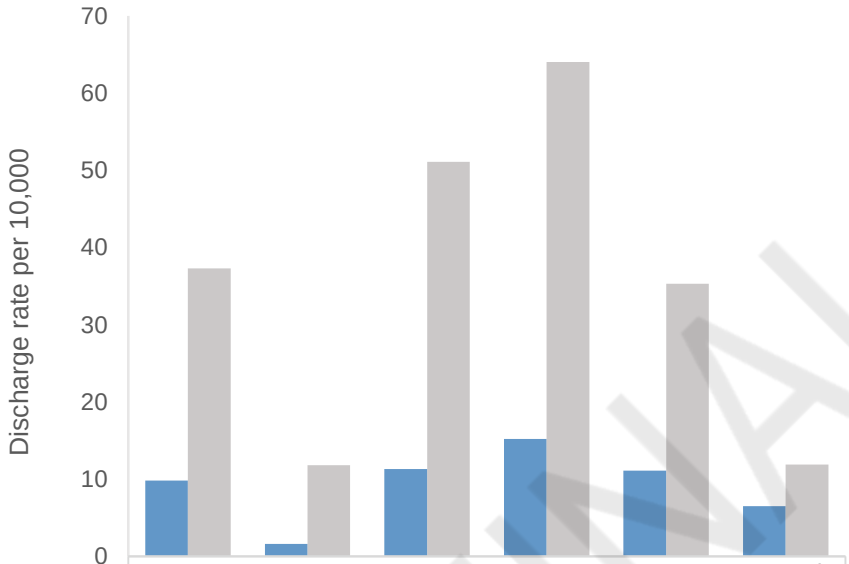
	Total	15-19	20-44	45-64	65 and older
Inpatient Discharges	7.30	0.60	8.60	15.10	4.70
ED Discharges	15.60	3.60	24.10	27.20	5.10

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics.*

Discharge Rates for Drug Dependence, Abuse or Misuse

In 2016, in Arizona, the rate of ED discharges with drug dependence, abuse or misuse as the first-listed diagnosis was 37.3 per 10,000, and the rate of hospital discharges was 9.8 per 10,000. Rates of ED visits and hospital discharges peaked for those aged 20-44, and then decreased with increasing age (See Exhibit 32).

Exhibit 32. Hospital and ED Discharge Rates per 10,000 with Drug Dependence, Abuse or Misuse as First-Listed Diagnosis by Age in Arizona, 2016



	Total	Under 15	15-19	20-44	45-64	65 and older
Inpatient Discharges	9.8	1.6	11.3	15.2	11.1	6.5
ED Discharges	37.3	11.8	51.1	64	35.3	11.9

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

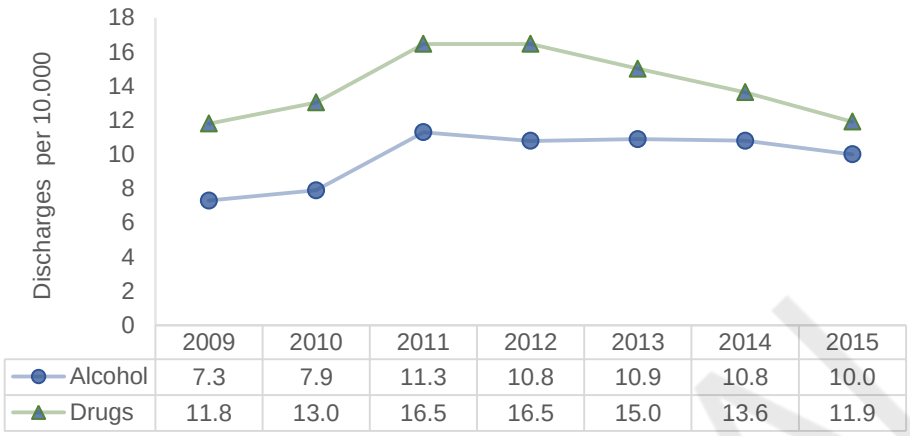
In 2016, there were 51,203 hospital discharges that included any mention of drug dependence or drug abuse. Counts and rates of hospital discharges were provided for three specific categories of drugs; for these data it is important to note that more than one type of drug could be identified on a discharge record.

- amphetamines and other psychostimulants: 18.5 per 10,000(12,627 discharges)
- cocaine: 4.0 per 10,000 (2,757 discharges); and,
- opioids, including heroin, morphine, methadone, opium; synthetics with morphine like effects: 27.0 per 10,000 (18,445 discharges). Opioid data are discussed in more detail in separate sections of this report.

Trends in Discharge Rates for Alcohol Abuse

The discharge rates of hospital inpatients with alcohol abuse as the first-listed diagnosis was 7.3 per 10,000 in 2009 (4,806 discharges). The rate peaked in 2011 at 11.3 per 10,000, decreasing to 10.0 by 2015 (See Exhibit 33).

Exhibit 33. Trends in Hospital Discharge Rates per 10,000 for Alcohol Abuse and Drug Dependence, Abuse and Misuse as First-Listed Diagnosis in Arizona, 2009-2015.



	2009	2010	2011	2012	2013	2014	2015
Alcohol	7.3	7.9	11.3	10.8	10.9	10.8	10.0
Drugs	11.8	13.0	16.5	16.5	15.0	13.6	11.9

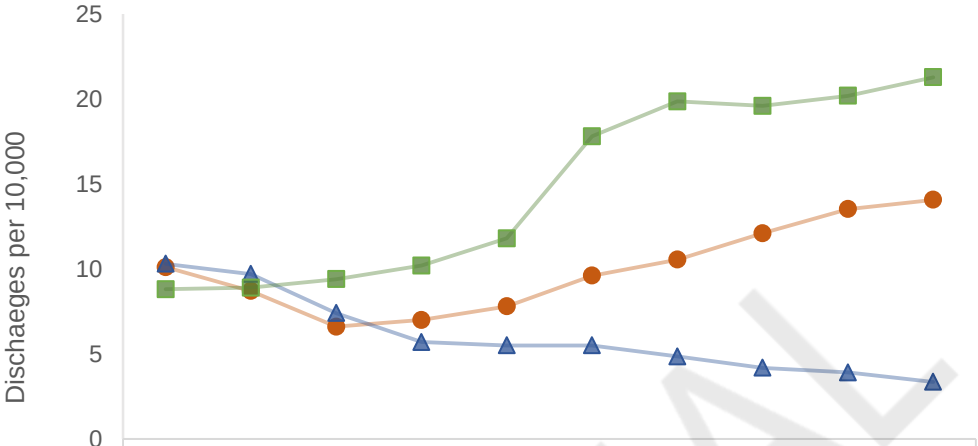
Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

Trends in Discharge Rates for Drug Dependence, Abuse or Misuse

The discharge rates of inpatients with drug dependence, abuse or misuse as the first-listed diagnosis increased from 11.8 per 10,000 (7,790 discharges) in 2009 to 16.5 per 10,000 in 2011 and 2012. The rate began decreasing in 2013 and was 11.9 per 10,000 by 2015 (See Exhibit 33 above).

Although the overall rate of drug related discharges decreased, there were substantial increases in discharges for specific categories of drugs. Specifically, discharges for opiates and amphetamines increased in Arizona, while discharges for cocaine decreased between 2009 and 2016 (See Exhibit 34).

Exhibit 34. Trends in Hospital Discharge Rates per 10,000 for Specific Categories of Drugs in Arizona, 2009-2015.



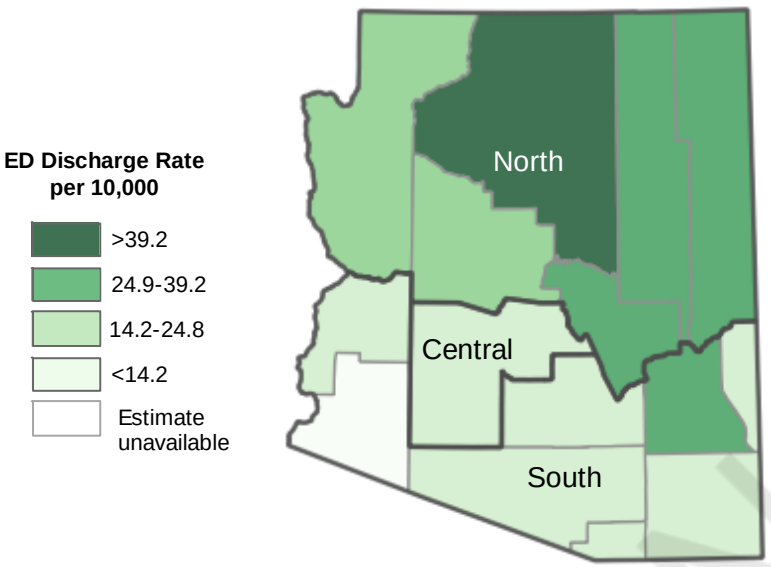
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Amphetamines	10.1	8.7	6.6	7.0	7.8	9.6	10.5	12.1	13.5	14.1
Cocaine	10.3	9.7	7.4	5.7	5.5	5.5	4.9	4.2	3.9	3.4
Opiates	8.8	8.9	9.4	10.2	11.8	17.8	19.9	19.6	20.2	21.3

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) Hospital inpatient discharges and emergency room visits statistics.

Discharge Rates for Alcohol Abuse by Arizona County

Rates of Emergency Department (ED) discharges with alcohol abuse as the first-listed diagnosis differed by county across Arizona. Coconino County had the highest rate (58.6 per 10,000, 836 discharges), and La Paz County had the lowest rate (6.6 per 10,000, 14 discharges; data unavailable for Yuma) (See Exhibit 35). For hospitalizations, Navajo County had the highest rate (18.7 per 10,000, 206 discharges) and Santa Cruz County had the lowest rate (3.2 per 10,000, 16 discharges) (See Exhibit 36). It is noteworthy that many of the counties experiencing high rates of alcohol discharges are located in the North Region.

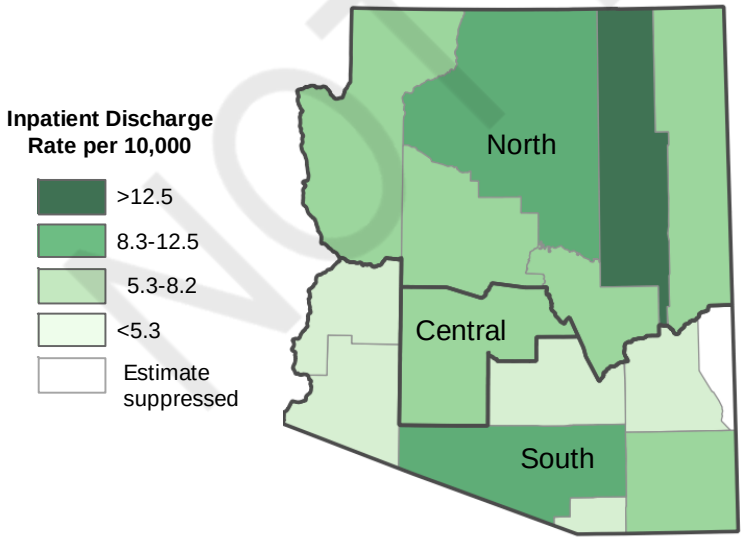
Exhibit 35. Emegency Department Discharge Rates per 10,000 for Alcohol Abuse as First-Listed Diagnosis, by Arizona County, 2016



Rank	County	Rate
1	Coconino	58.6
2	Navajo	39.2
3	Apache	37.3
4	Graham	31.6
5	Gila	28.9
6	Mohave	24.8
7	Yavapai	20.0
8	Pima	14.1
9	Maricopa	13.6
10	Cochise	12.9
11	Greenlee	11.5
12	Pinal	11.0
13	Santa Cruz	10.9
14	La Paz	6.6
	Yuma	--

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics.*

Exhibit 36. Hospital Discharge Rates per 10,000 for Alcohol Abuse as First-Listed Diagnosis, by Arizona County, 2016



Rank	County	Rate
1	Navajo	18.7
2	Coconino	12.5
3	Pima	11.2
4	Apache	8.2
5	Gila	7.7
6	Yavapai	7.3
7	Cochise	7.2
8	Maricopa	6.4
9	Mohave	6.0
10	Graham	5.2
11	Pinal	5.0
12	Yuma	3.4
13	La Paz	3.3
14	Santa Cruz	3.2
N/A	Greenlee	N/A

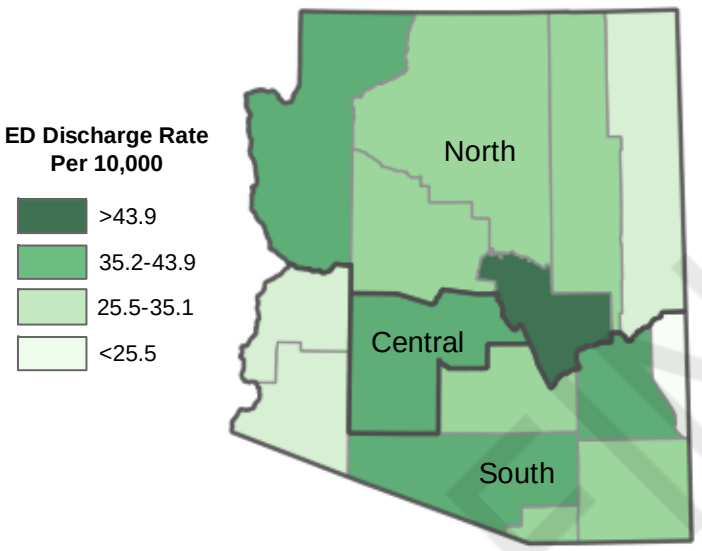
Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics.*

Discharge Rates for Drug Dependence, Abuse or Misuse by Arizona County

Rates of hospitalization and ED discharges for drugs differed by Arizona county. Gila County had the highest rate of ED discharges (49.9 per 10,000, 271 discharges) and Apache County had

the lowest rate (17.1 per 10,000, 123 discharges) (See Exhibit 37). For hospitalizations, Pima County had the highest rate of discharges (14.0 per 10,000, 1,414 discharges) and Santa Cruz County had the lowest rate (3.0 per 10,000, 15 discharges) (See Exhibit 38).

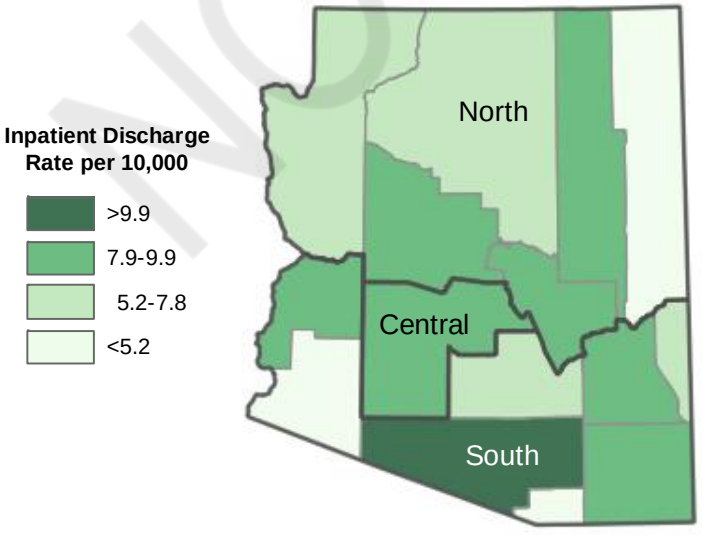
Exhibit 37. Emegency Department Discharge Rate per 10,000 for Drug Dependence, Abuse or Misuse as First-Listed Diagnosis, by Arizona County, 2016



Rank	County	Rate
1	Gila	49.9
2	Graham	43.9
3	Mohave	43.0
4	Pima	39.5
5	Maricopa	38.7
6	Yavapai	35.1
7	Cochise	33.2
8	Navajo	31.9
9	Pinal	31.9
10	Coconino	28.8
11	Santa Cruz	28.5
12	La Paz	25.4
13	Yuma	24.8
14	Greenlee	21.1
15	Apache	17.1

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

Exhibit 38. Hospital Discharge Rate per 10,000 for Drug Dependence, Abuse or Misuse as First-Listed Diagnosis, by Arizona County, 2016



Rank	County	Rate
1	Pima	14.0
2	Maricopa	9.9
3	Navajo	9.9
4	Yavapai	9.0
5	Gila	8.7
6	Cochise	8.6
7	La Paz	8.5
8	Graham	8.1
9	Coconino	7.8
10	Pinal	7.1
11	Mohave	6.9
12	Greenlee	6.7
13	Yuma	5.1
14	Apache	4.7
15	Santa Cruz	3.0

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

In interpreting data on hospitalizations and ED discharges across geographic areas, it is important to note that a higher discharge rate is not necessarily indicative of greater risk. For example, in some regions treatment services may be limited and/or inaccessible to many individuals in need of emergency department or hospital care. In these regions, the number of discharges may be low, while the number of deaths could be relatively high. The ratio of deaths to total hospital discharges is a useful indicator to identify areas where substance users may be less likely to have access to life-saving treatments and are most at risk for death. These data indicate La Paz, Mohave and Gila Counties have the highest ratio of deaths to hospital discharges in drug related instances (See Exhibit 39).

Exhibit 39. Ratio of the Count of Drug-Related Deaths to Inpatient Discharges for Drug Abuse, Misuse or Dependence as First-Listed Dianosis by Arizona County, 2016

County Rank for Ratio	County	# of inpatient discharges for drugs	# of drug-induced deaths	Ratio of deaths to hospital discharges for drugs
1	La Paz	18	10	0.56
2	Mohave	142	70	0.49
3	Gila	47	20	0.43
4	Yuma	110	40	0.36
5	Yavapai	199	70	0.35
6	Graham	31	10	0.32
7	Apache	34	10	0.29
8	Navajo	109	30	0.28
9	Cochise	111	30	0.27
10	Pinal	292	60	0.21
11	Maricopa	4,092	800	0.20
12	Coconino	111	20	0.18
12	Pima	1,414	250	0.18
14	Greenlee	7	0	0.00
14	Santa Cruz	15	0	0.00
TOTAL	**Arizona**	**6,732**	**1470**	**0.22**

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

Disparities in Alcohol Abuse

Disparities in rates of alcohol abuse discharges were detected by gender and race/ethnicity. Males had higher rates of alcohol abuse discharges for both ED visits and hospitalizations than females (ED Visits: 22.5 vs 8.9 per 10,000; Hospitalizations: 10.4 vs 4.2 per 10,000). American Indian/Alaska Natives had higher rates of hospitalization discharges than all other race/ethnicities combined (Hospitalization visits: 21.2 per 10,000) (See Exhibit 40). This may correspond to the finding that there were higher rates of alcohol abuse discharges in counties with a higher proportion of American Indian/Alaska Natives. Data were not available to estimate disparities in ED discharge rates by race/ethnicity.

Exhibit 40. Hospital Discharge Counts and Rates per 10,000 for Alcohol Abuse as First-Listed Diagnosis by Race/Ethnicity in Arizona, 2016

Race/Ethnicity	Count	Rate per 10,000
White non-Hispanic	3,491	9.0
Hispanic or Latino	674	3.2
Black/African American	141	4.4
American Indian/ Alaska Native	614	21.2
Asian or Pacific Islander	31	1.3
Refused/Unknown	28	N/A

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

Disparities in Drug Dependence, Abuse or Misuse

Males had slightly higher rates of inpatient discharges with drug dependence, abuse or misuse as the first-listed diagnosis than females (10.4 vs 9.3 per 10,000), and slightly higher rates of ED discharges (41.7 vs 32.9 per 10,000). White non-Hispanics had the highest rate of inpatient discharges (12.2 per 10,000) and blacks had the highest rate of emergency room visits (65.9 per 10,000) (See Exhibit 41).

Exhibit 41. Inpatient Discharge and ED Discharge Counts and Rates per 10,000 for Drug Dependence, Abuse or Misuse as First-Listed Diagnosis by Race/Ethnicity in Arizona, 2016

	Inpatient Discharge		ED Discharge	
Race/Ethnicity	**Count**	**Rate per 10,000**	**Count**	**Rate per 10,000**
White non-Hispanic	4,716	12.2	15,431	39.8
Hispanic or Latino	1,296	6.2	6,092	28.9
Black/African American	351	11.0	2,104	65.9
American Indian/ Alaska Native	256	8.8	1,423	49.1
Asian or Pacific Islander	59	2.4	266	10.9
Refused/Unknown	54	NA	178	NA

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

Mortality

Mortality data are also published by the Arizona Department of Health for drug- and alcohol-induced deaths. Drug-induced deaths include deaths from "mental and behavioral disorders due to psychoactive substance use, accidental poisoning by and exposure to drugs, suicide by drugs, homicide by drugs; and poisoning by drugs, undetermined intent." Alcohol-induced deaths include deaths from "mental and behavioral disorders due to alcohol use, degeneration of nervous system due to alcohol, alcoholic polyneuropathy, alcoholic cardiomyopathy, alcoholic gastritis, alcoholic liver disease, finding of alcohol in blood, accidental poisoning by and exposure to alcohol, intentional self-poisoning by alcohol; poisoning by alcohol, undetermined intent" (ADHS, 2018).

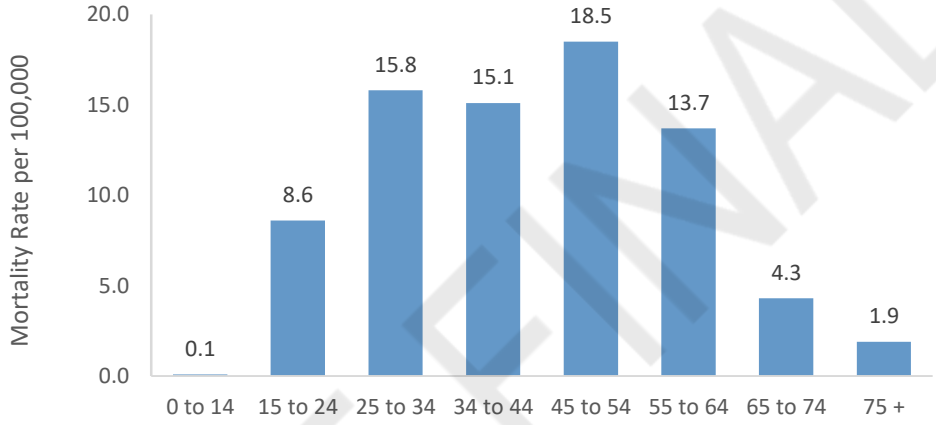
Age-Adjusted Alcohol-Induced Mortality Rates

The age-adjusted alcohol-induced mortality rate in Arizona in 2016 was 17.6 per 100,000. According to the CDC data from 2015, Arizona ranked 4th in the country for alcohol poisoning deaths with an age-adjusted rate of 1.87 per 100,000 people (CDC, 2015). Arizona also ranked 4th in death rates from chronic liver disease and cirrhosis. Although not all liver disease is caused by alcohol, there is a strong association between heavy alcohol consumption and liver disease, and an estimated 10-15% of heavy drinkers will develop cirrhosis (Mann et al, 2004). In 2016, Arizona's age-adjusted death rate for chronic liver disease and cirrhosis was 14.9 per 100,000 compared to 10.7 per 100,000 nationally.

Age-Adjusted Drug-Induced Mortality Rates per 100,000

The age-adjusted drug-induced mortality rate in Arizona in 2016 was 20.1 per 100,000 (1,470 deaths), and the age-adjusted opioid-induced death rate was 11.1[4]. The Arizona Department of Health Services released early data for opioid-induced death rates in the summer of 2018 (ADHS, 2018). Based on these data, the number of reported deaths in 2017 attributed to opioids was 949. For opioids, death rates peaked for those aged 45 to 54 (18.5 per 100,000), and then declined steadily for ages over 55 (See Exhibit 42).

Exhibit 42. Opioid Average 10-Year Death Rate per 100,000 Population in Arizona by Age Group, 2007-2017



Source: Arizona Department of Health, Bureau of Public Health Statistics, 2016 Arizona Opioid Report

Trends in Alcohol-Induced Mortality Rates

Trend data were available for mortality counts (not rate), for alcohol-induced deaths. In Arizona, the overall death count for alcohol-induced deaths increased from 637 in 2006 to 1,310 in 2016. Multi-year Data were also available to estimate mortality rates from chronic liver disease and cirrhosis in Arizona, which showed an increase from an age-adjusted death rate in 2006 of 11.4 per 100,000 to 14.9 per 100,000 in 2016.

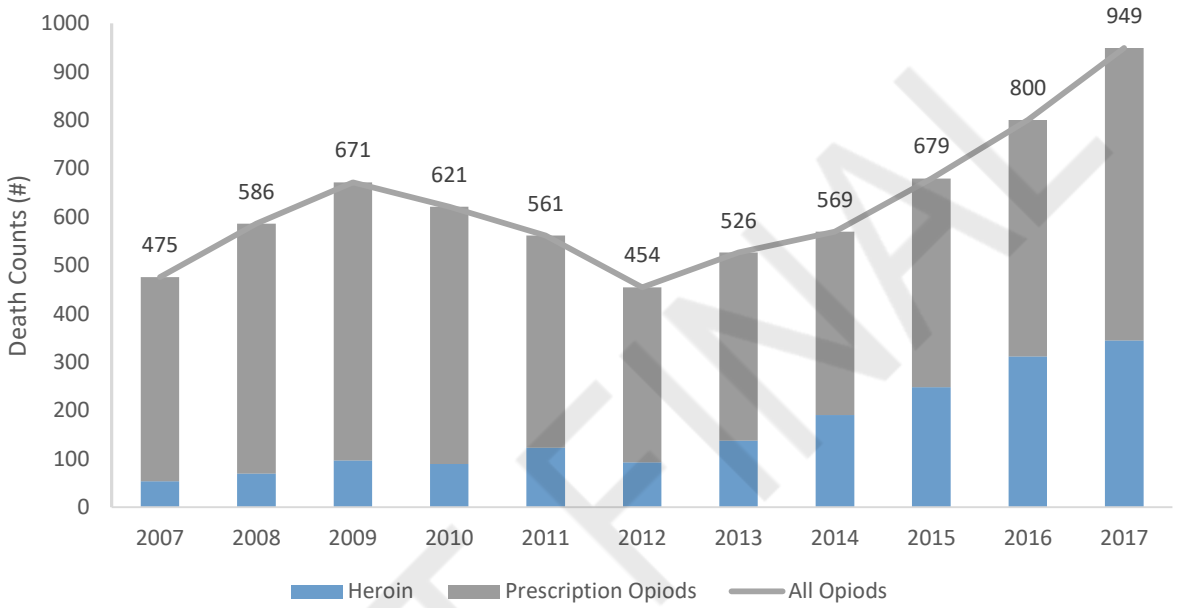
Trends in Drug-Induced Mortality Rates

Trend data were available for mortality counts (not rates) for drug-induced deaths. In Arizona, the overall death count increased overtime from 910 in 2006 to 1,470 in 2016. Mohave County saw the greatest increase in deaths in this time from 20 to 70 (250%), based on 2-year averages (2006-2007 and 2015-2016, respectively).

[4] The 2016 opioid mortality rate was based on a death count of 790; updated data were released in 2018, and the mortality count was adjusted to 800. Updated rates for 2016 were not published based on the revised death count – all 2016 rates presented in this report are based on the 790 count.

In Arizona, opioid deaths declined between 2009 and 2012, but have reversed that trend in recent years. (See Exhibit 43). Opioid deaths have increased 109% since 2012. Heroin related deaths increased significantly in the past decade, from 11% of opioid deaths in 2007 to 39% in 2016, before dropping slightly to 36% in 2017. Prescription and synthetic opioid deaths have also been increasing (ADHS, Opioid Report, 2018).

Exhibit 43. Trends in Number of Opioid Deaths by Heroin and Prescription Opioids in Arizona, 2007-2017



Source: Arizona Department of Health, Bureau of Public Health Statistics, 2017 Arizona Opioid Report

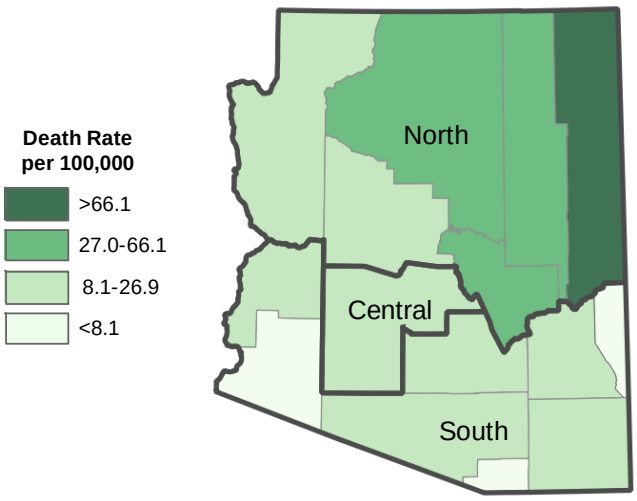
Mortality Rates for Alcohol-Induced Deaths by Arizona County

In 2016, Apache County had the highest alcohol-induced death rate (87.9 per 100,000), and Yuma County had the lowest death rate (6.6 per 100,000) (See Exhibit 44). Chronic liver disease and cirrhosis death rates were highest in La Paz County (56.8 per 100,000) and Gila County (55.9 per 100,000), with the lowest in Greenlee County (7.2 per 100,000). High alcohol-induced mortality rates are concentrated in the counties in the North Region of Arizona, mirroring risks observed for hospital and Emergency Department discharge rates.

Mortality Rates for Drug-Induced Deaths by Arizona County

Gila County had the highest drug-induced death rate (41.0 per 100,000) and Apache and Greenlee Counties had the lowest death rates (7.2 per 100,000 and less than 1 per 100,000) (See Exhibit 45). La Paz County had the highest opioid induced death rate (36.5 per 100,000) and Yuma and Greenlee Counties had the lowest death rate (less than 1 per 100,000) (See Exhibit 46).

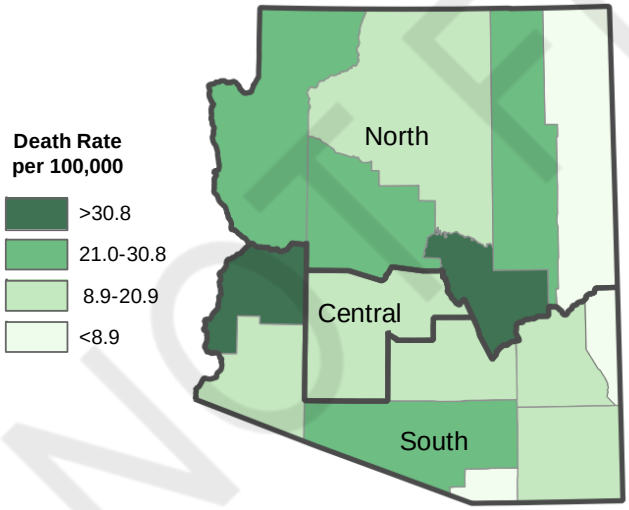
Exhibit 44. Alcohol-Induced Death Rates per 100,000 by Arizona County, 2016



Rank	County	Rate
1	Apache	87.9
2	Gila	66.1
3	Navajo	65.9
4	Coconino	48.0
5	La Paz	26.9
6	Mohave	22.4
7	Graham	19.2
8	Yavapai	18.1
9	Pima	17.1
10	Pinal	14.7
11	Cochise	14.1
12	Maricopa	14.0
13	Santa Cruz	8.0
14	Greenlee	7.2
15	Yuma	6.6

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

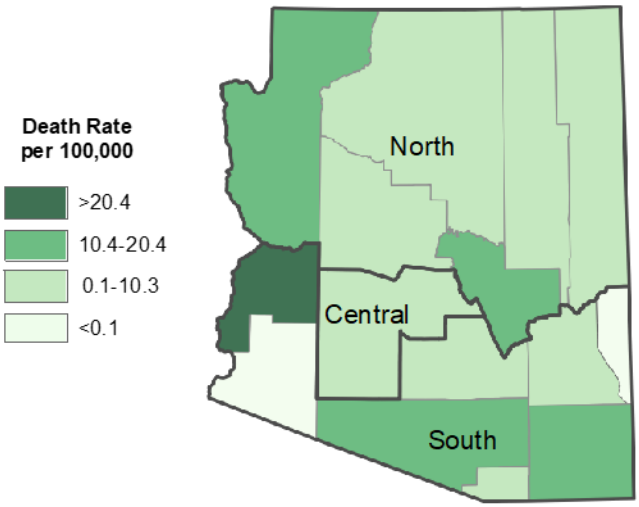
Exhibit 45. Drug-Induced Death Rates per 100,000 by Arizona County, 2016



Rank	County	Rate
1	Gila	41.0
2	La Paz	39.1
3	Mohave	30.8
4	Yavapai	27.8
5	Pima	25.4
6	Navajo	22.9
7	Yuma	20.9
8	Graham	20.2
9	Cochise	19.1
10	Maricopa	17.8
11	Pinal	14.7
12	Coconino	14.5
13	Santa Cruz	8.8
14	Apache	7.2
15	Greenlee	0.0

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

Exhibit 46. Opioid-Induced Death Rates per 100,000 by Arizona County, 2016



Rank	County	Rate
1	La Paz	36.5
2	Mohave	20.4
3	Pima	17.3
4	Gila	16.8
5	Cochise	15.1
6	Maricopa	10.3
7	Yavapai	9.0
8	Santa Cruz	8.8
9	Pinal	8.1
10	Navajo	6.2
11	Graham	5.7
12	Coconino	4.4
13	Apache	4.1
14	Greenlee	0.0
14	Yuma	0.0

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

Opioids in Arizona
Data and Response

In 2017 there were 949 deaths due to opioids in Arizona, an increase of 109% since 2012. On June 5, 2017, Governor Douglas A. Ducey declared a public health emergency to address the opioid crisis. The Arizona Opioid Action Plan was released in September 2017 and implemented over the next year. The plan had numerous goals to address the opioid crisis, including improving prescription and distribution practices. The opioid crisis is now monitored closely with weekly opioid surveillance data provided by the Arizona Department of Health Services.

These data indicate that between June 15, 2017 and August 30, 2018 there were:

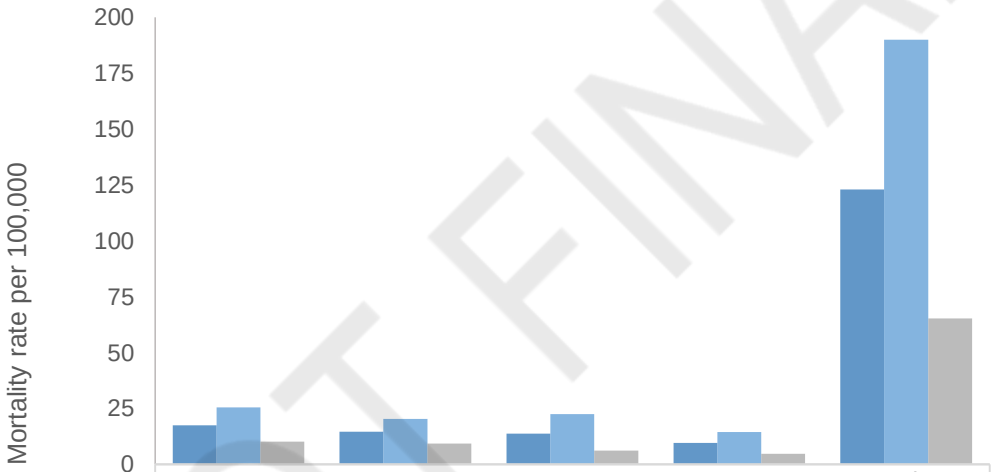
- 1,677 suspected opioid deaths
- 10,974 suspected opioid overdoses
- 25,660 naloxone doses dispensed
- 6,866 naloxone doses administered, and
- 952 Arizona babies born with neonatal abstinence syndrome.

On January 26, 2018, Governor Ducey signed the Arizona Opioid Epidemic Act. The public health emergency ended May 29, 2018. The emergency response and next steps are summarized in the Arizona Opioid Emergency Response Report- June 2017 to June 2018.

Disparities in Alcohol-Induced Death Rates

- Gender: The age-adjusted alcohol-induced mortality rate differed by gender. Males were more likely to die from alcohol than females (25.5 per 100,000 vs 10.2 per 100,000) (See Exhibit 47).
- Race/Ethnicity: There were also pronounced disparities in the alcohol-induced death rates by race/ethnicity. American Indian/Alaska Natives had a disproportionately high rate of alcohol-induced deaths at over eight times higher than any other racial/ethnic group (See Exhibit 47). The death rate for males was higher for each racial/ethnic group. Male American Indian/Alaska Natives had an alcohol death rate of 190.0 per 100,000.

Exhibit 47. Alcohol-Induced Death Rates per 100,000 by Gender and Race/Ethnicity in Arizona, 2016



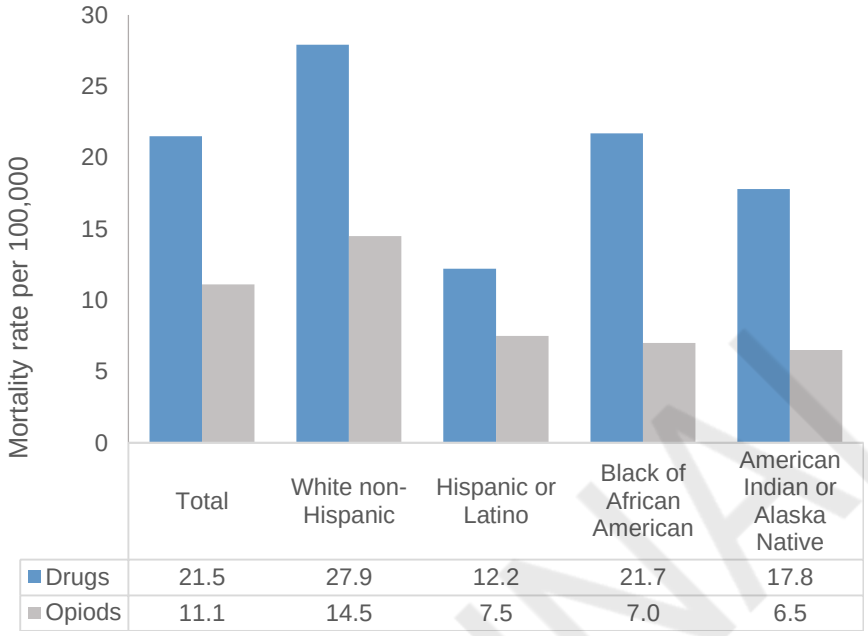
	Total	White non-Hispanic	Hispanic or Latino	Black/ African American	American Indian/ Alaska Native
Total	17.6	14.7	13.8	9.7	123.0
Males	25.5	20.4	22.5	14.5	190.0
Females	10.2	9.3	6.1	4.8	65.3

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

Disparities in Drug-Induced Death Rates

In 2016, males were more likely to die from drug-induced deaths than females (28.2 vs 24.8 per 100,000), and from opioid-induced deaths than females (14.5 vs 7.6 per 100,000). Non-Hispanic whites had the highest rate of any drug-induced death or opioid-induced deaths (See Exhibit 48).

Exhibit 48. Opioid and Drug-Induced Death Rates per 100,000 by Race/Ethnicity in Arizona, 2016



	Total	White non-Hispanic	Hispanic or Latino	Black of African American	American Indian or Alaska Native
Drugs	21.5	27.9	12.2	21.7	17.8
Opiods	11.1	14.5	7.5	7.0	6.5

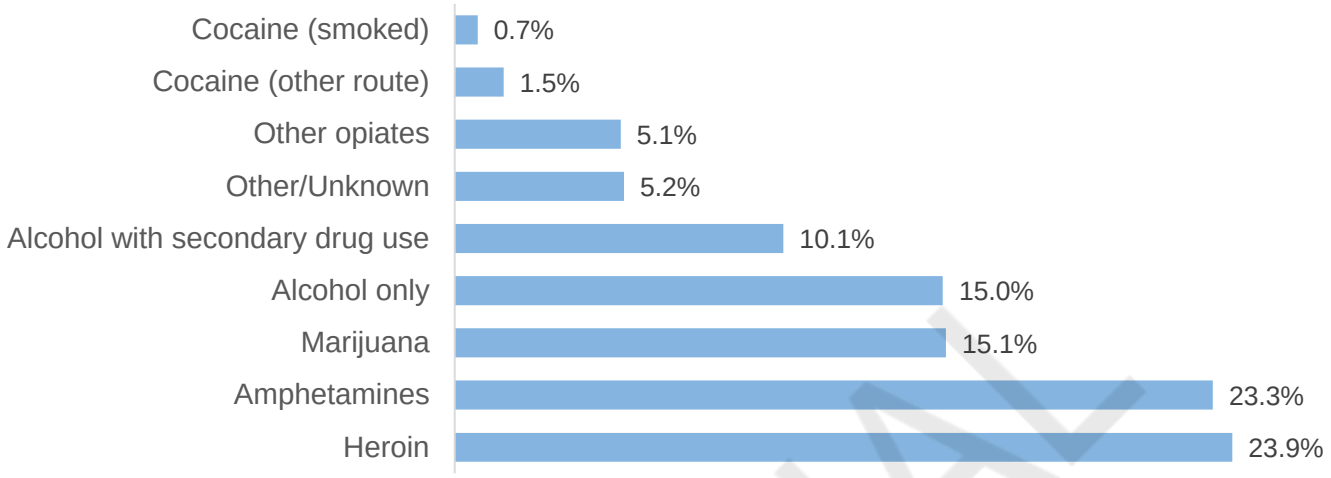
Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

Substance Use Treatment Admissions

The Center for Behavioral Health Statistics and Quality at SAMHSA maintains the Treatment Episode Data Set (TEDS), which tracks administrative data on substance use admissions for each state. Based on data submitted to TEDS through April 3, 2018 for the treatment year 2017, there were 26,615 substance use admissions in Arizona in 2017.

Most admissions were for heroin (23.9%) and amphetamines (23.3%). The greatest percentage of admissions occurred in those aged 26 to 30 (21.6%), and among whites (84.6%). More than half of those in treatment were male (57.4%) (See Exhibit 49).

Exhibit 49. Percentage of Substance Use Admissions by Primary Substance of Misuse among Arizonans Aged 12 and Older, 2017



Source: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administrations, Treatment Episode Data Set

Suicide

Suicide is a leading cause of death among individuals who misuse alcohol and drugs, and there is a large body of research demonstrating an association between substance use and suicide (SAMHSA, 2016; Center for Substance Abuse Treatment, 2009; Wilcox et al, 2004). Individuals who misuse, or are dependent on, alcohol have a suicide risk 10 times greater than the suicide risk of the general population; the risk of suicide for injecting drug users is 14 times greater than the general population's risk (SAMHSA, 2016). Nationally, approximately 22% of suicide deaths involve alcohol intoxication, and 20% involve opiates (Center for Substance Abuse Treatment, 2009).

This report presents data on three indicators of suicide:

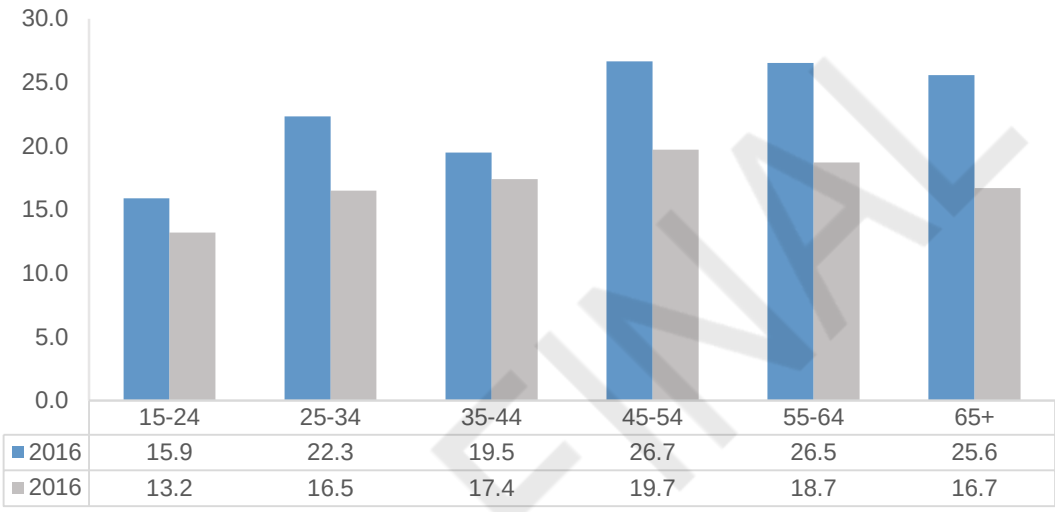
- suicide death rates,
- suicide attempts, and
- serious thoughts of suicide.

Suicide Death Rates

According to data from the 2016 National Center for Health Statistics, the age-adjusted suicide death rate in Arizona was 17.7 per 100,000, which was higher than the national suicide death rate of 13.5 per 100,000. Arizona ranked 17th of all states in terms of suicide rates. The Arizona Department of Health Services (ADHS) reported that in 2016 there were 1,256 suicide deaths in the State, and 60% were carried out by firearms.

For all age groups, suicide rates were higher in Arizona than the United States. The greatest absolute difference in suicide rates between Arizona and the United States occurred for those aged 65 or older (25.6 vs. 16.7 per 100,000). In Arizona, rates peaked among adult 45 and older (See Exhibit 50).

Exhibit 50. Age-Adjusted Suicide Mortality Rates per 100,000 by Age Group for U.S and Arizona, 2016



	15-24	25-34	35-44	45-54	55-64	65+
2016	15.9	22.3	19.5	26.7	26.5	25.6
2016	13.2	16.5	17.4	19.7	18.7	16.7

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016) *Intentional self-harm (suicide), Arizona, 2006-2016.*

Veteran Suicide Death Rates

Arizona is home to seven military bases located in five counties: Maricopa, Yuma, Pima, Cochise, and Coconino. A 2015 census report indicated there are 522,188 veterans residing in Arizona. Easy access to military and veteran accommodations and entitlements such as discounted groceries and retail stores, free or discounted prescriptions, medical and mental health treatment, and social activities make Arizona a popular state for veterans to retire in. Services provided on military bases also keep the cost of living nearly four percent lower than the US average and fosters a sense of social norms and connectedness that comes with the commonality of having served in the armed forces. An updated study completed by the U.S. Department of Veterans Affairs (2018) reported that in 2016 Arizona lost 227 veterans to suicide (217 male and 10 females) and that they commit suicide at quadruple the rate of civilians, with most committing suicide by gunshot (79.3%). After accounting for differences in age, the Veteran suicide rate in Arizona was significantly higher than the national Veteran suicide rate ($p<0.0001$) (Exhibit 51) as well as the overall national suicide rate ($p=<.00001$) (Exhibit 52).

Exhibit 51. Arizona, Western Region, and National Veteran Suicide Deaths, by Age Group, 2016

Age Group	Arizona Veteran Suicides	Western Region [a] Veteran Suicides	National Veteran Suicides	Arizona Veteran Suicide Rate [b]	Western Region Veteran Suicide Rate [b]	National Suicide Rate [b]
Total	227	1,576	6,079	44.1	35.0	30.1
18-34	31	224	893	68.9	47.9	45.0
35-54	49	418	1,648	41.9	38.8	33.1
55-74	89	595	2,259	39.9	30.6	25.9
75+	57	337	1,274	43.8	33.4	28.3

[a] States included in the western region were Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming
[b] Rates presented are unadjusted rates per 100,000
Source: Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention. Veteran Suicide Data Report, 2005–2016. September 2018.

Exhibit 52. Arizona Veteran and Overall Arizona, and National Suicide Deaths, by Age Group, 2016

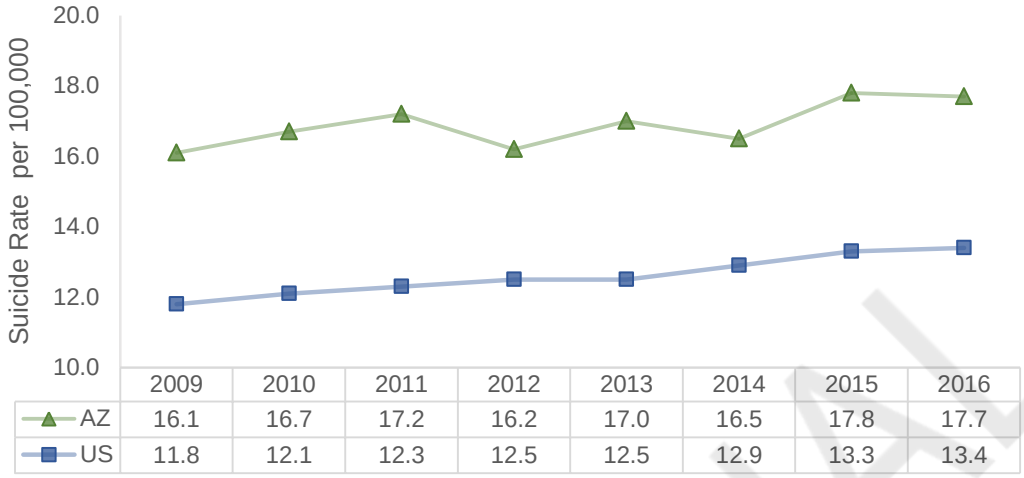
Age Group	Arizona Veteran Suicides	Arizona Total Suicides	Western Region [a] Total Suicides	National Total Suicides	Arizona Veteran Suicide Rate [b]	Arizona Suicide Rate [b]	Western Region Suicide Rate [b]	National Suicide Rate [b]
Total	227	1,236	11,105	43,427	44.1	23.4	19.0	17.5
18-34	31	333	3,061	11,997	68.9	20.9	16.6	16.1
35-54	49	396	3,854	15,467	41.9	23.4	19.5	18.6
55-74	89	373	3,155	12,162	39.9	24.6	19.9	17.3
75+	57	134	1,035	3,801	43.8	27.6	23.0	18.5

[a] States included in the western region were Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming
[b] Rates presented are unadjusted rates per 100,000
Source: Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention. Veteran Suicide Data Report, 2005–2016. September 2018.

Trends in Suicide Death Rates

Data from the Arizona Department of Health Bureau of Vital Statistics reveal an overall increase in suicide death rates between 2009 and 2016, from an age-adjusted mortality rate of 16.1 per 100,000 to 17.7 in 2016. From 2009 to 2016, Arizona consistently had a higher suicide rate than the national rate. Increases in suicide death rates in Arizona were observed for all age groups except for those aged 35-44, whose rate decreased slightly from 20.7 per 100,000 in 2006 to 19.5 per 100,000 in 2016. The greatest absolute increase in suicide rates was observed for youth aged 25 to 34, from 15.3 per 100,000 in 2009 to 22.3 per 100,000 in 2016 (See Exhibit 53).

Exhibit 53. Trends in Age-Adjusted Suicide Mortality Rates per 100,000 for U.S. and Arizona, 2009-2016



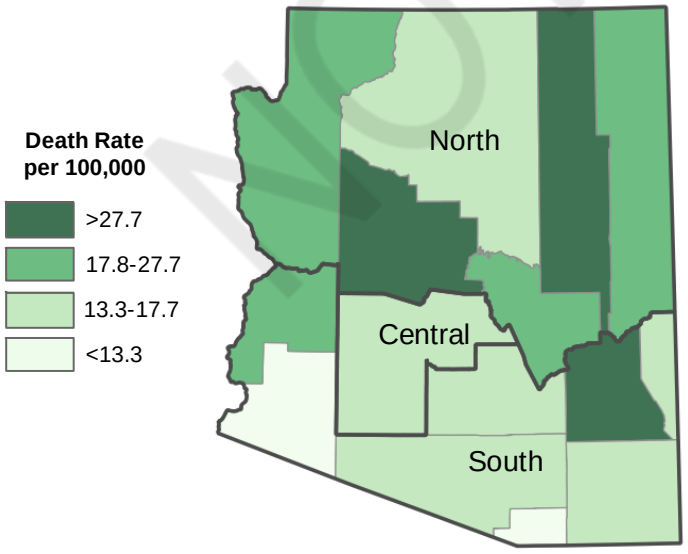
	2009	2010	2011	2012	2013	2014	2015	2016
AZ	16.1	16.7	17.2	16.2	17.0	16.5	17.8	17.7
US	11.8	12.1	12.3	12.5	12.5	12.9	13.3	13.4

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016) *Intentional self-harm (suicide), Arizona, 2006-2016.*

Suicide Death Rates by County

Suicide mortality rates in Arizona differed substantially by county. Yavapai, Navajo and Graham Counties all had suicide mortality rates over 30 per 100,000, while Santa Cruz County had a suicide mortality rate of 9.7 per 100,000. Most of the counties with high rates of suicide were concentrated in the Northern Region (See Exhibit 54). .

Exhibit 54. Age-adjusted Suicide Mortality Rates per 100,000 by Arizona County, 2016



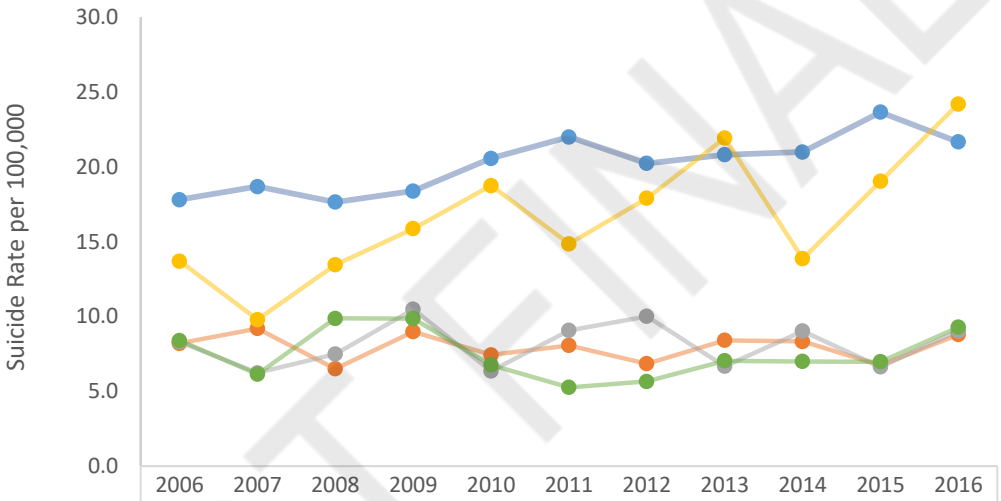
Rank	County	Rate
1	Yavapai	32.7
2	Navajo	32.0
3	Graham	30.5
4	Mohave	27.7
5	Apache	25.9
6	Gila	25.4
7	La Paz	22.2
8	Cochise	17.7
9	Pima	17.2
10	Greenlee	16.4
11	Maricopa	15.9
12	Coconino	15.8
13	Pinal	15.5
14	Yuma	13.2
15	Santa Cruz	9.7

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. Age Adjusted Mortality Rates for Selected Leading Causes of Death, 2016

Disparities in Suicide Death Rates

- Racial/Ethnic Disparities: Based on 2016 data, American Indian/ Alaska Natives and non-Hispanic whites experienced the greatest age-adjusted suicide rate of all racial/ethnic groups in Arizona (24.2 per 100,000 and 27.7 per 100,000, respectively). Rates for Hispanics, blacks, and Asian/Pacific Islanders were all less than 10.0 per 100,000. Additionally, trend data showed that not only did American Indian/Alaska Natives and non-Hispanic whites have a higher suicide rate in 2006 than their peers, but that their suicide death rates continued to accelerate overtime. (See Exhibit 55).

Exhibit 55. Trends in Age-Adjusted Suicide Mortality Rates per 100,000 in Arizona by Race/Ethnicity, 2006-2016



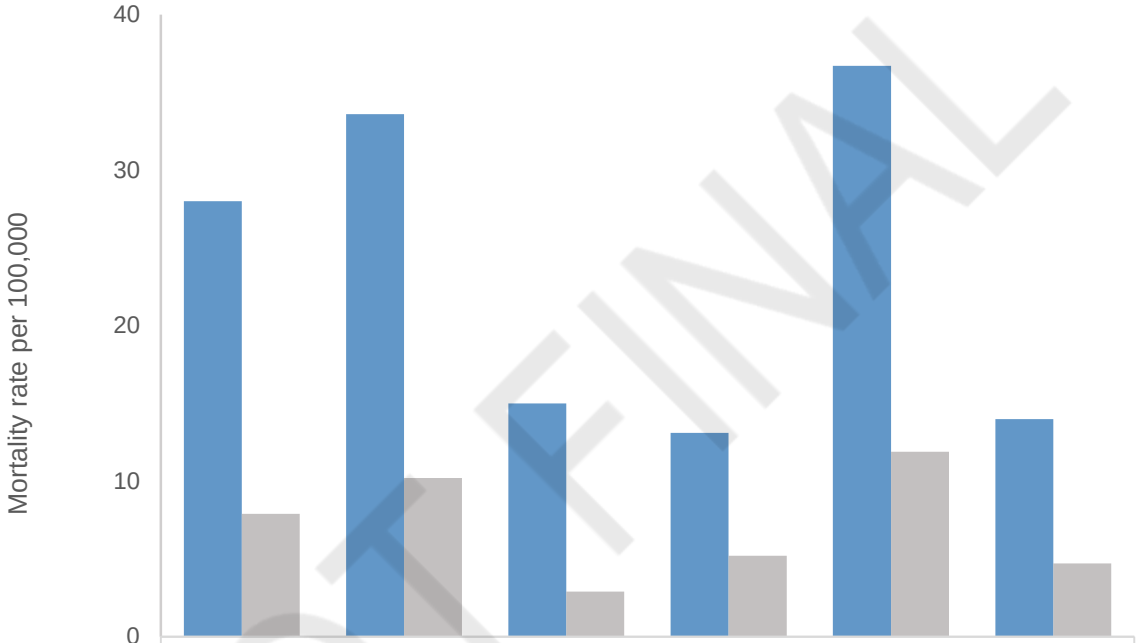
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
White	17.8	18.7	17.6	18.4	20.6	22.0	20.2	20.8	21.0	23.6	21.7
Hispanic	8.2	9.2	6.5	9.0	7.4	8.1	6.8	8.4	8.3	6.7	8.8
Black	8.3	6.2	7.5	10.5	6.4	9.1	10.0	6.7	9.0	6.6	9.0
American Indian	13.7	9.8	13.5	15.9	18.7	14.9	17.9	21.9	13.9	19.0	24.2
Asian/PI	8.4	6.1	9.9	9.9	6.8	5.3	5.7	7.0	7.0	7.0	9.3

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016) *Intentional self-harm (suicide), Arizona, 2006-2016.*

- Gender Disparities: Across all examined age groups and years, males experienced much higher suicide rates than females. In 2016, the age-adjusted suicide rate for males was 28.0 per 100,000 compared to 7.9 per 100,000 for females. This means males were over three times more likely to die from suicide than females. Males also saw increases in age-adjusted suicide rates between 2009 and 2016 (2009: 24.6 per 100,000; 2016: 28.0 per 100,000) while female suicide rates remained relatively constant (2009: 8.1 per 100,000; 2016: 7.9 per 100,000). (See Exhibit 56)
- For females, the death rate peaked for those aged 55-64 (13.3 per 100,000). For males, the death rate peaked for those 65 and older (46.6 per 100,000) with risk continuing to

increase with increasing age. Specifically, the rate among males 75-84 was 55.3 per 100,000, and rose to 75.6 per 100,000 among those 85 and older. Certain other sub-groups of males also had disproportionately high suicide rates. American Indian/Alaska Native males had a suicide rate of 36.7 per 100,000, and white non-Hispanic males had a rate of 33.6 per 100,000.

Exhibit 56. Age-Adjusted Suicide Mortality Rates per 100,000 in Arizona by Gender and Race/Ethnicity, 2016



	Total	White non-Hispanic	Hispanic or Latino	Black of African American	American Indian or Alaska Native	Asian/Pacific Islander
Males	28	33.6	15	13.1	36.7	14
Females	7.9	10.2	2.9	5.2	11.9	4.7

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016) *Intentional self-harm (suicide), Arizona, 2006-2016.*

Self-Inflicted Injuries

Data on inpatient hospitalizations and emergency department visits for self-inflicted injuries were taken from the 2016 Suicide Prevention Report prepared by the Arizona Department of Health Services, Office of Injury Prevention. The report used data from Arizona's 2012 to 2016 vital statistics.

Inpatient Hospitalizations for Self-Inflicted Injuries

- Rates in Arizona: For every completed suicide in Arizona in 2016, there were two self-inflicted injury-related hospitalizations. The age-adjusted hospitalization rate for self-inflicted injuries was 42.8 per 100,000 residents in 2016 (2,843 inpatient hospitalizations). Hospitalization rates peaked for those aged 15-24.
- Trends Overtime: Hospitalizations due to self-inflicted injury have decreased in Arizona from 2012 to 2016 (58.4 per 100,000; 42.6 per 100,000). Given the increase in the suicide mortality rate observed over the same time period, these data suggested suicide attempts are more likely to result in fatalities than in the past.
- Disparities in Hospitalization Rates:
    - Race/Ethnicity: White non-Hispanics and American Indian/Native American residents had the highest hospitalization rates (55.3 per 100,000; 53.3 per 100,000, respectively).
    - Gender: Overall, females were more likely to be hospitalized for self-inflicted injuries than males. This is in contrast to the gender disparities in suicide mortality rates that indicated males were over three times more likely to commit suicide than females. For females, those aged 15 to 19 had the highest rate of hospitalization (122.6 per 100,000).

Emergency Department Visits for Self-Inflicted Injuries

- Rates: For every completed suicide in Arizona in 2016 there were five self-inflicted injury-related emergency department (ED) visits. The ED rate for self-inflicted injuries was 103.1 per 100,000 residents in 2016 (6,750 ED visits). ED rates peaked for those aged 15-19 (344.6 per 100,000), and then decreased with increasing age.
- Trends Overtime: ED visits due to self-inflicted injury have increased slightly in Arizona from 2012 to 2016 (96.7 per 100,000; 103.1 per 100,000).
- Disparities in Hospitalization Rates:
    - Race/Ethnicity: White non-Hispanics had the highest ED hospitalization rate (130.4 per 100,000), followed by American Indian/Native Americans (120.0 per 100,000), and black non-Hispanics (119.3 per 100,000).
    - Gender: Overall, females were more likely to visit the ED for self-inflicted injuries than males. This is in contrast to the gender disparities in suicide mortality rates that indicated males were over three times more likely to commit suicide than females. For females, those aged 15 to 19 had the highest rate of ED visits (482.0 per 100,000).

Self-Reported Suicide Attempts Among High School Youth

Data on self-reported suicide attempts in the past year were collected during the 2017 YRBS and are only available for high school students.

- Prevalence of Suicide Attempts: According to data from the 2017 YRBS, high school students in Arizona were significantly more likely to report that they attempted suicide in the past year than youth nationally. Approximately 11.3% of Arizona high school students attempted suicide in the past 12 months, compared to 7.4% nationally (p=0.02).
- Trends in Suicide Attempts: There were no significant changes in reports of suicide attempts among Arizona high school students between 2008 and 2017.
- Disparities in Suicide Attempts: Disparities in suicide attempts existed across sub-populations of youth by sexual identity and race/ethnicity.
    - Sexual Identity: Compared to their peers, Arizona high school students identifying as gay, lesbian or bisexual were over four times more likely to report they attempted suicide (34.7% vs 8.2%, p<0.001), and more than eight times as likely to report that their suicide attempt resulted in an injury, poisoning or overdose that had to be treated by a doctor or nurse (20.5% vs 2.5%, p<0.001).
    - Race/Ethnicity: Compared to non-Hispanic whites, Hispanic high school students reported a higher prevalence of attempted suicide (13.3% vs 7.7%, p<0.001).
    - Suicide attempts among Arizona high school students did not differ significantly by gender.

Suicidal Thoughts

Prevalence of Suicidal Thoughts in Arizona

- Youth: Data from the 2017 YRBS estimated 19.2% of Arizona high school students seriously considered committing suicide during the past year, which did not statistically differ from the national estimate of 17.2%. NSDUH does not estimate serious thoughts of suicide among youth 12 to 17.
- Adults: Data from the 2015-2016 NSDUH estimated that 4.0% of Arizonans had serious thoughts of suicide in the past year; a prevalence of 4.0% was also reported nationally. Serious thoughts of suicide were most common among those 18 to 25 (8.9%), decreasing to 3.2% among those 26 or older.

Trends in Suicidal Thoughts

- Youth: There were no significant changes in the prevalence of suicidal thoughts among Arizona high school youth between 2008 and 2017.
- Adults: The prevalence of serious suicidal thoughts also did not change overall for adults between 2008 and 2016. However, there were significant increases in this time period for young adults aged 18 to 25 (6.6% to 8.9%, p=0.039). Similar increases were observed for young adults nationally. There was no significant change overtime for adults 26 or older.

Prevalence of Suicidal Thoughts by RBHA

There were no statistically relevant differences in suicidal thoughts by RBHA in Arizona.

Youth Disparities in Suicidal Thoughts:

Disparities in suicidal thoughts in the past year existed across sub-populations of youth by sexual identity and race/ethnicity.

- Sexual Identity: Compared to their peers, Arizona high school students identifying as lesbian, gay or bisexual were three times more likely to report they seriously considered suicide in the past year (15.1% vs 49.9%, $p<0.001$). This means nearly half of all students identifying as gay, lesbian or bisexual reported that they seriously considered suicide in the past year.
- Gender: Females were more likely to report that they seriously considered suicide than males (23.8% vs 14.0%, $p<0.001$). Suicidal thoughts among Arizona high school students did not differ significantly by race or ethnicity.

Drug Related Arrests

The Arizona Department of Public Safety publishes the *Crime in Arizona Report* which includes data on drug-related arrests in the State. According to this report, there were 1,240 arrests for the sale or manufacture of marijuana, and 15,839 arrests for marijuana possession in 2016. With the exception of driving under the influence, the largest number of drug related arrests were for marijuana possession.

Between 2010 and 2016, there were decreases in arrests for the sale or manufacture of marijuana, as well as the manufacture of "opium, cocaine, or derivatives" (1,254 to 1,010). However, there were substantial increases in arrests for the possession of "opium, cocaine, or derivatives" between 2010 and 2016 (from 1,980 to 3,360). (See Exhibit 57)

Exhibit 57. Drug-Related Arrests in Arizona in 2010 and 2016

	# of Arrests 2010	# of Arrests 2016
Drugs: Sale or Manufacturing		
Opium, cocaine, derivatives	1,254	1,010
Marijuana	1,659	1,240
Synthetic narcotics	535	705
Other dangerous non-narcotics	720	867
Drugs: Possession		
Opium, cocaine, derivatives	1,980	3,360
Marijuana	18,076	15,839
Synthetic narcotics	2,750	4,516
Other dangerous non-narcotics	4,981	5,235
Driving Under the Influence	37,981	21,883

Source: Arizona Department of Public Safety, Crime in Arizona Report, 2010 and 2016

Alcohol Related Crashes

The National Highway Traffic Administration reported 232 crash fatalities involving at least one driver with a BAC of 0.08% or higher in Arizona in 2016. This means approximately 24% of all traffic related fatalities were alcohol related in Arizona. Nationally, alcohol accounts for 28% of all crash fatalities.

- Prevalence Overtime: Long-term trends show alcohol-impaired driving fatalities decreased between 2005-2007 and 2014-2016 (370 vs 234).
- Prevalence by County: Alcohol related fatality rates per 100,000 people were highest in Apache (19.2) and La Paz (14.7) Counties.

The *2016 Motor Vehicle Crash Facts for Arizona*, prepared by the Arizona Department of Transportation (ADOT), provided additional data on alcohol related crashes. In this report, alcohol related crashes included all crashes where an investigating officer indicated that a driver, pedestrian or bicyclist had been drinking alcohol, whether or not it was substantiated by a blood or breath test. According to this report, the number of alcohol related crashes in 2016 was 4,942 and the number of alcohol crash fatalities was 302.

- Prevalence by Age: Data from this report indicate that in Arizona approximately 31% of drivers involved in alcohol related crashes were 25-34 years old. The risk of being a driver in an alcohol related crash declined for older and younger age groups.

- Disparities in Alcohol Related Crashes: ADOT data also show that males were more likely to be drivers involved in alcohol related crashes than females (73.0% vs 26.2%).

DUI Arrests

According to the *State of Arizona Highway Safety Annual Report FY2017* published by the Arizona Governor's Office of Highway Safety, there were 26,077 Driving Under the Influence (DUI) arrests, 5,028 drug impaired driving arrests, and 1,349 under-21 DUI arrests in FY2017. As seen in Exhibit 55, there were 37,981 DUI arrests in 2010 and 21,883 DUI arrests in 2016 indicating a significant reduction over that time, but in 2017 this number increased notably.

Although the number of total DUI arrests and under-21 arrests decreased between 2012 and 2016, the number of drug impaired DUIs increased between 2012 and 2016 (from 4,511 to 5,028). However, increased surveillance over that time period makes it difficult to know the true increase of drug impaired driving.

Self-Reported Alcohol Impaired Driving

In considering impaired driving it is important to note that arrests and fatalities capture only a small portion of all drug and alcohol impaired driving. Survey data seek to estimate the actual prevalence of alcohol impaired driving. The most accurate estimates of alcohol impaired driving came from the National Roadside Survey (NRS), which ended in 2013-2014. The NRS randomly sampled weekend nighttime drivers to test for the presence of alcohol and drugs. Data from this survey revealed a substantial decrease in the prevalence of alcohol impaired driving, from 7.5% in 1973 to 1.5% in 2012-2014 (Berning et al, 2015). Unfortunately, state-specific data were not estimated by the NRS.

Today, data on alcohol and drug impaired driving are collected by the YRBS and the BRFSS. These data are based on self-report, and thus limited in their accuracy as compared to the NRS.

<u>Youth Prevalence of Alcohol Impaired Driving</u>

According to data from the 2017 YRBS nearly 1-in-5 (19.2%) Arizona high school students rode with a driver who had been drinking alcohol in the 30 days before the survey. An estimated 6.2% of high school students reported that they personally drove after drinking alcohol in the prior 30 days. Neither estimate of alcohol impaired driving in Arizona differed from national estimates.

<u>Adult Prevalence of Alcohol Impaired Driving</u>

Data from the 2016 BRFSS provided recent state and national estimates of alcohol impaired driving in the past month. In Arizona, an estimated 2.5% of respondents 18 and older reported driving under the influence.

Youth Trends in Alcohol Impaired Driving

The 2017 YRBS did not begin asking about alcohol impaired driving until 2013. Between 2013 and 2015, there were significant decreases in overall reports of drinking and driving (9.0 vs 6.2, p=0.04). However, the decreases were predominately due to declines in male drinking and driving from 10.8% to 6.7% (p=0.03). The prevalence of drinking and driving did not decline significantly for females (6.7% vs 5.7%, p=0.60), although females still reported less drinking and driving overall than males. High school students in Arizona were significantly less likely to report that they rode with a driver who had been drinking between 2003 and 2017 (36.2% vs 19.2%, p<0.001).

Adult Trends in Alcohol Impaired Driving

Data on alcohol impaired driving in Arizona could be sourced from the BRFSS as early as 2012. These data showed minor but not statistically significant declines in reports of alcohol impaired driving in the past month during this time (2012: 3.2%, 2014: 3.3%, 2016: 2.5%). There were more pronounced declines for males between 2012 and 2016. The prevalence for females remained constant at 1.3% between 2012 and 2016.

Prevalence of Alcohol Impaired Driving by Region:

No data were available on self-reported alcohol impaired driving by region.

Youth Disparities in Alcohol Impaired Driving:

Hispanic students in Arizona were significantly more likely than non-Hispanic white students to report that they rode with someone who had been drinking (22.8% vs 16.2%, p <0.001), although there were no racial/ethnic differences in students' self-report of drinking and driving. There were no significant disparities in alcohol impaired driving by sexual identity or gender.

Adult Disparities:

Males were significantly more likely to report impaired driving than females (3.4% vs 1.3%, p=0.004). The prevalence of alcohol impaired driving was significantly lower for non-Hispanic whites (2.1%) and Hispanics (2.4%) than non-Hispanic blacks (4.7%), or other racial groups (5.2%), with an overall chi-square of p=0.004. There were no significant differences in reports of impaired driving by educational attainment or employment status.

Marijuana and Other Drug Impaired Driving

According to the *2017 Report to Congress on Marijuana-Impaired Driving* (Compton, 2017), marijuana is the second most commonly detected drug in crash-related drivers (alcohol is the first). However, the definitive effects of marijuana use on driving are poorly understood; the report cites numerous reasons for this. First, there is no gold standard method to identify

marijuana impairment. Blood tests, which are frequently used, are limited because the level of Tetrahydrocannabinol (THC) in the blood and the degree of impairment are not highly correlated. Specifically, peak levels of THC are observed right after smoking, while peak impairment occurs one or two hours later. Additionally, chronic marijuana users may have detectable levels of THC in the blood even if they have not recently used marijuana. This means it is difficult to evaluate impairment based on the presence of THC.

Additionally, the report notes that studies seeking to estimate the actual effects of marijuana on driving have been inconclusive, and it remains unknown how much marijuana use actually contributes to crashes. The only large-scale case-control crash risk study in the United States found that after adjusting for age, gender, ethnicity and alcohol concentration, there was no significant increase in risk associated with THC (Romano et al., 2014). More research is needed to understand the specific driving risks associated with marijuana consumption. Risks from other drugs are similarly poorly understood. The *2017 Report to Congress on Marijuana-Impaired Driving* provides recommendations about monitoring and addressing marijuana impaired driving based on these limitations.

Not surprisingly, there are limited reliable data on the effects of marijuana and other drug impaired driving, particularly at the state level. The National Roadside Survey showed a substantial increase in the prevalence of drivers that had used marijuana, from 8.6% in 2007 to 12.6% in 2014. By comparison, alcohol impaired driving nationally decreased during the same period from 12.4% to 8.3% (Berning et al, 2015).

Arizona specific data from the National Highway Traffic Safety Administration Fatal Reporting System (FARS) indicated increases in the percentage of traffic fatalities that involved marijuana from 2.9% in 2010 to 5.1% in 2014. However, given the unresolved limitations as noted above, it is unclear if the increases in the prevalence of THC truly indicate meaningful increases in marijuana impaired driving.

Qualitative Findings: Substances

Several community members and professionals across regions acknowledged the difficult of "aligning a substance with a demographic" because there are many contributing factors that go into why a person chooses a particular substance. However, there are a few overall trends from the focus groups and interviews that should be noted: *Alcohol* was reported to be a substance use issue for all subpopulations; *marijuana* use was reported to be common among youth, veterans, Native Americans and some older adults; *methamphetamine* was reported to be used frequently by veterans and Native Americans; *opioid* use was recognized as a significant substance use issue by the veteran, older adult and Native American communities; *prescription drugs* and *over-the-counter drugs* were reported to be used heavily by older adults and youth.

Other substances that came up during the focus group discussions and interviews included heroin, fentanyl and spices (synthetic marijuana). Several respondents reported fentanyl and spices were extremely strong and often caused a lot of harm. As stated above, these qualitative findings should not be generalized to these subpopulations, as they are a small sampling of perspectives from across the State.

Youth

Substances Most Used

Across regions, youth and adults serving youth who participated in focus groups reported youth most frequently use alcohol, marijuana, and vaping substances (containing nicotine or THC). Similarly, professionals serving youth across regions who were interviewed reported alcohol and marijuana as the biggest issues among youth, including college students. While some community members and professionals from the Northern and Central regions reported opioid use as an issue for youth in their community (including one professional from Mohave County who stated opioids are creating the most harm for youth in that county due to overdoses), many professionals reported youth are not using opioids very much in their communities and noted the "opioid conversation is overshadowing other issues". For example, one adult-serving-youth focus group participant in Sierra Vista reported there is a "buzz about opioids, but I haven't met any families personally with a kid who had issues with it." Professionals serving youth across regions noted marijuana is a growing problem for youth because it impacts the brain development and because society's "perceptions of harm and legality" have changed. One professional in the Southern region explained how marijuana affects children's brains by stating, "When you have a youth who normally activates the reward center in the brain [by] getting a good grade or making a sports team… they will continue with goal setting and achieving goals. Let's say the same youth smokes marijuana and the reward cells are activated with weed instead, they get that same good feeling without having done anything. If you feel that good, why would you study on a test? When a youth can seek artificial high why do they need parental approval for that reward?"

A youth focus group member in the Central region recalled that at his school last year, students as young as eighth grade "used to smoke weed." A professional serving youth in the Northern region cautioned, "We haven't begun to see the impact of early [marijuana] use impacting life success. It may hinder kids from launching into adulthood." In addition, one professional in the Southern region noted marijuana appears be a more serious issue for Native American students than students from other ethnic groups, as a larger percentage of Native American youth are referred to juvenile court.

Vaping (either nicotine or THC-laced substances) was mentioned as a popular substance for youth in all four adult-serving-youth focus groups. The flavors that manufacturers put into

these substances "gets these kids hooked," according to one adult-serving-youth focus group participant in the Southern region. Another adult-serving-youth participant in the Southern region explained, "Kids are vaping in the restrooms in middle school," while a third adult-serving-youth Southern region focus group participant stated, "My boyfriend's son, a sophomore, sees kids vaping in the class, teacher turns their back, they take a puff, everybody's waving their notebooks around." Youth in the Central and Northern regions confirmed that some youth vape behind teachers' backs. Moreover, a youth participant in the Northern region stated on the bus, "People usually duck down under the seats to vape."

In addition to alcohol, marijuana and vaping, prescription drug use was mentioned as a serious substance use issue for youth at adults-serving-youth focus groups in the Southern, Northern and Central regions. Focus group participants reported that children get prescription drugs from their parents and mix them with other things such as cough syrup. A focus group participant in West Phoenix mentioned that some youth use Adderall®, which is prescribed for attention deficit hyperactivity disorder (ADHD), as a recreational drug. Additionally, a professional in the Southern region who was interviewed reported some students in the region use Xanax.

Notably, multiple professionals serving youth in the Northern region who were interviewed agreed this area sees significant meth and heroin use among youth. One professional in the Northern region reported the community "is experiencing a resurgence of meth and heroin". Adult-serving-youth focus group participants in the Northern region also reported that meth is a significant issue for youth in the area, especially for 18 to 20-year-olds. According to one adult-serving-youth focus group participant in the Northern region, heroin is popular because it's cheaper than marijuana. The use of meth by youth was also brought up by adult-serving-youth during the Central region focus group. In addition, multiple professionals serving youth in the Southern region noted that gummy bears and chocolates laced with fentanyl or other substances have caused a lot of harm for youth in the community, including at least one fatality. Other substances used by youth which focus group participants mentioned included tobacco (Central and Southern regions); over-the-counter medication (like cough syrup; Central and Northern regions), energy drinks (with or without alcohol; Central and Northern regions), caffeine pills and black tar heroin (Central region); spice, bath salts, and adulterants such as fentanyl (Northern region); cocaine (used by football players and cheerleaders) and LSD (used by high school students; Northern region).

Most Harmful Substances

Alcohol, marijuana and opioids (including hospitalization and death due to accidental opioid overdose) were reported to cause the most overall harm across regions by participants in the adults-serving-youth focus groups. However, professionals serving youth also had different opinions about which substance is currently creating the most harm for youth in their

communities. One professional serving youth in the Southern region stated, "Alcohol is the worst because it is the most easily accessible and the most widely abused." However, another professional from the Southern region noted, "Students on more serious drugs cause trouble in school and are disruptive and defiant. They require time for evaluation, their parents have to take them to hospital – it disrupts the education flow for the student and for staff who have to process it. It creates the need for public relations management for the school and causes legal troubles for the student."

Consequences of Use

Common consequences of youth substance use that were noted during focus groups and interviews (aside from overdose, hospitalization and death), include crime, school suspensions, legal problems, developmental harm (from marijuana), inability to get a job, sexual assault, trafficking, teen pregnancy, domestic violence, homelessness, sexually transmitted diseases, child abuse, severance of parental rights, and suicide (especially related to marijuana use). In addition, one focus group participant in the Northern region reported sometimes youth cannot fully recover after using a substance like spice (synthetic marijuana) only once, and this sometimes prevents youth from returning to school/college after summer break.

Acquisition of Substances

Adult-serving-youth focus group participants in all regions reported multiple times that youth get substances at school from other youth. One focus group participant in the Southern region stated, "It's in the schools, hallways, bathrooms… The kids know who [and] where they can get it from." One adult-serving-youth focus group participant from the Southern region explained, youth are bringing prescription drugs to school and "kids are being told that a pill is cure… Youth say to each other, 'If you're feeling that way, I'll share mine with you.'"

In addition, adults-serving-youth from all regions reported youth get substances at parties (including desert parties, bonfires, house parties, and skittles parties). According to youth focus group participants, skittles parties are where youth ask people to bring different kinds of pills from home, combine them all together, and youth at the party reach in and swallow whatever they grab.

Focus group participants from all regions reported youth commonly obtain substances from parents or caregivers and steal prescription drugs like oxycodone or over-the-counter drugs like cough syrup from their parents' or grandparents' medicine cabinets. Adults-serving-youth focus group participants in the Central region reported parents sometimes give cigarettes to younger adolescents because they think it will prevent them from experimenting with other drugs and parents often let older adolescents experiment with other drugs at home because they consider it to be safer than the youth experimenting with them outside of the home.

In addition, in Central and Northern regions, participants reported youth often get substances through younger family members such as siblings and cousins. Participants in the Central region explained that in their region, doctors readily prescribe substances like Xanax and Percocet, making these substances readily available in addition to already accessible drugs such as marijuana, heroin, and hard drugs One adult who serves youth in the Central region stated that in that area, youth sometimes steal prescription drugs from homes up for sale during open houses. Adults serving youth in the Central and Southern regions reported some youth buy drugs from drug dealers. In addition, one participant in the Northern region noted that stores and pharmacies do not monitor the cough medicine merchandise closely enough.
Other places respondents reported youth get substances included Mexican pharmacies (which historically have had more lax regulation and cheaper prices), community members who sell prescription medication, truck stops, and from community members with marijuana cards. Additionally, youth see marijuana advertisements on social media and may find out where to get marijuana that way.

Veterans

Substance Use

A professional serving veterans in the Southern region (who was also a veteran himself) reported that for those in the military, alcohol is the main substance that is used and "there is definitely a trend towards [prescription] opiates with so much of us coming out with pain…..all of us have chronic problems, chronic back problems and all of our joints …[and]…we do get prescribed opiates pretty regularly without any real issue." According to this professional who serves veterans, the substances veterans use most frequently are alcohol, opioids, methamphetamine and combinations of the same. Vietnam-era veterans tend to use alcohol, marijuana and meth, while younger veterans tend to use opioids and some marijuana. Meth is used less frequently in the military population than the veteran population, "because no one cares about how much you drink when you're on active duty and you get the opiates from your doctor."

Veterans at focus groups in all three regions also reported meth is a substance use issue for veterans in their communities. One participant in the Southern region stated meth is readily available and affordable. In addition, focus group participants in the Southern and Central regions stated that many homeless veterans use meth to stay awake at night as a way of staying safe. One female veteran focus group participant in the Central region explained, "Meth was great for staying awake and staying protected, especially as a female."

Veterans at the Northern focus group reported that alcohol is a substance use issue for veterans because veterans often grow up in families where alcohol is misused, and alcohol is a gateway drug that "leads to all other drug use". Several veterans at the Northern region focus group

agreed that alcohol is readily available on base, such as one veteran in the Northern region who stated, "… when I was in the Navy, right next to the soda machine was a beer machine… you could get a beer out of the thing any time day or night. Everything you did was around drinking. The macho thing was how much can you drink and how much can you party and not miss a day of work."

In the Southern region, one veteran explained marijuana is used by some veterans partly because it is cheaper than other drugs, while a veteran in the Central region asserted, "People claim [marijuana] is a gateway drug and I agree. I also agree it is an exit drug. As a heroin addict, the craving is strong… [and] you get sick if you don't have it. Once I quit, I had all of this, 'I want to get high, not self-medicate, I want to get high'. So, I knew that I didn't want to do heroin, I knew what I'd been through… So, I jump on the weed… Smoking the weed eased up my cravings for anything else."

Northern veteran focus group participants reported substance use among veterans often results in crime, homelessness and sometimes death. Moreover, veterans in the Southern focus group reported many veterans don't pay for drugs; rather they barter for drugs by offering food and space for parties in exchange. Veterans in the Southern region also stated that the proximity to the border means many substances such as cocaine, meth and marijuana are readily available. Lastly, several veterans in the Central region agreed some veterans "will say [their] drugs are not working in order to get the narcotic".

Older Adults

Substance Use

Focus group participants in all three regions reported that alcohol is frequently used by older adults in Arizona. In the Northern region, one participant reported that the small rural nature of many towns gives older adults the most access to alcohol. Another Northern region focus group participant explained alcohol is readily available at events held by older adult communities or older adult homes. This participant related, "I was totally amazed at the number of people who were there [at a senior facility's wine and cheese night] and the size of the wine glasses that they had. And a lot of these people have dementia or trouble walking or whatever… and the [glasses] were almost full…"

Southern and Central focus group participants also reported general use of prescription drugs in addition to specifically benzodiazepines as a substance use issue for older adults in their communities. One focus group participant in the Southern region reported older adults' slowed metabolism made misuse of prescription drugs more dangerous. Sometimes misuse is intentional, but often times it is accidental, according to a focus group participant in the Central region. In addition, poly-drug use (such as mixing marijuana pills with other medication or

alcohol) was mentioned as an issue in the Southern and Central regions. Focus group participants in the Southern and Central regions also highlighted that many times older adults are not aware of possible interactions with other medications. Focus group participants reported that other substances sometimes used by the older adult population include opioids, marijuana (often used initially to improve sleep and alleviate pain), methamphetamine, and heroin.

Consequences

Older adult focus group participants in all regions reported injurious falls (often requiring hospitalization) were a common result of substance use in the older adult population. Focus group participants explained other consequences of substance use in the older adult population include: overdose (Southern and Central regions), death (Northern region), liver problems (Central region), and DUI (Central region). One focus group participant in the Southern region noted some older adults who have cognitive decline or who lack money for food are manipulated into transporting drugs over the border.

Acquisition

In the Southern and Northern regions, several focus group participants reported that older adults frequently trade or share medications with friends and neighbors; two participants in the Southern region explained sometimes older adults steal or buy substances from their peers. In the Central and Northern region, participants stated sometimes caregivers take older adults to the store in order to buy alcohol or other substances and in the Southern region, and one participant reported some older adults go to Mexico to buy prescription medication because it is cheaper there and/or "they are not getting what they want here". Similarly, in the Southern and Central regions, several participants reported some older adults "physician-hop" (i.e., go to multiple physicians and get multiple simultaneous prescriptions to use). As one older adult focus group participant who works with older adults in the Southern region stated, "If they're not happy with their doctor, [some older adults] switch doctors to find one that agrees with their belief system." This participant also explained, while there are shared databases that aim to prevent simultaneous prescription misuse of controlled substances, they are not being used regularly by most doctors.

LGBTQ Populations

Substances Used

LGBTQ focus group participants in the Southern region reported what gets used by individuals in the LGBTQ communities depends on trends, availability, socioeconomic status, and personality type. As one participant explained, "When you are a regular user of a substance … its connected to personality… Someone who is an opioid user will not one day, say, use crack." Another participant concurred by stating, what substance someone uses depends on whether

"you're a 'downer girl' or an 'upper girl'". A focus group participant in the Central region stated, "My friends do a lot of 'I need to relax drugs' downer drugs, like low dose heroin, pot, pills, mind numbing pills." A Southern region focus group participant reported, "Meth is always popular everywhere," and some participants in the Southern region explained that they felt meth is causing the most harm for the LGBTQ populations in their community. In addition, LGBTQ focus group participants across regions reported alcohol is used by the LGBTQ populations. Other substances LGBTQ focus group participants noted as widely used by the LGBTQ populations include marijuana, cocaine, fentanyl, and prescription medication (including Adderall®).

Consequences

LGBTQ focus group participants reported that domestic violence, violence in the community and sexual assault at parties often result from substance use in the LGBTQ populations, as well as individuals falling victim to over-policing for nonviolent drug offenses with little to no rehabilitation options instead of drug charges.

Acquisition

Across all three regions, LGBTQ focus group participants stated members of the LGBTQ communities commonly get substances through their friends or "friends of friends". As one participant in the Southern region put it, "Queer people don't venture out, they don't want to risk it." According to focus group participants, other ways the LGBTQ populations gets access to substances include: drug dealers (Southern and Central regions), relatives (Southern and Northern regions), parents/caregivers or friends' parents (Northern region) and shoplifting or using fake IDs (Northern region).

Tribal Populations

Substance Use

Tribal leaders that were interviewed reported the Tribal members often use alcohol, opioids, and methamphetamine. A Pascua Yaqui elder who was interviewed reported youth often hide alcohol in their "Polar Pop Styrofoam cup" so that adults can't tell what they are drinking. He also noted that marijuana is a substance use issue in the Pascua Yaqui community in the Central region and that "kids say, 'It's legal, why can't I smoke it?'"

Pascua Yaqui focus group participants also reported that alcohol and methamphetamine are substance use issues in the community that cause a lot of harm. One Pascua Yaqui member explained, "Older people are more alcoholics because back in the day there weren't as much drugs, now today they are most used to drinking alcohol… to cope. Younger [people], they go for whatever is out there… they don't care about the alcohol." While another Pascua Yaqui member rejoined, "Alcohol … is slower acting, but it's still killing people in our community…

It's still killing my family members. Do they dabble in other drugs too? Yes, but what started it? It's the alcohol and it's a legal drug. I think it's important to recognize that alcohol is a drug. It's where it starts." Multiple Tribal members explained that alcohol use in their communities lead to high rates of cirrhosis of the liver and affects "everyone that lives in [the] home", often leading to domestic violence, grandparents raising children, and/or children failing in school. A Pascua Yaqui member added, "Now that [doctors] are having more control over [prescription opioids] … now [people] turn to using heroin and meth because they can't get the opiates anymore." As stated above, these findings represent a small sample and should not be generalized across all Tribal communities, or the Tribal communities in which the respondents are members of.

Refugee Populations

Professionals who work with the refugee populations in the Southern region reported that the major substance use issues in the refugee community are alcohol and cigarettes, with alcohol causing the most harm. In addition, youth also talk about themselves or family members using "weed", but lack understanding that this is marijuana. The professionals interviewed were not aware of any refugee youth involved in substance use. Respondents indicated Congolese men and Bhutanese men and women seem to have higher rates of substance use compared to other refugees, likely because both populations have spent a long time in refugee camps and experienced "pretty intense trauma."

Respondents reported alcohol affects not only refugees' health but also refugees' family and community. Dependency interferes with daily life, job, school, relationships, and carrying out daily activities. Consequences include loss of jobs, which exacerbates financial strain and increases risk of domestic violence. Alcohol issues lead refugees to use their partners' money to buy alcohol rather than spending money on basic needs. Respondents emphasized that possible consequences of substance use are particularly dire for this population, as criminal charges for domestic violence will affect their potential for a green card or citizenship. According to respondents, substance use "definitely affects the resettlement process."

Promotores

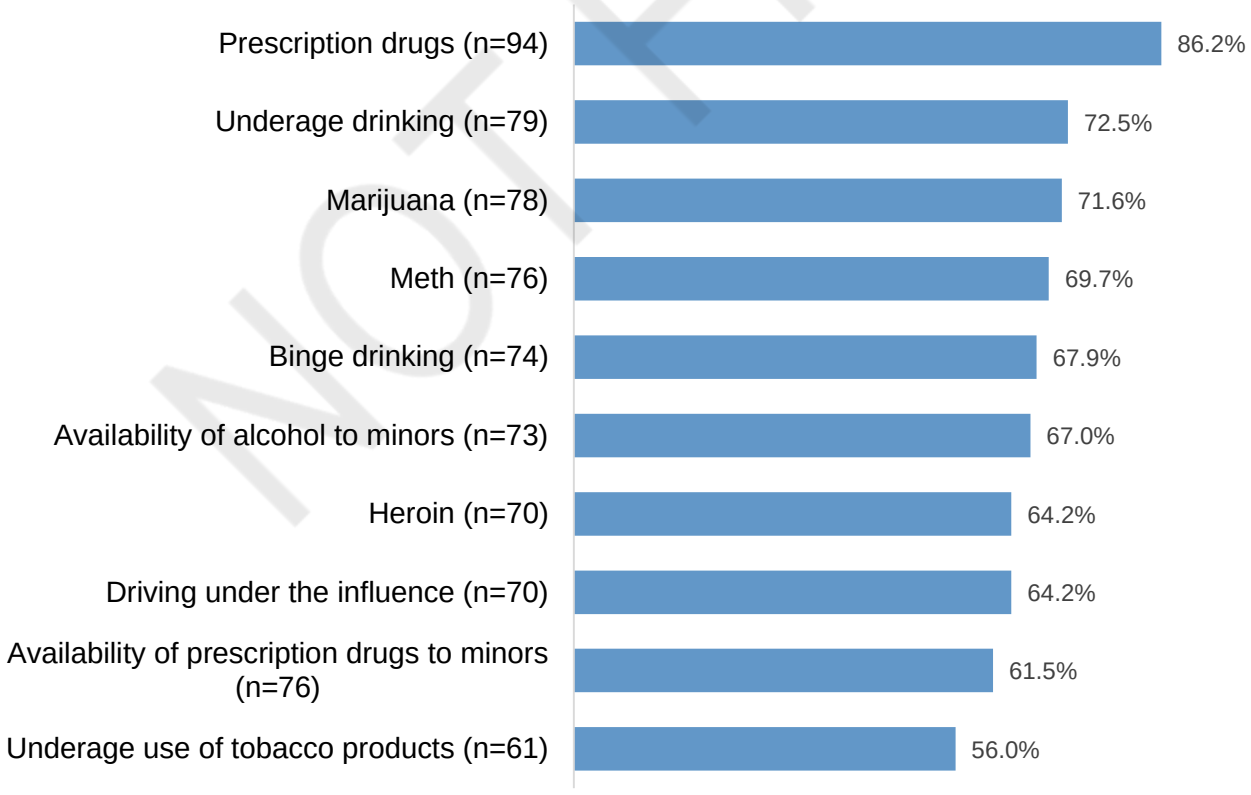
A Promotora is a Hispanic/Latino community member who receives specialized training to provide basic health education in the community without being a professional health care worker and serve as liaisons between their community, health professionals, and human and social service organizations. Promotores in the Phoenix area reported that the substances they see most used are alcohol (due to the low cost), and marijuana for both youth and adults because it is considered normal. Youth are often using e-cigarettes because they do not see them as harmful. Both youth and adults are using cocaine, crystal meth, prescription drugs, paint

thinner, benzodiazepines, spice (synthetic marijuana) and prescription drugs. Respondents talked about the unintentional overdose of prescription medication often seen in older adults in their communities. For youth, they acquire substances from friends at school, and are sometimes offered them for free. They also steal from parents and grandparents to use or sell. Sometimes, parents buy alcohol for youth because they feel it is better to learn how to drink at home, "where in general" drinking tends to be a cultural norm for men. Benzodiazepines tend to enter the home after being brought in from Mexico. Marijuana acquisition routes include marijuana dispensary cards, home deliveries of marijuana and other drugs, easy access on the street, getting marijuana from people they know who have a marijuana card, and growing marijuana. There was agreement that many individuals in their community have a serious addiction problem and that some of the major consequences of this use are unemployment and loss of one's family.

Workforce Survey

Respondents were asked about what substances were the major issues in their community. Respondents could report more than one type of substance issue (See Exhibit 58). The most commonly reported major substance use issue was prescription drugs.

Exhibit 58. Major Substance Issues* (N=109)



*Respondents could choose more than one substance use issue.

Sixteen respondents reported one or more "other" major substance use issues in their community, which fell into the following themes:

- Availability of marijuana to minors/Marijuana use in minors during ongoing brain development
- Vaping
- All Opioids
- Drugs and Suicide
    - Over medicating with drugs - risk for suicide
    - Substance use related suicide
- All tobacco products at all ages
- Accessibility of alcohol
- Selling alcohol to already intoxicated people
- Older adult medication mismanagement
- Siblings supplying to family members
- Specific drugs
    - Prescription stimulants
    - Prescription benzodiazepines
    - Fentanyl (synthetic opioid)
    - Spice
    - Cocaine
    - Ecstasy

Prevention: Current Efforts

Community Prevention Inventory

The Community Prevention Inventory (Appendix D) includes a wide spectrum of coalitions, organizations, and programs from across Arizona, although it should not be considered an all-inclusive listing of prevention resources in the State. Altogether, 41 prevention coalitions are included in the inventory. Most of the coalitions are associated with a specific geographic area and are organized around a population, while a few work around a single issue (e.g., opioids) statewide. Approximately one third of the coalitions are in Maricopa County, and about one fifth are located in Pima County. Based on the Statewide Substance Abuse Coalition Leaders in

Arizona (SACLA) membership list, additional information obtained from the RBHAs and prevention organizations, all counties except for Greenlee, La Paz, and Yuma have prevention coalitions. However, there may be additional prevention coalitions operating that do not participate in SACLA. The data collected also suggests that prevention coalitions cannot be universally viewed as stable entities providing prevention resources in a community. The leader of a coalition included on the SACLA's list reported that their coalition was not currently functioning; another noted that their coalition is only in a formative stage, and other coalition leaders did not respond to information request e-mails.

The target substances of prevention coalitions show great variation. Most prevention coalitions target multiple substances, with alcohol (i.e., underage drinking) being most commonly reported, followed by marijuana, opioids, and prescription drugs. Three coalitions included synthetics as one of their targeted substances and two mentioned tobacco, although these may also be targeted by coalitions that reported targeting "all" substance or "other substances" in addition to a named one. The most commonly cited combination of targeted substances was alcohol, marijuana, and prescription drugs. No prevention coalitions explicitly named methamphetamine as a targeted substance, and it is not clear whether the coalitions that address tobacco also address e-cigarettes and vape pens.

It is clear from the inventory that capacity varies greatly by coalition. Some coalitions are implementing multiple programs in their community, sometimes at multiple sites (e.g., schools). Some coalitions provided a detailed list and description of programming and activities while others offered only a broad view of their work (e.g., Strategic Prevention Framework). Although there are more coalitions in larger, urban counties, some rural counties have coalitions that have substantial outreach capabilities to youth and other community members, based on the types and amount of programming and activities they implement. The most commonly mentioned types of programs and activities included public awareness campaigns, prescription drug take back events, school assemblies, youth groups, community presentations/town halls, parent education, life skills programs, and safe graduation/prom events. About 30% of the coalitions reported using one or more evidence-based programs, with Rx-360 being the most commonly cited. Only a small number of coalitions mentioned having programs or events that specifically target marijuana, although they may address marijuana as part of broader drug education efforts.

State universities, particularly Arizona State University and the University of Arizona, reported having an extensive array of prevention programs and activities, the majority of which focus on alcohol and/or other drugs. The universities utilize a number of evidence-based programs including substance use education and screening (some of which are online), substance-free social programming, challenging social norms around alcohol and other drugs through social marketing/media, and evidence-based environmental strategies such as substance-free residence halls.

Non-profits (other than prevention coalitions), educational institutions, and government agencies also provide community prevention resources, with most of the information gathered from these types coming from RBHAs and on-line research. The prevention programs provided by these entities include ones that target the needs of seniors as well as supporting harm reduction.

The inventory's section on Tribal organizations' prevention efforts includes programs both geographically-focused (e.g., Guadalupe, Maricopa Counties) and more regional efforts. The former includes youth skills and parent education. Of particular interest in all of the Tribal prevention efforts is a focus on incorporating American Indian values and cultural knowledge. Additionally, Tribal programs are some of the few in the inventory that specifically address methamphetamine use and/or misuse. Information is needed from additional Tribes to present a more complete picture of substance use prevention in those communities.

Qualitative Findings: Current Prevention Efforts

In all focus groups and interviews conducted, the question was asked:

> "What does the community do to try to prevent use of substances in your community?"

Asking this question assisted in filling gaps of understanding pertaining to any statewide prevention efforts not being captured by the community inventory or the workforce survey. Findings below include data from focus groups and interviews conducted across the State. The types of prevention efforts presented are those with evidence supported by these conversations. Not all focus groups shared current prevention activities in their communities often due to a lack of knowledge or understanding about what types of programs and efforts existed. Also, in general, the prevention programs listed in the community inventory is not repeated below if it was reiterated by a focus group participant or interviewee.

Youth (and those serving youth)

Youth, and those serving youth, provided some examples of current prevention efforts including:

- Public Service Announcements (PSAs) and Public Awareness Campaigns
- Pro-Social Programs
- Student Led Groups and Youth Conferences
- Family Nights
- School Presentations
- Fairs and other Community Prevention Events
- Conferences/Summits
- Teacher Education about Substance Use and/or Misuse
- Peer-to-Peer Advocacy and Youth Clubs
- Substance Free Peer Leadership Programs
- Videos
- Parental Engagement
- Red Ribbon Week

- RX Drug Take Back Programs
- Harm Reduction Programs including Needle Exchanges and SBIRT
- Re-enforcing Tribal youths' connection to their culture, customs, and traditions so they use the coping skills their ancestors established before they were introduced to alcohol and other substances.
- Governor's Office of Youth, Faith and Family's "I've Got Something Better" campaign
- Governor's Office of Youth, Faith and Family's "Overcome Awkward" Campaign
- Governor's Office of Youth, Faith and Family's "Healthy Families, Healthy Youth" middle school program
- Governor's Office of Youth Faith and Family's "High School Health and Wellness" Program
- Governor's Office of Youth, Faith and Family Prevention and Treatment Locator website
- School Mazes (offering education on the impact risky choices such as substance use have on a youth's life)
- Collaboration with Collegiate Recovery Programs
- Community education on the use of Adverse Childe Experiences (ACES) to identify youth at risk for substance use/self-medication
- Prevention Related Games

> *When we do our Campaign norms at the middle school planning to do that again… game….last time we did cup pong… like beer pong almost, questions in the cups that related to marijuana, alcohol, or prescription drugs and they answer questions…..the … 6th and 7th graders really enjoyed that game… so we're doing something again like that and we are doing something for the high school, which is good because they wanted us to be at the high school*. (Maricopa County adult)

Veterans

Veterans provided some examples of current prevention efforts in their community including:

- Coalitions that help to provide a variety of services and resources to veterans.
- Veteran Transition Programs

- VA Buddies Program
- Tribal Ceremonies for veterans returning from service.
- Organizations that provide some prevention programs, including the RWB, the Legion, the Vet Center, National Community Health Partners, VFW (Veterans of Foreign Wars), Arizona Western College Veteran Services, and DAV (Disabled American Veterans).
- Diversion Programs
- Social Activities that do not include substances.

Older Adults

Older adults provided some examples of current prevention efforts going on including:

- Education and Outreach
- Companionship Programs
- Peer Discussion Groups
- Alternative Health Classes
- Medication Disposal Programs
- Medication Reconciliation Programs

Tribal Populations

In a Key Informant interview with a member of the Inter-Tribal Council of Arizona (ITCA), the interviewee mentioned that they do not have a program that addresses substance use and/or misuse and they do not receive funding to address any of these topics. Their prevention programs focus mainly on teen pregnancy prevention, crime prevention, and disease prevention (including sexually transmitted infection). The respondent was not familiar with individual Tribes' prevention programs. ITCA prevention programs however, do discuss culture resilience and how it is important to go back to traditional ways to heal from historical trauma, "going back to our ceremonies and our kinship responsibilities and … learning how to eat or reintroducing our indigenous foods." Furthermore, many programs try to use a holistic focus on the individual and their family, without emphasizing one specific area of health, with the goal of connecting mental health, physical health, spiritual health, and emotional health. A lot of Tribes are trying "to bring in their indigenous ways or knowledge along with the Western way to help the individual. Because you still need both to help that person." "We have our prayers. We have our ceremonies. We have our stories… so it's just going back to that."

Although ITCA does not provide any substance use and/or misuse prevention programs, over the last four years they have been helping Tribes develop their skills to do health and other prevention; learning how to conduct an assessment or put a survey together, report-writing, and leadership training for coalition members. "So, we've done a lot of capacity building skills building over the last four years." These activities help Tribes organize programming for their SAMHSA grants.

For prevention efforts, the Gila River Indian Community has health initiatives through the Recreation Department and the Hospital such as fitness programs and fitness challenges. One community key informant interviewed from the Gila River Indian Community shared that avoidance of substances is a general goal of these efforts but that they do not discuss it directly. The community has a block grant-funded prevention coalition (the Gila River Prevention Coalition) that puts on events and has a booth at health initiative events. They are mostly suicide-focused and have suicide prevention events that they sponsor at district service centers targeting the whole community and include promotional items. They do have pamphlets on substance use targeting different substances. The key informant did not know how effective these efforts were, but felt that tracking success stories could be helpful.

The Navajo Nation reaches its Tribal members around the world through the use of their radio program. Substance abuse prevention and education are provided in both the Navajo and English languages by a father and daughter team. The male broadcaster provides the messaging in the Navajo language and his daughter repeats what he stated in English. The ability to reach its Tribal members anywhere in the world is particularly meaningful for Tribal members who serve in the armed forces because they can feel isolated when away from the reservation and their culture. The use of the father and daughter team promotes the Tribe's sense of family, as well as models its customary respect for its elders.

The Yavapai Apache Nation's substance abuse prevention program fuses culture with substance use prevention education by helping youth develop coping skills to manage symptoms related stress and boredom. This is achieved through teachings from their elders about what the youths' ancestors did to cope prior to colonialism and the introduction of alcohol. The Yavapai Apache Nation also incorporates the development of youth leaders and peer support through their implementation of MPWRD program.

Centered Spirit, a Pascua Yaqui Tribal behavioral health program in Guadalupe, offers educational programs and holds community events where they distribute educational material and have educational games for children about substance use and/or misuse. The programming includes instruction how to live a healthy lifestyle and follow Pascua Yaqui customs and traditions and is the only prevention program in Guadalupe. Children attend schools in different school districts in nearby towns, so there are not any school prevention programs in Guadalupe. The fact that the Tribe is supporting the Centered Spirit program is

one of the community's strengths and is a strong indicator that the Tribe is committed to substance use and/or misuse prevention. Additional funding would help the Tribe strengthen and expand the program.

Refugee Populations

Interviews with two key informants that work with refugee populations agreed that there are ongoing prevention efforts for refugees. In the Tucson area, Family Passages at La Frontera (the "only program of its kind") offers one-on-one or group prevention efforts in the populations' first languages and from volunteer facilitators from the target populations (Iraqi, Somali, Congolese in the past, Russian).

Four prevention strategies are currently available in the community serving refugee populations:

(1) *Botvin's Life Skills*, which includes substance use and/or misuse topics, it is used with kids and adults. A first language facilitator translates for adults/parents, who are often illiterate in their own language. The kids are provided the program in English using the Botvin curriculum that corresponds to their language level (rather than grade);

(2) *RX 360 about Prescription Drug Misuse Program* from the State (for adults and kids);

(3) *ASU/Parent Institute's American Dream Curriculum* addresses protective factors by assisting parents to help their children to be successful in education. The educational focus is important to the refugee community;

(4) the *Youth to Youth Peer to Peer Program* for children.

La Frontera's respondent reported that they have great success with American Dream. Parents stay engaged and "outcome measures are through the roof." La Frontera does not collect data on actual use by participants in prevention efforts (because of social bias that undermined honesty) but reported that all the programing is effective in changing attitudes towards alcohol and drugs and noted that efforts are effective "because they are delivered in first [native] languages."

Refugee and Immigrant Service providers (RISPNet) is a coalition that all settlement agencies, the Health Department, law enforcement, and service providers are a part of and includes refugee community representatives. RISPNet discusses different topics at community meetings and 1-2 sessions a year are on substance use and/or misuse. The refugee community representatives take information from these monthly meeting back to their communities in an effort to "raise awareness."

Although the IRC (International Rescue Committee) used to do substance use support groups,

(which participants liked) they no longer have the capacity. When IRC encounters a client with an alcohol issue, they meet with them one-on-one and refer them to counseling. "When we talk with a person with issues, we talk about available treatment but also the possible consequences" – extreme consequences for this population.

Tangential prevention efforts include a soccer team for kids from dysfunctional families.

Promotores

Promotores conduct workshops and trainings for parents to model how not to let youth touch alcohol. Principals often allow promotores to present at schools, but parents do not attend. Programming also occurs at churches to help the community learn how to "say no". Community centers and public places have posters with prevention messages, but respondents indicated they are boring and people most likely don't pay attention. A desire to be more creative and more culturally appropriate in prevention programs was expressed. Some examples of this more creative programming included a drug prevention drama performance at a mall and a Drug Prevention Expo conducted by a church organization that had stations with different drugs and interactive role play with actors at each station.

Innovations in Prevention Programs

A selection of some innovations in prevention programs that were mentioned by key informants are noted below:

> "At the high school we work hard on building relationships with kids and making sure they have their social and emotional needs met. Because we have a lot of kids coming from non-traditional families and single parent households. We have a relationship building class that is 30 minutes a day and keep kids all four years to build that trust. Each teacher stays with 20 kids over four years. Then we know every kid has one adult for help if they need it. To primarily give students a sense of belonging. If there are issues they are having they can have at least one adult that they can trust and talk to. A place where someone cares about them. If you have those things in your life you have a shot at saying no to drugs. We have seen kids struggling in other communities and they come here and are successful. The difference is the relationships we build. I know it works." (Central Arizona School Administrator Key Informant)

> "Since the juvenile detention center was closed, a Navajo County after-school program at an at-risk high school was started. The program was designed by the Navajo County School District using the Kids of Hope program as a model. This model is used in juvenile detention facilities and many schools are starting to adapt it to their own needs. The program offers different activities including life skills and activities that are interest driven by the students. The aim of the program is to try and create positive lifelong

change. Some children come voluntarily and children in probation also attend. From 2:00 to 4:00 there are youth care workers (not probation officers) in one building right next to the office space for probation officers. Their proximity has proven to be very useful. Currently there are 22 attendees, but we are just scraping the surface. Part of the issue is transportation. It takes a long time for kids to travel to the program, and this is a real challenge. In addition to this after school program, the probation office offered a summer program and some at-risk youth who were going to be sent to Florence for juvenile detention were able to participate and work their way out of their sentences. The after-school program is only two years old, so any evidence is just anecdotal at this point. However, the reasoning behind the program is that if kids are engaged during those time frames, there will be less substance use, because availability is reduced." (Navajo County Key Informant)

"More recently in Maricopa County, environmental strategies (such as enforcing social host ordinances) have been integrated with traditional prevention efforts, such as life skills programs in schools and parenting programs. Adding in the enforcement of social host ordinances has had a greater combined impact than life skills and parenting programs alone. In addition, prevention experts are using social media campaigns to expand the reach of coalitions. The social media campaigns target research findings specific to each population. For example, one social media campaign targets parents who thought that youth were getting drugs from outside of the home when they were really getting drugs from the parents' medicine cabinets." (Maricopa County Key Informant)

Workforce Survey

As stated above, a workforce survey was developed to collect information from statewide members of the Substance Use Prevention Workforce. A number of questions contained in the survey assisted in adding information and insight about what current prevention efforts are occurring in Arizona, and also described the background and expertise of this workforce. There were 142 respondents to the Prevention Workforce Survey. Although it is not possible to determine the formal generalizability of this findings without knowing the degree to which this number represents the entire Substance Use Prevention Workforce, this number is substantial and includes one or more individuals representing every county in Arizona, making the results a useful resource to guide planning.

Demographics

Exhibit 59 illustrates the distribution of education levels across respondents. The majority of respondents (53.6%) had a postgraduate education.

Exhibit 59. Distribution of Education Levels (N=140)

	Number	Percentage
High school graduate	4	2.9%
Some college	23	16.4%
College graduate	38	27.1%
Postgraduate	75	53.6%
Total	140	100%

Exhibit 60 illustrates the distribution of languages spoken fluently by the respondents. The majority of respondents spoke only English. Languages other than English and Spanish that were reported were German, Portuguese, Samoan, and Apache.

Exhibit 60. Distribution of Languages Spoken Fluently (N=141)

	Number	Percentage
English only	112	79.4%
English and Spanish	23	16.3%
English and another language	5	3.5%
Spanish only	1	0.7%
Total	141	100%

Exhibit 61 illustrates the length of time respondents had worked in substance use prevention at the time of the survey. The largest percentage (35.9%) had worked in substance use prevention for over 10 years.

Exhibit 61. Length of Time Working in Substance Use Prevention (N=142)

	Number	Percentage
Less than one year	23	16.2%
2-4 years	36	25.4%
5-7 years	17	12.0%
8-10 years	15	10.6%
More than 10 years	51	35.9%
Total	142	100%

Exhibit 62 illustrates the work status of respondents. Most respondents reported they work full time in substance use prevention.

Exhibit 62. Work Status of Respondents (N=142)

	Number	Percentage
Full time	109	76.8%
Part time	17	12.0%
Volunteer	10	7.0%
Other	6	4.2%
Total	142	100%

Six respondents reported that they had an "other" work status and five elaborated in an open-ended question. "Other" responses included:

- Administrative supervision for a prevention program
- Member of recovery community
- Coalition coordination for education, prevention and advocacy
- General Administrative functions
- SAMHSA grant - FR-CARA

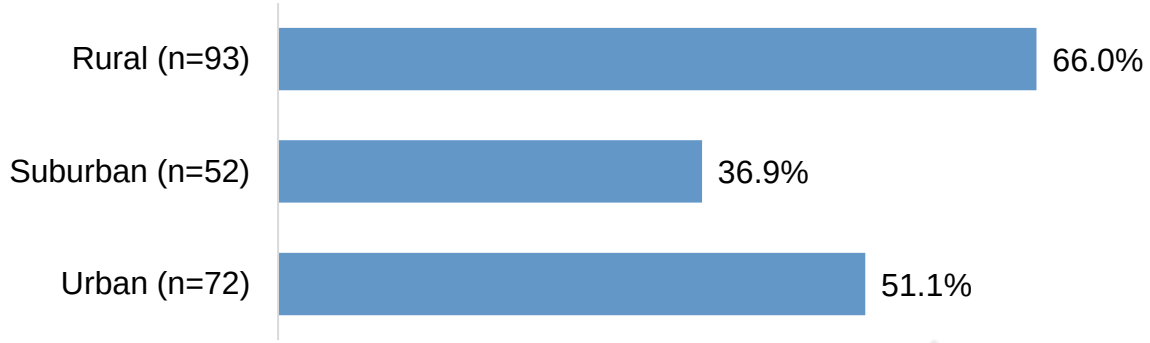
Exhibit 63 illustrates the counties in which the respondents reported working. Respondents could report more than one county and several respondents reported working in more than one county (n= 28); most respondents (n=113) reported working in only one county. There was representation reported in every Arizona county, with the largest representations serving the two counties with the largest urban centers – Maricopa (n=54) and Pima (n=31).

Exhibit 63. Counties where Respondents Engage in Substance Use Prevention (N=141)

County	Number
Apache	8
Cochise	15
Coconino	18
Gila	20
Graham	14
Greenlee	10
La Paz	8
Maricopa	54
Mohave	17
Navajo	12
Pima	31
Pinal	17
Santa Cruz	12
Yavapai	22
Yuma	9

Exhibit 64 illustrates the type of communities served: rural, suburban and urban. Respondents could report more than one type of community and many respondents (n= 54) reported working in more than one type of community; most respondents (n=87) reported working in only one type of community. Rural communities were the most commonly represented.

Exhibit 64. Types of Communities Served (N=141)



*Respondents could report more than one type of community.

Workforce Qualifications

Exhibit 65 illustrates what training respondents reported they had received to help them be more prepared to support substance use prevention efforts. Respondents could report having more than one kind of training. The most frequently identified training was Cultural Competency, which 71.1% of respondents reported they received. There were indications that suicide prevention training such as Applied Suicide Intervention Skills Training (ASIST) and SafeTALK may be more accessible to those working in substance use prevention than more directly relevant training such as SAPST (Substance Abuse Prevention Specialist Skills Training). This may also reflect a joining of prevention efforts in both areas in this workforce.

Exhibit 65. Training related to substance use prevention that respondents reported they had received (N=97)

	Number	Percentage
Cultural Competency 101	69	71.1%
Strategic Prevention Framework - Introduction to the Strategic Prevention Framework	47	48.5%
ASIST	46	47.2%
Strategic Prevention Framework - Strategic Planning/Logic Models	45	46.4%
Strategic Prevention Framework - Coalition Capacity Building/Coalition Development	40	41.2%
SafeTALK	38	39.2%
Strategic Prevention Framework - Conducting a Community Needs Assessment	37	38.1%
SAPST (Substance Abuse Prevention Specialist Skills Training)	33	34.0%
Strategic Prevention Framework - Evaluation/Sustainability	32	33.0%
QPR (Question, Persuade, Refer)	23	23.7%

Twenty-one respondents reported obtaining "other" training to help them be more prepared to support substance use and/or misuse prevention efforts, providing responses that fell into the following themes:

- Screening Brief Intervention and Referral to Treatment (SBIRT)/Motivational Interviewing
- Academic Degrees/Certifications (e.g., MSW)
- Mental Health First Aid
- Trauma
    - Adverse Childhood Events (ACEs)
    - Domestic/Sexual Violence
    - Child Abuse Training
- General Curricula
    - Substance Use
    - Youth Mental Health
    - General Mental Health

    - Ethics
    - Life Skills
    - Adolescent Brain Development
- Specific Curricula
    - Rx-360
    - Stand Up Speak Up (Cultural Competence/Empowerment)
    - Indian Country Drug Endangered Children (DEC)
- Training in Program/Practice Implementation
    - 7 Challenges Teen
    - Harm Reduction
    - Collaborative Assessment & Management of Suicidality (CAMS)
- Administration (e.g., Case Management, Substance Abuse Train the Trainer)

Two respondents volunteered that they had no specialized training in substance use and/or misuse prevention.

Exhibit 66 illustrates where respondents reported getting substance use prevention-related trainings and certifications. Respondents could report receiving training from more than one source.

Exhibit 66. Where Respondents Reported Getting Substance Use Prevention-Related Trainings and Certifications (N=89)

Training Source	Number	Percentage
SAMHSA (Substance Abuse and Mental Health Services Administration)	78	87.6%
CADCA (Community Anti-Drug Coalitions of America)	41	46.1%
TRBHA (Tribal/Regional Behavioral Health Authority)	34	38.2%
OJJDP (Office of Juvenile Justice and Delinquency Prevention)	15	16.9%
SPRC (Suicide Prevention Resource Center)	8	9.0%

Thirty respondents reported obtaining training from an "other" source different from those provided; responses fell into the following themes:

- Federal Government

- HRSA (Health Resources & Service Administration, Fed)
- HIDTA (High Intensity Drug Trafficking Area Program, DEA) (n=3)
- ONDCP (Office of National Drug Control Policy)
- DOJ (Department of Justice)
- National Conferences

- State Government
  - Governor's Office
  - State Conferences
  - "Some trainings offered by [the] State"
- Community Training
  - Coalitions and Partnerships (n=5)
  - Trainings held within the community
  - WYGC (West Yavapai Guidance Clinic)
  - Northern Arizona Council of Governments (ACOG)/Area Agency on Aging (AAA)
- Non-Profits
  - NIDA (National Institute on Drug Abuse)
  - drugfree.org
  - Drug Policy Alliance
  - End Violence Against Women International (EVAWI) (trauma-informed care)
  - National Center on Domestic Violence, Trauma and Mental Health (trauma-informed care)
- Healthcare Organizations
  - Health Choice Arizona
  - Cenpatico
  - Touchstone Health Services
- Continuing Education
  - Online Continuing Education Units (CEUs) (e.g., Relias Academy) (n=3)
  - CEU for Arizona Board of Behavioral Health Examiners (AZBBHE)
  - Continuing Medical Education (CME)

    - American Society of Addiction Medicine (ASAM)
    - National Commission for Health Education Credentialing (NCHEC/CHES)
- Academic Institutions
    - ASU (e.g., Southwest Interdisciplinary Research Center (SIRC)) (n=4)
- Journals (e.g., American Family Physician) (n=2)
- Conferences and Seminars (e.g., American Academy of Family Physicians conferences) (n=2)
- Moral Reconation Therapy (MRT)

Thirty-four respondents reported that they were qualified to conduct trainings in substance use and/or misuse prevention. They reported being qualified in the trainings as illustrated in Appendix E, organized by the counties in which prevention work was reported. No one working in Apache County reported having training capacity.

Respondents were asked if they have Arizona Certified Prevention Professional (ACPP) certification. Of 116 respondents who answered the question, only nine (7.8%) reported that they had ACPP certification. Of these, most (n=7) had a Level IV; one had a Level II and one had a Level I. In addition to ACPP, The Arizona Board for Certification of Addiction Counselors (ABCAC) also offers a Certified Prevention Specialist (CPS) designation. Respondents were not asked directly about this certification.

Respondents were asked to report on the types of substance use prevention in which they engaged. Respondents could report more than one type of substance use prevention in which they engaged. Most respondents (n=119 of 140) reported engaging in more than one type of substance use prevention effort. Exhibit 67 illustrates the number of individuals who reported engaging in each type of prevention work. The most common type of prevention that respondents reported engaging in was providing information, followed by enhancing skills and providing support.

Exhibit 67. Types of substance use prevention respondents engaged in. (N=140)

	Number	Percentage
Provide information (e.g., presentations, PSAs, billboards, programs, classes)	111	79.3%
Enhance skills (e.g., training, classes, programs)	102	72.9%
Provide support (e.g., mentoring, referrals, youth clubs, providing alternate activities)	91	65.0%
Enhance access/reduce barriers (e.g., transportation, housing, childcare, access to treatment, education)	61	43.6%
Modify/change policies (e.g., public policy, laws)	35	25.0%
Change consequences (e.g., incentives/disincentives including citations, fines, rewards)	23	16.4%
Change physical design (e.g., parks, landscapes, signage, lighting)	14	10.0%

*Respondents could report more than one type of substance use prevention they engaged in.

Seven respondents reported that they engaged in an "other" type of prevention work, providing responses that fell into the following themes:

- administration/oversight (n=7),
- substance use treatment (n=4),
- change systems (e.g., cross-sector integration),
- training for First Responders, and
- provide funding to community groups doing substance use and/or misuse prevention work.

Respondents were asked to report on the types of substance use prevention happening in their community and were provided with the same response options as the above question. Respondents could report more than one type of substance use prevention happening in their community. Almost all respondents (132 of 140) reported more than one type of substance use prevention effort happening in their community. Exhibit 68 illustrates the number of individuals who reported each type of prevention effort happening in their community. The most common type of prevention that respondents reported was happening in their community was providing information, followed by enhancing skills and providing support. These types of efforts were reported by a very high percentage of respondents.

Exhibit 68. Types of Substance Use Prevention Happening in Respondents' Communities* (N=140)

	Number	Percentage
Provide information (e.g., presentations, PSAs, billboards, programs, classes)	131	93.6%
Enhance skills (e.g., training, classes, programs)	125	89.3%
Provide support (e.g., mentoring, referrals, youth clubs, providing alternate activities)	117	83.6%
Enhance access/reduce barriers (e.g., transportation, housing, childcare, access to treatment, education)	88	62.9%
Modify/change policies (e.g., public policy, laws)	50	35.7%
Change consequences (e.g., incentives/disincentives including citations, fines, rewards)	49	35.0%
Change physical design (e.g., parks, landscapes, signage, lighting)	31	22.1%

*Respondents could report more than one type of substance use prevention they engaged in.

Two respondents reported an "other" type of prevention work in their community, providing the following responses:

- [developing a] coalition; and
- change systems (e.g., cross-sector integration).

Respondents were asked, "What types of substance use prevention efforts do you think work the best for preventing substance use problems based on your experience?" The most common responses relating to primary prevention are illustrated in Exhibit 69. See Appendix E for the full list of responses, including responses related to treatment.

Exhibit 69. The Most Common Response Themes to "What types of substance use prevention efforts do you think work the best for preventing substance use problems based on your experience?"

Theme	n
Activities available (e.g., for youth, low-cost/free after school care)	15
Meeting basic needs (e.g., career training/jobs/economic mobility, financial assistance, housing, education, healthcare/mental healthcare, transportation)	13
Education/training generally	13
Education/awareness efforts for the community	8
Education/awareness classes/efforts at the family level	7
Education/awareness classes address danger/ long term effects of substance use and/or misuse	6
Coalitions/community-driven efforts	6
Honest dialogue (e.g., with youth)	5
Education/awareness classes/efforts at the school level	5
Programming for youth/adults with emotional risk factors (e.g. trauma, children of addicts/users)	5
Comprehensive/holistic strategies at multiple levels of the community with common messaging	5
Schoolchildren/youth	5
Mentoring	4
Creating connectedness (e.g., with family, school, community	4
Reach kids before they become at risk/before use starts	4

The following quotes highlight themes related to the question asked above:

> "There needs to be prevention information in the schools, in the home and the community. The best people to do this are primary preventionists. They are always out in the community. When prevention coalitions are funded they multiply each dollar spent by bringing 100s of people together to help do the work. The prevention force is strong and needs to be funded and fully utilized as a first line of defense. People need to hear face to face from people they know and trust that they are supported and to engage them in prevention education.....Local efforts go a long way and they are best facilitated by local prevention groups. This helps the messaging be on target for the local community as well."

"A comprehensive mix of strategies addressing a multitude of domains (individual, family, community, institutional, environmental), so the same messages reach everyone in the community and are consistent over time. We need to change the conditions in the communities we serve (i.e. address the intervening variables about why substance use is happening) in order to reduce substance use. We also need to be able to fund adequate evaluation efforts to be able to support effective prevention programs and make modifications as needed. One-time parent nights are not enough. Collaborations with community-based coalitions are critical."

"Social and emotional learning skills, coping and wellness skills, and reality-based education (i.e. real-life stories and people who have overcome substance use disorder). Most critical is that the efforts are truth based, not fear based, and are accurate, not full of "worst case scenarios" or inflated harm statistics."

Respondents were asked, "What substance use prevention activities have you seen that have been the most successful in engaging the community?" The most common responses relating to primary prevention are illustrated in Exhibit 70. See Appendix F for the full list of responses, including responses related to treatment.

Exhibit 70. The Most Common Response Themes to "What substance use prevention activities have you seen that have been the most successful in engaging the community?"

Theme	n
Community-building/Social events (e.g., town halls, community fairs, programs with food, for the whole family)	13
Coalitions	10
Family/parent-oriented	9
Alternative activities (e.g., generally, after prom, after graduation)	7
Information-sharing (that lets people make their own decisions)	6
School-based	5
Casual Face to face interactions/not "professional"	4
Enhance skills (e.g., Teaching critical thinking skills/life skills to schoolchildren)	4
Promoting youth leadership	4
Fun/ Associated with a fun event	4
Community education (e.g., Symposiums that highlight educational warning signs of substance use and/or misuse.)	4

Respondents were asked, "Are there any types of substance use prevention efforts that you don't think help much or at all?" The most common responses relating to primary prevention are illustrated in Exhibit 71. See Appendix F for the full list of responses, including responses related to treatment.

Exhibit 71. The Most Common Response Themes to "Are there any types of substance use prevention efforts that you don't think help much or at all?"

Theme	n
Scare tactics	15
General handouts/posters/marketing material/commercials/media campaigns	10
Just say no strategies	9
Programming that demonizes drug users/negative messaging	6
Single presentations/events not connected to a larger strategy (e.g. town halls)	4
Relying on untrained staff (e.g. at schools) to deliver the program unsupported (rather than partnering with prevention experts/coalitions)	4

Addressing Demographic Characteristics and Underlying Causes

Respondents were asked, "How does your substance use prevention program take into consideration demographic characteristics of the participants of your program (race/ethnicity, urban/rural, veterans, LGBTQ, youth, seniors, foreign language users, etc.)." The most common response relating to primary prevention was taking primary language into consideration. In order to effectively highlight all strategies that respondents are using to take into consideration demographic characteristics of participants, all responses relating to primary prevention are illustrated in Exhibit 72. See Appendix F for the full list of responses, including responses related to treatment.

> "Before implementing program or PSAs for a target population we will talk to our target population to receive feedback. In all of our prevention activities, we ask for feedback and speak with our target population to learn if it is culturally competent for that population."

> "CLAS standards are in force, and each contracted program has guidelines on each standard. These include making program tools accessible, making adaptations to reading level, language, font size, method of dissemination, etc. For example, our LGBTQ program uses tools to capture a variety of gender identification options, and our older

adult program uses large font on their evaluation and program materials."

"One has to be aware and willing to adapt to the needs of the ones you are trying to help. If poverty is huge with a specific group, having food anytime you work with them (and maybe some left over for them to take home is important)."

"We are required to complete an educational program aimed at increasing understanding and awareness around how to foster and inclusive and welcoming climate for the LGBTQ community."

Exhibit 72. All Themes to "How does your substance use prevention program take into consideration demographic characteristics of the participants of your program?"

Theme	n
Primary language taken into consideration (e.g., interpretation provided; hire bilingual staff)	19
Program tailored to/inclusive of the population (e.g., youth, seniors, LGBTQ)	17
Be ready to serve everyone from any demographic/treat everyone with respect	17
Tailoring materials/evaluation tools (e.g. language, font, gender options)	8
Training staff in subpopulation issues (e.g., cultural competency, LGBTQ, trauma-informed)	7
Seek feedback from the target population (e.g., before or while implementing a strategy)	7
Recognize/Identify/understand the demographic characteristics/needs of the target population/community (e.g., needs assessment)	6
Hire staff/recruit coalition members/volunteers from the community/demographic	5
Collaborate with partners/agencies that work with the target population (e.g. LGBTQ)	5
Promote accessibility (e.g., Reach them in a common/convenient location/schedule at a convenient time)	3
Financial considerations (e.g. providing food, no cost services)	2
Awareness in facility management (e.g., bathrooms not segregated by gender, disability-accessible bathrooms, microphones at trainings for seniors)	2
Aware of potential for prejudice by participants/try to address	2
Adapt programs to be culturally relevant	1
Inclusive marketing materials	1

Tailor referral options	1
Outreach efforts to marginalized communities	1

The following quote is an example of an agency seeking to recognize and integrate demographic characteristics in a holistic way:

> "We use specific strategies for specific populations. For example- we know that our rural, oppressed populations living in poverty are never going to throw away their drugs. So, for them we educate and propose locking caps and lock boxes. We have to be culturally sensitive and realistic. These people do not have access to nor can afford Rxs so they do keep them even after the ailment has subsided. Whatever population we are working with we make sure that we have representatives of that population working on the team to guide strategies and to deliver interventions. We use local translators vs. "professional" translators who often use commercial translating programs that do not speak to the local populations served. We use someone from the community we are speaking to do the translation. It is cheaper and more effective. For elderly populations it is important to have microphones as many are hard of hearing."

Respondents were asked, "How does your agency/coalition/organization address underlying causes of addiction (e.g., poverty, historical trauma, systematic oppression, poverty)?" The most common responses related to educating staff/providers/coalition leaders. In order to effectively highlight all strategies that respondents are using to address underlying causes of addiction, all responses relating to primary prevention are illustrated in Exhibit 73. See Appendix F for the full list of responses, including responses related to treatment.

Exhibit 73. All Themes to "How does your agency/coalition/organization address underlying causes of addiction?"

Theme	n
Providing general resources and referrals to meet basic needs	9
Educating staff/ providers/coalition leaders (e.g. on ACES; systemic oppression; cultural awareness)	8
Youth-focused poverty-prevention strategies (e.g. teen pregnancy prevention, decision-making; social skills; general education)	4
Collaborating with the local community	3
Whole family education	2
Addressing social isolation for seniors	2
Not ignoring the issue	2
Tailoring programming for the population (e.g., language awareness/using primary language)	2
Addressing mental health	2
Including underlying causes information shared (e.g., using a curriculum that recognizes underlying risk issues	2
Educating community (e.g. on ACES; underlying causes of addiction)	2
Adult-focused poverty-prevention strategies (e.g. resume development; healthy relationships)	2
Teaching participants to advocate for themselves	2
Recognizing local historical trauma	2
Hiring from within the local community	1
Youth shelters	1
Collaboration with other agencies (e.g. working with high risk youth)	1
Utilizing available resources from the State, etc.	1
Diversion program	1
Providing access (e.g., going to the community)	1
Providing positive alternate activities	1
Advocate for policies that address underlying causes	1

"Our agency hires from within the communities we serve to get an "insider" perspective and to have someone who is aware of any historical considerations."

"Being mobile and bringing our information and resources to communities, rather than always making them come to us."

Other volunteers indicated that they did not address underlying causes and six respondents specifically noted that they did not have sufficient resources to do so:

"It doesn't do it well. We do not have enough money or staff to do this justice. We are just barely scratching the surface of a huge problem for our community."

"It is difficult to do any of this work with the constant reductions to funding and resources."

"Our organization's prevention and education section is unfortunately very small, and thus are not able to address upstream factors/underlying causes as much as we wish to."

"Very little to none. We are funded by a grant to concentrate on working with the medical community. There are no funds available to address this issue. All mental health facilities in our community are at capacity and only focus on their current members- no outreach is done."

"We never have enough funding, but the community looks to us to do it all. Coalitions really bring people and resources together and without funding it becomes difficult to do this."

Causal Factors

Secondary Data Analysis

Substance use prevention efforts aim to modify the underlying factors that are associated with substance use and/or misuse, either by preventing known risk factors, or by enhancing protective factors (Hawkins, Catalano & Miller, 1992). Epidemiological data can help estimate the prevalence of risks and protective factors, identify areas of relative susceptibility and strength, monitor changes overtime, and guide practitioners and policymakers to make the most informed decisions regarding prevention services.

Risk and protective factors are often organized using a socio-ecological framework, which helps highlight unique risks that exist across different levels of influence (e.g., the individual, relationship, society and community levels). For instance, at the individual level risk factors may include a genetic predisposition to substance use and/or misuse or a negative self-image. At the relationship level, pro-social and supportive relationships are protective against substance use and/or misuse, while maltreatment or lack of parental involvement are

considered risk factors. At the community level, neighborhood poverty, violence, and school environments influence risks for substance use. Finally, at the societal level, substance use norms and laws can influence patterns of use and misuse (SAMHSA, 2018).

It is important to note that interpreting risk and protective factors is not straightforward. The causal mechanisms of substance use and/or misuse are thought to be multifaceted and complex. The exact pathways that lead some individuals to substance use and/or misuse while other individuals do not engage in these behaviors are not completely understood. Additionally, risk factors important to one subgroup, or at one specific developmental period in the life course, may be less influential for other subgroups or at other times (Swendsen et al, 2009). It is generally accepted that risk factors are correlated with one another and cumulative in nature. Stated another way, this means that the presence of a single risk factor predicts additional risk factors, and that the quantity of risk factors an individual has is highly correlated to their likelihood of using or misusing alcohol, tobacco or drugs (SAMHSA, 2018).

Although numerous factors have been shown to be associated with substance use, epidemiological data are regularly collected for only a limited number of indicators. This section of the report summarizes the available quantitative data on risk and protective factors for adults and youth. In reviewing this section, please note that certain sociodemographic factors are also correlated with substance use and/or misuse risk, including lower educational attainment, poverty, unemployment, and other indicators of social disadvantage. Many of these indicators were already presented in the section on "Arizona's Demographics" and are not revisited in detail in this section of the report. As previously stated, these factors are not uniformly distributed across Arizona, with numerous areas across the State experiencing disproportionate levels of social disadvantage that may influence substance use and/or misuse risks.

Perceived Risks from Substance Use

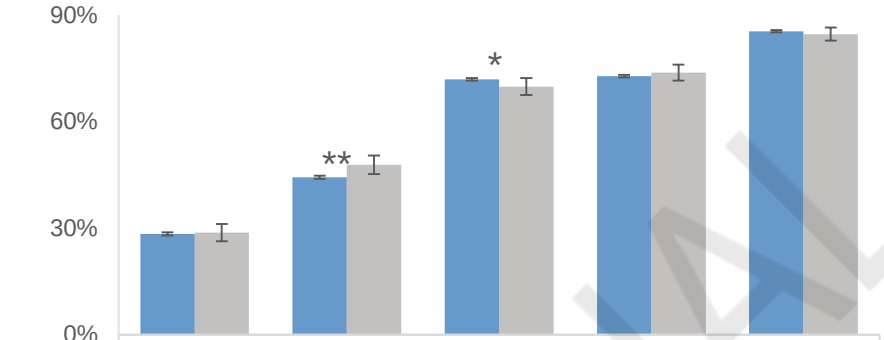
Research demonstrates that greater perceptions of harm from alcohol, tobacco or drugs is associated with lower rates of substance use (Lipari et al, 2017). NSDUH asks respondents how much risk of harm they perceive from the following substance use behaviors:

- smoking marijuana once a month
- drinking five or more alcoholic beverages once or twice a week
- using cocaine once a month
- smoking one or more packs of cigarettes a day
- trying heroin once or twice

In Arizona, perception of harm was highest for "trying heroin once or twice" (84.6%), and lowest for "smoking marijuana once a month" (28.7%). Arizona's 12 and older population

perceived marginally less risk from cocaine use than national estimates (69.9% vs 71.9%, p=0.078), and more risk from binge alcohol use (47.8% vs 44.3%, p=0.007) (See Exhibit 74).

Exhibit 74. Prevalence of Perceptions of Great Risk of Harm from Substance Use Among those 12 and Older in the U.S. and Arizona, 2015-2016



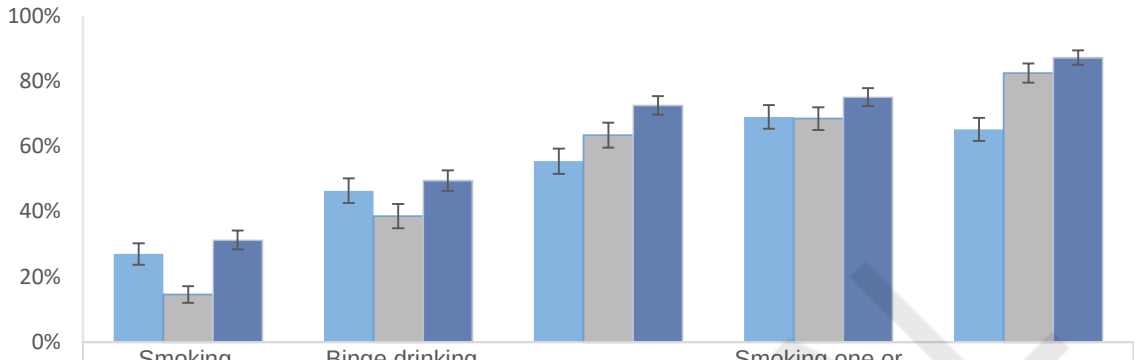
	Marijuana	Binge Drinking	Cocaine	Smoking	Heroin
U.S.	28.4%	44.3%	71.9%	72.8%	85.4%
Arizona	28.7%	47.8%	69.9%	73.8%	84.6%

Difference between the prevalence estimate for the total U.S. and Arizona is marginally significant at p<0.10, or significant at p<0.05**
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Differences by age group

There were differences in patterns of perceived risk by age group for each measure of substance use. Specifically, in Arizona youth 12 to 17 perceived the least amount of risk for heroin and cocaine use of any age group. Adults aged 18 to 25 perceived the least amount of risk for binge drinking and marijuana use (See Exhibit 75).

Exhibit 75. Prevalence of Perceptions of Great Risk of Harm from Substance Use by Age Group for Arizona, 2015-2016



	Smoking marijuana once a month	Binge drinking once or twice a week	Using cocaine once a month	Smoking one or more packs of cigarettes per day	Trying heroin once or twice
12 to 17	27.1%	46.5%	55.6%	69.1%	65.3%
18 to 25	14.6%	38.7%	63.6%	68.6%	82.6%
25 and older	31.4%	49.6%	72.7%	75.2%	87.4%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015-2016

Mental Health

The co-occurrence of mental and substance misuse disorders is well-documented in the literature. Prospective studies have confirmed that individuals with serious mental illness (SMI) are more likely to transition to substance use, misuse, dependence and abuse than their peers without SMI (Swendsen et al, 2010). These data suggest mental health status is not only correlated with substance use but is an independent risk factor for substance use.

Data from the 2015-2016 NSDUH estimated the prevalence of past year major depressive disorder (MDE) and serious mental illness (SMI). Serious mental illness (SMI) is defined by SAMHSA as "adults aged 18 or older who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM-IV that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities". MDE is defined as "a period of at least two weeks when an individual experienced a depressed mood or loss of interest or pleasure in daily activities." The term serious emotional disturbance (SED) is used to refer to children and youth who have had a diagnosable mental, behavioral, or emotional disorder in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. Current national surveys do not have an indicator of SED.

In Arizona, an estimated 310,000 (6.0%) of the adult population 18 or older experienced past year MDE and 208,000 (4.0%) of the adult population met the criteria for SMI. National estimates did not statistically differ from Arizona estimates for the population overall.

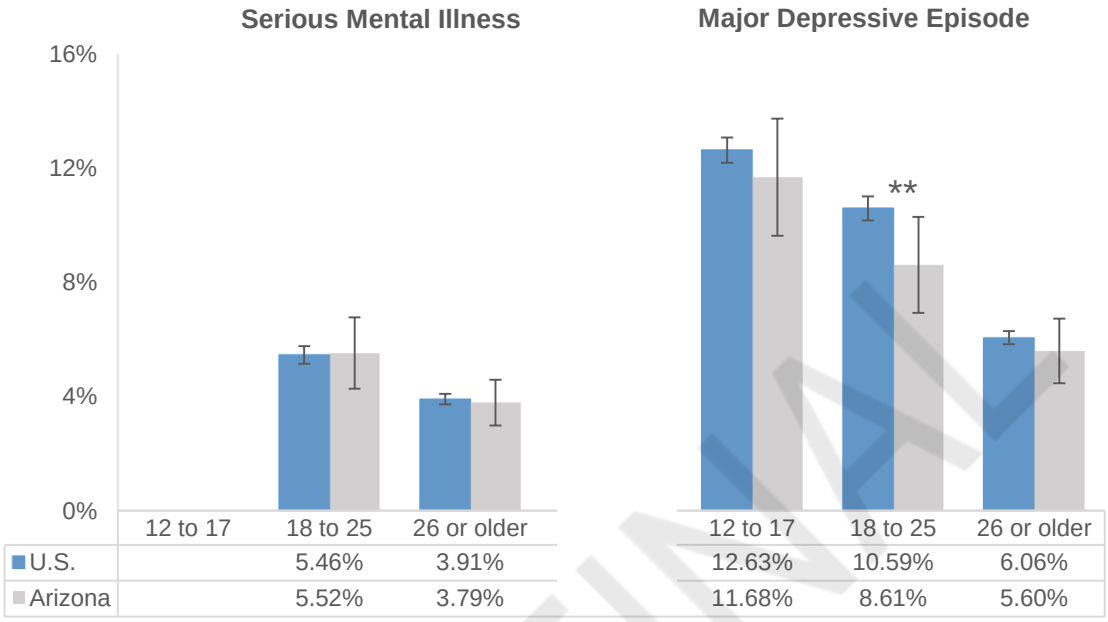
Youth Prevalence

According to data from the NSDUH, the prevalence of MDE peaked for those aged 12 to 17, with an estimated 11.7% of youth reporting past year MDE. This did not statistically differ from national estimates (12.6%) (See Exhibit 76). Caution should be used when comparing NSDUH estimates with MDE between youth and adults because separate questionnaire modules were administered for adults over 18 and youth ages 12 to 17.

The 2017 YRBS also estimated the percentage of high school students that "felt sad or hopeless almost every day for two weeks or more in a row so that they stopped doing some usual activities, during the 12 months before the survey." According to these data, high school students in Arizona were significantly *more* likely to report poor mental health than youth nationally (36.4% vs 31.5%, p=0.02).

The somewhat contradictory findings regarding NSDUH and YRBS estimates could be explained by true differences in prevalence of MDE (i.e., Arizona high school students reported more MDE than youth nationally, while Arizona's youth in general reported less MDE than youth nationally). These differences could also be explained by chance, or by differences in sampling and estimation methodology (including differences in the years of data collection) between the two surveys.

Exhibit 76. Prevalence of Serious Mental Illness and Major Depressive Episode in the U.S. and Arizona by Age Group, 2015-2016



	Serious Mental Illness			Major Depressive Episode		
	12 to 17	18 to 25	26 or older	12 to 17	18 to 25	26 or older
U.S.		5.46%	3.91%	12.63%	10.59%	6.06%
Arizona		5.52%	3.79%	11.68%	8.61%	5.60%

**Difference between the prevalence estimate for the total U.S. and Arizona is significant at p<0.05
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

Another indicator of mental health and substance use risk come from the 2016 Arizona Youth Survey. Students in 8th, 10th and 12th grades were asked about their reasons for using substances in 2012, 2014 and 2016. Reasons related to mental health were among the top five most commonly endorsed reasons for using substances. Although the prevalence increased from 2012 to 2016 for each of the top five reasons, the percent increase was greatest among those reasons related to mental health (See Exhibit 77). Specifically, there were larger increases in students that endorsed the personal use of substances to "deal with stress" (27.2% vs 37.3%), and those who used substances to "avoid being sad" (20.9% vs. 29.8%).

Exhibit 77. Trends in the Prevalence of the Top Five Reasons for Using Substances Among Arizona Students in 8th, 10th and 12th Grades, 2012-2016

Reasons for substance use	2012	2014	2016
To have fun	42.2%	40.1%	49.3%
To deal with stress	27.2%	28.5%	37.3%
To avoid being sad	20.9%	23.1%	29.8%
To get high	30.1%	30.4%	36.9%
New and exciting	18.8%	18.7%	22.7%

Source: Arizona Criminal Justice Commission. Arizona youth survey 2016: State of Arizona

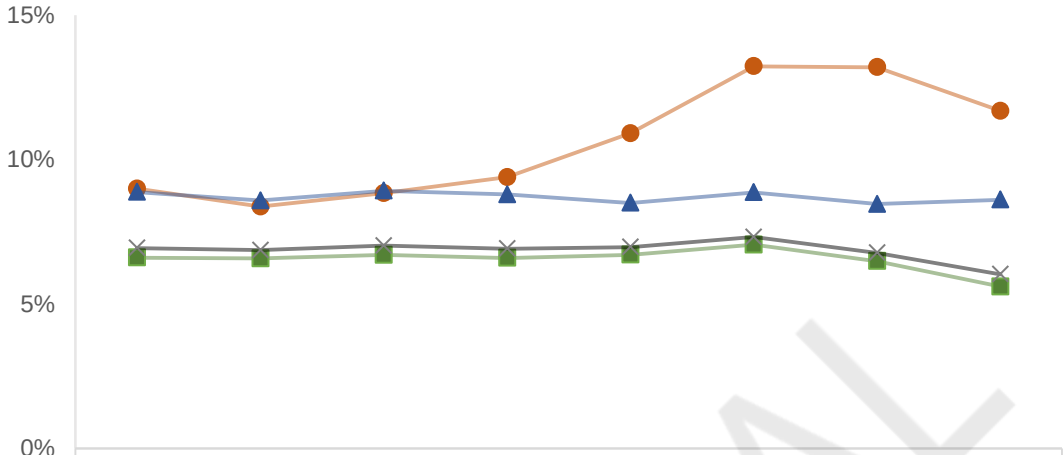
Adult Prevalence

Data from the 2015-2016 NSDUH indicated the prevalence of SMI was highest for those aged 18 to 25 (5.5%) and then decreased slightly for those aged 26 or older (3.8%)(See Exhibit 76). SMI estimates in Arizona did not statistically differ from national estimates. MDE also decreased with increasing age (See Exhibit 76). MDE estimates in Arizona did not statistically differ from national estimates for any age group except young adults, who reported significantly less MDE in Arizona than nationally (8.6% vs 10.6%, p=0.044).

Youth and Adult Trends

In Arizona, there were marginally significant increases in the prevalence of MDE between 2008 and 2016, but only for youth aged 12 to 17 (9.0% vs 11.7%, p=0.05) (See Exhibit 78). Prevalence peaked in 2013-2014 (13.2%), with a similar trend being reported nationally, suggesting MDE for youth may be on the decline; additional years of data are needed to confirm this trend. There were also significant increases in the prevalence of SMI between 2008 and 2016, but only for those aged 18 to 25 (3.7% vs 5.5%, p=0.025) (See Exhibit 79). Significant increases in the prevalence of SMI were also observed nationally for young adults.

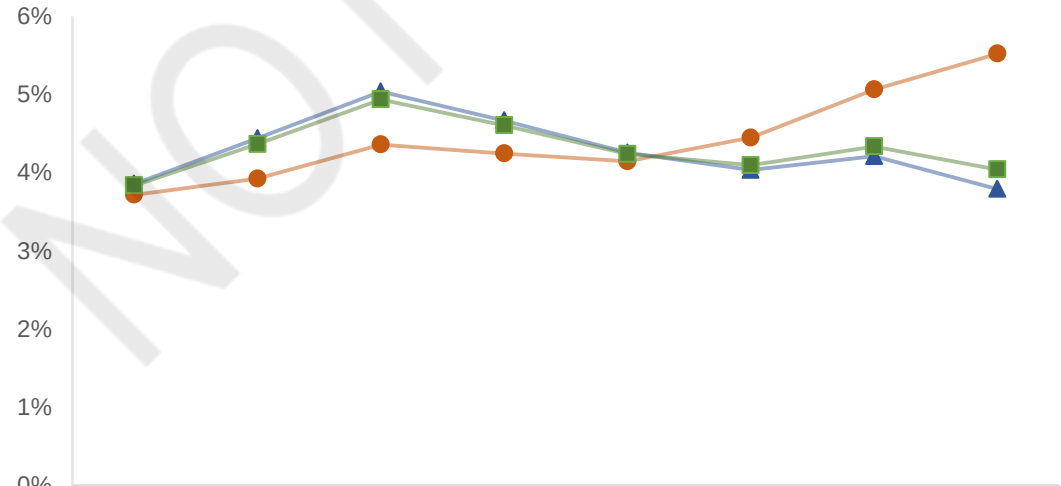
Exhibit 78. Trends in Prevalence of Past Year Major Depressive Episode in Arizona by Age Group, 2008-2016



	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
12 to 17	9.0%	8.4%	8.8%	9.4%	10.9%	13.2%	13.2%	11.7%
18 to 25	8.9%	8.6%	8.9%	8.8%	8.5%	8.9%	8.5%	8.6%
26 or older	6.6%	6.6%	6.7%	6.6%	6.7%	7.1%	6.5%	5.6%
18 or older	6.9%	6.9%	7.0%	6.9%	7.0%	7.3%	6.8%	6.0%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014- 2016
Note- NSDUH does not calculate the prevalence of MDE for the 12 and older population because of differences in the questionnaire module for those under 18.

Exhibit 79. Trends in Prevalence of Past Year Serious Mental Illness in Arizona by Age Group, 2008-2016



	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
18 to 25	3.7%	3.9%	4.4%	4.2%	4.1%	4.4%	5.1%	5.5%
26 or older	3.9%	4.4%	5.0%	4.7%	4.3%	4.0%	4.2%	3.8%
18 or older	3.8%	4.4%	4.9%	4.6%	4.2%	4.1%	4.3%	4.0%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014- 2016
Note: SMI is not calculated for those under 18

Prevalence by RBHA

There were no statistical differences in MDE or SMI prevalence across RBHAs in Arizona.

Youth Disparities

The 2017 YRBS data revealed disparities in mental health status among sub-populations of Arizona's high school students.

- Gender: Female high school students in Arizona were significantly more likely than males to report poor mental health (46.4% vs 26.3%, p=<0.001).
- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual had a substantial increased risk of poor mental health (31.6% vs 69.7%, p<0.001). The risk was most pronounced for females identifying as gay, lesbian or bisexual, with three out of four (75.8%) reporting a depressive episode. In fact, gay, lesbian and bisexual female students experienced significantly more depressive episodes than heterosexual females (75.8% vs 40.5%, p<0.001), and marginally more than males identifying as gay or bisexual (75.8% vs 54.5%, p=0.05).
- Race/Ethnicity: There were no significant differences in alcohol consumption indicators between non-Hispanic White and Hispanic high school students. There were no data available to estimate disparities in mental health in YRBS for American Indian youth.

Adult Disparities

Data were not available to estimate disparities in mental health for adults.

Early Age of Substance Use

Numerous studies have found that early age of first substance use, in addition to being detrimental to youth's health and development, is an important predictor of later substance use, misuse, dependence and abuse (Grant et al, 2001; Nkansah-Amankra et al, 2016). Data from the 2017 YRBS provided estimates of the percentage of Arizona high school students that tried alcohol, tobacco, or marijuana before the age of 13.

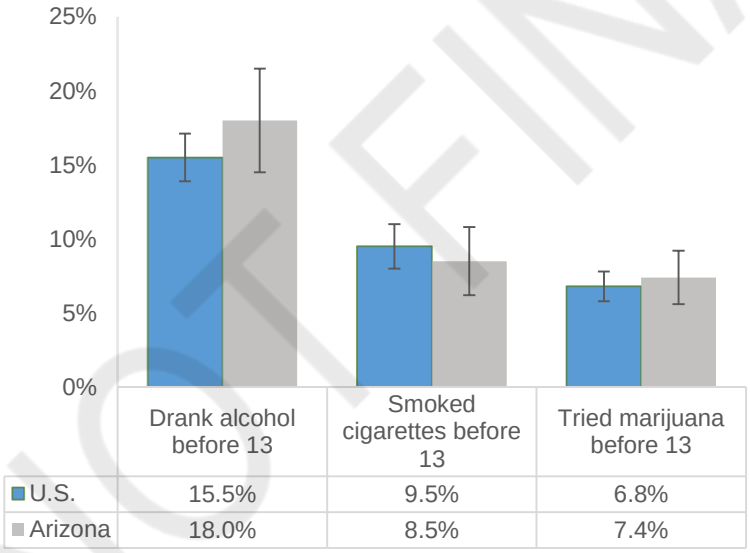
Alcohol Use

An estimated 18.0% of Arizona high school students reported that they had their first drink of alcohol, other than a few sips, before the age of 13 (See Exhibit 80). Arizona's estimate of early alcohol use did not differ significantly from the national estimate. Trend analyses reveal there were significant decreases in the prevalence of early alcohol use between 2009 and 2017 (29.5%vs 18.0%, p<0.01).

The YRBS 2017 revealed important disparities in early age of alcohol use among sub-populations of Arizona high school students.

- Gender: Female high school students in Arizona were significantly less likely than males to report early alcohol use (15.0% vs 20.8%, p=0.01).
- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual had a substantial increased risk of early alcohol use (27.5% vs 16.6%, p=0.01).
- Race/Ethnicity: Hispanic high school students were significantly more likely to report that they drank alcohol before 13 than non-Hispanic white students (21.4% vs 14.6%, p=0.02). Estimates for other racial and ethnic groups were not available.

Exhibit 80. Prevalence of Early Age of Substance Use Initiation among High School Students for the U.S. and Arizona, 2017



	Drank alcohol before 13	Smoked cigarettes before 13	Tried marijuana before 13
U.S.	15.5%	9.5%	6.8%
Arizona	18.0%	8.5%	7.4%

Source: Centers for Disease Control and Prevention. High School Youth Risk Behavior Survey Data, 2017.

Cigarette Smoking

An estimated 8.5% of Arizona high school students reported that they first tried cigarette smoking before 13, which does not differ significantly from national estimates (See Exhibit 78). No trend data were available for this measure.

The YRBS 2017 revealed important disparities in early age of cigarette smoking among sub-populations of Arizona high school students.

- Gender: Female high school students in Arizona were less likely than males to report

early cigarette smoking, although the differences were only marginally significant (6.8% vs 9.9%, p=0.05).

- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual had a substantial increased risk of early cigarette smoking (7.2% vs 15.8%, p<0.001).
- Race/Ethnicity: Hispanic high school students were significantly more likely to report that they tried cigarette smoking before 13 than non-Hispanic white students (10.5% vs 5.6%, p<0.001). Estimates for other racial and ethnic groups were not available.

Marijuana Use

An estimated 7.4% of Arizona high school students reported that they tried marijuana before the age of 13. Arizona's estimates of early marijuana use do not differ significantly from the national estimate. There were significant decreases in the prevalence of early marijuana use between 2009 and 2017 (2009: 11.8% vs 2017: 7.4%, p<0.01)

The YRBS 2017 reveal important disparities in early age of marijuana among sub-populations of Arizona high school students.

- Gender: Female high school students in Arizona were significantly less likely than males to report early marijuana use (5.1% vs 9.7%, p<0.001).
- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual had a substantial increased risk of early marijuana use (14.4% vs 6.2%, p=0.02).
- Race/Ethnicity: Hispanic high school students were significantly more likely to report that they used marijuana before 13 than non-Hispanic white students (10.5% vs 3.7%, p<0.001). Because of sample size limitations, estimates for other racial and ethnic groups were not available.

Availability of Substances

Ease of access to substances is another important risk factor for youth substance use. Additionally, where and how youth gain access to substances can provide important information for prevention programmers and policymakers seeking to limit access to youth substance use and/or misuse.

Alcohol Use

The 2017 YRBS asked high school students who reported current drinking if they "usually got the alcohol they drank by someone giving it to them." Approximately 38.8% of Arizona

students endorsed this risk factor. This prevalence did not statistically differ from national estimates.

The YRBS 2017 revealed important disparities in ease of access of alcohol use among sub-populations of Arizona high school students.

- Gender: Female high school students in Arizona were significantly more likely than males to report that someone gave them the alcohol they consumed in the past month (44.6% vs 32.5%, p=0.03).

- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual were less likely to report that someone gave them the alcohol they consumed (28.3% vs 41.2%, p=0.01).

No other significant disparities were reported by race/ethnicity or grade level. Additionally, the prevalence of this risk factor did not change significantly between 2009 and 2017.

The 2016 AYS asked 8th, 10th and 12th graders in Arizona where they obtained the alcohol they consumed in the previous 30 days. The most common places were at a party (42.3%), or by giving someone else money (25.7%).

Drugs on School Property

The 2017 YRBS asked high school students if they were "offered, sold, or given an illegal drug on school property (during the 12 months before the survey). Nearly 30% of high school students endorsed this risk factor, which was significantly higher than youth nationally (29.1% vs 19.8%, p<0.001). However, the prevalence of this risk factor decreased significantly in Arizona between 2009 and 2017 (34.6% vs 29.1%, p=0.02)

The YRBS 2017 investigated disparities in this risk factor by gender, race/ethnicity, grade level and sexual identify. Of these groups, only sexual identity significantly predicted differences in the prevalence of drug availability at school:

- Sexual Identity: Compared to high school students identifying as heterosexual, those students identifying as gay, lesbian, or bisexual were significantly more likely to report drug availability at school (45.4% vs 27.3%, p=0.01).

Parental Substance Use

Parental substance use is directly correlated with youth substance use. Data from the 2016 Arizona Youth Survey (AYS) estimated the percentage of Arizona youth who ever lived with an alcoholic or drug user (See Exhibit 81). Approximately one quarter of Arizona youth reported that they lived with an alcoholic, and between 14% and 19% reported that they lived with a drug user.

Exhibit 81. Prevalence of Arizona Students in 8th, 10th and 12th Grade Reporting Parental Substance Use 2016

Indicator	8th Grade	10th Grade	12th Grade
Ever lived with an alcoholic	23.1%	25.2%	26.4%
Ever lived with a drug user	13.8%	17.2%	19.2%

Source: Arizona Criminal Justice Commission. *Arizona Youth Survey 2016: State of Arizona.*

Parental Attitudes Toward Substance Use

Research has also indicated that youth who perceived their parents as more tolerant of substance use are more likely to use substances. Data from the 2016 AYS asked 8th, 10th and 12th graders in Arizona their reasons for not using substances. An estimated 59.7% of students said they did not use substances because they thought their parents might be disappointed in them. The 2016 AYS also asked participants if their parents think it is wrong for them to use cigarettes, alcohol or drugs; higher scores reflected less favorable parental attitudes towards youth substance use (See Exhibit 82).

Exhibit 82. Prevalence of Arizona Students in 8th, 10th and 12th Grade Reporting Parental Disapproval of Substance Use by Grade, 2016

Parents believe it would be wrong for me to…	8th Grade	10th Grade	12th Grade
Use prescription drugs without a doctor's recommendation	98.2%	97.9%	96.9%
Smoke marijuana	97.7%	95.8%	92.9%
Smoke cigarettes	98.7%	98.2%	96.4%
Drink nearly every day	98.0%	97.0%	94.6%

Source: Arizona Criminal Justice Commission. *Arizona Youth Survey 2016: State of Arizona*

Experiences of Violence, Assault and Bullying

Numerous other risk factors are associated with youth substance use. In their national analysis of risk factors for adolescent substance use and dependence, Kilpatrick et al (2000) concluded that "adolescents who had been physically assaulted, who had been sexually assaulted, who had witnessed violence, or who had family members with alcohol or drug use problems had increased risk for current substance abuse/dependence." Dube et al (2003) found the risk of future substance use and/or misuse increased as the number of adverse childhood experiences

(ACEs) increased, and that those with five or more ACEs were 7 to 10 times more likely to report drug use.

The YRBS provided prevalence estimates for a number of these risk factors, including experiences of forced sexual intercourse, violence and bullying. Arizona and national estimates do not differ significantly for most risk factors, however Arizona youth were significantly less likely to report they were in a physical fight in the past 12 months (6.2% vs 8.5%, p=0.02), and were significantly more likely to report that they did not go to school because they felt unsafe (10.2% vs 6.7%, p=0.02)

The 2017 YRBS data revealed important disparities in these risk factors among sub-populations of Arizona's high school students. For almost all indicators, males were significantly more likely to report the risk factor than females; gay, lesbian and bisexual students were more likely to report the risk factor than heterosexual students. Risk factors specific to students identifying as gay, lesbian or bisexual are detailed in a separate section of this report.

Exhibit 83. Percentage of High School Students Reporting Substance Use Risk Factors in the U.S. and Arizona and P-Values for Significant Difference Between Estimates, 2017

Risk Factor	AZ	US	p-value
Were ever physically forced to have sexual intercourse	8.2	7.4	0.50
Were in a physical fight- Past 12 months	21.1	23.6	0.19
Were in a physical fight on school property-Past 12 months	6.2	8.5	0.02**
Were electronically bullied- Past 12 months	15.2	14.9	0.86
Were bullied on school property- Past 12 months	19.2	19.0	0.90
Did not go to school because they felt unsafe at school or on their way to or from school- Past 30 days	10.2	6.7	0.02**
Were threatened or injured with a weapon on school property- Past 12 months	7.9	6.0	0.08*
Carried a weapon- Past 30 days	15.6	15.7	0.99
Carried a weapon on school property- Past 30 days	3.5	3.8	0.69

Source: Centers for Disease Control and Prevention. *High School Youth Risk Behavior Survey Data, 2017.*

Community Risk Factors for Arizona Youth

At the state-level, poorer economic status, lower educational attainment, and lower estimates of family and community well-being are associated with youth substance use and/or misuse. The Annie E. Casey Foundation's KIDS COUNT data monitors key indicators of children's well-being on a state basis. As of 2018, Arizona ranked 45th in the nation for children's well-being, suggesting substantially above average risks exist for Arizona youth.

KIDS COUNT Data
https://datacenter.kidscount.org

Arizona ranked 45th in the nation for our children's overall well-being

- **Economic Rank: 46th**
  - Percent of children living in poverty: 24% (2016)
  - Children living in families where no parent has full-time, year-round employment: 31% (2016)
  - Children living in households that spend more than 30% of their income on housing: 32% (2016)
  - Teens aged 16 to 19 not attending school and not working: 11% (2002)
- **Education Rank: 45th**
  - Children aged 3 and 4 not in pre-kindergarten program 62%
  - 4th grade reading achievement levels: 70% below proficient
  - 8th grade math achievement levels: 66% below proficient
  - High school students not graduating on time: 13% of those 25 to 34 had not graduated from high school; the four-year graduation rate was 80% (2016)
- **Family and Community Rank: 46th**
  - Children in single-parent households: 38% (2016)
  - Children by household head's educational attainment: 17% had not graduated high school (2016)
  - Children living in areas of concentrated poverty: 23% (2012-2016)
  - Total teen births: 37 per 1,000 females aged 15-19 (2012)

Community Risks: Practices and Laws

At the community-level, common practices and laws can influence substance use and/or misuse. The two community-level risk factors explored in this section are opioid prescription practices and legalization of medical marijuana.

Opioid Prescription Practices

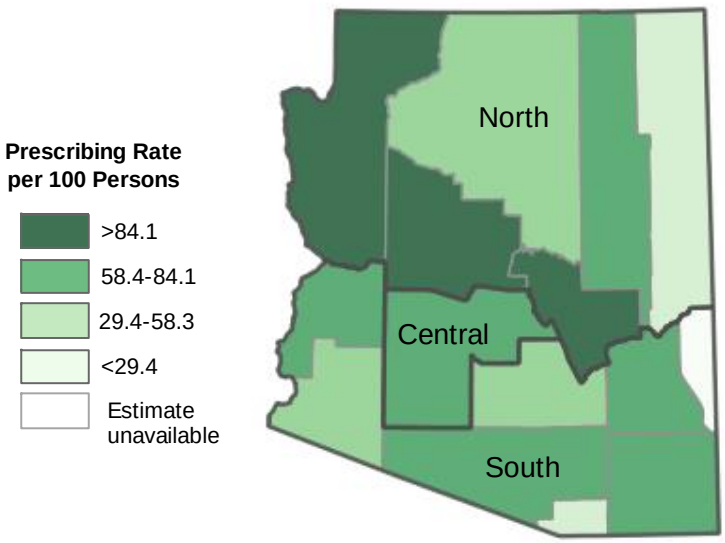
There is a strong association between opioid-related deaths and the opioid prescription practices of medical professionals. According to the CDC, "prescription opioid-related overdose deaths and admissions for treatment of opioid use disorder have increased in parallel with increases in opioids prescribed in the United States, which quadrupled from 1999 to 2010." (MMWR, 2017, p. 698).

The CDC provides data on opioid prescription rates at the county, state and national levels. These data come from the QuintilesIMS Transactional Data Warehouse, which provides "estimates of the number of opioid prescriptions dispensed in the United States based on a sample of approximately 59,000 pharmacies, representing 88% of prescriptions in the United States" (MMWR, 2017, p. 697). A prescription is defined as "an initial or refill prescription dispensed at a retail pharmacy" and does not include mail order data.

The national prescription rate peaked in 2012 at 81.3 prescriptions per 100 U.S. residents. By 2016 the rate had fallen to 66.5 prescriptions per 100 U.S. residents. The 2016 rate in Arizona was slightly higher at 70.2 prescriptions per 100 people. There were substantial differences in opioid prescription rates by individual counties across Arizona. Mohave and Gila Counties both had more opioid prescriptions than residents (127.5 and 110.0 per 100 people, respectively), while Apache County had only 18.5 prescriptions per 100 people. Data were not available for Greenlee County (See Exhibit 84).

A number of actions have been taken to improve, among other things, opioid prescription practices in Arizona in the past year. These accomplishments are summarized in the Arizona Opioid Emergency Response Report- June 2017 to June 2018. A complete list of enacted opioid-related legislation in Arizona can also be found on the National Conference of State Legislatures website. The opioid prescription data presented in this report are from 2016 and may not reflect recent improvements.

Exhibit 84. Opioid Prescribing Rates by Arizona County, 2016



Rank	County	Rate
1	Mohave	127.5
2	Gila	110.0
3	Yavapai	97.8
4	Graham	84.1
5	Cochise	79.0
6	La Paz	78.3
7	Pima	74.0
8	Maricopa	68.2
9	Navajo	67.5
10	Pinal	58.3
11	Yuma	56.6
12	Coconino	51.4
13	Santa Cruz	29.3
14	Apache	18.5
	Greenlee	--

Source: Centers for Disease Control, Opioid Prescribing Rates by County, 2016

Arizona Medical Marijuana Act

On April 14, 2011 the Arizona Medical Marijuana Act (AMMA) went into effect, legalizing medical marijuana use in the State for seriously ill patients with a doctor's approval. Nationally, studies investigating the effects of marijuana legalization on prevalence of marijuana use have been mixed, with some samples showing a near doubling in prevalence of past year use among adults (Hasin et al, 2015), while other studies have demonstrated only modest increases in past year use and no increases in the prevalence of current use, or marijuana use disorder (Gruzca et al, 2017). A recent national analysis of the effects of marijuana laws on adult marijuana use concluded that marijuana laws enacted in US were associated with some increased marijuana use, but only among adults aged 26 and older, and only in states with recreational marijuana laws, not medical marijuana laws (Williams et al, 2017).

It is unknown what percentage of Arizona marijuana users have medical marijuana cards or are using marijuana only for medical reasons. Data published by ADHS for May 2018 indicate there were 169,478 active medical marijuana qualifying patients in the State, including 207 active cardholders under 18. Data from the NSDUH suggest there were approximately 696,000 past year marijuana users in 2016 and 422,000 past month users. In Arizona between 2008 and 2016, past year marijuana use increased significantly for adults aged 26 or older (7.3% to 9.5%, p=0.035). Increases were not observed for other age groups, or for past month marijuana use. Given the significant increase in marijuana use for older adult populations, it is noteworthy that as of May 2018 approximately 75% of medical marijuana cardholders in Arizona were older than 30.

One hypothesized risk of medical marijuana is increased marijuana access for those without a medical marijuana card. The 2016 Arizona Youth Survey (AYS) asked 8th, 10th and 12th graders in Arizona where they obtained the marijuana they used. Approximately 17.0% said they got their marijuana from someone with a medical marijuana card, up from 10.8% in 2012. As noted earlier, there has been no change in the prevalence of marijuana use for youth aged 12 to 17 between 2009 and 2017, making it difficult to understand how medical marijuana access impacts marijuana consumption patterns among youth.

Qualitative Findings: Causal Factors

In the statewide focus groups and interviews conducted, two of the questions asked sought to understand what the causal factors for substance use and/or misuse might be (in that community):

What causes people in your community to use [these] substances?

Are there any particular issues people in your community have that are contributing to using these substances?

Findings below include those from focus groups and interviews conducted across the State. The themes presented are those with evidence supported by these conversations.

Overall

A number of themes related to causation of substance use and/or misuse were identified across all or most populations /communities visited and in interviews conducted with key informants. These major causes included:

- Self-medication via substance use and/or misuse, resulting from unaddressed behavioral health needs due to a lack of behavioral health services, the inability to access mental health services or the identification of a behavioral health disorder

  > "There are a lot of mental health issues and the county and school district level have limited resources. There are not enough school counselors, mental health supports, or psychologists in the county. We have zero juvenile psychologists in our county! Zero! The county does its best with telemedicine, but it is limited and doesn't reach everyone." (Interview with Navajo County Key Informant)

- Easy access to a variety of substances for all age groups, populations and communities.

- Isolation, a lack of social support, and/or someone to talk to for help can lead to substance use and/or misuse.

- The reduction and regulation of prescribed opioids leading to street drug use (e.g.

heroin).

> "Some of the top doctors writing prescriptions for opioids were in Mohave county even though the population is really low. Three doctors were investigated in Mohave County that were prescribing huge amounts of opioids. These doctors were shut down… Then when you can't get prescriptions you move to street drugs." (Interview with Mohave County Key Informant)

- Unsupervised youth leads to substance use and/or misuse.
- Limited funding and the requirements of core competencies in schools prohibiting effective prevention programs from occurring, thus leading to substance use and/or misuse.
- Normalization of marijuana and other substances through social media, peers, entertainment, advertising and culture leads to substance use and/or misuse.

> "There's 15 positive messages about marijuana for every one that talks about the harms and risks. So, when you're up against that kind of an environment… (in our county we have the highest per capita of marijuana cardholders… there's only so much that you can do to fight social norms. It's really difficult in a culture where the supply of marijuana is so socially acceptable." (Interview with Pima County Key Informant)

- A feeling of hopelessness about the current state of the world.

> "If people are already feeling hopeless, this constant daily occurrence of people striving so hard and they see people of power misusing that power, and that that erodes people. People need relief, they want it to be better so they might act better themselves. Or they want to be better so they pick a victim or scapegoat. Then there are those that just want to get away from it all so they smoke a joint. So as a community when we see youth that are marginalized and are oppressed, those are the people that they need something better and higher to ascribe to. When they ask, why be a part of all of this, it is not going to make a difference anyway - so they party to bring relief or fun for them. Not realizing it can make their life even worse." (Interview with Pima County Key Informant)

Youth and those serving youth

Youth and those serving youth provided in depth insights into the causal factors that lead to substance use issues for Arizona youth. Some key themes that came forward were:

1) Youth are self-medicating with substances due to mental health issues/trauma and a lack of or inability to access mental health services.

"Family drama, bullying, school, divorce making you so depressed you drink your feelings away." (Phoenix youth)

"One reason why people might lean towards substance abuse, they have a lot of family problems, some families are horrible to kids. A lot of kids at my school are so young and they can't get away from their families, drug use is a release from that toxic environment." (Prescott youth)

"'I want to kill myself' is so normalized, we say it all the time without thinking. A lot of people associate drugs with that. I know a lot of people affected by depression and anxiety and have gone to rehabs, so it is associated with hurting yourself. If we made progress to help people with suicidal thoughts, it's just another topic. 13 reasons why [television show], it's so normalized, its numbing us, video games where you go and pick up hookers and shoot people, you are numbing your mind. So many people have family issues and no one pays attention to their issues, when they say they want to kill themselves it is their way sometimes to get attention. No one is listening to them." (Prescott youth)

"I can talk about the suicide attempts, part of parent groups, kid come from all over, a lot of parents with children with depression, trauma in their lives, don't have the coping mechanisms, parents don't know how to help. Kids cutting themselves. Parents whose kids have attempted/committed suicide say their kids are using marijuana is commonly reported as used. Not an issue in one part of town, a lot of kids who are hurting. Kids who need other resources and substances, that's how their trying to cope." (Sierra Vista adult)

"[They] Want an Escape. For youth and adults. Kids have to deal with a lot today. Adults as well. A sense of peace and euphoria sense and they want that escape …then you have to increase to something stronger...then it just dominoes from there. It is a mental health thing, but people just want an escape, a quick escape." (Sierra Vista adult)

"My child struggled…we called ahead and they said there were resources, counselors but no, there is one counselor for three schools. One counselor for all those kids. My child didn't see a school counselor for the first year we were here. I had to find resources for him myself. I'm the parent who knows how to do that. There are a lot of parents who don't or don't have the ability to. …I'm at that school and I see the kids who have the same issues and I see them struggling…sitting in the office crying…no counselor…eventually those kids will

turn to other things to cope… They aren't being taught coping mechanisms." (Sierra Vista adult)

"There is a lot undetected…. no behavioral health in town, Parents tell kids to cope, get over it. Therapist wants three times a week which is unstainable to travel out of town. Kids don't always want medication. Not enough quality mental health services in this community. And there is a stigma if seen going into the service center, it's an embarrassment." (Globe adult)

"Addressing the drugs problems… there is a huge stigma problem here and everywhere. When we talk about getting families involved, there's a problem, a mental health problem, a substance abuse problem, and we're not going to get that handled until we get a handle on those problems. …mental health care is missing; substance abuse care is missing…the whole continuum of care is not in place. Your doctor tells you to go to a counselor. Ok. You don't have to go because there's no follow up. Until we get continuum of care in place, we'll keep going on like this." (Globe adult)

"I think its trauma and lack of affordable mental health services that are available to anyone regardless of their political status… I have a lot of kids who are undocumented… there's a lot of trauma… it's the whole family (not just youth)." (Phoenix adult)

"Trauma, underlying stressors, broken families, depression, they are self-medicating to not feel." (Kingman adult)

"We have lack of resources for our youth. If my kid 17-18 has a drug problem, where do I take them? …There aren't enough beds for our youth. Where do you send a desperate parent? They want to help their child but there are no resources. You have to go to Phoenix because there is nowhere else to go." (Kingman adult)

"We generationally have seemingly created people that have poorer coping skills. So their ability and willingness to feel is not there. They want everything to be good and happy, they don't want to feel life." (Kingman adult)

"I have been trying to get my son help since the end of May [time of focus group was August]. His Doctor has never experienced addicts, so I was referred to Mohave mental health. It takes so long to get help, and after months the kid is further along [in their crisis]. There is not enough help in our health facilities to help everyone in their time of need." (Kingman adult)

2) Due to a lack of healthy, affordable, fun activities for youth, they engage in substance use and/or misuse.

> "There is nothing for children to do …since the bowling alley left …but there's nothing for adults as well, you have to dig in and find something to do. No money, can't do this. My six-year-old wants to know why we live here?" (Sierra Vista adult)

> "Pay to Play athletics is a problem… you have to pay to be on a sport... can't be involved in a positive activity if don't have the money… [otherwise] nothing to do." (Phoenix adult)

3) Youth today currently lack coping skills or the social/emotional tools to deal with life's challenges which leads them to substance use and/or misuse.

> "I think kids are not taught how to deal with stress, especially in the crucial years because parents don't know how to talk to them…about how to manage stress...if they turn to their parents they just say, 'You will get over it.' The kids turn to alcohol…marijuana…other drugs, and it ruins their life at a young age. They've been using it as self-medication for years." (Globe adult)

> "To teach coping skills its tough, they have this block, it's like this attitude of being spoiled, being entitled, being obstinate, their brains are still developing. I blame our generation that didn't teach them good coping skills. To not just go to a substance." (Kingman adult)

> "We generationally have seemingly created people that have poorer coping skills. So their ability and willingness to feel is not there. They want everything to be good and happy, they don't want to feel life. To teach coping skills it's tough, they have this block, it's like this attitude of being spoiled, being entitled, being obstinate, their brains are still developing. I blame our generation that didn't teach them good coping skills. To not just go to a substance." (Kingman adult)

> "It is a slow progression, and new drugs keep getting introduced. But if we switch our thoughts away to true prevention like stress and coping mechanisms then our youth will grow up learning how to manage their anger and stress so they don't turn to these substances and abuse them. There is room to improve." (Flagstaff Key Informant)

4) Peer pressure leads to substance use and/or misuse.

"Popularity is peer pressure and a want, if you have weed or access to it or you're 18 and can get Juuls [vape brand] immediately everyone loves you. You immediately become popular if you have access to this stuff." (Prescott youth)

5) The use of substances has been normalized by popular culture, social media, marketing, peers and the legalization of marijuana which is leading to substance use and/or misuse.

"It's very open, all the kids know. Kids think it is popular and the thing to do…Depends on what group you're in [but] there are a lot of goody two shoes using…If someone is drinking it is [considered] normal for young people." (Prescott youth)

"You are listening to these artists that talk about getting high – [there is] celebrity influence." (Prescott youth)

"People see things on social media… movies, it influences them, glamorizes it… they want to look cool like the people onscreen… like Brad Pitt… with alcohol or smoking … in movies people have to do that for their roles… influences [kids] …especially social media… people are posting themselves doing drugs… and [kids are] like 'oh, it looks cool… I want to do it.'" (Phoenix youth)

"Television and Netflix shows, you see a lot of people who will use Adderall ® or abuse just basically any kind of substance... it's like teens we look up to, and like the top 50 most influential kids… even people younger than us… just like getting into middle school or in middle school and they are role models to them…… and when you see these people on TV, and they are portraying that character, even if they don't take drugs themselves but their character is… I know from my little brothers… they take things way too seriously, watching anything, it sticks to them like glue… if you see another teen or adult you look up to using, it influences you… for younger kids it definitely influences them and I think that is a step towards using… and when you see peers using or playing around with it… it's baby steps… it's not something that just happens."(Phoenix Youth)

"Alcoholism is super normalized now, if someone is drinking it is normal for young people. Social media has a lot to do with it. People talk about drinking all the time. It's just so normalized. Alcoholism is the norm." (Prescott youth)

6) A lack of family values and lack of family supervision of youth (or a stable adult for youth) to turn to leads to substance use and/or misuse.

"[Kids feel like] No one loves me at home, they just don't care if I live or die, then I'm gonna go over to this group and see what they have for me." (Sierra Vista adult)

"Parents give it to the kids… alcohol… they'll just let them smoke … or they'll have a party and the parents are upstairs watching TV while the kids are having parties downstairs … with weed, drinking…I haven't been to the parties but I've heard… [there are a lot of middle school parties, they start in the 6th grade]."(Phoenix youth)

"When I say when I'm down I say I'm fine. I don't really tell my friends when I'm down. I didn't have good friends last year and it was rough. I don't want to annoy people, when you ask to talk to people they don't want to talk to me. I feel like I don't have anyone to talk to." (Prescott youth)

"Peer pressure is always a thing, goes back to communication with your kids, the kids who have someone in their life, it doesn't have to be parents – an aunt, a grandparent, clergy member, soccer coach – who is pouring into them and encouraging them is most likely to be that kid that's not gonna be influenced by anyone and everyone." (Sierra Vista adult)

"Lack of family values, lack of structure … no traditional families or examples of that.. that starts to wear; before you had kids had mom, dad, and could afford for mom to stay home with the kids, now you can't; Now nearly impossible for one to stay home. There is little involvement of parents doing things with the kids now –like hiking, going camping, to the lake, …there's tons of stuff to do here even outdoors but parents are busy on Facebook, on phones, online, they are tired, and I get it, I'm a parent, I'm tired but you have to make sacrifices. There is community lack...not a lot of motivation for family, more like, 'Let's give the kids something to do. Here's our kids, do something with them.' Not 'Can we do something with our kids.'" (Globe adult)

"The lack of supervision of the youth, the single parent, they are working 2-3 jobs to make ends meet. They don't have the funds to put them in proper care or programs so they are at home unsupervised." (Kingman adult)

"We do live in a rural impoverished community where a lot of the parents are working to just make ends meet so they don't have the time to spend with their kids and invest that time, so they do have a lack of supervision." (Kingman adult)

"There are a lot of family issues. The traditional family is not as commonplace as it once was, having mom and dad home every night and having expectations for the kids, expecting them to be followed, monitoring their social media, activities, where they are going, having family time each night, all of these things seem to be going away. A lot of kids come from single family households. We live in a mining community where parents have to do shiftwork late at night. So in single family homes, kids may not see their parents at all. Their interaction might be minimal. The degradation of the family and a serious lack of parenting skills, this is a downward slope and has been for a long time." (Interview with Greenlee County Key Informant)

7) Due to inadequate funding and resources given to schools, and the demands of Arizona's core competencies, there is not enough time or resources for effective prevention programs in schools which leads to substance use and/or misuse.

"Globe is considered a 'D' school, now focused on curricula issues to improve their 'sad' grade, they cut out all other services, just core subjects – math, science – become their main focus. All the extracurricular activities—these are not important right now…focus on getting our grade up Doesn't mean the kids don't need [the core curricula] but cutting out all this other stuff is a mistake, because kids can't focus if they are having all these other problems…I have a child in junior high. There is a lot of pressure to cram info in before state testing…pressure on the kids to study, study, study and score high…not because they want their students to do well but because they want their school to do well so that they can get money... not really about caring about the kids. We're gonna lose our jobs if we don't get our grade up." (Globe adult)

"They cut the school week to four days [because of education budget cuts]. So, for a four-day week, to try and get in there to teach something is hard. So, there is an extra day with a lack of supervision. Instead of two days to get in trouble they have three days to get in trouble. Many schools are going to the four-day week." (Kingman adult)

8) Substances are easy to hide now in schools (vapes and edibles) and teachers do not notice (or ignore) the use of substances leading to continued use.

"Kids are sneakier with it, get clear Vodka in water bottles… Kids do it at middle school too… carry water bottles… you can smell it." (Phoenix youth)

"[Students use] mostly at football games, teachers don't know… I went to a game and they went under the bleachers and in the bathroom smoking and

vaping… more common to do drugs in the bathrooms…a lot of hiding spots at the high school." (Phoenix youth)

"My boyfriend's son, a sophomore, sees kids vaping in the class, teacher turns their back, they take a puff, everybody's waving their notebooks around. The vaping is happening a lot." (Sierra Vista adult)

9) Prescription Drug use, and over prescription of drugs can lead to substance use and/or misuse. (This finding is also supported by a recent study that found among new heroin users, three out of four report having misused prescription opioids prior to using heroin (Cicero, Ellis & Surratt, 2014)).

"Kid started opioids due to sports injury… he was prescribed opioids and then he got addicted and moved on to heroin… I know that's what happened to a young man in my high school over here… he was a really good athlete." (Phoenix adult)

10) Pressure for youth to be perfect leads to substance use and/or misuse.

"The obvious - peer pressure- but also there's a huge push for perfectionism, overachieving, so kids who wouldn't have been drug users, are now using Xanax®, Adderall®, and even athletes using performance enhancing drugs… There's been an interesting shift in that lately. Drugs to keep you up longer, etc. It's the idea of being bigger, better, stronger, faster…" (Phoenix adult)

"Honors students put high stress on themselves… that's where you see suicide attempts… sometimes they cope through medicinal use or drinking, marijuana, etc. They are the forgotten group." (Phoenix adult)

Additional causal factors that emerged from focus groups and interviews included:

- Experimentation/curiosity
- Wanting to have fun and feel "good"
- Taking drugs to study
- Intergenerational substance use
- Easy access to substances
- Youth stealing medications from family and others and selling or using them
- Those that are prescribed medications selling these to others at school
- Youth feeling "invincible" from the harms of drugs and alcohol, and
- Community characteristics (e.g. poverty, rural setting, lack of transportation, transient community).

Veterans

Those affiliated with the Veteran community shared a variety of reasons why they felt veterans were using and/or abusing substances. Some key themes that came forward were:

1) Veterans miss the adrenaline rush they got in the service; that's why many turn to drugs.

> "When you are in the military, you have your good time boys to have fun together. You may be drinking excessively but are in good shape. When you are out, it's a downer without your buddies and new stresses… and you don't have the adrenaline rush from when in the service. There is nothing comparable to that which you did in the military, that can give you that kind of rush." (Yuma veteran)

2) Untreated chronic pain and dental pain leads to street drug use.

> "We have a lot of people who have chronic pain. Up here in rural AZ, we don't have the level of care other areas have. If you think of a vet in a rural area, where are those people with chronic pain going to get treatment. If they don't have the eligibility to get treatment, where are they going to go?" *(*Flagstaff veteran)
>
> "Well, military training is tough … you have all the injuries like loading bombs by hand… [carrying maybe over 100 pounds]. You have to come back and somehow prove that this happened to you and that you incurred that injury while in service. It is so hard to get approved… [and] with special ops, they don't want a thick medical file on them. They just want to get patched up and move on. So later in life they can't prove those injuries." (Flagstaff veteran)

3) Veterans use substances to self-medicate for untreated mental health issues related to military service including Post Traumatic Stress Disorder (PTSD) and other trauma.

> "I kind of feel there might be some psychiatric issue[s] to the whole measure of drug use, self-medicating..." (Phoenix veteran)
>
> "In the military you can't bring up mental health issues because you would be kicked out and … now you're trying to figure out navigating the V.A. system on your own when you're suffering from depression and you have financial strain." (Interview with Pima County Key Informant)

4) Substance use is normalized and encouraged in the military which leads to substance use and/or misuse.

"When I was in the NAVY, right next to the soda machine was a beer machine… you could get a beer out of the thing any time day or night. Everything you did was around drinking. The macho thing was how much can you drink and how much can you party and not miss a day of work." (Flagstaff Veteran)

5) The difficulty in reintegrating into society once out of the military leads to substance use and/or misuse.

"A lot of times when we get out of the marine corps, you come from being a staff sergeant, a point of authority, and then you go to mopping floors… You don't feel important anymore… You used to say 'jump' and people would jump… and then you go into a place flipping burgers." (Yuma veteran)

"When vets come home they have PTSD, but the key to that is … they just need to find something to do to occupy their thoughts and time. It's way too easy to think they will just sit at the bar for the rest of their life, right? But they can heal themselves just by being occupied…It doesn't mean it goes away… you can still have nightmares, but you're just preoccupied with other things now that are more important to you in life. You see parolees get a dog, and all of the sudden they're not doing crime… let them go work on a ranch somewhere, give them something to do and a little bit of structure and let them deal with that emotional thing." (Flagstaff veteran)

"… So I get out service, I run around, I get a job at Target or whatever… it's not enough… Those barriers of life start to become an issue – and it might be… because I've been somewhere being catered to… I could go to my room, I could go get a chow, I don't pay for anything when I'm in the service, and when I come out, now I need a job. And for a lot of us, it's our first time [trying to find a job]." (Phoenix veteran)

"You are a badass, that steady pay check stopped…people don't realize there are no options. Mentally it [expletive] with you that you can't get a job at a 99 cents store. I started smoking and doing other things." (Yuma veteran)

6) Changes in prescription practices leading to street drug use.

"Until recently it was very easy for veterans to get prescription opioids from doctors, but regulations are changing abruptly to reduce opiate prescribing by doctors; doctors are prescribing alternative approaches such as 'stretching' for veterans with a history of chronic pain and there is concern they going to the street for opioids." (Interview with Pima County Key Informant)

Additional causal factors that emerged from focus groups and interviews included:

- Doctors overprescribing medications
- Lack of access to veteran medical care in rural areas (which leads to self-medication with drugs)
- Veterans not knowing where to access services and supports when they return home from service
- Loneliness
- Financial stressors
- Many veterans coming from military families where drinking is a family norm

Older Adults

Older adults shared a variety of reasons why seniors may be using and/or abusing substances. Some key themes that came forward were:

1) Loneliness and isolation lead to substance use and/or misuse.

> "Getting into and providing someone with that companionship, that connection with at least one other person… that goes to the heart of preventing any type of substance abuse." (Prescott older adult)
>
> "I live in a senior apartment complex that has a sliding scale and its very nice… This is in Prescott Valley… [The apartment complex is] big… [350 apartments]. I will run into someone in the hall and I'll say, "Oh are you new?" and they'll say, "No, I've been here five years…" So [there's] isolation even in a confined area… And we do have events… but the same people 50 show up for those… So where are all of those other people?" (Prescott older adult)

2) Loss of role after retirement leads to substance use and/or misuse.

> "As a culture we identify so much with our role… [Once people retire], there's a loss of role, whether it's from an office, as a parent or as a grandparent… Role is what determines worth in this culture… and when you lose that there's of course the dependence on something else to alleviate that…" (Tucson older adult)

3) Prevention activities are not geared towards older adults, often only youth.

> "One of the things that is rather discouraging to me in this area [is that there is] very little targeting to older adults… [prevention activities are] all targeted to youth… because I think that's where people's hearts are and there's a belief that if we get them younger, then that's prevention. We have a grant… we are getting people less isolated and more connected… the research is clear that it improves health, emotional health, all of that… But in terms of targeted

prevention efforts specifically about education, I don't know that there's anyone else doing it… There's no question in our mind that's there's a need… and that our colleagues and friends and people we work with don't have the information sometimes that they need. Prevention that I learned has to be targeted to a population." (Prescott older adult)

4) Over-prescription of pain medications transitioning to street drug use after increased regulations.

"I've had several surgeries including oral surgery and every time I've had a procedure, the first thing they do is hand me a script for a narcotic, and I don't take narcotics. I refuse them. But it's automatic each time. And they hand me a script and I have to ask what it is. And then when they tell me what it is, I say I want something else... I think it really is an issue of over-prescription that's happening today." (Tucson older adult)

Additional causal factors that emerged from focus groups and interviews included bodies responding differently to substances with age, and financial stress from living on a fixed income.

LGBTQ Populations

Individuals affiliated with the LGBTQ communities had a wealth of information to share about the reasons why they felt individuals in their community were using and/or abusing substances. Some key themes that came forward were:

1) Minority stress, including disconnection or rejection from family/community, leads to substance use and/or misuse.

"When you are queer you experience a baseline level of stress that is higher, messages that you are wrong and gross." (Flagstaff youth)

"When someone hits rock bottom, if their families neglected them, they feel alone, trapped or can't express themselves, or they don't know why their feeling this way or understand why people are attacking them, it brings you to do it because it makes you feel different and stop feeling the way you do to release all that pain." (Phoenix youth)

"I think People feel isolated … that causes them to want to use something because using might feel like a community to them." (Tucson youth)

"I know some people that their parents don't accept them for being LGBT and that causes a lot of stress and annoyance, so they try drugs to help stress and

anxiety." (Prescott youth)

2) A lack of safe substance-free areas to hang out or to engage with other LGBTQ in their community leads to substance use and/or misuse.

> "LGBT + alcohol, there are gay bars and events, there aren't like gay coffee shops so if you are a minor and wanting to avoid alcohol, the social events seem to revolve around alcohol." (Flagstaff youth)

3) A lack of, or the inability to access, appropriate and LGBTQ-friendly mental health services leads to self-medication via substance use and/or misuse.

> "I think substance use happens when your needs aren't being met. LGBT are more isolated and living in communities where we don't feel so accepted. People know these things are bad for us. Building social supports and mental health is so important. At NAU they have only 20-minute appointments with counselors at the mental health center because funding has been cut. Making those counselors have practices that are LGBT friendly, pronouns on intake forms, not assuming sexual practices, not being sensitive to gender, body parts. LGBT friendly practices are uncommon." (Flagstaff youth)

Additional causal factors that emerged from focus groups and interviews included peer pressure, addiction resulting from recreational experimentation, , curiosity and easy access to substances.

Tribal Populations

When speaking with Tribal members about causation of substance use and/or misuse, the dominant theme was that trauma, historical trauma and mental health issues lead to substance use and/or misuse. One community key informant interviewed from the Gila River Indian Community shared that emotional causes of substance use and/or misuse in the Tribal community could include feeling alone, unsupported or overwhelmed, and that substances provide numbness to pain and negative emotions. He stated that those who feel less connected to the Tribe and its culture are most vulnerable, most lost or feeling alone. These thoughts were also supported by members of the Pascua Yaqui Tribe:

> "It's really anything traumatic that happens to the kids… Any sort of pain, bullying, domestic violence, depression, anything that you went through. Even if you don't remember, there is something inside of you that remembers so there is this trigger, it's still inside you, so every time you are around it, just makes you feel worse, so you go and do something to yourself that makes you feel better, but it destroys your insides." (Pascua Yaqui Tribe Member)

> "Trauma… not only in communities of color but definitely Native Americans… we have to look at historical trauma that's unresolved, and that plays into intergenerational trauma… it all fits together … it's going to manifest itself…"(Pascua Yaqui Tribe Member)

Poverty was also mentioned as a causal factor of substance use by a member of the Pascua Yaqui Tribe:

> "One of the primary causes of alcohol and drug use in the community is poverty. Guadalupe has a large number of families who are living below the poverty line. There is not an outlet for children. Many children are being raised by grandparents or single mothers and they often drop out of school to work and earn money for the family. This causes stress and children turn to alcohol and drugs looking for relief. Interfamily relations also create stress which causes people to drink." (Interview with Pascua Yaqui Key Informant)

Other causal factors mentioned included community members being "desensitized" to alcohol use in that "parents would rather have their children drinking alcohol then using drugs", as well as peer pressure, lack of law enforcement, coping with deaths in the family, easy access to substances and the influence of social media, popular culture and entertainers.

Refugee Populations

Interviews with individuals that work with the refugee populations in Arizona shared some key insights into what might be causing substance use for this community. Causes of substance use and/or misuse for refugees may include extreme stressors and avoidance of mental health treatment. Although some refugees may possess pre-existing substance issues (especially alcohol, even from populations where it's forbidden, because it is common in refugee camps), people in the refugee community also have experienced challenges that make them especially vulnerable to substance use and/or misuse. They lack knowledge and "they come with trauma…have sometimes been tortured." They also may have PTSD, stress from the experience of coming to a new country (and starting a new life), having limited resources, and having limited money. In this context, substance use "can be a coping mechanism even for those who did not use before." Cultural taboos around getting mental healthcare or seeing a counselor, and the difficulty of addressing trauma through therapy may lead to use. One respondent noted, that it is "easier to access these types of things [alcohol, cigarettes] than to go see a counselor to process trauma." Men are especially likely to see therapy as stigmatizing and one respondent noted that men seem to be smoking specifically to deal with trauma. It has been noted that refugees are more comfortable with the idea of mental health treatment if they received some in a refugee camp.

Social influences may lead to use. Although staff try to integrate refugees around the city there

is limited housing such that most reside at a few apartment complexes and form social groups where drinking alcohol may be contagious. Youth want to fit in and are vulnerable to peer pressure.

Refugees also can have injuries that require pain medication. Prescription drug problems are linked to lack of health literacy for refugees and immigrants, who may use their prescribed medication "until they feel better" and then share them with someone who has the same symptoms. When addicted, adults get repeat prescriptions or "doctor shop", while youth primarily turn to street drugs.

Respondents also indicated that there are not a lot of "first language" or native language behavioral health services in the community for refugees, especially group therapy. It was reported that refugees often have trouble locating services even with court-mandated substance use and/or misuse treatment.

Promotores

The causal factors for youth substance youth reported by promotores in the Phoenix area were similar to many other causal factors mentioned above, including:

- Dysfunctional families leading to a lack of attention and contact with parents; youth not trusting parents enough to share their feelings with them
- Ignorance about effects of substance use
- Youth being bombarded with messaging in music, movies, TV, and media images that normalize substance use
- ACES (adverse childhood experiences), childhood stress and trauma (including intergenerational trauma), verbal, sexual, physical and emotional abuse in the home
- Depression in children and lack of mental health care
- Lack of coping skills and life skills
- Depression due to lack of opportunities for immigrant youth
- Normalization of substance use in the home
- Youth in foster system being abandoned at age 18 and falling through the cracks
- Doctors over-prescribing

Some causal factors of substance use and/or misuse were also mentioned for older adults including:

- Not having access to healthcare thus self-medicating.
- Switching doctors, pills, and treatments frequently.
- Not having enough money to care for themselves and using drugs to ease their pain and make the days go faster.
- Being unable to afford Obamacare, even for immigrants that have health insurance.

Promotores also shared that veterans in their community use substances to cope with mental and physical trauma.

Prevention Needs

Qualitative Findings

In the statewide focus groups and interviews conducted, two questions were asked related to what substance use prevention efforts are needed (in that community):

What kinds of substance use prevention approaches would work the best in your community?

What kind of prevention efforts does your community need more of?

Findings below include those from focus groups and interviews conducted across the State. The themes presented are those capable of being supported with evidence from these conversations.

Overall

A number of themes related to needs for prevention of substance use were identified across all or most populations/communities visited and in interviews conducted with key informants. These needs for substance use and/or misuse prevention included:

- Educating parents about substance use issues with youth as well as increasing parental (or other caregiver) involvement in their children's lives.
- Improving access and capacity of mental health services and resources.
- Addressing social isolation and the lack of individualized support for many populations.
- Allocating more resources and time for prevention programs in schools.
- Start prevention programs at younger ages and in lower grades.
- Better training and educating doctors about prescription drug issues.
- Training and educating medical and behavioral health providers to improve cultural competency and sensitivity towards unique populations.
- Creating and implementing more culturally competent and culturally sensitive prevention programs.
- Providing education to people who don't think they'll ever use substances or become addicted.
- Creating public awareness campaigns and prevention messaging that is creative, relevant, modern and persuasive.
- Informing people about prescription medication "takebacks".
- Educating the general public so they can be part of the solution (like Mental Health First Aid).
- Effective integrated care (medical and behavioral healthcare)
- Implementing more stringent liquor license regulations.
- Prison reform

Youth (and those serving youth)

Youth, and those serving youth, provided suggestions for substance use prevention efforts for Arizona youth. Some key themes that came forward were:

1) Suitable messaging for kids/not scare tactics.

> "Stop and think about what you are doing…We get told not to use all the time…kids know what they are doing" (Prescott youth)
>
> "You can't just say 'Don't use drugs and alcohol or else you die'… it's not gonna click in their head and won't come across them as that bad…so that's something that I've always wanted not to do…. just give them the facts and don't force it on them that they're gonna die if they use." (Youth from town of Maricopa)
>
> "Over time… it blends into just this attitude… don't do drugs… do start to take it as a joke." (Maricopa County youth)
>
> "You need someone dynamic ...someone who can built [sic] positive relationships [to teach the material]." (Interview with Tucson-based School Professional Key Informant)

2) Involve parents/direct messaging to parents.

> "Talk to the parents… so they can discipline their children more...lock up the medicine and get alcohol out of their reach, so they know not to do this, so they don't die or get lung cancer." (Youth from town of Maricopa)
>
> "All of the generations talking about this is the problem affecting the community…people who use drugs come and talk." (Maricopa County youth)
>
> "I think in the rural communities they tend to be conservative communities so promoting things that focus on family approaches to substance abuse prevention then some other approaches. Holistic approach is important." (Interview with statewide Key Informant)

3) Better parent support/engagement/Meaningful incentives to promote parent engagement (food, gas cards, etc.).

> "First time the school has done anything it was voluntary, we had to sign up for it this year, for 8th grade, a seminar on how to approach the subject with your child, what causes it, what they may be exposed to. A Family Night. A great thing, put on by the superintendent, funded by the governor's office. Of 600-800

kids at the school we didn't even fill up the cafeteria with parents." (Sierra Vista adult)

"One parent showed out of a 500-kid population. Head is in social media or the bar… They are not going to show up for anything like prevention – "Don't tell me what to do and don't tell me what I'm doing is wrong." (Globe adult)

4) Schools need to have enough support to focus on more than core curricula, raising their grade/Community-School Partnerships/Community collaboration.

"AZYP (Arizona Youth Partnership) had evidence-based programs but the schools do not have enough time to let them implement them…ends up being with kids in alternative schools when it's too late." (Kingman adult)

"How are schools supposed to do publicity/marketing, youth leadership, community coalition …all of these process together, they are not going to [pursue the grant money]... Trying to get this money to the schools for prevention, there has to be a different way to do it.. where they can participate but do not have to do too much work... it is a lot of the work, and I don't blame them for not taking the money." (Sierra Vista adult)

5) Ways to promote coping skills for kids.

"If we could figure out a way to provide our kids with goals, let them know that failure is ok, failure is part of success. Need to know that that's alright. The programs that we do have got to address that, bring families and kids into that." (Globe adult)

"If we switch our thoughts away to true prevention like stress and coping mechanisms, then our youth will grow up learning how to manage their anger and stress so they don't turn to these substances and abuse them." (Interview with North RBHA Key Informant)

6) Effective evidence-base programs for kids.

"The problem with the evidence-based programs is the time, number one, time consuming and they don't have the staff to run the evidence-based program." (Sierra Vista adult)

"Does anyone have a good program we can model ourselves after? We all have evidence-based, it's just evidence-based somewhere else …You need to take a little bit from Virginia, Tennessee, adapt it so it can work here." (Globe adult)

7) School counselors/mental health resources for kids/someone kids can talk to without risk/navigator for kids.

"There is one counselor for three schools. Pediatric psychologist moved away and now they just have teleconference counseling for kids." (Sierra Vista adult)

8) Community/parent education to meet basic needs/upstream prevention.

"The Strengthening Families program has been really effective because it engages families in substance abuse prevention even if the families don't realize that's part of the goal." (Interview with statewide Key Informant)

"It's mental health, parents who need help finding a job, getting a bus route through a safe area…advocacy for any issue, not just substance abuse...It is a breakdown in culture... that needs to be built back up." (Sierra Vista adult)

9) Start programming in lower grades.

"Schools don't have enough time, say 'just one time [single presentation] is all you need to do' and only for high school seniors when it should be for 4-5th grade." (Globe adult)

"The younger we can serve youth, 4-6th graders with Botvin Lifeskills I think that is so much more helpful with younger kids for prevention." (Interview with statewide Key Informant)

10) Prosocial things for kids to do/free opportunities to "de-stress"/ school clubs/sponsorships for sports.

Additional themes for primary prevention needs related by youth included:

- Presentation by people who have suffered consequences;
- Not shame-based;
- Anonymous call line for stress relief;
- Friends and social support;
- More people involved;
- More funding for efforts;
- Middle school programming;
- Videos at school and for parents;
- Pamphlets for all topics and aimed at all age groups;
- Prevention messaging from superstars/idols/celebrities;
- Engage more kids in youth prevention clubs;

- Facts, not scare tactics;
- Peer to peer advocacy/ "talk to your friends";
- Guest speakers in their age group;
- Prevention-related games in the classroom by school staff with prizes;
- Good props for classroom presentations;
- Not social media strategies; and
- Drug searches at school.

Some youth informants articulated that **current efforts for youth are not effective:**

> "Everything that we could have done has already been has been done, programs - don't drink, don't do drugs - Everything has been repeated and repeated and repeated...there is no approach right now that works." (Prescott youth)
>
> "They have a drug program, but kids don't do it because they want to continue to feel good from the drugs." (Phoenix youth)

Additional community-level themes for primary prevention needs related by youth-serving adults included:

- Accessible mental health services;
- PSAs & public awareness campaigns;
- Policies and laws;
- Education/interventions with doctors;
- Better regulation;
- Law enforcement funding and staffing;
- Municipal bodies on board;
- Unified messaging from the state level;
- Booklet of community resources;
- City investment in community infrastructure; and
- Emergency resource/support system/person for parents.

Additional program-related themes for primary prevention need related by youth-serving adults included:

- Safe place/drop in center;
- Suicide response;
- Realistic curricula;
- More than just one presentation;
- School involved in prevention/School-base curricula;
- Youth conference;
- More successful media connection to advertise efforts;
- School presentations of personal stories;

- Knowledge of how to evaluate efforts;
- Quality meeting space;
- Transportation;
- School-based training in basic skills (e.g., character);
- Youth speakers (popular kids, harmed kids);
- Mentoring program;
- Youth involvement/youth engagement; and
- Old program models/scare tactics (e.g. DARE; McGruff the Crime Dog; Red Asphalt)

Additional parent-related themes for primary prevention needs related by youth-serving adults included:

- Functioning parent groups at the junior high and high schools;
- Resource/navigator for parents seeking help with their teen;
- Intervention/support for using parents; and
- Parents on the same page with prevention.

Other themes for primary prevention needs related by youth-serving adults included:

- Youth having a chance to recognize that there are opportunities outside their rural community;
- Address prevention worker burnout;
- Recognize/acknowledge kids' pain; and
- Educate/provide programming in colleges.

Themes for secondary prevention needs related by youth-serving adults included:

- Reframe the marijuana issue to consider community acceptance as medicinal;
- Harm reduction; and
- Diversion Programs/decriminalization for kids/honest resource for help where they won't get in trouble.

A statewide key informant described the need for coordinated efforts:

> "Any community has to have a variety of different initiatives within the prevention world to make it a robust program and something that really works. Building on a community coalition is key to really make change, but also you need those EBPs, need to target community, youth and family. I think that's what missing a lot, things are pieced together here and there. We will have prevention funders that really force you into a box of what you can do, sometimes it's like you can only do coalition work no EBPs for example. So even if the community wants to educate kids about drugs, sometimes the funding doesn't cover that. A more

holistic approach that addresses all levels in the community...our communities need to fill in the gaps of prevention. There is prevention happening in almost every community, coalitions almost everywhere. Prevention has become so disjointed and there are so few resources, so it is like scraping the bottom and piecing things together. Need to fill in those gaps and let communities define what those gaps are."

Veterans

Individuals affiliated with the veteran community shared ideas for prevention. Some key themes that came forward that could address primary prevention were:

1) Programs with staff that can connect with veterans (e.g., employ veterans; help veterans feel genuinely cared for).

   "If you don't have providers that are genuinely trying to build relationships or trust with the veterans, they will see right through you and not want to participate with whatever it is you are trying to offer them. I think that's probably the biggest piece… If you don't have someone within your agency who can identify with them… talk their language and understand what they [or] their families may have experienced, then you have pretty much lost their attention or their respect. [Agencies are not successful because] they don't want to take themselves out of their office go and meet people where they are at, on the streets or in the community, to take 30 minutes and have a conversation and get to know a little bit about them… Providers need to have an understanding of what veteran culture is." (Flagstaff Veteran)

2) Programming that gets veterans involved in "something that's meaningful".

   "When vets come home they have PTSD, but the key to that is … they just need to find something to do to occupy their thoughts and time. It's way too easy to think they will just sit at the bar for the rest of their life, right? But they can heal themselves just by being occupied…It doesn't mean it goes away… you can still have nightmares, but you're just preoccupied with other things now that are more important to you in life. You see parolees get a dog, and all of the sudden they're not doing crime… let [veterans] go work on a ranch somewhere, give them something to do and a little bit of structure and let them deal with that emotional thing." (Flagstaff Veteran)

   "It goes against the mental health profession to give tasks but [veterans] really respond well to coming up with a written game plan, direction, time limits. They

are structure-oriented. You give us a daily schedule we're happy as can be because we know what we're doing every minute of the day. I think that's one strength that you can capitalize on with the veterans." (Interview with Tucson Key Informant)

3) Education and information-sharing for Veteran's Administration (VA) doctors (e.g., discussing accurate degree of risk for opioid addiction; scheduling in-person conversations between groups of VA doctors and groups of VA patients about opioid issues; helping doctor's approach patients "individually" and not assuming all are at high risk for addiction).

4) Prevention efforts to address homelessness for veterans (e.g., Crisis Center), alternatives for veterans that can respond quickly to poverty issues such as homelessness with a place to shower, eat, rest for 24/48 hours, get resources etc.; more communication/coordination between the State and veterans about homeless veterans.

Additional primary prevention needs related to programs that emerged for the veteran community included:

- A program that assigns a peer partner/sponsor/buddy to each vet who can help guide them through the transition/provide resources for at least three months like in Vet Court or in the service;
- Education/prevention/treatment of PTSD starting earlier;
- Making it mandatory for vets to check-in/attend meetings once per month with a central resource center when coming home in order to receive benefits;
- offering dental coverage to prevent vets from using drugs for pain; and
- More outreach staff willing to go into places on the street that other people not willing to go to meet with veterans.

Some secondary prevention needs emerged, particularly:

1) More effective outreach to veterans when they get out of the military including welcoming, screening, and offering resources.

"I think it would be good where someone could go and people there are actually knowledgeable of all of the [programs]… when I went to AWC I found about the Legion, and here at the Legion I found out about DAV, VFW and all of the other programs; at the VFW I found out about other programs, and through NHCP I found out other programs. But if there was one place I could have gone at the

beginning to find out about all of the programs, it would have benefited me a lot." (Yuma veteran)

"When people get out you just need to ask them, 'Are you doing ok? Is there anything we can help you with?'" (Flagstaff Veteran)

"You can see some… especially the older vets… tear up because nobody welcomed them back or honored them. The non-native people come back [and] drag [the trauma] with them." (Flagstaff veteran)

A key informant in Tucson also noted several secondary prevention needs, including:

- During treatment with veterans, it is important not to focus on the substance use to the exclusion of the underlying cause (e.g. depression, anxiety) when someone is dual diagnosed;
- Communication between agencies should be improved but is undermined by billing practices (among other things). Veterans might be simultaneously involved with the VA and with community providers to meet different needs, as well as have AHCCCS and own their insurance, but "no communication goes along with that" so agencies do not collaborate; and
- The treatment community struggles with two secondary prevention approaches - total sobriety and reduction on use/harm reduction. The "total sobriety approach" can seem arbitrary; some AA meeting "won't accept you if you on [prescribed] Xanax…but medical marijuana is ok." Some harm reduction strategies such as the Housing First model and reducing use to medical marijuana can be effective.

Older Adults

Older adults shared variety of ideas about what substance use prevention efforts are needed for seniors. Some key themes that came forward were:

1) Providing older adult-specific education and support for older adults that meet their unique needs.

"When I was in graduate school for higher and adult education in the 80's, the whole emphasis was the 'Aging of America' and the whole baby boomer population… and 'This is where all of our programming needs to focus'… and there's been absolutely zilch, especially in mental health." (Prescott senior)

"One of the things that is rather discouraging to me in this area [is that there is] very little targeting to older adults… [prevention activities are] all targeted to youth… because I think that's where people's hearts are and there's a belief that

if we get them younger, then that's prevention. We have a grant… we are getting people less isolated and more connected… the research is clear that it improves health, emotional health, all of that… But in terms of targeted prevention efforts specifically about education, I don't know that there's anyone else doing it… There's no question in our mind that's there's a need… and that our colleagues and friends and people we work with don't have the information sometimes that they need. And then there are different generational issues for shame… what you admit to and what you don't." (Prescott senior)

"For older adults the physical organs change, and their metabolism changes and it could be something as 'benign' as an antihypertensive medication mixed with something else and something else that they used quite well when they were young. When you get older, these can become dangerous… There's a risk of being affected adversely by a number of medications just because of the changes as we age." (Tucson senior)

2) Educating the general public/family/friends so they can be part of solution.

"Starting by educating people who are health conscious so they can share information and/or volunteer and help those in need." (Prescott senior)

3) Addressing social isolation (e.g., more peer support and intergenerational programming to alleviate loneliness).

"Getting in and providing someone with that companionship, that connection with at least one other person… that goes to the heart of preventing any type of substance abuse." (Prescott senior)

4) Educating physicians about older adult substance use issues.

"I've had several surgeries including oral surgery and every time I've had a procedure, the first thing they do is hand me a script for a narcotic, and I don't take narcotics. I refuse them. But it's automatic each time. And they hand me a script and I have to ask what it is. And then when they tell me what it is, I say I want something else... I think it really is an issue of over-prescription that's happening today." (Tucson senior)

5) More focus on prevention of health problems and opportunities to receive alternative health (acupuncture, qigong, etc.)

"There is a growing group of many seniors who want to age well and be as healthy as possible for as long as possible… [Seniors are doing] essential oils…

qigong and all of those other things… I think those are the places that you reach people who are interested in their health. They are more apt to want this, and they are going to listen… but they also have friends from their volunteer jobs and everything else they're doing that they can share it with." (Prescott senior)

Additional primary prevention needs related to education that emerged for the senior community included:

- Targeted training for in-home caregivers;
- Older adult-specific education/training for professionals;
- Clear information about "How much is too much" alcohol for older adults;
- Providing education to people who "don't think it will happen to them"; and
- Professional videos or TV programs for seniors to watch at home in which peers share their first-hand experiences of using substances and becoming addicted.

Other primary prevention needs that emerged for the senior community included:

- Mailings from pharmacies notifying when medication has expired;
- Physical fitness programs at senior center for pain prevention;
- Music therapy;
- Articles about prevention in the local newspaper;
- More effective messaging (billboards, tv ads);
- TV shows on older adult prevention; and
- A local coalition for substance use prevention for older adults.

A few secondary prevention themes emerged for seniors, including the need for treatment services targeted to older adults generally and for older adult women (who experience greater shame and denial).

LGBTQ Populations

Individuals affiliated with LGBTQ communities shared ideas about prevention efforts that could benefit these communities. Some key themes that came forward for primary prevention were:

1) The need for more safe, non-judgmental spaces to hang out or to engage with other LGBTQ.

> "It is hard to have safe spaces for LGBT kids. You need to look for LGBT colors for a safe space and a safe zone so you can find the people that can help you, that are an ally…seeing physical reminders that you would be accepted." (Flagstaff youth)

2) Pro-social programs/community centers (with free activities and snacks).

> "It would help if there were events happening where people can hang out for free especially if there were snacks… just a place and something for free… I like to just read … and be around people who are sort of similar to me." (Tucson adult)

3) Better access to appropriate mental health services/LGBTQ-friendly behavioral health services (thereby avoiding self-medication via substances).

> "At NAU they have only 20 minute appointments with counselors at the mental health center because funding has been cut. Making those counselors have practices that are LGBT friendly, pronouns on intake forms, not assuming sexual practices, not being sensitive to gender, body parts. LGBT friendly practices are uncommon." (Flagstaff youth)

Additional primary prevention needs that emerged for the LGBTQ community included:

- Educating parents on how to talk openly with their children
- Education in K-8 schools
- A help line for LGBTQ
- Educating the community on how to be better LGBTQ allies
- Offering other coping mechanisms besides drugs or other outlets to express anger and concerns
- Less marketing for substances, and a lower availability of drugs.

A few secondary prevention themes emerged, the most common of which was:

1) Harm reduction/needle exchange.

Additional secondary prevention needs that emerged included learning from LGBTQ individuals what helps them stop using, and AA-like group for LGBTQ and community rehabilitation instead of incarceration for non-violent drug offenses.

Tribal Populations

Community members of two Arizona Tribes shared their ideas about what substance use prevention efforts are needed for their Tribal communities Some key themes that came forward were:

1) Doing prevention work grounded in the Tribal culture:

> "We have a cultural society, if they could inform the youth and teach them life skills… that's where I think they could do a lot of good." (Pascua Yaqui focus group participant)

> "The best approach for native communities is help people focus on the community and not just on the individual by "reintroducing our cultural ways, our stories, our prayers. And I think some of the Tribes are now looking at that and bringing that back into the community and you know that's what we use. A long time ago when we were going through tough times, that's what we would turn to …. our ceremonies and prayers." (Key Informant from the Inter-Tribal Council of Arizona)

A key informant from the Gila River Indian Community felt that the most successful substance use prevention efforts with this population would be culturally-based such as incorporating songs and stories to help younger people identify with the Tribe for both youth and adults.

The key informant from ITCA indicated that Tribes are relying on an indigenous approach framework rather than the Western framework to good effect. She described the mistrust of mainstream culture that lingers in native communities, in part due to the historical experiences such as American Indian children being adopted out to non-native families or adoption agencies after parents were told that the children were going to visit with these families and come home. The respondent noted the conflict between funding opportunities to support substance use prevention services and the best approaches for Tribes; funding for mainstream resources is available to Tribes but "a lot of time we push these evidence-based intervention models on them and say, 'You have to use this,' but you know a lot of times those models don't work for Tribes." She stated:

> "I think that's really important for funders to know that…. I think a lot of Tribes are trying to go that route …. trying to utilize what they have in their community now what they've always used before… but sometimes that can be hard when you're applying for a grant because we have all these lists of evidence-based models they want you to use."

A North RBHA key informant agreed that tailored programming for Tribes was appropriate:

> "Culturally, Tribal specific, responding to these community needs. Not being afraid to have a small program respond to an issue that affects a smaller portion of the community. It may not be attractive to the State though to say we reached 400 people this year instead of 4000. But if we respond to them in a culturally specific way I think that is more powerful than a pamphlet."

The most common suggestion from a focus group with members of the Pascua Yaqui community was having "someone to talk to." A participant also recommended making programming available to community members who were not members of the Tribe:

> "The Tribe is doing an excellent job in behavioral health… one unfortunate thing is most of the programming is only for Tribal members, what happens to rest of population who needs services? Town is not acknowledging there's a problem… you can see they are not here in this focus group… I think they are so busy… putting out fires… our youth are being hurt out there."

Other suggestions from the focus group with the Pascua Yaqui included:

- Law enforcement engagement;
- Pro-social programs;
- Community discussions/focus groups;
- Community engagement programs or events;
- Parents talking to and supporting their children;
- Teen events;
- Prevention messaging at church; and
- Trainings/workshops.

The key informant from the Gila River Indian Community suggested other prevention efforts needed:

- Outreach about resources provided by professionals and by peers regarding professional help (treatment), jobs, and economic development, including information about both local resources and resources in surrounding communities; and
- More communication by health initiatives about substance use and prevention.

He noted that there are some cultural taboos around the topic of substance use, and peer-to-peer efforts can get around the taboo. The respondent agrees that someone telling their own story at a health or coalition event would be an effective approach if done well (he has seen it done "kind of scattered"). This would require efforts to train speakers who have experienced substance use issues to be better speakers. He felt that the best approaches for secondary prevention with Tribal community member were one-on-one peer support.

The key informant from ITCA suggested other prevention efforts needed:

- Programming that addresses alcohol and meth use delivered by ITCA;
- Support or different services for families that address cultural losses that affect community health; and

- Better access to Tribal-specific data (not aggregated for all Tribes).

Refugee Populations

Interviews with three individuals who work with the refugee population in Southern Arizona (Eritrean, Congolese, Sudanese, Somali, Afghani, Pakistani, Burundi and Bhutanese) revealed some recommendations for substance use prevention. They described the best approaches to addressing prevention with the refugee populations as training in-group members similar to a promotora model. They said that approaches conducted in first (native) languages were most important and that refugees are more willing to listen to other refugees than service providers and are more likely to learn from people who have been in this country longer. A "trusted member of the community" needs to deliver the programming. "We've had the wrong facilitator in the past and it didn't work." It requires a community member with a "good reputation" to go out into the community and meet its members "where they are." Using one-on-one versus group strategies depends on the target population.

Similar to the Tribal community respondents, they recommended culture-based groups like a drumming circle they used to have. One respondent (a refugee herself) felt that having substance prevention addressed by a spiritual leader, especially in their own language, would be helpful as it is connecting it with their cultural beliefs.

The respondents reported that refugee youth do not seem to be particularly vulnerable to substance use and/or misuse, possibly because they tend to value education more than American youth, which is reiterated by parents. They reported that the best prevention strategies with youth were tangential efforts like sports and supporting their parents. "The more supported the parents are the better for the kids." The children suffer less from acculturative stress and the parents are less caught up in their own needs. One respondent (a refugee herself) stated that it is hard for parents to be fully involved in the education system due to language barriers, noting that youth take on a lot of this responsibility.

There was concern that the State is moving away from direct service to coalitions. While this may be more efficient (and direct service more expensive) there is a good reason to maintain direct services in the case of refugees because coalition programming is in English and Spanish only and doesn't take literacy level into account. The refugee population needs linguistically appropriate, translated education materials, but not all are literate in their own language so more visuals would also be helpful.

Refugees are often from community-oriented populations and secondary prevention efforts should help people understand that it affects more than themselves – it affects their family and the community. It might help to hear it from the community rather than the service providers. Once engaged, linguistically appropriate services are not as available as they should be,

including at the case management level (e.g., reminding them of an appointment in their own language).

All respondents noted the unique strengths of these communities for resisting substance use that can be built on, especially resiliency and learned coping strategies for dealing with extreme stress. "They have already experienced hardship. It's made them strong." These are "some of the most resilient people in the world - What they have been through to get here." "All they've been through before and once they get here." They are guided by hopes and dreams of a better future. The youth want to get an education and make a difference in their home countries. The communities are closely knit families and help each other a lot. They typically have strong religious and cultural beliefs. If they need treatment, refugees are adaptable and have the potential to learn how to adapt to a healthier lifestyle.

Promotores

Promotores reported a desire for more prevention workshops for children and youth. Respondents felt schools should provide prevention programs in health education, but currently this does not occur in their school district in Phoenix. Other ideas included:

- Mandatory guidance counseling sessions to assist youth with post high school options to address kids having few opportunities to lead them away to drug use;
- More educational materials related to prevention;
- Help for those who need treatment for substance use and/or misuse but can't afford it even if they have insurance;
- Parents networking and talking more to one another;
- Parents nurturing kids' self-esteem more;
- Parents having more conversations about dangers of substance use with kids; and
- More programs to keep kids busy such as leadership programs and resources to allow kids to participate in extracurricular activities which means sometimes parents need to be educated to enroll their kids in these activities.

Higher Education

Interviews with four key informant university staff who were engaged in prevention efforts identified some suggestions specific to the higher education population, where alcohol use is a major issue. The higher education respondents suggested making presentations more interactive and moving away from PowerPoints to be more flexible - "having a little more freedom to incorporate different activities and a little just different teaching styles". Other ways to improve on prevention included more broadly implementing SBIRT (Screening, Brief Intervention and Referral to Treatment) strategies, and expanding awareness of dangers related to mixing alcohol with other substances. The higher education respondents identified the best ways to reach their students with prevention. They recommended less high-handed strategies ("Don't do this because it's bad for you"; "This is going to kill you") in favor meeting them

"where they are and giving them tools to make some changes and some reasons for why they should consider those changes, without being prescriptive and mandating –'You have to do this kind of thing'…because they feel like they're invincible and they don't necessarily agree with that." Students seem to register the messaging around social norms, the statistics that reveal that not all students are drinking. University-age students "want to feel empowered, they want to be able to read that information and then have that knowledge themselves to make their own decisions, feel like they're making the decisions themselves and no one's telling them what to do…..they take all the information they learn from us, from the media, from different things and they kind of use that as a guide but it's not anyone telling them exactly what they can or can't do."

Workforce Survey

Responses from prevention workers across the State also shared ideas on resource needs, challenges in working in prevention, and other recommendations regarding future prevention efforts.

Needed Resources

Respondents were asked, "What are the main challenges that you experience as a substance use prevention 'specialist' in your community or at your agency/coalition/organization?" The most common responses relating to primary prevention are illustrated in Exhibit 85. See Appendix F for the full list of responses, including responses related to treatment.

> "Not having enough time or money to do our job effectively. We need more staff…"
>
> "Remember the Arizona campaign about tobacco in the 1990s that led to Arizona having the lowest tobacco use nationally today? That's what we need regarding opioids. Show little kids what their lives will look like if they use drugs. Scare them. Make them want a better life."
>
> "Parent involvement is a challenge. Parents frequently don't see the need to put the time and effort into gaining the knowledge and skills to help their children resist drugs. A large portion of parents don't acknowledge the need for it until their child has been caught using drugs."
>
> "[There are] not enough prevention "champions" at the state level to advocate for prevention in the State and coordinate prevention efforts."

"…The schools are hard-pressed to make time to both deliver academic curriculum and perform well on State tests and allow prevention specialists to work with youth during the school day."

Exhibit 85. The most common response themes to "What are the main challenges that you experience as a substance use prevention "specialist" in your community or at your agency/coalition/organization?"

Theme	n
Funding/consistent funding/flexible funding (e.g., for coalitions, for prevention staff committed to a single community, prevention programs, transportation, snacks/incentives, for an evaluator; for community outreach; to research what is effective; treatment)	34
Not enough time to do the job well/lack of staff (e.g., to cover the needed partners, to cover the territory)	7
Engaging the community to participate in prevention efforts	7
Finding volunteers (e.g., for coalitions, promotores)	5
Engaging parents to participate in prevention efforts	5
Educating the public/ Community does not recognize the risk from drugs	5
Engaging community institutions/authorities to support prevention efforts (e.g. schools, the State)	5
Collaborating with other area agencies (e.g., sharing space for prevention programs; cross referrals)	4
Lack of resources generally	4

The following quotes describe less common themes but in informative detail.

> "Prevention Specialists don't seem to be recognized as a profession in Arizona. …This work is underpaid, making it difficult to attract and retain educated, experienced, and motivated staff. Many of the people I have met in prevention didn't necessarily set out to have a career in this profession, so they must do a lot of the learning on their own, and yet there are not many in-person affordable and accessible learning opportunities to keep up with drug trends, terms, types, or uses."

> "A lot of the prevention material is too wordy."

> "That we don't have time to prevent substance use. We spend all of our time treating it."

> "The focus is chasing the overdose numbers. When prevention saves lives from the beginning it is hard to measure but it is easy to track how many people you have brought back from the brink of death- but why should we wait until that point? We know that prevention works. We need to invest in the front end to keep people from becoming addicted to begin with."

> "We cannot get our providers in this community (both within our organization and out) to stop prescribing medication with potential for addiction intelligently. That is, we can't

> get them to consider non-addictive medicines first (i.e. Strattera for AD/HD vs. Ritalin or Ibuprofen over opioids). Further, we also struggle with ensuring they're using our well-trained behaviorists, physical therapists, or acupuncturist or other pain-based specialists before just writing a prescription and wishing the patient luck."
>
> "Working with youth who are already using isn't prevention, it's intervention and it has be a struggle to cope with the changes prevention has seen in the last three years."

Some issues respondents raised about funding:

> "Funding is also always a challenge in prevention and health promotion."
>
> "Funding. And not having secured funding over multiple years. It's difficult to work in a community when funding ends and begins. You lose trust [from] the community."
>
> "Funding, Funding. Funding. Did I say funding? As a rural program funding provides the life line to cover the costs of programs, transportation and should cover the cost [of] food/snacks as incentives for attendance. Feed them and they will come."

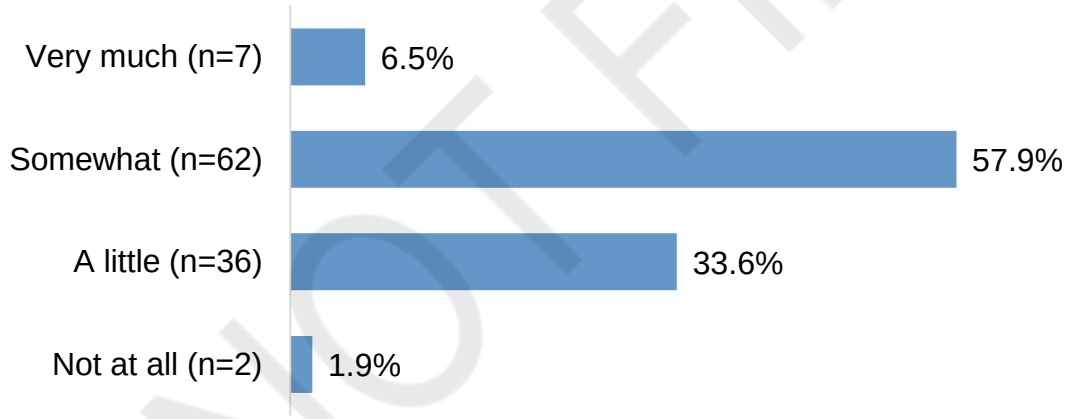
Respondents were asked to report on resources other than funding that would help the community be more effective in substance use and/or misuse prevention efforts. Respondents could report more than one type of resource. Exhibit 86 illustrates the number of individuals who reported that each resource was needed to help their community be more effective in substance use prevention efforts. The most common type of resource needed was help engaging the community. Respondents were also asked how engaged their community is in substance use prevention efforts. Almost all respondents (91.5%) reported that their community was a little to somewhat engaged in prevention efforts. Few reported that their community was very engaged. (See Exhibit 87).

Exhibit 86. Types of Resources Needed to Help their Community be More Effective in Substance Use Prevention Efforts (N=108)

	Number	Percentage
Help engaging the community	91	84.3%
Data on their community	71	65.7%
Prevention experts	64	59.3%
Facilities/building/space	59	54.6%
Help evaluating the impact of prevention programs	58	53.7%
Help with strategic planning	43	39.8%
Help running meetings	34	31.5%

*Respondents could report more than one type of substance use prevention resource needed.

Exhibit 87. How Engaged is the Community in Efforts (N=107)



Fourteen respondents reported one or more "other" resources that were needed besides those listed. Their responses fell into the following themes:

- Additional Staff (2)
- More Training Opportunities
    - Media Training
    - Free Trainings from Industry Experts
- Communicating the importance of collaboration to reduce duplication of efforts.
- Engaging professionals with authority.

    - Recruiting local government officials for education and awareness events and coalition participation to help them identify where they can be most effective.
    - More presence from "higher ups"
- Modeling best practices that are not criminalizing or stigmatizing.
- Recovery Meeting Materials
- Stronger Legal Interventions (e.g., for those arrested for dealing, using any drug legal or not legal, RX prescription drugs usage addiction).
- Annual Conference
- Housing Resources

Two respondents also noted that data, when it is provided, needs certain characteristics to be useful, specifying "up to date," "complete," and "timely."

Respondents were asked, "What resources for substance use prevention are sufficient in your community?" The most common responses relating to primary prevention are illustrated in Exhibit 88. See Appendix F for the full list of responses, including responses related to treatment.

Exhibit 88. The Most Common Response Themes to "What resources for substance use prevention are sufficient in your community?"

Theme	n
Public information (materials, dissemination opportunities)	6
Coalitions	5
Training and support for prevention professionals	4

Thirty-five respondents volunteered that there were not enough prevention resources. Examples of these responses included:

> "Naloxone trainings… Those are flooding all communities. But as for primary prevention, I don't think any communities have sufficient resources for substance abuse prevention. Prevention continues to be de-valued. More resources are being moved to treatment."

> "Prevention resources are drying up in Pinal County. Every non-profit and agency is going after the same pocket of funds. More funding is being put into treatment than prevention which in my opinion is not okay."

"There are currently none. The State Block Grant that funded coalitions was withdrawn at the RBHA level - hence no job."

"There are never enough resources. We need more prevention and early intervention, counseling not just for kids, but for families entirely. We need to incorporate this topic [into] the day to day school curricula and have parents involved and participating."

"Substance misuse is associated with a wide range of health and social problems including heart disease, stroke, HTN, various cancers, mental disorders, driving under the influence, sexual assault, rape, unintended pregnancy, sexually transmitted infections, intentional and unintentional injuries and property crimes. ……. More evidence-based prevention interventions…that could be carried out before the need for treatment, could delay early use and stop the progression from use to problematic use or to a substance use disorder all of which are associated with costly individual, social, and public health consequences."

"There is not enough money for more of a workforce to implement the strategies that we know work. Our State gives just enough to say they are doing something, but we are not able to do it in a meaningful way. Most dollars go to our big brother, Treatment… Do we really want to reduce costs and help people? Then we need to put more money, effort and time into prevention so that people will not need treatment."

One respondent wrote, "I believe there are sufficient resources for prevention, but inadequate knowledge of the resources available."

Evaluation of Efforts

Respondents were asked, "What methods are you using to evaluate whether your substance use prevention program or practice is effective?" The most common responses relating to primary prevention are illustrated in Exhibit 89. See Appendix F for the full list of responses, including responses related to treatment.

Exhibit 89. The Most Common Response Themes to "What methods are you using to evaluate whether your substance use prevention program or practice is effective?"

Theme	n
Pre/post or follow-up surveys or knowledge assessment with participants	29
Unspecified questionnaire/survey	16
Community surveys/feedback	8
Review results of external surveys (e.g. AYS)	7
Official records (e.g. overdose rates, police records)	5
Outcome evaluation generally	5
Process evaluation generally	4
Using an evidence-based program	4

While the most common responses (in pre/post/follow-up surveys or knowledge assessment with participants) related to potentially effective evaluation, responses also highlighted a lack of understanding for many respondents of what it means to evaluate a program *for effectiveness*. For example, strategies such as process evaluation generally; community surveys/feedback; or using an evidence-based program do not typically provide reliable evidence of effectiveness of a program (although using an evidence-based program may reduce the expectation that evaluating program effectiveness is needed). Further, seven respondents volunteered that there were *no efforts* to evaluate whether their program was effective.

Respondents were asked, "What kinds of evaluation needs does your community have that are not being met?" The most common responses relating to primary prevention are illustrated in Exhibit 90. There were few themes common across respondents, possibly due to the lack of understanding of evaluation, which was highlighted in their responses to the previous question. See Appendix F for the full list of responses, including responses related to treatment.

Exhibit 90. The Most Common Response Themes to "What kinds of evaluation needs does your community have that are not being met?"

Theme	n
AYS (e.g. more schools, quicker results, include LGBTQ data)	5
Formal evaluation strategies	5
Community Needs assessment	4

Conclusion

The 2018 Arizona Statewide Prevention Needs Assessment aimed to answer the following four key questions about substance use prevention in Arizona:

1. What are the current substance use issues in Arizona by region and subpopulation?
2. What substance use prevention programs are occurring in Arizona?
3. What are the causes for using and/or misusing substances in Arizona?
4. What are the recommendations for the future of substance use prevention in Arizona?

Critical Findings

The second and third steps in the Strategic Framework Process are capacity building and planning. The hope is that in conducting the first step (assessment) that findings can be generated that are specific, data-informed, and impactful in the subsequent strategic planning process that can lead to meaningful policy change. With these criteria in mind, the following key findings of the needs assessment have been identified:

1) **An increasing number of Arizonans of all ages and in all regions are suffering from untreated mental health issues that are leading to substance use and/or misuse.** Barriers to treatment include the lack of appropriate/available treatment (long waiting lists or lack of services in underfunded regions), stigma associated with accessing treatment, the cost and complexity of receiving treatment, and the reduction of mental health services and supports in schools and universities across the State. Suicide rates in Arizona are significantly higher than the national average, which bolsters the finding, that the mental health needs of our State require enhanced support.

2) **LGBTQ identified individuals in all regions are experiencing significantly more risk factors for, consequences of, and issues with substance use and/or misuse as compared to non-LGBTQ identified individuals.** This health disparity is one of the most prominent findings of this Statewide Needs Assessment. It is clear that there is work to do to reach this population more effectively with prevention efforts, resources and supports here in Arizona.

3) **Vaping (e-cigarettes, etc.) is increasing in Arizona for youth in middle and high schools and is significantly higher than national averages.** This new substance use trend should be considered with future prevention programs.

4) **The counties that are experiencing the most severe consequences of substance use in Arizona are: (1) Gila County, (2) Navajo County, (3) Mohave County, and (4) Pima County.** Secondary data analyses indicate these three counties are experiencing more severe consequences of substance misuse (hospitalizations and deaths) than all other counties in Arizona. Prevention programs should target these high need/high risk regions.

5) **A lack of social support and/or someone to turn to/talk to is a protective factor for substance use and/or misuse to which many Arizonans do not have access.** Increasing social isolation was a repeated theme across all regions and subpopulations. Future prevention efforts should consider prioritizing this key protective factor for their communities.

6) **The normalization of marijuana and other substances may be leading to increased substance use.** Due to the legalization of marijuana and the normalization of substance use in entertainment, social media, marketing/advertising and families/communities, individuals may not be adequately exposed to, or educated about, consequences of use and may also be less inclined to respond to these types of messages due to this normalization.

7) **Reductions in funding and resources for schools prohibit effective prevention programs from being delivered to high needs communities.** Due to lack of funding and resources for some school districts (e.g. schools having to move to four-day school weeks), it is difficult to implement prevention programs due to schools needing to prioritize time and resources to focus on and meet the requirements for core competencies.

8) **Recent efforts to combat the prescription drug opioid crisis in Arizona are leading to increased street drug use.** Many efforts have been made in Arizona to reduce opioid use including RX take back days, educational efforts, and oversight and regulation of opioid prescribers. Some communities that are regulating the prescription of opioids more strictly are finding individuals are resorting to heroin and other street drugs once they are no longer able to procure opioids from their physicians.

9) **Prevention programs that are culturally competent, engaging and up to date are more effective and should be prioritized.** Across the State, and particularly among youth, many current prevention efforts are seeing limited engagement and results that may be due to an inability to grasp the attention of the target population. More modern and up to date prevention program strategies should be considered and developed to attract

and engage more effectively the populations being served. In addition, the cultural sensitivity of a prevention effort should always be considered before implementation in a community.

10) **If basic needs are not being met (e.g. shelter, food, safety, physical health, mental health, social support) then prevention programs and efforts often fail.** Though there are a number of services available in communities to address these issues, many regions in Arizona still experience these difficulties. Prevention efforts should take into account the basic needs of the communities they serve, and offer, where possible, supports or referrals to address these basic needs parallel to prevention programming.

Strengths of Needs Assessment

A major strength of this needs assessment is the breadth and depth of data collected and analyzed. The four-pronged project approach (secondary data analysis, focus group and interview data collection, community inventory survey and workforce survey) helped to build a comprehensive understanding of the prevention needs and assets in Arizona. A cross section of communities, individuals and populations represented in this assessment paint a dynamic and detailed picture of the State. Relatively recent data was available for the majority of secondary data measures for both Arizona and national comparisons. In addition, response rates for both the Prevention Workforce Survey and the Community Prevention Inventory were healthy considering the short time frame for collection, and covered a wide cross section of regions, communities and populations.

Another strength of this needs assessment was the collaborative support and help received by so many individuals and organizations across the State to share data (or help locate data), coordinate and schedule focus groups (including offering spaces to conduct them and recruitment), and share information with helpful and informed individuals in focus groups and interviews. The excitement and appreciation expressed by the prevention community about the State's commitment to conducting this needs assessment was palpable.

Limitations

Secondary Data Analysis

There are a number of limitations to the secondary data analysis that should be considered when interpreting findings.

(1) Survey samples may not be representative of the target population, either because of chance, low response rates, or some error in survey methodology. Survey respondents may answer survey questions inaccurately, either because they cannot recall the event

correctly, did not understand the question, or because they want to provide a more socially desirable response. Social response bias can be especially problematic when survey questions ask about something illegal, like drug use. As a result, survey data may under-estimate the true prevalence of an event. Additionally, when sample sizes are small, it is more difficult to make accurate estimates or detect true differences between estimates. All data were also cross-sectional in nature, making it difficult to evaluate causality. Finally, administrative data sources are prone to error, especially due to mistakes or inconsistencies in mortality coding or disease classification. Errors in administrative data sources are difficult to identify and evaluate.

(2) Most indicator data were compiled from multiple data sources. Users are cautioned not to directly compare prevalence estimates from different data sources.

(3) Changes to national and statewide survey methodology or items overtime can compromise trend analyses attempting to compare data across baseline dates.

(4) Data were not available for several key indicators and priority populations; the most notable groups were American Indian/Alaska Native populations, especially at the Tribal level and LGBTQ adults.

(5) Online analytical tools, when available, were limited in the statistical analyses they could perform making it difficult to completely assess disparities and test hypotheses. Finally, due to lags in data collection and processing, the most recent data for many indicators were from 2016. These data may not accurately reflect current substance use patterns, risks and consequences in Arizona. In the future, targeted data collection and analytical efforts could help improve information about substance use in Arizona.

Focus Groups and Interviews

It is important to note that the time frame for the evaluation team to complete the entire Statewide Needs Assessment was very short, but despite this, primary data collection for focus groups and interviews were successfully conducted with groups and individuals that responded quickly to requests from the evaluation team. Although an enormous amount of support and requests were made, due to scheduling issues, travel coordination, resource availability, and willingness to participate, the reader should interpret qualitative findings as a **sampling** of perspectives in Arizona. There may be selection bias involved in the reporting on those groups and interviews because of the criteria mentioned above. In addition, it is important that the reflections of those members from the Pascua Yaqui and Gila River Indian Community focus groups and interviews not be generalized to each other or to other Tribes in Arizona. In future assessments, it will be a priority to include more Tribal communities in the data collection process.

Community Inventory and Workforce Survey

The community inventory and workforce survey were digital surveys sent to providers and workers across Arizona. Response rates for each survey were moderate, but only represent a

sampling of perspectives and programming. In addition, the level of detail provided by respondents in the community inventory varied widely, offering a range of detail on each program. Numerous follow up attempts were made to increase participation in both surveys, but due to time constraints, not all voices and viewpoints could be represented in these data summaries.

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Appendix A: Key Informant Interview Protocol

Date of Interview:_____ Start Time: _____ End Time: _____
Interviewee: _____
Special population if relevant: _____
…….I'm _____ from LeCroy & Milligan Associates. We are working with AHCCCS to conduct a Substance Abuse Prevention Needs Assessment for the State of Arizona. As part of this effort, we are interviewing people with expertise in substance abuse prevention in Arizona. Am I speaking with _____ [candidate's full name]_____?

I understand that you have been involved with substance abuse prevention and I'd like to ask you some questions about your experience [with *special population* as relevant]. The interview will take about 30 minutes. Is this a good time to talk?

I'll be tape recording our conversation so we can capture your ideas clearly. Is that ok?

I'd like to make sure you know that:

- There are no right or wrong answers;
- Your participation is voluntary; and
- You can choose to not answer any question or end the interview at any time.

Shall we get started?

---

1. What do you think are major substance use issues in [region/community/special population]?
2. What substances are causing the most harm in [region/community/special population]?
    a. What kinds of harm are they causing?
    b. Are you aware of any substances that are causing more harm for any specific groups compared to the community as a whole?
3. What causes people in [region/community/special population] to use these substances?
4. Are there any particular issues people in [region/community/special population] have that are contributing to using these substances? (Prompt as needed: mental health issues, financial challenges, physical health problems, etc.]
5. What does the community do to try to prevent use of these substances in [region/community/special population]?
6. How effective are these efforts?
    a. How could they be improved to be more effective?
7. What kinds of substance use prevention approaches would work the best for [region/community/special population]?

a. [As appropriate] Are the best prevention approaches different for youth and adults? How so?

8. What kind of prevention efforts does [region/community/special population] need more of?
9. What are some particular strengths of this [region/ community/special population] that prevent substance use?

Special Population Experts

10. [For special population experts] Are the substance use issues for [the subgroup] the same or different from the general population? How so?
11. [For special population expert] Are the substances that are causing harm in [the subgroup] the same or different from the general population? How so?
12. Are the causes of substance use the same for [the subgroup] the same or different from the general population?

Healthcare Experts

13. What changes have you seen recently to practices in the medical profession that reduce the risk for prescription drug misuse?
    a. Are there prescription practices or other practices that the medical field could change to enhance prevention efforts?

That was my last question. Thank you for your time and sharing your thoughts……

Appendix B: Focus Group Protocol

Introduction

a. Thank everyone for attending

b. Introduce facilitator, note taker and give a brief overview of LeCroy & Milligan Associates

c. Explain the purposes of the focus group:

- We are helping the State of Arizona learn more about alcohol and drug use and community prevention efforts. We'd would like to hear your ideas about these issues to help us understand how they affect the local community and how prevention efforts are working.
- Today's group discussion will take about 90 minutes. We will finish by ____.
- To show our appreciation for your participation, you will receive a gift card at the end of today's meeting.

d. Set Guidelines:
We have some guidelines that we find work well with focus groups and we'd like to suggest these:

- This is a brainstorming activity. There are no wrong answers. We're happy to hear a range of opinions and it's fine if people have different ones.
- We'd appreciate it if only one person talks at a time. Please do not interrupt or cut off other participants when they are sharing.
- Everyone should get an opportunity to speak to every question and no one should dominate the conversation; you are all experts and have something important to share.
- So that people can feel free to share their opinions, we ask that you not later share with anyone anything said by the other participants here today.
- Please turn off your cell phones or switch them to vibrate. Please go outside to take any calls that are urgent.
- Please feel free to quietly get up to use the rest room or get yourself something to drink at any time. The rest rooms are located _____.

Do you have any other grounds rules you'd like to suggest?

e. To help us document the information you share…….

- Please speak loud enough so everyone in the room can hear.
- We are going to be writing your ideas down so please try not to speak too fast.

- When we share your ideas with others, we will not say, "Charlie said this," or, "Beverly said that." Everything will be anonymous. We will identify people as Participant 1, Participant 2, etc.
- Here's how we'd like the focus group to go today: I will read a question. Then we would like you to discuss and respond to the question. It's not necessary to go around the room in order. Imagine you are sitting in your living room talking with each other about this subject, rather than talking to me as an interviewer. I will only add something if I have a follow-up question based on what people have been saying.

f. Ask permission to use tape recorder
   - Because it's hard to catch everything when we're writing and your opinions are important to us, we are going to record this discussion group. Only our research team will be able to listen to the recording.

g. Ask if there are any questions

h. Have participants introduce themselves

i. Turn on tape recorder and start the group discussion.

Questions

1. What do you think are major substance use issues in your student community?
2. What substances are causing the most harm in your student community?
3. What kind of harm is caused by these substances for your student community? What causes students in your community to use these substances?
4. Are there any particular issues your students have that are contributing to using these substances? (Prompt as needed: mental health issues, financial challenges, physical health problems, etc.)
5. How do students in your community get these substances?
6. What does the community or learning institution do to try to prevent use of these substances in your student community?
   a. How effective are these efforts?
   b. Are there ways they could be improved to be more effective?
   c. What kinds of prevention approaches would work the best in your student community?
7. What kind of prevention efforts does your student community need more of?
8. Is there anything else you would like to tell us?

Appendix C. Supplementary Demographic Data

County	Total Population	Hispanic or Latino (of any race)	White alone	Black or African American alone	American Indian/ Alaska Native alone	Asian alone	Other
Apache	72,346	5.9%	18.6%	0.5%	72.7%	0.4%	1.9%
Cochise	128,177	34.4%	56.3%	3.7%	0.8%	1.7%	3.0%
Coconino	138,064	13.7%	54.6%	1.3%	26.0%	1.7%	2.7%
Gila	53,179	18.5%	63.2%	0.6%	15.3%	0.8%	1.6%
Graham	37,529	32.1%	51.5%	1.8%	12.6%	0.7%	1.2%
Greenlee	9,224	46.5%	47.8%	1.8%	3.3%	0.6%	0.1%
La Paz	20,304	26.2%	58.9%	0.4%	12.1%	0.7%	1.8%
Maricopa	4,088,549	30.3%	56.9%	5.0%	1.5%	3.8%	2.5%
Mohave	203,629	15.7%	78.3%	1.0%	1.9%	1.1%	2.0%
Navajo	108,209	11.0%	41.9%	0.7%	43.2%	0.6%	2.6%
Pima	1,003,338	36.1%	53.3%	3.2%	2.4%	2.6%	2.4%
Pinal	397,604	29.2%	57.9%	4.3%	4.6%	1.7%	2.3%
Santa Cruz	46,547	83.2%	15.3%	0.2%	0.2%	0.8%	0.3%
Yavapai	218,586	14.1%	81.2%	0.5%	1.6%	0.8%	1.9%
Yuma	203,292	62.0%	32.7%	1.8%	0.9%	1.1%	1.5%

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Apache County Drug-Free Alliance (ACDFA)	Apache County RBHA: Steward Health Choice Arizona	youth and parents	Rx Drugs, Alcohol, Marijuana	Reality Tour (youth and parents do it together)	Little Colorado Behavioral Health; North Country Health Care	GOYFF -Parents Commission grant; SAMHSA (DFC grant
Be Awesome Youth Coalition	Santa Cruz RBHA: Arizona Complete Health	youth, parents, community members	Marijuana and alcohol	Too Good for Drugs (life skills) for 5th graders; Parent University, Rx-360	Maricopa Unified School District and Maricopa Police Department	Cenpatico for coalition; Governor's Office for mentoring; mini-grant from Casa Grande Alliance for Partnership for Success (PSS)
Way Out West (WOW) Coalition	Maricopa County RBHA: Mercy Care	youth, parents	Underage drinking, marijuana, Rx drugs	Currently reviewing programs, will soon decide what to implement. "Make Buckeye drug-free."	Buckeye Elementary School District; Buckeye Union H.S. District; Buckeye Police Dept.; Southwest Behavioral Health; Estrella Publishing	SAMHSA (DFC grant)
Santa Cruz County Drug Free Community Coalition	Santa Cruz RBHA: Arizona Complete Health	youth, parents	Marijuana, alcohol, and opiates	All Stars (EB). Parent workshops - Rx 260, 360 for Padres, opiates workshop, check points on prom night etc. in collaboration with Nogales Police Dept. - test youth coming back from Mexico; presentations in middle school assemblies	Santa Cruz County School Superintendent, Nogales Unified School District Superintendent, Mariposa Community	SAMHSA (DFC grant)

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
					Clinic	
Urban Indian Coalition of Arizona (UICAZ)	Maricopa County RBHA: Mercy Care	American Indian youth and adults	Underage drinking, marijuana, Rx drug/opioid abuse, suicide prevention	The UICAZ is a community-driven coalition focused on educating and preventing substance use and abuse by adolescents; dedicated to discussing, advising and collectively working together to create awareness and address issues within the Native American community. UICAZ sponsors the Gathering of Native Americans (GONA) is a community event that provides culturally specific substance use prevention information eliciting community healing through topics of historical and cultural trauma experienced over generations. GONA is for the whole family, with age appropriate programming.		SABG
CARE Coalition (Community Alliance for Resources and Education)	Maricopa County RBHA: Mercy Care	youth, parents, community members	Alcohol, marijuana, prescription drugs	Rx-360 (youth, adults), Families in Action, community development (coalition, youth council), public awareness campaigns	Touchstone Health Services	Office of Adolescent Health- teen pregnancy prevention, SAMHSA (Project AWARE)- mental health, GOYFF –

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
						Parents Commission grant
Safe Out LGBTQ Youth Coalition	Maricopa County RBHA: Mercy Care	LGBTQ young adults aged 13-26	Alcohol, marijuana, prescription drugs and suicide	Education, collaboration, outreach & connection and community involvement	Terros Health	SABG
Mohave Substance Treatment, Education, and Prevention Partnership (MSTEPP)	Mohave County (Kingman) RBHA: Steward Health Choice Arizona	Youth (prevention), adults (recovery)	All	Arizona strategies "Tool Kit"	Kingman Police, Kingman Regional, Southwest Behavioral Health, Mohave Mental Health, Sonoran Prevention Works, Mohave County Department of Public Health, Probation, Drug court	Donations, Arizona Opioid State Targeted Response grant (STR) grants
Copper Basin Coalition	Gila County RBHA: Steward Health Choice Arizona	All ages	Opioids and all other substances, mental health wellness	Community Naloxone Distribution Project- community and peer-to-peer trainings Medication safety and proper sharps disposal- community and peer-to-peer trainings Rx-360, town halls, parent nights, various community events	Gila County Public Health Department, Gila County Sheriff's Office, Sonoran Prevention Works	We are 100% volunteer and operate by financial donations and in-kind donations.
Arizona Suicide Prevention Coalition	Statewide	All populations - i.e. youth, older adults,	The coalition addresses substance use as	The Coalition supports evidence-based programs, such as ASIST, safeTALK, QPR, Signs of Suicide, and another	The key partners are organizations who are invested in the	The Coalition doesn't receive specific funding,

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
		veterans, Native Americans, working-aged men; the focus is on these high-risk groups that are specifically affected by suicide.	part of suicide prevention.	suicide prevention media campaign called Man Therapy. The Coalition sponsors many trainings (ASIST, safeTALK) throughout the year. The Coalition supports evidence-based programming through our annual HOPE/Suicide Prevention conference and the Local Outreach to Suicide Survivors conference. Through a partner agency, Teen Lifeline, the Coalition supports Teen Suicide Prevention Awareness events in September, in conjunction with World Suicide Prevention Day. Also, the Coalition supports the efforts of EMPACT-SPC and their annual Survivors of Suicide Day Conference and the Jeremyah Memorial 5K Walk/Run to Support Survivors of Suicide.	mission of suicide prevention -i.e. behavioral health and crisis centers, hospitals, schools, state entities.	although is partnered with other suicide prevention agencies who receive funding from Mercy Care. The coalition receives funding through a state-wide conference that is sponsored/suppo rted by our community partners.
Help Enrich African American Lives Coalition (HEAAL)	Maricopa RBHA: Mercy Care	Youth and parents	Alcohol, Marijuana, Rx Drugs	Drug Prevention 4Teens - Evidence-based Rx 360 - Evidence-based, Community Forums, Basketball Camps, Youth leadership, Youth Peer education, adult community education, billboards, newspaper, Facebook, community health/resource fairs, youth media camp, legislative advocacy	South Mountain WORKS Coalition, Phoenix Police Dept., Maryvale YMCA, Urban Indian Coalition AZ, Tempe Coalition, Maricopa County Sheriff's Office, Maryvale Adolescent Prevention Partnership, South	Mercy Care, SAMHSA (Drug Free Communities Grant)

Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
					Mountain High School, Maryvale Community Center, Substance Abuse Coalition Leaders of Arizona	
Coolidge Youth Coalition	Maricopa County RBHA: Mercy Care	Youth K-12	Alcohol, Rx drugs, marijuana, tobacco, suicide	CYC collects core measurement data from Coolidge Unified Schools every 2 years by using the Arizona Youth Survey. CYC has for the past decade implemented environmental strategies such as SHO/URG, sticker shock, alcohol advertisement reduction (enforcing current signage code) and a permanent RX Drop Box location. CYC collaborates and implements sustainable prevention strategies in the Coolidge Community such as "The Green Zone" Anti-bullying curriculum; "Go Green – Don't Let Drugs Pollute Your Life" and the "Pinal County RX Pilot Program" among many others. They continue to deliver new & effective prevention strategies to Coolidge such as "Save a Life Stop Underage Drinking" campaign and "Just Drive" distracted driving campaign. CYC is collaborating with local treatment agencies to help Coolidge Schools	Youth, Parents, Law enforcement, Schools, Businesses, Media, Youth-serving organizations, Religious and fraternal organizations, Civic and volunteer groups, Healthcare professionals, State, local, and tribal agencies with expertise in substance use, Other organizations involved in reducing substance use	Drug Free Communities Support Program Private/Corporate Funding

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				update their current Drug and Alcohol Policy by offering counseling services. Starting August 2018, CYC will be going into 6th, 7th, 8th grades with Coolidge PD School Resource Officer to implement evidenced-based Marijuana Prevention Curriculum (NIDA) into the classroom.		
Healthy Pima	Pima County RBHA: Arizona Complete Health	All demographics affected by the opioid overdose epidemic.	All substances. However, action plans have been created for the prevention of Opioid overdoses through the year 2020	The Substance Misuse and Mental Health Alliance is comprised of six task forces dedicated to promoting mental health and addressing the misuse of over-the-counter and prescription medications, as well as the use of illicit drugs, that affect the health and wellbeing of Pima County youth, families, and the larger community.	Medicine Assisted Treatment Centers, Hospitals, Law Enforcement, Nonprofit organizations, faith-based communities, school administrators, community members, students, etc.	CDC, ADHS, and from whom ever can support the action plan initiatives.
(M.A.P.P.E.D.) Mohave Area Partnership Promoting Educated Decisions.	Mohave County (Bullhead City and the surrounding areas of Fort Mohave, Mohave Valley, Topock, Davis Camp, Katherine Heights, Fort Mohave Indian Reservation, Laughlin, NV and	The citizenship within the Colorado River Communities.	All types of substance use.	Currently hiring an education specialist to implement the Evidence-based Botvin Program (or an equivalent). Recovery in the Park, Walk Away from Drugs, Red Ribbon Week Events, Bike Safety Rodeo, Fire Prevention and Life Safety Fair, parades, Senior and Winter Visitors Expo, Community Health Fairs, Veterans Stand Down, Summer Library Programs, Town Halls and educational presentations to various community and	Bullhead City Police & Fire, many members of the medical community.	Donations and a small amount of grant funding

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
	Needles, CA)			religious groups. Each month the members brainstorm ways to reach all ages within the community.		
South Mountain Working to build Opportunities, Resources, Knowledge, and Skills (WORKS) Coalition	Maricopa County RBHA: Mercy Care	Youth (ages 12-17)	Alcohol, Marijuana, and Rx drugs	Above the Influence, Rx-360, PAC 360, Town Halls, door hangers, sticker shocks, community youth theater, Drug take back, education, youth leadership, youth council, movie screenings	South Mountain Community Library, HEAAL Coalition, First Pentecostal Church, South Mountain High School, Phoenix PD	Drug Free Communities Grant
MATFORCE, the Yavapai County Substance Abuse Coalition	Yavapai County RBHA: Steward Health Choice Arizona	Youth Recovery Community Parents/ Caregivers Elderly	All illegal and legal substances that are abused.	Substance Use Education in Schools - 15 different curricula Parenting Education Yavapai Reentry Project Professional Trainings such as Motivational Interviewing, Adolescent Brain Public Awareness on risks and harms of drugs and alcohol Strategies on Opioid Crisis Overdose Fatality Review Marijuana Harmless? Think Again! Campaign Youth Contests Youth Group Activities School Assemblies Red Ribbon Week Activities Stand with Me, Be Drug Free Week	We have over 300 committee members and partner with schools, the medical community, business community, faith-based community, recovery community, nonprofit organizations, government, etc.	GOYFF - Parents Commission grant; STOP Grant through SAMHSA Attorney General's Office PFS Grant Yavapai County
Casa Grande Alliance	Pinal County (Casa Grande) RBHA: Arizona Complete Health	Youth and adults	All substances	SADD, M.O.S.T. Campaign (Making Our Students Think): A social-norming model program implemented in partnership with local SADD Chapters and under the mentorship of University of Arizona's Campus Health Service. This campaign is youth-led and adult supervised, Anti-	CGA has over 50 organizations, agencies, and individuals from all of the 12 sectors.	GOYFF - Parents Commission Grant AHCCCS - Partnering For Success grant

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				drug Rally/SMART Moves Program, Play Healthy: A health-promotion program aimed at youth athletes, parents, and coaches. This unique program informs parents, coaches, and young athletes how players' health choices impact athletic performance and the success of their team. Strong Families, Prescription Drug Misuse Prevention Project, Prevention Poster Program		
Tempe Coalition	Maricopa County (Tempe) RBHA: Mercy Care	12-18 year old youth, parents, community members	Alcohol and marijuana	Town Halls, school assemblies, skill building workshops. As a coalition, we do not do programming. We support programs and services.	City gov't, local businesses, school districts, youth serving organizations, treatment organizations, ASU	Drug Free Communities Support Program
Cochise Health & Social Services Arizona Prescription Drug Overdose Prevention Program	Cochise County RBHA: Arizona Complete Health	Prescribers, Pharmacists, Law Enforcement, Community Members, Youth	Opioids/ Prescription Medications	Rx Drug Misuse & Abuse Initiative Community Toolkit which includes the following strategies: Strategy 1: Reduce Illicit Acquisitions and Diversion of Prescription Medications Strategy 2: Promote Responsible Prescribing and Dispensing Policies and Practices, Sign Up to Save Lives Campaign Strategy 3: Enhance Rx Drug Practices and Policies among Law Enforcement Strategy 4: Increase Public Awareness and Patient Education about the Risks of Rx Drug Misuse and Abuse Strategy 5: Enhance	Cochise Addiction Recovery Partnership Impact, Sierra Vista/Douglas Substance Abuse Coalition, Chiricahua Community Health Centers Inc., SEABHS Sonoran Prevention Works, Southern Arizona Opioid Consortium, Wellness Connections,	The Arizona Department of Health Services Office of Injury Prevention administers funds provided by the Centers for Disease Control Prevention for operation of the Prescription Drug Overdose (PDO)

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				Assessment and Referral to Treatment. Outreach activities include health fairs, law enforcement events, Students Against Destructive Decisions (SADD)	Douglas/Bisbee Police Departments	Prevention for States grant.
Arizona SADD (Students Against Destructive Decisions)	Statewide	Middle and High School students	Drugs, alcohol	Various drug and alcohol awareness campaigns. Town Halls, Mock Crashes, Safe and Sober Prom nights, homecoming night, relay for life, various health and safety fairs, youth prevention conference.	Schools, parent groups, law enforcement, and firefighters	Governor's Office of Highway Safety, private donations
Chandler Coalition on Youth Substance Abuse	Maricopa County (Chandler, Gilbert) RBHA: Mercy Care	Teens, Adults	Opioids, Alcohol, Marijuana, ATOD	CCYSA created - Evidence Supported (we create the majority of our own presentations) Botvins Life Skills. Student presentations, Parent Presentations, Community Presentations, School Staff presentations, free Evaluations and Referrals into treatment, Tabling & Resource events, Shoulder Tapping, Advocacy, Take Backs, Compliance checks.	We have about 30 key partners from: Medical, Pharmaceutical, Prevention/ Intervention, Schools, City Government, Rehabilitation, Mental Health, and Faith based.	SAMHSA (DFC grant and STOP Act grant)

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Copper Corridor Community Substance Abuse Coalition	Pinal County (Globe, Miami, and the Copper Corridor -Superior, Kearny, Hayden, Winkelman, Mammoth, San Manuel ,and Oracle) RBHA: Steward Health Choice Arizona	Youth, Young Adults, Parents	Rx drugs, opioids, marijuana	Community Naloxone Distribution Project- community and peer-to-peer trainings Medication safety and proper sharps disposal- community and peer-to-peer trainings Rx-360, town halls, parent nights, various community events		SAMHSA (DFC grant and STOP Act grant)
Development in Gila County for Young Adults (DIG YA)	Gila County RBHA: Steward Health Choice Arizona	Youth (under 21 years old)	Underage drinking			SAMHSA (STOP Act grant)
Fountain Hills Youth Substance Abuse Prevention Coalition	Maricopa County (Fountain Hills) RBHA: Mercy Care	Youth and their parents	Alcohol Prescription Drugs Marijuana	Text-A-Tip (environmental strategy) Evidence-based Safe Homes Network (environmental strategy) Rx-360 - Youth and parents - Evidence-based Rx Take Back programs Public Information campaigns. We partner on many of these activities with our coalition leaders taking most of the lead - Town Halls, parent nights, Falcon Fiesta (safe graduation party), Back to School Bash, sports nights	Drug Free Communities, CADCA, Town of Fountain Hills, Maricopa County Sheriff's Office, businesses, Fountain Hills Times, Fountain Hills Unified School District, Fountain Hills High School , Fountain Hills Elementary School, Fountain Hills Middle School, Fountain Hills PTO, Faith Community -	Drug Free Communities Grant - SAMHSA

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
					Church of the Ascension, Presbyterian Church, Shepherd of the Desert, Fort McDowell Yavapai Nation	
The Healthy People Coalition (HPC)	Tohono O'odham Nation (GuVo District)	Tohono O'odham, particularly youth	Underage drinking	Too Good For Drugs (Evidence-based), Safe and Sober Movie Nights Safe and Sober Arcade Nights Family Fun Nights Fun Runs Safe and Sober Holiday Parties After School Program Summer Adventure Program	Native American Advancement Foundation (NAAF), Healthy O'odham Promotion Program (HOPP), Cenpatico, Gu Vo District and Community Councils	Cenpatico Native American Advancement Foundation
Southern Arizona Opioid Consortium	Cochise County, Graham County, Pima County (rural) RBHA: Arizona Complete Health	Those affected by opioid use disorder inclusive of family and caregivers' Grades 6-9 students First responders & EMS	Opioids	Botvin Life Skills - Opioid Prevention education for grades 6-9 (Cochise County). Southern Arizona "Find Help & Treatment Close to Home" referral rack card Magnet with Cochise & Pima Co crisis line and Arizona Poison Control phone numbers - use by providers, first responders or general public Participation in community events primarily in Cochise County.	Northern Cochise Comm Hospital, TMC, Cenpatico, Wellness Connections, Community Bridges, Air Methods, Med Transport, Addiction Network, SAHBHS, Community Partners: Cochise Co Health Dept, Willcox School District, City of Douglas, City of Willcox, City of Bisbee,	HRSA grant funding an FTE only. Ends 6/30/18.

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Impact Sierra Vista	Cochise County (Sierra Vista, Fort Huachuca and Hereford) RBHA: Arizona Complete Health	Youth 12-19 and parents of youth 12-19	Alcohol-Underage Drinking and Marijuana Prevention	Project Alert: Middle School Evidence-based Program 8 sessions of 40 mins SADD Youth Leadership Program: 1 hr. Week or Biweekly sessions MADD Parent Workshop for the prevention of substance use in youth Marijuana Harmless: Think Again! Presentation for Cochise County NIDA Brain Power presentations for elementary schools. Annual Cochise County Youth Leadership and Empowerment Conference, Red Ribbon Week Brain Power Presentations for Elementary Schools, National Drugs and Alcohol facts week, International Overdose Awareness day.	Parents, Sierra Vista Schools, Youth, Cochise County Sheriff's Department, Cochise County Health Department, Lori's Place, Cochise County Youth Probation, Cochise County Superintendent.	Substance Abuse Block Grant
Young Adult Association of Havasu (YADAH)	Mohave County (rural areas-Lake Havasu City) RBHA: Steward Health Choice Arizona	10-17 year olds	alcohol, marijuana and opioids	Love Notes (Evidence-based), Rx-360, Alcohol 360, Meth 360, Marijuana 360, town halls, prom night, health fairs, teen maze (substance use related), monthly coalition meetings, assemblies at schools,	social service agencies	DFC
Nexus Coalition for Drug Prevention (NCDP)	Navajo County (Showlow, Pinetop-Lakeside) RBHA: Steward Health Choice Arizona	Target population is youth 10-18 but we educate K-12 We also educate parents/community	Alcohol, Marijuana, Rx drugs	Mpowrd, 2BMowrd - Evidence-based Mpact - Non Evidence-based. Parent-Teen University twice a year with parents and youth. Town Halls, Safety Village, Red Ribbon, Dump Your Drugs, Freshman University, Drug-Free Art Contest, Mid School Presentations, Prom Mailing, Senior Graduation Mailing, P/T Conference Parent Education, AZ Gives,	We have 12 Sector Representatives. Youth, Parents, Business Community, Media, Schools, Youth-serving organizations, Law enforcement, Religious, Civic &	Drug Free Communities Grant. We are in our 5th year. Just applied for 6th year. Will find out if we get to stay up and running in Oct

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				National Prevention Week, Junior Leadership Academy, Shoe Drive Project, Town Lighting, Appeal Letter Mailoffs etc.	volunteer, Healthcare professionals, Local govt. & others such as Recovery Program	2018.
BeMedSmart	Pima County RBHA: Arizona Complete Health	Older Adults 65 + and their caregivers	Misuse of prescription medication including opioids, OTC medication, and nutritional supplements, etc.	Evidence-based: Wellness Initiative for Senior Education (WISE) - English and Spanish versions. PowerPoint presentation: Prevention of Prescription Medication on Misuse in Older Adults adapted from Rx-360. Collect Sidewalk Surveys -Distribute safe disposal fliers such as Dispose A Med fliers.	Pima County Health Dept., Dispose A Med Partnership, Medication Abuse Prevention Coalition (MAPIC), Community Prevention Coalition (CPC), Arizona High Intensity Drug Trafficking Area (HIDTA / Counter Narcotics Alliance (CNA) / Tucson Police Dept. (TPD), Behavioral Health Refugee ....(RISPNET)	Substance Abuse Block Grant (SABG) funds - Arizona Complete Health
Marana Prevention Alliance	Pima County RBHA: Arizona Complete Health	Youth	Marijuana and Rx drugs	Dispose-A-Med, medication lockboxes, medication disposal, youth coalitions, information dissemination at community events, Marana Red Ribbon Week, "Teen Maze" events at local high schools.	Local government, law enforcement, school district.	DFC

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Substance Abuse and Prevention Education Coalition (SAPE)	Pima County (Ajo) RBHA: Arizona Complete Health	Middle and high school youth	Underage drinking, Rx drugs, and marijuana	Providing Botvin's Life Skills program in middle school, engaging behavioral health staff in schools to improve protocols related to substance use and dependency	Arizona Youth Partnership, Arizona Complete Health, Ajo Unified School District	AHCCCS (Partnership For Success grant), Arizona Complete Health, GOYFF (Health and Wellness grant)
Douglas Community Coalition	Cochise County (Douglas) RBHA: Arizona Complete Health		Underage drinking, Rx drugs,		Douglas Police Department, Portable Practical Educational Preparation (PPEP), University of Arizona, Mexican Consulate, ARIZONA@WORK	SABG
Coconino County (currently forming)	Coconino County RBHA: Steward Health Choice Arizona	Not yet decided	Not yet decided	Not yet decided	Coconino County Public Health Services District, Flagstaff Shelter Services, Catholic Charities, and the Coconino County Continuum of Care	None at this time
Liberty Partnership Kino Neighborhoods Coalition (LPKNC)	Pima County (Neighborhoods in the southern part of Tucson) RBHA: Arizona Complete Health	Youth and parents	Alcohol, Rx drugs, marijuana	Strategic Prevention Framework	Sunnyside Unified School District, Tucson Police Department, neighborhood associations	

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Pima County Community Prevention Coalition	Pima County RBHA: Arizona Complete Health	Youth, parents/caregivers, schools, community	Underage drinking, marijuana, opioids, synthetics	Power Parents, Marijuana 360, RX 360, youth coalitions, multiple strategies across multiple sectors	Over 100 members, over 35 organizations	GOYFF – Parents Commission grant; Local, state, county, federal
Amado DFC Coalition	Pima County and Santa Cruz County (Amado area) RBHA: Arizona Complete Health	Youth, parents, schools, community	Underage drinking, marijuana, opioids, synthetics, border issues, local medical marijuana grow sites	Power Parents, Marijuana 360, RX 360, youth coalitions, multiple strategies across multiple sectors	Rural community members (Amado area) and organizations	
Isaac Community in Action Coalition	Maricopa County (Maryvale) RBHA: Mercy Care	Youth, parents, churches, schools, community organizations	Tobacco, marijuana, alcohol, opioids, synthetics	Increase membership capacity and organizational partnership	Urban community organizations	Federal
Catalina Community Coalition	Pima County (Catalina) RBHA: Arizona Complete Health	Community-wide but focus on 18 to 20-year olds	Underage drinking, Rx drugs	Requested permission to implement Botvin Life Skills in middle and high school, planning to implement curriculum for 18-20-year-old youth	Arizona Youth Partnership	AHCCCS (Partnership For Success grant)
Sahuarita Community Coalition	Pima County (Sahuarita) RBHA: Arizona Complete Health	Community-wide but focus on 18 to 20-year olds	Underage drinking, Rx drugs	Requested permission to implement Botvin Life Skills in middle and high school, planning to implement curriculum for 18-20-year-old youth	Arizona Youth Partnership	AHCCCS (Partnership For Success grant)

Other Community Organizations and Programs

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Touchstone Health Services	Maricopa County RBHA: Mercy Care	youth, parents	Alcohol, controlled substance, Rx drug misuse	Substance use education for youth and caretakers (Rx 360), family-based substance use education (Families in Action), and community awareness (CARE Coalition & public awareness campaign).		GOYFF – Parents Commission grant
Area Agency on Aging, Region One	Maricopa County RBHA: Mercy Care	Older adults 55+	Alcohol, Prescription Drugs and Suicide		A member of MEBHAC (Maricopa Elder Behavioral Health Advocacy Coalition)	SABG; GOYFF STR Prevention Funding
Teen Lifeline	Maricopa County RBHA: Mercy Care	Schools in Maricopa County (youth, administrators, parents)	Youth suicide		A member of Arizona Suicide Prevention Coalition (AZSPC)	SABG
Sonoran Prevention Works	Statewide		Harm reduction	Provide community workshops, trainings, referrals, consultation, and risk reduction materials to individuals, families, and organizations in order to prevent HIV, Hepatitis C, overdose, and the perpetuation of stigma. Also facilitate the largest free naloxone distribution network in the state.		
Arizona Youth Partnership	Maricopa County RBHA: Mercy Care	Youth		Peer leadership programs such as SAD, YES, Sources of Strength, and University leadership programs		

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Pinal Gila Council for Senior Citizens - Arizona City Triad						
MSTEPP - STR Opioid Prescription Abuse Prevention	Mohave County RBHA: Steward Health Choice Arizona			Community Lunch and Learn Events		
RallyPoint	Major metropolitan areas	Veterans	Substance use and suicide prevention		An initiative of La Frontera Arizona in partnership with the Arizona Department of Veterans Services	
University of Arizona Center for Rural Health's Arizona First Responders Initiative (FR-CARA)	Statewide	First responders	OD prevention	Naxalone and OD prevention training	Arizona Department of Health Services, Sonoran Prevention Works,	SAMHSA
Youth4Youth program	Maricopa County RBHA: Mercy Care		N/A	Youth development (leadership skills development - public speaking, problem solving) - he conducts training sessions in school, youth decide how to move forward on activities in their school	Buckeye Elementary School District	
Arizona Department of Liquor Licenses	Statewide	Youth	Underage drinking	Arizona strategies "Tool Kit"		GOYFF – SABG Prevention Funding

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
and Control						

Universities

Arizona State University						
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, marijuana	Challenging collegiate alcohol and other drug social norms social marketing/ media (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU staff, student leaders, faculty	Alcohol, Other drugs, Opioids	C-3: Compassion, Communication, Connection - ASU's Screening, Brief Intervention and Referral to Treatment training program (EBP)		GOYFF – STR Prevention Funding
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, Other drugs	Recovery Rising Substance Free Socials (EBP)		GOYFF – Collegiate Recovery Program Funding
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol	Electronic Check-Up to Go for Alcohol (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Marijuana	Electronic Check-Up to Go for Marijuana (EBP)		Student fees and grants

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ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol	Alcohol Wise Online Education (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol	Under the Influence Online Sanctions Education (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Marijuana	Marijuana 101 Online Sanctions Education (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, Marijuana, Prescription Drug abuse	Screen U online screening (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, Other Drugs	AOD Peer Education Program		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, Other Drug, Opioids	ASU Maroon and Gold Ribbon Week Awareness Event (in conjunction with Red Ribbon Week and ASU Homecoming)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, Other Drugs, Prescription Medicines, Opioids	One More Step Walk and Health Expo (Awareness Walk)		Student fees and grants

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ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Prescription Drugs	Safe Medication Disposal Campaign (EBP)		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, Other Drugs	Step Up Bystander Skill Building Program		Student fees and grants
ASU Educational Outreach and Student Services	Maricopa County	ASU students	Primarily alcohol	Environmental strategies (EBP): Tail gate policies, Substance free residence halls, restrict alcohol sponsorship and advertising, alcohol-free programming, welcome to the neighborhood police and ASU rounds for fall semester		Student fees and grants
ASU Health Services, Wellness and Health Promotion	Maricopa County	ASU students	Alcohol, other drugs	Presentations for groups and classes (Evidence Informed Program): includes social norms correction, peer influence, values clarification.		Student fees and grants
Northern Arizona University						
SBIRT Expansion @ NAU	Coconino County	NAU students	Alcohol, marijuana, prescription drugs	SBIRT		GOYFF (State Targeted Opioid Response Grant)

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Primary AOD Prevention @ NAU	Coconino County	NAU students	Alcohol, marijuana, prescription drugs	Personalized feedback intervention (eCheckUpToGo, ScreenU); skills training; normative re-education; educational presentations/tabling events; social norms campaigns; peer-to-peer education; training for clinical and campus staff		GOYFF (State Targeted Opioid Response Grant)
Collegiate Recovery Program	Coconino County	NAU students	n/a	Dedicated CRP lounge space; weekly recovery meetings; comprehensive referral network; sober social events; staff and faculty training around recovery support		GOYFF (Collegiate Recovery)
University of Arizona						
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, other drugs	BASICS (EBP)		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, Marijuana	Student Health Alcohol and Drug Education (EBP)		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol primarily	The Buzz		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol primarily	Challenging Collegiate Alcohol Abuse Social Norms Media (EBP)		GOYFF – Collegiate Recovery Funding

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, other drugs	Cats After Dark alcohol/drug-free social programming (EBP)		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, other drugs	Awareness events around campus		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, other drugs	Red Cup Q & A Columns		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, other drugs	Presentations in classes and to student groups		Student fees and grants
University of Arizona Campus Health Service	Pima County	UA students	Alcohol, other drugs	social media (Facebook, U Tube, Instagram, Twitter)		

Tribal Organizations and Programs

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Gila River Health Care BHS Prevention Program & The Gila River Prevention Coalition	Maricopa and Pinal Counties	Gila River tribal community	Alcohol, marijuana, prescription drugs	Botvin's Life Skills, Active Parenting, ASIST, QPR, SafeTALK, Reconnecting Youth/CSAT and Signs of Suicide	Gila River Tribe	AHCCCS SABG Block Grant and First Things First
Pascua Yaqui Behavioral Health Centered Spirt Program	Guadalupe	Pascua Yaqui Tribal members and immediate family	All	Youth life skills groups, individual, couples, family and group therapy, methadone/suboxone maintenance, psychiatric evaluation, and psychiatric medication follow-up. CSP also offers crisis evaluations for emergency situations.		Program generated funds
Guadalupe Community Partnership (GCP)	Guadalupe	Youth and adult community members		Prevention through education	Tribal departments, town government, community programs, and assorted health agencies that serve the town of Guadalupe	The Pascua Yaqui Tribe's Guadalupe Prevention Partnership program sponsors GCP
Meth Suicide Prevention Initiative	Guadalupe	PYT tribal members and Guadalupe community members	Meth	This initiative promotes the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to methamphetamine abuse and suicide prevention from a community-driven context.	Pascua Yaqui Tribe, Town of Guadalupe, Guadalupe Prevention Partnership, Guadalupe Community Partnership	Indian Health Services

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Inter-Tribal Council of Arizona - Methamphetamine and Suicide Prevention Initiative (MSPI)	Tribal areas in Arizona, Utah, and Nevada	Tribal members	Meth and suicide prevention	The Methamphetamine and Suicide Prevention Initiative (MSPI) promotes the use and development of evidence-based and practice-based models that represent culturally-appropriate prevention and treatment approaches to methamphetamine abuse and suicide prevention from a community-driven context. (1) Increase tribal, Urban Indian Organization (UIO), and federal capacity to operate successful methamphetamine prevention, treatment, and aftercare and suicide prevention, intervention, and postvention services through implementing community and organizational needs assessment and strategic plans. (2) Develop and foster data sharing systems among tribal, UIO, and federal behavioral health service providers to demonstrate efficacy and impact. (3) Identify and address suicide ideations, attempts, and contagions among American Indian and Alaska Native (AI/AN) populations through the development and implementation of culturally appropriate and community relevant prevention, intervention, and postvention strategies. (4) Identify and address methamphetamine use among AI/AN		Indian Health Service 5-year grant (2015-2020)

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				populations through the development and implementation of culturally appropriate and community relevant prevention, treatment, and aftercare strategies. (5) Increase provider and community education on suicide and methamphetamine use by offering appropriate trainings. (6) Promote positive AI/AN youth development and family engagement through the implementation of early intervention strategies to reduce risk factors for suicidal behavior and substance use.		
Phoenix Indian Center - Urban Indian Coalition of Arizona (UICAZ)	Maricopa County	American Indian Youth, Adults, and Elders	Underage drinking, youth drug use, parent communication	To create a sustainable coalition that addresses prevention of suicide, underage drinking and use/abuse of marijuana and prescription drugs through the foundation of cultures to improve the overall well-being of Urban American Indian youth and families. This is accomplished through the services we provide: • Urban Indian Coalition of Arizona • Parenting in Two Worlds • Living in Two Worlds Middle School Curriculum • Gathering of Native Americans • Community Education and Awareness Presentations around Historical Trauma,	Native American Connections; Phoenix Indian Medical Center; Inter Tribal Council of Arizona; Native Health; Pasqua Yaqui Tribe; Phoenix Union High School District; Mesa Public School, Tempe Elementary School District; Help Enrich African American Lives (HEAAL) Coalition	Mercy Care; GOYFF – Parents Commission grant

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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				Rx360, Marijuana, and Underage Drinking • SafeTalk trainings • ASIST trainings		

Appendix E: Workforce Training Topics Available by County

County	Topics
Apache	None
Cochise	Botkins Life Skills Marijuana 360 RX 360 MADD underage drinking presentation Substance Abuse Prevention Youth leadership QPR (2) SAPST
Coconino	Rx-360 Marijuana 360 Meth 360 Strengthening Families 10-14 Program Botvins Life Skills SAPT SPF Indian Country DEC ACEs Cultural Comp 101 Logic models Strategic planning Grant writing, Tribal Action Planning (TAP) SBIRT Motivational interviewing Alcohol, marijuana and prescription drugs Alcohol
Gila	Mental Health First AID Mental Health First Aid - Adult and Older Adult, ASIST (2) SafeTALK (2) Drug Trends Overdose awareness and Naloxone usage Rx-360 (4) Marijuana 360 Meth 360 Alcohol Strengthening Families 10-14 Program Botvin's Life SkillsTalk Saves Lifes Underage Drinking

County	Topics
	Marijuana use SBIRT Wellness Initiative for Senior Education (WISE) Rx Matters
Graham	Rx-360 The Buzz Alcohol True stories Strengthening Families SAPST ASIST QPR
Greenlee	SAPST ASIST QPR
La Paz	Rx-360 Marijuana 360 Meth 360 Alcohol Strengthening Families 10-14 Program Botvin's Life Skills SAPST ASIST QPR
Maricopa	SPF generally (4) SPF needs assessment (2) SPF coalition development/capacity building (2) Rx-360 (2) SAPST (2) Alcohol/Alcohol Prevention (2) Marijuana/Marijuana Prevention (2) Diversion for youth in schools Substance Abuse generally Mental Health First AID Drug Trends Risk Assessment Motivational Interviewing Building Resilience Active Parenting CDSMP Prevention basics Risk and protective factors SPF implementation Strengthening Families EBPs generally (2)

County	Topics
	SPF evaluation and sustainability Cultural competence Environmental strategies Best practices in suicide prevention and safe messaging guidelines and standards YMFA The science of prevention Cultural aspects of substance use ASIST (2) SafeTALK (3) suicideTALK
Mohave	Motivational Interviewing SBIRT, SAPST Rx-360 Marijuana 360 Meth 360 Alcohol Strengthening Families 10-14 Program Botvin's Life Skills
Navajo	Rx-360 Marijuana 360 Meth 360 Alcohol/alcohol abuse (2) Strengthening Families 10-14 Program Botvin's Life Skills Mental Health First AID ASIST SafeTALK Drug Trends Substance abuse
Pima	Motivational Interviewing Naloxone Stages of Change History of 12 Step Understanding Homelessness Housing First Overdose Prevention Harm Reduction 101 QPR (4) Marijuana 360 SAPST (3) ASIST (2) Cultural Competency Botvin's Lifeskills, Botvin's LifeSkills Training TOT

County	Topics
	Rx-360 Mental Health First Aid (2) Youth Mental Health First Aid SPF coalition development (2) Volunteer management AZ Toolkit Training SPF generally (2) Strengthening Families Prevention basics Risk and protective factors SPF needs assessment Strengthening Families The older adult population and addiction EBPs generally
Pinal	Mental Health First AID Mental Health First Aid - Adult and Older Adult SAPST SBIRT ASIST (2) SafeTALK Drug Trends QPR (2) Rx 360 (3) Alcohol 360 Marijuana 360 (2) Meth 360, Strengthening Families 10-14 (2) Local drug trends based AYS data Adult substance abuse recognition Youth use of marijuana Alcohol Botvin's Life Skills Wellness Initiative for Senior Education (WISE) Rx Matters Community Assessment Environmental Strategies Fundraising Grant Writing
Santa Cruz	QPR SAPST (2) ASIST SPF coalition Development Volunteer management AZ Toolkit Training

County	Topics
Yavapai	Substance abuse generally
Yuma	SAPST ASIST QPR SBIRT

Appendix F: Workforce Survey Content Analysis

Prevention Workforce Survey Themes

Q10. What types of substance use prevention efforts are not currently available in your community that you think are needed?

Theme	n
Primary Prevention	
Meeting basic needs (e.g., jobs, housing/homeless shelters, financial assistance, transportation, mental health resources/crisis services, wellness programs)	11
Collaborative education/awareness efforts with local schools	10
Family-level education/skill-building approaches	9
Pro-social activities (e.g., for youth, free/inexpensive, substance-free	7
Early prevention efforts (e.g. elementary school)	5
Trauma-informed efforts/services/treatment	5
Education on marijuana/meth/heroin	5
More/accessible education/awareness/prevention efforts generally (e.g., North end of Navajo)	4
Teaching social/emotional skills/resilience	4
More environmental strategies (e.g. policy change/reduced access/limiting alcohol sales venues/limiting signage/enforcing social host)	3
Evidence-based prevention programs (e.g., generally, Prime for Life)	3
Teaching long term effects	3
Holistic approaches	3
Coalitions/funding for coalitions/adult coalitions	3
Teaching decision-making	2
Community-level education/awareness	2
Education/awareness for adults/older adults	2
Prevention efforts targeting adolescents (e.g. marijuana)	2
Age appropriate resources	1
Suicide prevention	1
Education on health literacy	1
Promoting leadership	1
Programming for children/families with emotional risk factors (e.g., who have experienced trauma) to prevent later SU	1
Evidence-based prevention programs for Latinos	1
Overdose prevention education	1
More long term/comprehensive prevention efforts	1
Educating the medical community	1
Mental health counselors in schools	1
Collaborate with schools to screen kids needing tx	1
Coalitions working in rural communities	1
Community mobilization/capacity-building	1
Positive mentors/leaders for teens in the community	1

Theme	n
Secondary Prevention: Harm reduction	
Harm reduction	9
Secondary Prevention: Treatment	
Access to treatment for low income	4
More RTCs/beds	4
More MAT centers/increased access to MAT	4
Detox centers (including for adolescents)	3
More treatment facilities	3
Quality rehab homes/housing/sober living for those coming out of tx	3
Family-level TX approaches	2
Better/more supportive hospitals and institutions	2
More access to referral/tx generally	2
More OP counseling	2
More services in rural areas	2
More treatment facilities for adolescents (e.g. Yuma)	2
Access to IOP treatment for adolescents (e.g. Yuma)	2
TX for seniors (affordable)	2
Stigma reduction	2
Bridges to tx provision (e.g. hospitals, juvenile detention)	1
Identifying treatment gaps	1
Treatment for veterans	1
RTC for women with children	1
More Tribal-focused services	1
Support groups	1
Insurance coverage for treatment	1
Secondary Prevention: Criminal justice-related	
Diversion strategies - implementation or improvement	3
More informed criminal justice system (e.g., trauma-informed policies/programs in the criminal justice system; law enforcement trained about addiction as a disease)	2
Intervention resources in jails	1
Collaboration with law enforcement/govt	1
Bridging juvenile probation with SU providers	1

Prevention Workforce Survey Themes

Q11. What types of substance use prevention efforts do you think work the best for preventing substance use problems based on your experience?

Theme	n
Primary Prevention	
Activities available (e.g., for youth, Low-cost/free after school care)	15
Meeting basic needs (e.g., Career training/jobs/economic mobility, Financial assistance, Housing, Education, Healthcare/mental healthcare, Transportation)	13
Education/training generally	13
Education/awareness efforts for the community	8
Education/awareness classes/efforts at the family level	7
Coalitions/community-driven efforts	6
Education/awareness classes address danger/ long term effects of SU	6
Family-level approaches	5
Programming for youth/adults with emotional risk factors (e.g. trauma, children of addicts/users)	5
Honest dialogue (e.g., with youth)	5
Education/awareness classes/efforts at the school level	5
Comprehensive/holistic strategies at multiple levels of the community with common messaging	5
Schoolchildren/youth	5
Teaching social/emotional/coping skills	5
Mentoring	4
Creating connectedness (e.g., with family, school, community	4
Parenting classes/support	3
Teach kids about resources	3
Teaching life skills	3
Teaching decision-making	3
Reaching older adults with prevention efforts (including companionship and activities)	3
Reduce access (e.g. drop boxes, alcohol)	3
Posters/PSAs/ads	3
Community/coalition collaboration	3
Serving high risk populations (LGBTQ, homeless/unaccompanied, low income areas, single parent households, etc).	3
Hearing from people who have lived addiction	3
Trauma-informed programs/approaches	3
Evidence-based programs (e.g., that increase knowledge, change attitudes)	2
Social norming campaigns	2
Reality-based/Not fear-based	2
Identify community need	2
Change community conditions that lead to SU	2
Develop leadership skills	2
Promote self esteem	2
Teach resistance/refusal skills	2
Peer to peer (e.g., students, youth groups)	2

Theme	n
Flexibility in funding so communities can tailor their efforts	2
Environmental strategies generally	2
Rx-360	1
Evaluation of effectiveness of prevention programs	1
Pilot demonstrations of prevention interventions	1
Engage the community/population	1
Medication management	1
Support groups for various community sectors	1
Skill building generally	1
Age appropriate resources	1
Age appropriate approaches	1
Culturally relevant approaches	1
Enforcement of codes (e.g. signage/alcohol placement in stores)	1
Community that focuses on safety	1
Policy changes generally	1
More law enforcement presence in neighborhoods	1
Neighborhood beautification	1
Group discussions	1
Education/awareness classes include law enforcement	1
Arts integration,	1
Prevention specialists	1
Training for parents/providers/caregivers in identifying risks	1
Education/awareness for the medical community	1
Address multiple substances	1
substance use education generally	1
Education/awareness classes address legal consequences	1
Cultural competence	1
Secondary Prevention: Harm Reduction	
Harm reduction	7
Secondary Prevention: Treatment	
Reach kids before they become at risk/before use starts	4
Recovery Coaches/peer support	4
Reducing stigma	4
MAT	3
Trained LE/medical staff (e.g. cultural competence, stigma)	2
Affordable treatment	2
Combination of individual and group therapeutic treatment	2
Reach users early	1
SBIRT	1
Standardized screening tools across systems	1
Immediate access to TX	1
Easily accessible treatment in the community (e.g. libraries)	1
IOP programs (for adolescents, adults)	1
12 Step programs	1

Theme	n
"Genuine" integrated care	1
TX programs with true incentives to maintain sobriety	1
Long term treatment	1
Well-trained law enforcement (e.g. mental health crisis response, naloxone/harm reduction)	1
Learn to handle cravings without MAT/MAT as a last resort	1
Secondary Prevention: Criminal justice-related	
Diversion/court-affiliated TX efforts	2
Not criminalizing mental illness/SA/Focus on TX	3

Prevention Workforce Survey Themes

Q12. What methods are you using to evaluate whether your substance use prevention program or practice is effective?

Theme	n
Primary Prevention	
Pre/post or Follow-up Surveys or knowledge assessment with participants	29
Unspecified Questionnaire/survey	16
Community surveys/feedback	8
Review results of external surveys (e.g. AYS)	7
Official records (e.g. overdose rates, police records)	5
Outcome evaluation generally	5
Process evaluation generally	4
Using an evidence-based program	4
Weight of RX drop off every six months	3
Casually with students/ clients who keep in touch/teachers	3
Focus groups	3
Satisfaction surveys	3
Number served	2
Track medical providers using prevention resources	2
Needs assessment surveys	2
Qualitative methods (unspecified)	2
Quantitative methods (unspecified)	2
System evaluation	2
Testing fidelity when using an evidence-based practice	1
Tracking program completion	1
Participant engagement (program records)	1
number of materials distributed,	1
School records	1
Stakeholder surveys	1
Using evidence-base screening tools	1
Tracking what kind of resources the client accesses	1
Surveys of non-participants (e.g., family)	1
Reviewing other studies of programs	1
Noting community trends	1
Evaluating achievement of grant goals	1
Secondary Prevention	
Treatment outcome evaluation generally	3
Relapse frequency/time to/positive lifestyle changes	3
Treatment utilization	2
Drug screens	2
Using a variety of treatment strategies	1
Successful Treatment completion	1
Number of individuals seeking treatment	1

Theme	n
Decrease in individuals going into treatment	1
Unspecified noting of Stability post treatment	1
Treatment goals met	1
"Hoping our patients don't die"	1
Patient surveys	1
Peer and family reports	1

Prevention Workforce Survey Themes

Q13. What kinds of evaluation needs does your community have that are not being met?

Theme	n
Primary Prevention	
AYS (e.g. more schools, quicker results, include LGBTQ data)	5
Formal evaluation strategies	5
Community Needs assessment	4
Community-specific data (narrower than county-level)	3
Follow-up data collection (e.g. knowledge change in perceptions of harm)	3
Demographics data on the community (including better gender ID and Latino/a/x id)	2
Community survey generally (e.g., for adults like the AYS)	2
Research: role of mental health in substance use	2
Local official record data across sources	2
Specific tools	2
One common evaluator (e.g., so findings are consistent across the community, so there is accessible TA consultation)	2
Using evidence-based curricula	2
Engaging the community to participate in community surveys	2
Baseline overdose data (e.g. rural, Tribal)	1
Track all substances	1
Baseline data for specific populations (e.g. rural, Tribal)	1
Regular surveys for community adolescents (e.g. when AYS is not collected)	1
Academic achievement	1
Research: Effects of legalization on drug use generally	1
Research: how at-risk populations cope with stress/trauma/adversity/ find meaning in life, would do to promote wellness (rather than resorting to self-medication with substances)	1
Data on who engages in poly-use	1
Substance use trends by age/ethnicity/gender	1
Geographic "hot spots"	1
Cost/benefit studies	1
Resource assessments	1
Short term follow-up (rather than long-term that involves the program)	1
Risk assessments	1
Dissemination of evaluation results in the community	1
Validated data collection tools (e.g., extent of use, history of use)	1
Evaluator to analyze community survey data	1
More tailored reporting for grant requirements	1
Volunteers to staff school surveying	1
Tracking support/knowledge for follow ups	1
Secondary Prevention	
Evaluation strategies that identify which programs are working best (e.g., Common data collection across local TX programs (e.g. AHCCCS and non-AHCCCS)	2
Demographics of needs	1
Follow up data collection (e.g. reentry success)	1

Theme	n
Follow-up screenings	1
Drug-testing	1
Treatment-related: screening of schoolchildren	1
How grant $$$ is being spent in the community (e.g., is opioid $$$ being spent on evidence-based programs, duplication)	1
Access to treatment (e.g. gaps in services; points of intercept)	1

Prevention Workforce Survey Themes

Q14. Are there any types of substance use prevention efforts that you don't think help much or at all?

Theme	n
Primary Prevention	
Scare tactics	11
General handouts/posters/marketing material/commercials/media campaigns	10
Just say no strategies	9
Programming that demonizes drug users/negative messaging	6
Single presentations/events not connected to a larger strategy (e.g. town halls)	4
Relying on untrained staff (e.g. at schools) to deliver the program unsupported (rather than partnering with prevention experts/coalitions)	4
Programming with older youth	3
Programs that do not give people the facts so they can make their own choices/tell them what to do	1
Programming of youth without their parents	1
Programs not evidence-based	1
Programs not tailored to the target population	1
Presentations with too many statistics/no case examples	1
Public Speakers	1
Outdated curricula (e.g., Botvin Life Skills)	1
Programming that does not teach refusal skills	1
Programming that fails to provide positive social/emotional development/autonomous decision-making	1
Programming that fails to identify alternatives to drug use	1
Programming that fails to acknowledge benefits to drug use	1
"Pledge campaigns" not connected to a larger strategy	1
Gateway drug information	1
Strategies not supported by the community (e.g., legal drinking age in local bars)	1
Putting the money into treatment instead of prevention	1
Disjointed efforts in the community	1
Coalitions	1
Youth involvement	1
Secondary Prevention	
Fear-based	4
Legal consequences	3
12-step programming	3
Rejection/Tough love	2
Tiered consequences without follow-through	1
Delaying treatment (i.e., access is not timely)	1
Being talked down to	1
Cold-turkey	1

Kicking people out for relapsing	1
Sober living communities that offer inadequate support/threats of losing housing	1
Tying recovery to religion	1
MAT as a first resort	1
MAT without long term counseling	1
Outpatient groups	1
TX Programs that are not evidence-based/trauma informed	1
Short-term residential (e.g. 28-days)	1
"Agreements"	1
Lack of holistic focus	1
Calling secondary prevention "prevention" (e.g., Naloxone)	1

Prevention Workforce Survey Themes

Q15. What substance use prevention activities have you seen that have been the most successful in engaging the community?

Theme	n
Primary Prevention	
Community-building/Social events (e.g., town halls, community fairs, programs with food, for the whole family)	13
Coalitions	10
Family/parent-oriented	9
Alternative activities (e.g., generally, after prom, after graduation)	7
Information-sharing (that lets people make their own decisions)	6
School-based	5
Promoting youth leadership	4
Enhance skills (e.g., Teaching critical thinking skills/life skills to schoolchildren)	4
Casual Face to face interactions/not "professional"	4
Community education (e.g., Symposiums that highlight educational warning signs of substance use.)	4
Fun/ Associated with a fun event	4
Age/culturally responsive (e.g. Language of materials)	3
Diverse community sector involvement	2
Specific prevention programs (e.g. Reality Tour, DARE)	2
Depends on the community and what is topical there	2
Universal anti-smoking campaigns are a model	2
Medication take-back events	2
Personal stories (e.g., Giving youth access to people who struggle with addiction)	2
Tabling	2
Interactive	2
Youth coalitions/youth involved in planning prevention efforts	2
collaboration between youth, school, parent/ and/or community	2
Mass media prevention messaging	2
Helping the community meet basic needs	2
Address perceptions of harm	2
Multi-agency	1
Local PSAs (with local kids)	1
Social media campaigns	1
Prescription inventories	1
Community connections for youth (e.g. mentoring)	1
Programs endorsed by word of mouth	1
When communities/schools trust the local prevention specialists	1
Supporting positive school social environments	1
Create awareness	1
Activities related to "hot button" topics/topics in the news	1
ACES-informed	1

Theme	n
Address refusal skills	1
Address community norms (e.g., with statistics)	1
Policy work	1
Mobile units (to address lack of transportation)	1
Secondary Prevention: Harm Reduction	
Harm reduction	5
Secondary Prevention: Treatment	
Counseling	4
Integrated care	1
Inpatient detox	1
Groups (e.g., AA, group therapy)	3
Longer term inpatient (i.e. more than 28 days)	1
IOPs	1
MAT	1
Mental health first aid	1
Meeting basic needs	1
Peer support/recovery coaches	3
Enhance access/reduce barriers (e.g., stigma)	3
Secondary Prevention: Law Enforcement	
Specialty drug courts/diversion	2

Prevention Workforce Survey Themes

Q16. What resources for substance use prevention are sufficient in your community?

Theme	n
Primary Prevention	
Public information (materials, dissemination opportunities)	6
Coalitions	5
Training and support for prevention professionals	4
Community efforts (e.g., health fairs)	2
Funding/grant funding	2
Funding for Life Skills education	1
Sufficient resources for prevention generally	1
Resources for youth and younger adults	1
School curriculum/activities for younger kids	1
Community support	1
Agency collaboration	1
Parenting education	1
Integrated healthcare	1
Resources for mental health providers for providers with $$$	1
Mental health homes	1
Primary Prevention: Harm Reduction	
Naloxone trainings.	2
Crisis response resources	1
Primary Prevention: Treatment	
12-steps	3
MAT	3
Outpatient	2
Inpatient Facilities	2
TX options for those who can afford it	1
Support groups/activities other than AA	1
Detox	1
TX for seniors	1
Referral system	1

Prevention Workforce Survey Themes

Q17. How does your agency/coalition/organization address underlying causes of addiction (e.g., poverty, historical trauma, systematic oppression, poverty)?

Theme	n
Primary Prevention	
Providing general resources and referrals to meet basic needs	9
Educating staff/ providers/coalition leaders (e.g. on ACES; systemic oppression; cultural awareness)	8
Youth-focused poverty-prevention strategies (e.g. teen pregnancy prevention, decision-making; social skills; general education)	4
Collaborating with the local community	3
Whole family education	2
Addressing social isolation for seniors	2
Tailoring programming for the population (e.g., Language awareness/using primary language)	2
Including underlying causes information shared (e.g., Using a curricula that recognized underlying risk issues	2
Educating community (e.g. on ACES; underlying causes of addiction)	2
Adult-focused poverty-prevention strategies (e.g. resume development; healthy relationships)	2
Teaching participants to advocate for themselves	2
Recognizing local historical trauma	2
Not ignoring the issue	2
Addressing mental health	2
Collaboration with other agencies (e.g. working with high risk youth)	1
Hiring from within the local community	1
Advocate for policies that address underlying causes	1
Providing positive alternate activities	1
Youth shelters	1
Utilizing available resources from the State, etc.	1
Diversion program	1
Providing access (e.g., Going to the community)	1
Primary Prevention: Treatment	
Trauma-informed programs/TX	7
TX for underlying causes	6
Assessing for underlying issues	4
Providing low/no cost TX	4
Comprehensive care	2
Meet people where they are	2
Stigma reduction/choose language of addiction	2
Serving populations that have suffered the underlying cause experiences	2
No wrong door policy/collaboration with first responders	1
"Resiliency Committee" advises TX team and programming	1
"Cultural competency advisors" advise TX team and programming	1

Prevention Workforce Survey Themes

Q18. How does your substance use prevention program take into consideration demographic characteristics of the participants of your program (race/ethnicity, urban/rural, veterans, LGBTQ, youth, seniors, foreign language users, etc.)?

Theme	n
Primary Prevention	
Primary language taken into consideration (e.g., interpretation provided; hire bilingual staff)	19
Be ready to serve everyone from any demographic/treat everyone with respect	17
Program tailored to/inclusive of the population (e.g., youth, seniors, LGBTQ)	17
Tailoring materials/evaluation tools (e.g. language, font, gender options)	8
Seek feedback from the target population (e.g., before or while implementing a strategy)	7
Training staff in subpopulation issues (e.g., cultural competency, LGBTQ, trauma-informed)	7
Recognize/Identify/understand the demographic characteristics/needs of the target population/community (e.g., needs assessment)	6
Collaborate with partners/agencies that work with the target population (e.g. LGBTQ)	5
Hire staff/recruit coalition members/volunteers from the community/demographic	5
Promote accessibility (e.g., Reach them in a common/convenient location/schedule at a convenient time)	3
Financial considerations (e.g. providing food, no cost services)	2
Aware of potential for prejudice by participants/try to address	2
Awareness in facility management (e.g., bathrooms not segregated by gender, disability-accessible bathrooms, microphones at trainings for seniors)	2
Outreach efforts to marginalized communities	1
Tailor referral options	1
Inclusive marketing materials	1
Adapt programs to be culturally relevant	1
Secondary Prevention	
Recognize/identify culture (e.g., to tailor intervention, meet language needs)	4
Understand how to tailor treatment according to subpopulation needs	2
Provide free/low cost treatment	2
Provide system navigation services	2
Recognize need for treatment for subpopulations/target historically disadvantaged populations	1

Prevention Workforce Survey Themes

Q19. What are the main challenges that you experience as a substance use prevention "specialist" in your community or at your agency/coalition/organization?

Theme	n
Primary Prevention	
Funding/consistent funding/flexible funding (e.g., for coalitions, for prevention staff committed to a single community, prevention programs, transportation, snacks/incentives, for an evaluator; for community outreach; to research what is effective; treatment)	34
Engaging the community to participate in prevention efforts	7
Not enough time to do the job well/lack of staff (e.g., to cover the needed partners, to cover the territory)	7
Finding volunteers (e.g., for coalitions, promotores)	5
Educating the public/ Community does not recognize the risk from drugs	5
Engaging community institutions/authorities to support prevention efforts (e.g. schools, the State)	5
Engaging parents to participate in prevention efforts	5
Lack of resources generally	4
Collaborating with other area agencies (e.g., sharing space for prevention programs; cross referrals)	4
Knowledge of what is effective/effective programs/culturally competent programs	3
Lack of trainings available	3
Lack of recognition of prevention specialist as a profession (e.g., lack of State credentialing for prevention specialists	2
Restrictive regulations (e.g., law enforcement data access, TX workforce regulations)	2
Finding a location for prevention programs (e.g., for youth groups/workshops)	2
Lack of knowledge about behavioral health	2
Lack of access to local data	2
Establishing community leadership in prevention efforts/sector representation in coalitions	2
Not prioritizing prevention relative to treatment	2
Engaging those most in need of the messaging (e.g., Intergenerational Users	2
Programs do not address underlying causes of substance use	1
Programming at the family level	1
Lack of understanding that fear-based presentations don't work/are harmful	1
Only interest in one-time presentations	1
Easy access to drugs in the community	1
Getting the medical community on board to reduce prescribing addictive medication	1
Promoting successful mentoring (e.g., bonding)	1
Sharing prevention-related information with target populations (e.g. seniors)	1
Less text-heavy/more language appropriate prevention materials	1
Lack of capacity	1
Overlooking target populations (e.g. seniors)	1
Considering treatment prevention	1
Demonstrating the cost effectiveness of prevention efforts	1
Able to afford professional evaluation assistance	1

Theme	n
Transportation (e.g. for youth)	1
Secondary Prevention: Treatment	
Treatment and support resources (e.g. for adolescents, in rural areas; detox; inpatient; MAT; post treatment housing)	10
Stigma	7
Criminalization of SU (e.g., Punitive drug court practices)	2
Understanding/Meeting the wraparound needs of clients (e.g., housing, those receiving MAT	2
Patient follow-through/Engaging people participating when they think it is voluntary"	2
Treatment participation requirements (e.g. attendance, abstinence)	2
Not requiring counseling of MAT clients	1
People being referred to a program they do not qualify for	1
Community awareness of services	1
Serving a population in a remote area	1
Affordable treatment and support resources (e.g. for people on Medicare)	1
Agencies not fully engaged in SA treatment (e.g. "dabbling")	1
Agencies not committed to long term Treatment	1
patient fear of having unmanaged pain	1
Insufficient workforce	1
Treatment retention	1
Admissions process to treatment (e.g., timely, collaborative, family-oriented)	1
Keeping kids in their school during Treatment	1
Care of treatment workforce/secondary trauma	1
Engaging adolescents in treatment	1

Appendix G: Short Reports (Youth, Veterans, Older Adults, LGBTQ)

Substance Use: *Youth in Arizona*

The 2017 Youth Behavioral Risk Factor Surveillance System* indicated a significantly higher percentage of Arizona high school students, compared to youth nationally, have ever tried an electronic vapor product .

1 in 5 Arizona high School Students used marijuana in the past month

1 in 7 Arizona high school students have at one time misused pain relievers

The prevalence of **illicit drug use disorder** was significantly higher for Arizona youth aged 12-17 (4.7%) that nationally (3.3%).

As part of the **2018 Arizona Statewide Substance Use Prevention Needs Assessment**, 3 focus groups were conducted with youth in Phoenix, the city of Maricopa and Prescott. Four focus groups were conducted with adults that serve youth (educators, parents, etc.) in sierra Vista, Phoenix, Kingman and Globe. Both groups were asked about what current and most harmful substance issues existed for youth, what they thought caused substance use/and or misuse for youth, and what would be effective prevention programming to combat these issues. A number of key informant interviews were also conducted with adults that work with youth.

* Centers for Disease Control and Prevention. (2017). High School Youth Risk Behavior Survey Data.

Prepared by LeCroy & Milligan Associates, Inc. for the 2018 Arizona Statewide Substance Use Prevention Needs Assessment

Causes of Substance Use and/or Misuse:
Thoughts from Youth and Those Serving Youth

1. **Youth are self-medicating with substances due to mental health issues/trauma and a lack of or inability to access mental health services.**
2. **Due to a lack of healthy, affordable, fun activities for youth, they engage in substance use and/or misuse.**
3. **Youth today currently lack coping skills or the social/emotional tools to deal with life's challenges which leads them to substance use and/or misuse.**
4. **Peer pressure leads to substance use and/or misuse.**
5. **The use of substances has been normalized by popular culture, social media, marketing, peers and the legalization of marijuana which is leading to substance use and/or misuse.**
6. **A lack of family values and lack of family supervision of youth (or a stable adult for youth) to turn to leads to substance use and/or misuse.**
7. **Due to inadequate funding and resources given to schools, and the demands of Arizona's core competencies, there is not enough time or resources for effective prevention programming in schools which leads to substance use and/or misuse.**

Substance Use Prevention Recommendations from Youth & Those Serving Youth:

Make sure youth have someone to talk to, someone to turn to for support and help

Start programming in lower grades

Teach children healthy coping skills so they don't turn to drugs

Give schools enough support so they can go beyond the core curricula and spend time on prevention and community-school partnerships

Involve parents in prevention efforts and offer meaningful incentives to promote parent engagement

Don't use scare tactics. Don't say, "Don't do drugs". Just provide the facts and build positive relationships

This publication was made possible by grant number T1010004 from SAMHSA. The views expressed in the report do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. government.

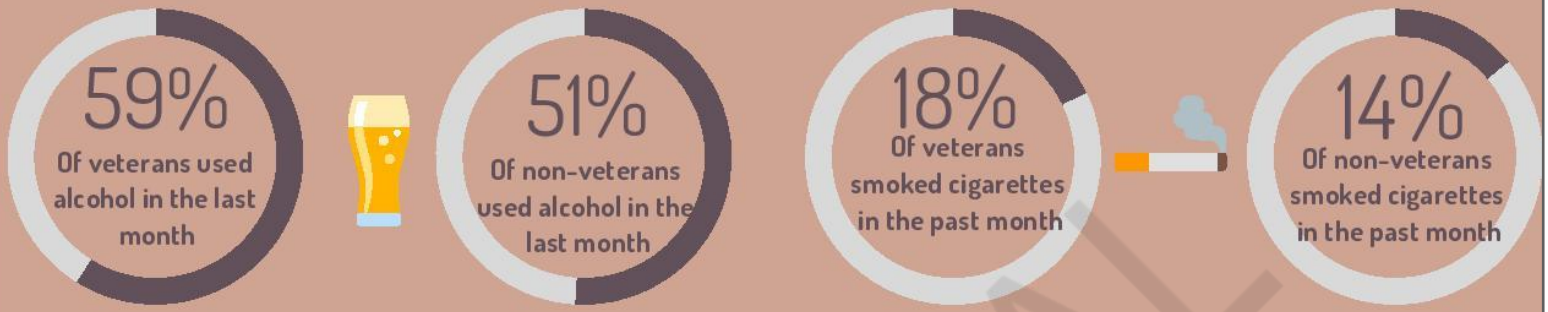
AHCCCS Arizona Health Care Cost Containment System

Prepared by LeCroy & Milligan Associates, Inc. for the 2018 Arizona Statewide Substance Use Prevention Needs Assessment

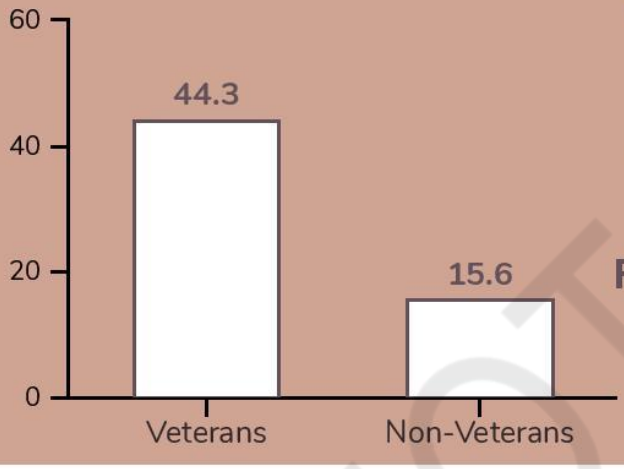
LeCroy & Milligan ASSOCIATES, INC.

Substance Use & Suicide: *Veterans in Arizona*

The 2016 Behavioral Risk Factor Surveillance System* indicated that veterans report significantly more alcohol and tobacco use in the past month than non-veterans:



Arizona Suicide Rates per 100,000 (2017)



The suicide rate among veterans are 3X higher than non- veterans in Arizona.**

For male veterans, suicide rates are 2X higher than for non-veterans.

For female veterans suicide rates are 5X higher, compared to non-veteran females.

As part of the 2018 Arizona Statewide Substance Use Prevention Needs Assessment, 3 focus groups were conducted with veterans in Flagstaff, Phoenix and Yuma. Veterans were asked about what current and most harmful substance issues existed in their community, what they thought caused substance use/and or misuse, and what would be effective prevention programming to combat these issues. In addition, one phone interview was conducted with a veteran Key Informant in Pima County.

* Centers for Disease Control and Prevention (2016). Behavioral Risk Factor Surveillance System Survey Data. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2016.
** ASU Center for Violence Prevention and Community Safety. Arizona Violent Death Reporting System. Data-At-A-Glance, Violent Deaths Involving Veteran Victims. January 1, 2017 to August 31, 2017.

Prepared by LeCroy & Milligan Associates, Inc. for the 2018 Arizona Statewide Substance Use Prevention Needs Assessment

Causes of Substance Use and/or Misuse: *Thoughts from Veterans*

1 **Veterans use substances to self-medicate for untreated mental health issues related to military service including PTSD and other trauma.**

In the military you can't bring up mental health issues because you would be kicked out and now you're trying to figure out navigating the V.A. system on your own when you're suffering from depression and you have financial strain. (Interview with Pima County Key Informant)

2 **Untreated chronic pain and dental pain leads to street drug use**

We have a lot of people who have chronic pain. Up here in rural AZ, we don't have the level of care other areas have. If you think of a vet in a rural area, where are those people with chronic pain going to get treatment? If they don't have the eligibility to get treatment, where are they going to go? (Flagstaff veteran focus group)

3 **Veterans miss the adrenaline rush they got in the service; that's why many turn to drugs.**

When you are in the military, you have your good time boys to have fun together. You may be drinking excessively but are in good shape. When you are out, it's a downer without your buddies and new stresses... and you don't have the adrenaline rush from when in the service. There is nothing comparable to that which you did in the military, that can give you that kind of rush. (Yuma veteran focus group)

4 **Substance use is normalized and encouraged in the military which leads to substance misuse.**

When I was in the NAVY, right next to the soda machine was a beer machine… you could get a beer out of the thing any time day or night. Everything you did was around drinking. The macho thing was how much can you drink and how much can you party and not miss a day of work. (Flagstaff veteran focus group)

5 **The difficulty in reintegrating into society once out of the military leads to substance use and/or misuse.**

… So I get out service, I run around, I get a job at Target or whatever… it's not enough… Those barriers of life start to become an issue…because I've been somewhere being catered to… I could go get a chow, I don't pay for anything when I'm in the service, and when I come out, now I need a job. And for a lot of us, it's our first time [trying to find a job]. (Phoenix veteran focus group)

Substance Use Prevention Recommendations from Veterans

Help vets get involved with something meaningful

Educate VA Doctors about opioid issues and how to approach patients individually

More education and peer support before discharge and right after to let vets know the resources available for them

Improve access and reduce stigma of mental health services for vets

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AHCCCS Arizona Health Care Cost Containment System

Prepared by LeCroy & Milligan Associates, Inc. for the 2018 Arizona Statewide Substance Use Prevention Needs Assessment

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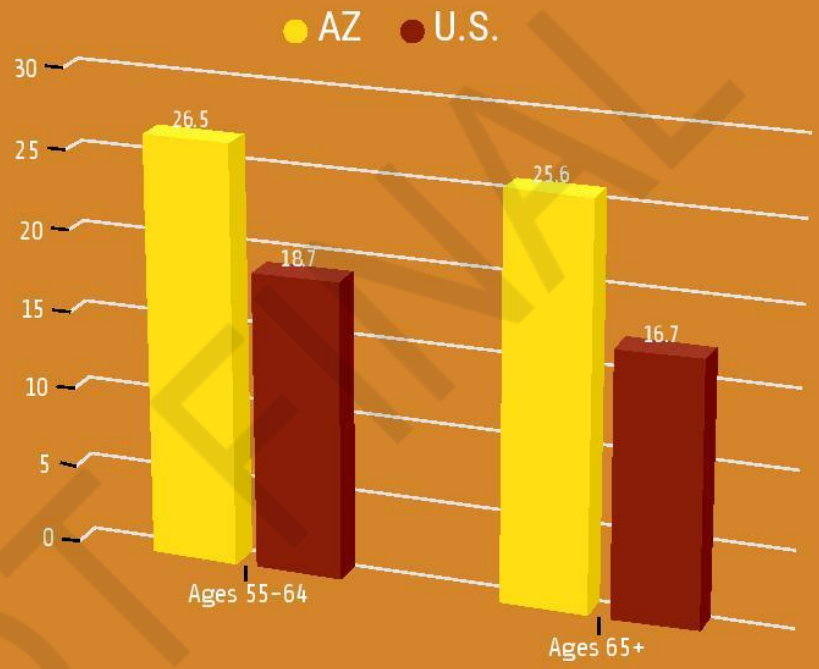
Substance Use & Suicide: Older Adults in Arizona

The suicide mortality rate for older adults in Arizona is significantly higher than the average suicide mortality rate for older adults in the U.S.

The greatest absolute difference in suicide rates between Arizona and the United States occurred for those aged 65 or older (25.6 versus 16.7 per 100,000).

Age-Adjusted Suicide Mortality Rates per 100,000 for U.S. and Arizona, 2016



FOR FEMALES IN ARIZONA, THE SUICIDE MORTALITY RATE PEAKED FOR THOSE AGED 55-64 (13.3 PER 100,000).

FOR MALES IN ARIZONA, THE SUICIDE MORTALITY RATE PEAKED FOR THOSE AGED 65 AND OLDER (46.6 PER 100,000).

SUICIDE RISK CONTINUES TO INCREASE WITH INCREASING AGE FOR MALES OVER AGE 65.

The rate among males aged 75-84 was 55.3 per 100,000, and rose to 75.6 per 100,000 among those aged 85 and older.

Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016) Intentional self-harm (suicide), Arizona, 2006-2016.

Prepared by Lecroy & Milligan Associates, Inc.
for the Arizona Statewide Substance Use Prevention Needs Assessment, September 2018

Substance Use in the Arizona Older Adult Population

As part of the 2018 Arizona Statewide Substance Use Prevention Needs Assessment, 3 focus groups were conducted with older adults in Tucson, Prescott and Phoenix. Older adults were asked about what current and most harmful substance issues existed in their community, what they thought caused substance use/and or misuse, and what would be effective prevention programming to combat these issues.

Causes of Substance Use and/or Misuse for Older Adults

1. **Loneliness and isolation lead to substance use and/or misuse.**
   Getting into and providing someone with that companionship, that connection with at least one other person… that goes to the heart of preventing any type of substance abuse. (Prescott older adult)

2. **Loss of role after retirement leads to substance use and/or misuse.**
   As a culture we identify so much with our role… [Once people retire], there's a loss of role, whether it's from an office, as a parent or as a grandparent… Role is what determines worth in this culture… and when you lose that there's of course the dependence on something else to alleviate that… (Tucson older adult)

3. **Prevention activities are not geared towards older adults, often only youth.**
   One of the things that is rather discouraging to me in this area [is that there is] very little targeting to older adults… [prevention activities are] all targeted to youth… because I think that's where people's hearts are and there's a belief that if we get them younger, then that's prevention… There's no question in our mind that's there's a need… and that our colleagues and friends and people we work with don't have the information sometimes that they need. (Prescott older adult)

4. **Over-prescription of pain medications which can sometimes lead to street drug use when prescription of pain medication becomes more regulated.**
   I've had several surgeries including oral surgery and every time I've had a procedure, the first thing they do is hand me a script for a narcotic, and I don't take narcotics. I refuse them. But it's automatic each time. And they hand me a script and I have to ask what it is. And then when they tell me what it is, I say I want something else… I think it really is an issue of over-prescription that's happening today. (Tucson older adult)

Substance Use Prevention Recommendations from Older Adults

Focus more on prevention of health problems and opportunities to receive alternative health (i.e., qigong, acupuncture, etc.)

Educate the general public/family/friends so they can be part of the solution

Address social isolation (e.g. more peer support and intergenerational programming)

Educate physicians about older adult substance use issues

Provide older adult-specific education and support that meet older adults' unique needs

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AHCCCS

Prepared by Lecroy & Milligan Associates, Inc.
for the Arizona Statewide Substance Use Prevention Needs Assessment, September 2018

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Substance Use Risks among LGBTQ Youth in Arizona

The 2017 Youth Risk Behavior Survey reveals troubling substance use patterns among Arizona high school students identifying as gay, lesbian and bisexual (unfortunately the 2017 YRBS did not include transgender students). Compared to their non-LGB peers, Arizona's LGB students report a higher prevalence of alcohol, tobacco and illicit drug use, suffer more consequences associated with substance use, and report a higher prevalence of substance use risk factors. These risks were supported through focus group research as well. The findings highlight an urgent need for more effective substance use prevention interventions targeted towards LGB youth.

Alcohol Use

Alcohol use is significantly higher among LGB students than their non-LGB peers.

53% of LGB students currently drink

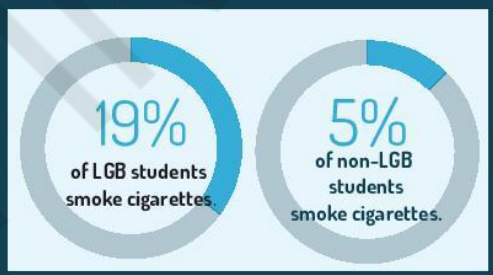
More than half of LGB students report drinking alcohol in the past month, compared to only 31% of non-LGB students.

32% of LGB students currently binge drink

1 in 3 LGB students report binge drinking compared to 17% of non-LGB students. Binge drinking is defined as 4 or more drinks for females and 5 or more drinks for males in a few hours.

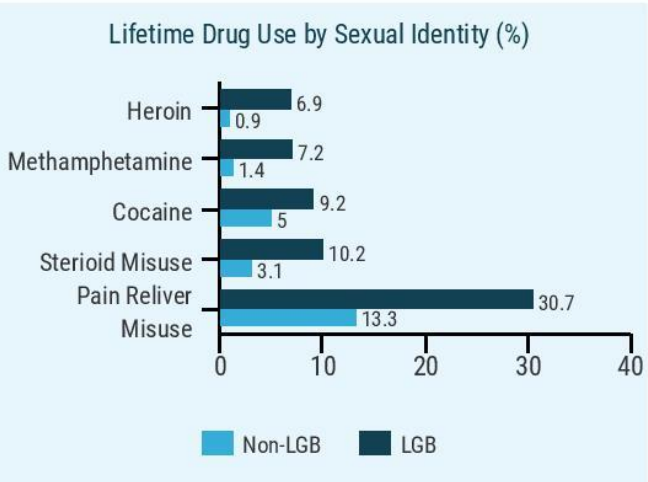
Cigarette Use

Nearly 1 in 5 LGB high school students report that they currently smoke cigarettes, which is 4 times higher than the prevalence of cigarette smoking among non-LGB students



Drug Use

LGB students are over twice as likely to report past month marijuana use than their non-LGB peers (38% vs 17%). Reports of lifetime drug use are also higher for LGB students. Lifetime misuse of pain relievers is the most commonly used substance, with 31% of LGB students reporting misuse, compared to only 13% of non-LGB students. Heroin use is 7 times more common among LGB high school students (6.9% vs 0.9%), mostly due to a much higher lifetime prevalence of heroin use among male gay and bisexual students (18%).



Notes: Pain reliever misuse is defined as taking medicine without a prescription or differently than as instructed by a doctor. Steroid misuse is defined as ever taking steroid without a prescription. All differences are at least marginally significantly at p<0.10, expect for differences in lifetime cocaine use which had a p-value of 0.13.

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Substance Use: Risk Factors and Consequences

First Substance Use Before 13

Early age of substance use initiation is an important predictor of later substance use, dependence and abuse. LGB students are significantly more likely to report that they tried alcohol, cigarettes and marijuana before the age of 13 than non-LGB students.

First Substance Use Before Age 13 (%)

All differences are statistically significant at p<.05

Victimization and Distress

Psychological distress and victimization are associated with higher rates of substance use (Newcomb, 2012). Compared to non-LGB students, LGB students report more past year :

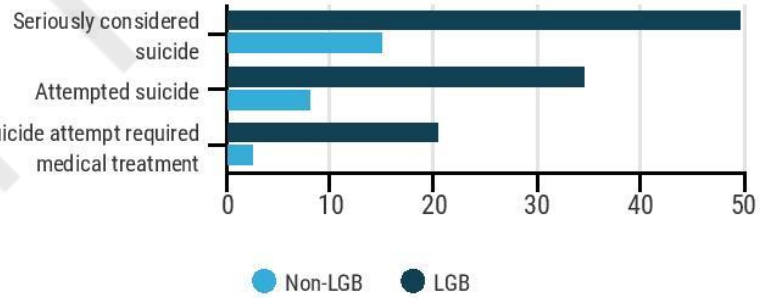
- bullying at school (41% vs 15%),
- electronic bullying (32% vs 13%),
- physical fighting (31% vis 18%), and
- ever been forced to have sexual intercourse(23% vs 6%).

70% of LGB students reported **persistent feelings of sadness or hopelessness in the past year** compared to 32% of their non-LGB peers

All differences are statistically significant at p<.001

Suicide is a leading cause of death among those who abuse alcohol and drugs (SAMHSA, 2016). LGBTQ youth are already at an elevated risk for suicide and suicide attempts. Substance use may compound these risks.

Report of Suicidal Thoughts and Behaviors (%)



All differences are statistically significant at p<.001

Focus groups conducted with the LGBTQ community across Arizona identified two major causal factors leading to substance use:
(1) Minority stress and
(2) A lack of appropriate, affordable, accessible, LGBTQ friendly mental health services

Suggestions for improved prevention efforts included:
1) Safe, substance free, non-judgmental LGBTQ spaces to connect and engage with others
2) Better access to appropriate LGBTQ friendly mental health services
3) Educating the community on how to be better LGBTQ allies including physicians, parents and teachers

- Centers for Disease Control and Prevention. (2017). High School Youth Risk Behavior Survey Data. Retrieved from http://nccd.cdc.gov/youthonline/
- Newcomb, M. E., Heinz, A. J., & Mustanski, B. (2012). Examining Risk and Protective Factors for Alcohol Use in Lesbian, Gay, Bisexual, and Transgender Youth: A Longitudinal Multilevel Analysis. Journal of Studies on Alcohol and Drugs, 73(5), 783-793.
- Substance Abuse and Mental Health Services Administration. (2016). In Brief: Substance Use and Suicide: A Nexus Requiring a Public Health Approach (HHS Publication No. SMA 16-4935, NSDUH Series H-52). Rockville, MD Retrieved from https://store.samhsa.gov/shin/content//SMA16-4935/SMA16-4935.pd

AHCCCS

Prepared by Lecroy & Milligan Associates, Inc.
for the Arizona Statewide Substance Use Prevention Needs Assessment, September 2018

LeCroy & Milligan ASSOCIATES, INC.

AHCCCS Statewide Substance Abuse Prevention Strategic Plan

December 2020

LeCroy & Milligan ASSOCIATES, INC.

AHCCCS Statewide Substance Abuse Prevention Strategic Plan - December 2020

Submitted to:
Arizona Health Care Cost Containment System (AHCCCS)
701 E. Jefferson Street
Phoenix AZ, 85034
Ph: (602) 417-4529

Submitted by:
LeCroy & Milligan Associates, Inc.
2002 N. Forbes Blvd. Suite 108
Tucson, AZ 85745
Ph: (520) 326-5154
Fax: (520) 326-5155
www.lecroymilligan.com

About LeCroy & Milligan Associates, Inc.:

Founded in 1991, LeCroy & Milligan Associates, Inc. is a consulting firm specializing in social services and education program evaluation and training that is comprehensive, research-driven and useful. Our goal is to provide effective program evaluation and training that enables stakeholders to document outcomes, provide accountability, and engage in continuous program improvement. With central offices located in Tucson, Arizona, LMA has worked at the local, state and national level with a broad spectrum of social services, criminal justice, education and behavioral health programs. LeCroy & Milligan Associates team members on this project included Darcy McNaughton, Tracey Thomas, Katie Haverly, Kerry Milligan, and Skyler LeCroy.

Suggested Citation:

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Acknowledgements

The Substance Abuse Block Grant (hereafter referenced as SABG) Program was authorized by US Congress to provide funds to States, Territories, and American Indian Tribes for the purpose of planning, implementing, and evaluating activities to prevent and treat substance use and/or misuse and is the largest Federal program dedicated to improving publicly funded substance use prevention and treatment systems. On July 1, 2016, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) the former designated State agency to administer the SABG Block Grant, merged with AHCCCS. This merger was passed by the legislature at the recommendation of the Governor and consolidated the administration of physical and behavioral health services under one agency. As a result, AHCCCS became the Single State Authority (SSA) in the administration for the SABG Blog Grant. This report represents the first AHCCCS Statewide Substance Abuse Strategic Plan after this merging.

AHCCCS contracted with LeCroy & Milligan Associates (LMA) to facilitate a statewide substance abuse prevention strategic planning process to create a three-year plan to guide the agency's priorities and efforts. The LMA strategic planning team included Darcy McNaughton, MBA, who served as the Project Lead, with facilitation and plan development support from Tracey Thomas, DrPH, Katie Haverly, MA, Kerry Milligan, MSSW, and Skyler LeCroy. Notetaking and data analysis assistance was provided by LMA interns Minerva Garcia and Andrew DiCenso.

The strategic planning process was successfully completed with the assistance and coordination of a Statewide Substance Abuse Prevention Strategic Planning Steering Committee. AHCCCS and LMA would like to give a special thanks to Steering Committee members for their guidance and dedication throughout the planning process. A complete list of organizations represented on the Steering Committee is included in Exhibit 4.

In addition, AHCCCS and LMA would like to thank the many individuals who participated in information gathering opportunities through planning meetings and discussions. These individuals provided important input and insight into the needs of our state and the opportunities to address those needs. Individuals represented a diverse group of organizations, which are included in Appendix A.

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Plan Overview

The Arizona Health Care Cost Containment System (AHCCCS) contracted with LeCroy & Milligan Associates (LMA) to facilitate a statewide substance abuse prevention strategic planning process to create a three-year plan to guide the agency's priorities and efforts. The planning process was guided by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF), which offers a comprehensive approach to understand and address substance use and related health problems unique to states and communities. Informed by this framework and aligned with the AHCCCS Statewide Substance Abuse Prevention Logic Model, this plan outlines strategies to tackle Arizona's most pressing substance-use related behavioral health problems.

SPF Graphic from SAMHSA, 2019

Creating the Statewide Strategic Plan

Step 1: Assessment

AHCCCS contracted with LMA to conduct a needs assessment and resource assessment to document substance use issues statewide and existing efforts and resources to address them.

Step 2: Capacity Building

To build capacity and readiness to address prevention needs and develop a statewide plan, a Statewide Substance Abuse Prevention Strategic Planning Steering Committee was formed.

Step 3: Planning

The Strategic Planning Group brought together representatives of **43** organizations across Arizona engaged in substance use prevention work to develop the plan. Planning committee members participated in four planning meetings to prioritize behavioral health problems, contributing risk and protective factors, and strategies.

Step 4: Implementation

Implementation steps were identified to address priority behavioral health problems based on assessment data and input from the Strategic Planning Group and Steering Committee. Implementation efforts reflect the six Center for Substance Abuse Prevention (CSAP) strategies.

Step 5: Evaluation

Preliminary evaluation activities were identified and will be further refined as strategies are further developed and realized.

Cultural Competence & Sustainability

Throughout the five-step planning process, cultural competence and sustainability were prioritized, and there is commitment among stakeholders to continue prioritizing cultural competence and sustainability throughout the plan's implementation and evaluation.

Strategic Plan Framework

Priority Behavioral Health Problems

Opioids	Alcohol	Meth	Marijuana	Vaping
Reduce percentage of adults, young adults (18–25), and youth (12–17) misusing opioids.	Reduce percentage of adults, young adults (18–25), and youth (12–17) using and binge drinking alcohol.	Reduce percentage of adults and young adults (18–25), using meth.	Reduce percentage of young adults (18–25) and youth (12–17) using marijuana.	Reduce percentage of youth (12–17) using vapor products.

Vision

Individuals, families, and communities across Arizona are informed, connected, engaged, and healthy.

Values

Culturally responsive, equity focused & inclusive, collaborative, community-based, solution-focused, innovative, bold, compassionate, and transparent.

Key Strategies

Environmental

Policies restricting sale/marketing of vapor products.

Targeted risk/protective factors: Accessibility of substances, substance-use related social norms.

Positive Alternatives

Culturally relevant community events & family recreational programs.

Targeted risk/protective factors: Mental health, family & community connection, social isolation

Prevention Education

Family & school programs, education on protective factors, & innovative delivery.

Targeted risk/protective factors: Risk perception, substance-use related social norms, family dysfunction

Identification of Programs & Referral to Services

Mechanism for knowing referral options & making referrals.

Targeted risk/protective factors: Mental health, trauma

Information Dissemination

Social media to reach parents & youth and campaigns on risks & telehealth options.

Targeted risk/protective factors: Risk perception, substance-use related social norms, mental health.

Community-Based Processes

Alignment of coalition work statewide, integrated approach to address root causes, & trauma-informed communities.

Targeted risk/protective factors: Trauma, mental health

Introduction

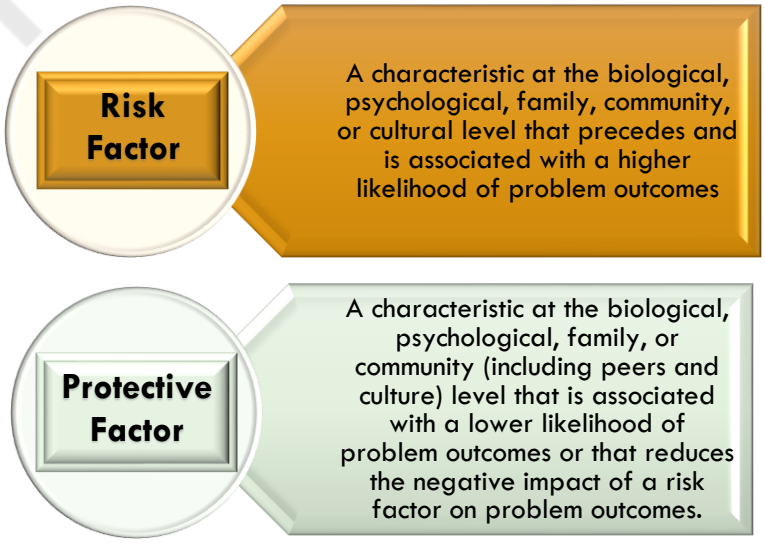
According to the National Survey on Drug Use and Health, 2017, substance use is highly prevalent in Arizona. For example, data from 2017-2018 prevalence estimates by state suggest that over 3% of Arizonans over the age of 12 had engaged in illicit drug use (other than marijuana) in the past month with nearly 11% indicating marijuana use within that time period. Nearly 50% of Arizonans had alcohol use during the past month with almost half of those, 23% of the population, engaging in binge alcohol use. Over 1% had used methamphetamines in the past year while 4% indicated pain reliever misuse during that time period (SAMHSA, 2018).

There is a great deal of data available from these and other sources that indicate the severity of the problems faced in Arizona. In order to address substance use, it is critical to think about priorities at the state and community levels, so that efforts may be aligned to have the greatest impact. This is the purpose of the SAMHSA Strategic Prevention Framework, which provides a comprehensive and consistent approach to consideration of substance misuse and related behavioral health problems (SAMHSA, 2019). Using this framework, this statewide strategic planning process and resulting document, takes a comprehensive approach to prevention, focusing on risk and protective factors that can be supported through effective programs, policies, and strategies.

There are several other key models and definitions that are utilized in the development of this plan, which are described below.

Risk and Protective Factors

Risk and Protective factors are the core framework which informs much of prevention research and practice. Risk and protective factors are a broad framework that help explain positive program impacts, where the greater number of protective factors is an associated with better outcomes while lower numbers of risk factors being associated with reduced the chance of problem behaviors (SAMHSA, 2019).



While multiple definitions exist, the definition provided by the National Research Council and Institute of Medicine (2009) proved helpful to this planning process (shown at right).

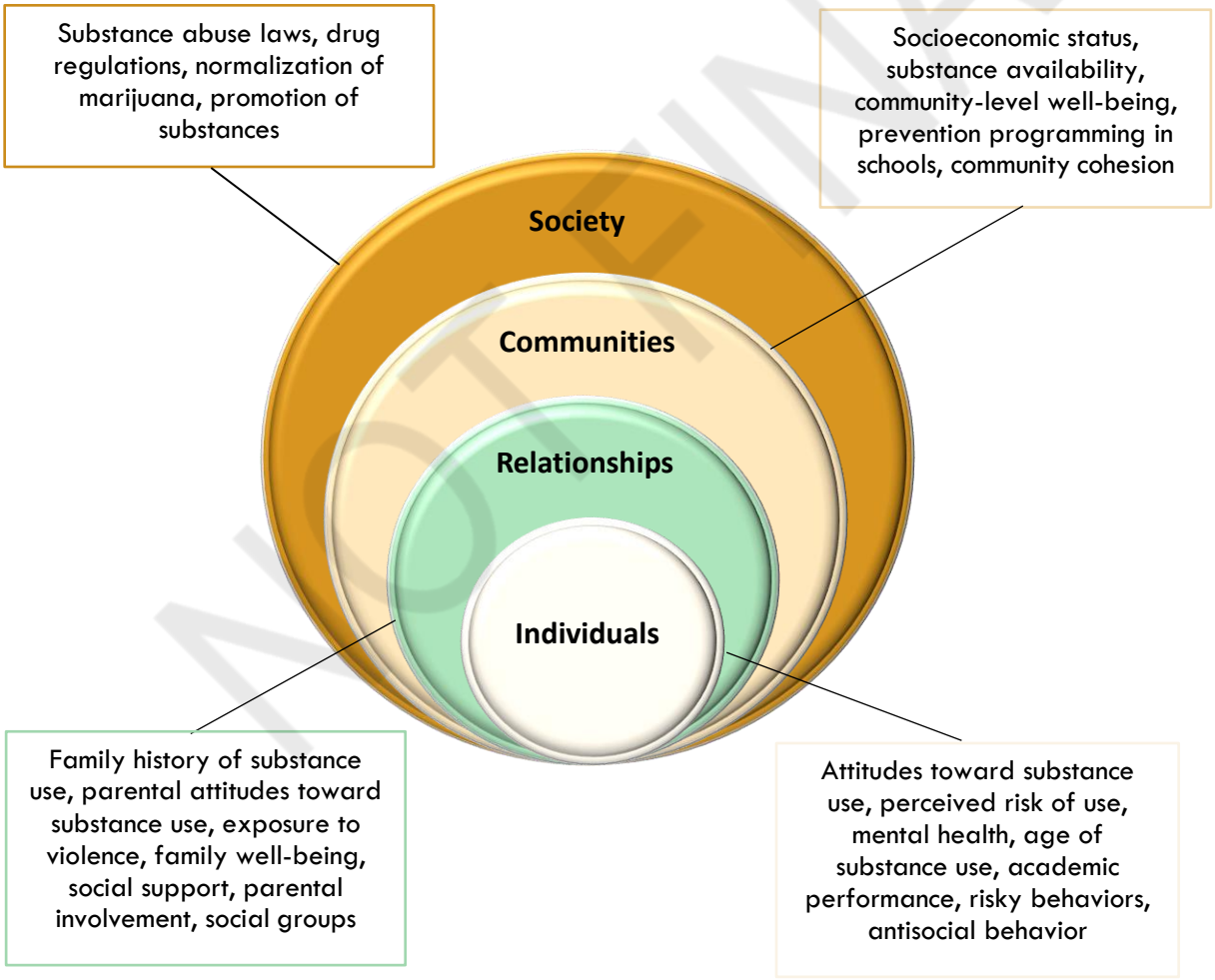
Socioecological Model

The socioecological model is a multi-level framework used to consider the context for risk and protective factors (e.g., individual, family, peer, and community levels) (SAMHSA 2019). Important principles of this model are as follows:

- Risk and protective factors are correlated and cumulative.
- Individual factors can be associated with multiple problems.
- Risk and protective factors are influential over time.
- Levels operate within and are also influenced by the next level.

This model, and examples of some common risk and protective factors considered within each level, are shown in Exhibit 1 below.

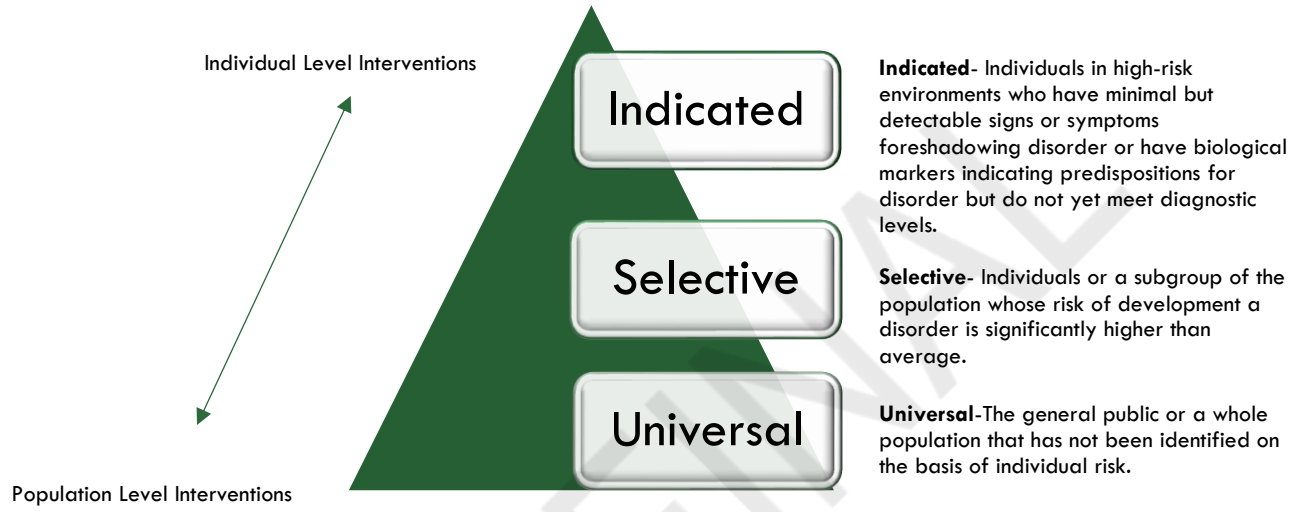
Exhibit 1. Socioecological Model with Risk and Protective Factor Examples



Primary Prevention and Risk Level

Primary prevention includes strategies intended for individuals not identified to be in need of treatment. According to SAMHSA information available on the Substance Abuse Prevention and Treatment Block Grant (2020), it may still be helpful consider these strategies for individuals of different levels of risk as shown in Exhibit 2 below.

Exhibit 2. Primary Prevention Risk Strategy Levels



SAMHSA Prevention Categories

SAMHSA has identified six categories of strategies, sometimes referred to as the six Center for Substance Abuse Prevention (CSAP) strategies. These are the recommended categories under which all primary prevention work may be organized.

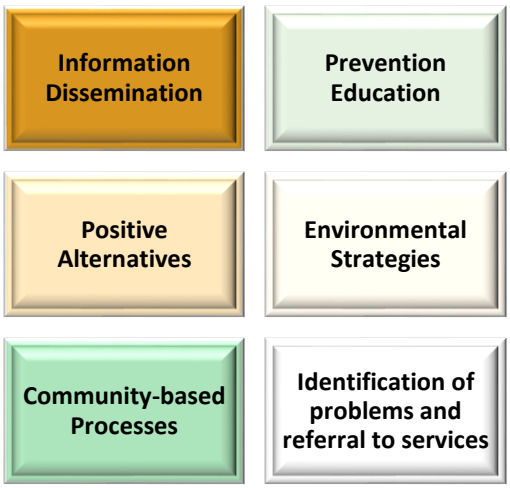
Community-based processes strengthen resources such as coalitions and increase community's ability to deliver prevention and treatment services.

Information dissemination increases knowledge and changes attitudes through one-way communication.

Environmental strategies are aimed at the settings and conditions in which people live, work, and socialize and include policy change.

Prevention education is an interactive approach to teaching skills.

Positive alternatives provide fun, structured activities so people have constructive, healthy ways to enjoy free time and learn skills.



Identification of problems and referral to services include assessments and referrals for individuals who are at high risk.

Strategic Prevention Framework Planning Process

In December 2019, the Arizona Health Care Cost Containment System (AHCCCS) contracted with LeCroy & Milligan Associates (LMA) to facilitate a statewide substance abuse prevention strategic planning process to create a three-year plan to guide the agency's priorities and efforts. This planning process was designed to follow the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Prevention Framework (SPF) which consists of five major steps: Assessment, Capacity Building, Planning, Implementation, and Evaluation (SAMHSA, 2019). The SPF is also guided by two cross-cutting principles that should be integrated into each of the steps above and these include cultural competency and sustainability. The Strategic Prevention Framework offers prevention planners a comprehensive approach to understanding and addressing the substance misuse and related behavioral health problems facing their states and communities to better prioritize resource distribution, improve strategy selections, and have a stronger impact on the communities served (SAMHSA, 2019).

Graphics from SAMHSA, 2019

Assessment

Graphics from SAMHSA, 2019

According to the SPF, it is important in the assessment phase to evaluate problems and related behaviors, risk, and protective factors and then prioritize problems based on different criteria including severity and magnitude. This assessment process was initiated back in 2018, when LMA was also contracted by AHCCCS to facilitate a Statewide Substance Abuse Prevention Needs Assessment (LeCroy & Milligan Associates, 2018). This comprehensive assessment provided a detailed overview of substance abuse issues statewide and for various sub-populations, as well as an in depth look at risk and protective factors by region and subpopulation.

In addition to this effort, data was collected from prevention providers and other stakeholders via an online survey in February 2020 and again in August 2020, with the focus of the second sample being on the impact of the Coronavirus Disease of 2019 (COVID-19) on substance abuse treatment and prevention efforts statewide. Because of COVID-19, additional data collection and data were incorporated to provide a preliminary overview of the evolving impact of the pandemic on lives and services in Arizona. Also, treatment providers were interviewed to gain their input on substance abuse trends from the field. In addition, LeCroy & Milligan Associates conducted an analysis of AHCCCS service utilization data for the timeframes of January-June 2019 and January-June 2020 and reviewed data from the Crisis Counseling Assistance and Training Program (CCP), a crisis program funded through FEMA that provides free and confidential support, education, and resource connection to individuals in the state experiencing negative impacts of the COVID-19 pandemic.

Exhibit 3. Resource Assessment Participation Overview

Method	Sample 1	Sample 2
Stakeholder survey	Conducted February 2020 **123** participants from 34 cities and representing 11 AZ counties 21% from the North Region 56% from the Central Region 15% from the South region 8% Missing Region <u>Sector Representation*</u> 54% nonprofit 32% government 20% coalition.	Conducted August 2020 **83** participants from 26 cities and representing 9 AZ counties 18% from the North Region 27% from the Central Region 53% from the South Region 2% Missing Region <u>Sector Representation*</u> 54% nonprofit 18% government 30% coalition
Treatment Provider Interviews	Not applicable	Conducted August/September 2020 15 participants Collectively participants organizations' serve all 15 AZ counties (few from North Region).
AHCCCS Utilization Data	January-June 2019 AHCCCS members with substance abuse utilization/service codes (64,161 members)**	January-June 2020 AHCCCS members with substance abuse utilization/service codes (76,475 members)**
Crisis Counseling Assistance and Training Program	Not applicable	Analyzed data on 540 individuals receiving services from June 22-September 30, 2020

*Participants could indicate more than one sector, so percentage does not total to 100%. Faith-based, school and business were also represented.

** Data was pulled as of August 1, 2020.

While none of these data can conclusively point to the impact of COVID-19, as other factors cannot be ruled out, it provided a snapshot of Arizona as of August 2020 and offered areas for exploration in the strategic planning process. Summary of key findings from this Resource Assessment are included in Appendix A. Findings from this report were used, along with the 2018 Needs Assessment and other secondary data, to facilitate consideration of behavioral health problems, local conditions and contributing factors, and prevention strategies during the strategic planning process.

Preparatory meetings were held with AHCCCS staff to review the assessment findings and to discuss and outline the strategic planning approach based on the findings as well as the changing prevention landscape due to COVID 19.

Capacity Building

Graphics from SAMHSA, 2019

Capacity building relates to building local resources and readiness to address prevention needs.

A number of activities were completed to address the capacity building Step 2 of the SPF model. The first initiative was to build a Steering Committee to help guide the strategic planning process that included individuals a wide range of agencies and sectors. The agencies included State agencies, Tribal agencies, Coalitions, Universities and Regional Behavioral Health Authority agencies.

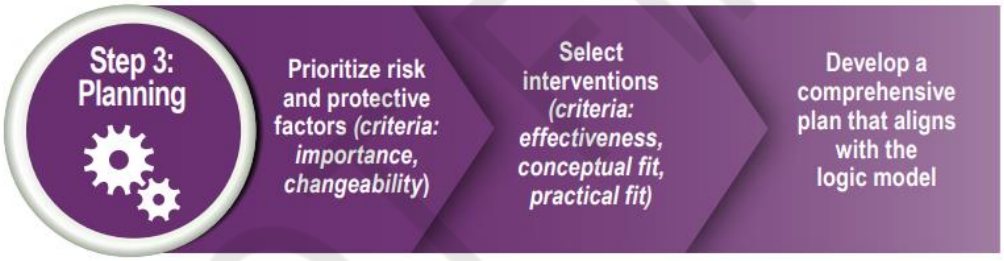
Exhibit 4. Organizations Represented on Statewide Substance Abuse Prevention Strategic Planning Steering Committee

Arizona Complete Health	Governor's Office of Youth, Faith and Family
Arizona Health Care Cost Containment System	Mercy Maricopa
Arizona National Guard Counterdrug Task Force	Pascua Yaqui Tribe
Arizona Substance Abuse Epidemiological Work Group (Epi Work Group)	Health Choice Arizona
Arizona Substance Abuse Partnership (ASAP)	Substance Abuse Coalition Leaders in Arizona (SACLAz)
Behavioral Health Planning Council	The Inter-Tribal Council of Arizona (ITCA)
Gila River Health Care	

The first Steering Committee meeting was held on February 13, 2020. The focus of this first meeting was to share the proposed strategic planning process and timeline with the group, to discuss potential challenges and proposed solutions to the process, to discuss how to ensure diverse stakeholder representation in the planning process, and to review the needs assessment findings. Feedback received from the Steering Committee helped to inform the first meeting with the larger Strategic Planning Group. Three other Steering Committee meetings were held virtually throughout the planning period to continue to receive feedback on the planning process and approach as it moved forward.

Next was the important task of outreaching to individuals to participate in the actual planning process alongside Steering Committee members. AHCCCS reached out to a wide range of providers, advocates, coalition leaders, State agencies, Tribal agencies, Regional and Tribal Behavioral Health Authority Agencies, and Universities via several emails to encourage participation. A total of 49 organizations were ultimately represented through participation in the Strategic Planning Group. See complete list in Appendix B.

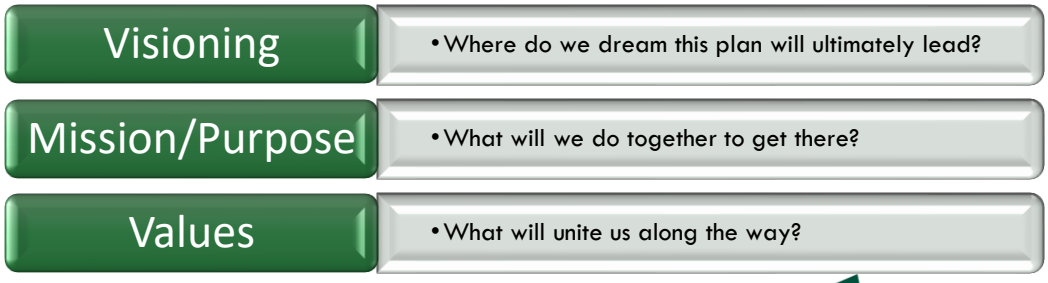
Planning



Graphics from SAMHSA, 2019

Step 3 of the SPF model embodied a large amount of the activity that occurred as part of the strategic planning process over the sequential meetings held with the Strategic Planning Group.

The first Strategic Planning Group meeting was held on February 28, 2020, in person before COVID 19 struck Arizona. A total of 7 Steering Committee members and 32 other Strategic Planning Group members attended the daylong session. The focus of the first meeting was to establish together the vision, mission/purpose and values that should guide the group forward in developing the strategic plan. Three questions helped to guide that process:



A number of activities were conducted with the Strategic Planning Group to help answer these questions which culminated in an overarching foundation to draw from throughout the rest of the strategic planning process. This framework is included in Exhibit 6 (page 19 of this report) as part of the strategic plan.

The second Strategic Planning Group meeting was held virtually due to COVID-19 on October 7, 2020, and 31 individuals participated. The focus of this meeting was to explore and address the long-term consequences and behavioral health problems that Arizona is currently facing regarding substance use. Data from the 2018 Arizona Statewide needs assessment, the resource assessment mentioned earlier, and AHCCCS substance use treatment utilization data were shared with the group to help provide some context for discussions that would occur in breakout sessions.

Exhibit 5. Strategic Planning Session Summary

The third Strategic Planning Group meeting was held virtually on October 21, 2020 and 24 individuals participated. The focus of this meeting was to address intervening variables (risk and protective factors) and local conditions & contributing factors to continue to develop a deeper understanding of the needs and priorities, as well as potential areas for intervention, regarding substance use prevention in Arizona. A core task of this meeting was to identify those risk and protective factors that were both of high importance and changeability.

The fourth Strategic Planning Group meeting was held virtually on November 2, 2020 and 22 individuals participated. The focus of this final meeting was the culmination of the preparatory work completed in the last three Strategic Planning Group meetings to help identify those strategies that should be targeted and prioritized in the final strategic plan and potential options for implementation.

All information and data collected from the breakout sessions for all four meetings were then utilized to help inform this strategic plan. A final session will likely be held in spring 2020 to share the plan for final consideration by stakeholders.

Implementation

Graphics from SAMHSA, 2019

Step 4 in the SAMHSA SPF model is implementation which moves the process from planning to action. Preliminary implementation steps are included in the strategic plan, and detail some of the next steps needed to move toward specific programs and priorities. Over time, those strategies that are identified will now begin to be delivered and existing services aligned better under this agreed upon statewide framework. It will be important during this period to establish supports for implementation including leadership and administrative support, provider training and support, and implementation monitoring.

Reporting and Evaluation

Graphics from SAMHSA, 2019

Step 5 of the SPF model is key and involves ongoing evaluation of the efforts that are being implemented as part of the Strategic Plan. Within the Strategic Plan, there are suggestions for ongoing ways to monitor and evaluate the effectiveness of the plan and the accuracy or fidelity with which it is implemented. As strategies are refined, these evaluation activities can be further specified.

In addition, AHCCCS has contracted with an external evaluator to assist with the development of the comprehensive evaluation plan for substance abuse prevention work in Arizona, that will ultimately need to align with the Strategic Plan. It is important to monitor the process/implementation of the plan in addition to the outcomes. If issues are discovered, or intended outcomes are not being realized, this ongoing evaluation allows for course corrections. In addition, it is important to be able to share the results of the evaluation with key stakeholders, providers, and communities.

Other SPF Considerations

Two other important SPF considerations that crosscut through the five-step process include cultural competence and sustainability.

Cultural Competence

To overcome systemic barriers that may contribute to disparities, it is important to consider cultural competence with the design of any strategic plan for substance abuse prevention. It is important that prevention programs and practices are developed and delivered in ways that ensure members of diverse cultural groups benefit from their efforts and that cultural traditions and beliefs are recognized and valued. SAMHSA identifies the following cultural competence principles for prevention planners (SAMHSA, 2019):

- Include the target population in all aspects of prevention planning.
- Use a population-based definition of community (i.e., let the community define itself).
- Stress the importance of relevant, culturally appropriate prevention approaches.
- Employ culturally competent evaluators.

- Promote cultural competence among program staff, reflecting the communities they serve.

These principles guided or were folded into the entire strategic planning process from the selection of Steering Committee and Strategic Planning Group members to the activities implemented in planning meetings. Arizona is a very diverse state with wide ranging needs across many different populations and communities, highlighting the critical importance of prioritizing the cultural competence principles as the plan is implemented and evaluated.

Sustainability

In prevention, sustainability relates not only to the capacity of communities to maintain positive prevention programs and outcomes over time but also to lasting effective strategic planning processes as well. This can include identifying those programs and/or practices that are proven effective that should continue to be supported. The challenge identifying and then supporting these efforts is that often prevention can take time, and outcomes may not always be dramatic or easily measured. Also, prevention priorities can change, and this was seen clearly this year with COVID 19. Adaptability is part of enhancing sustainability, thus, having a well-established strategic planning process can contribute to that ability when priorities shift and change. This requires commitment from a diverse group of collaborative stakeholders and agencies to recognize and respond quickly to changes over time.

Arizona Statewide Substance Abuse Prevention Strategic Plan

The following plan is an overarching blueprint the state may follow in order to align substance use prevention efforts across local and state levels. This plan was developed with significant data and stakeholder input, as detailed in the previous sections. For simplicity of use, not all data elements and findings are restated herein. Please reference Appendix A, along with the 2018 Needs Assessment, national secondary data sources, and the full Resource Assessment for more information about the data that led to the development of this plan. Included on the following pages are: 1) Strategic Plan Foundation (the overall vision, values, and purpose statements), 2) the completed SAMHSA Logic Model, and 3) charts of the selected strategies for each of the six SAMSHA prevention approaches.

Exhibit 6. Strategic Plan Foundation

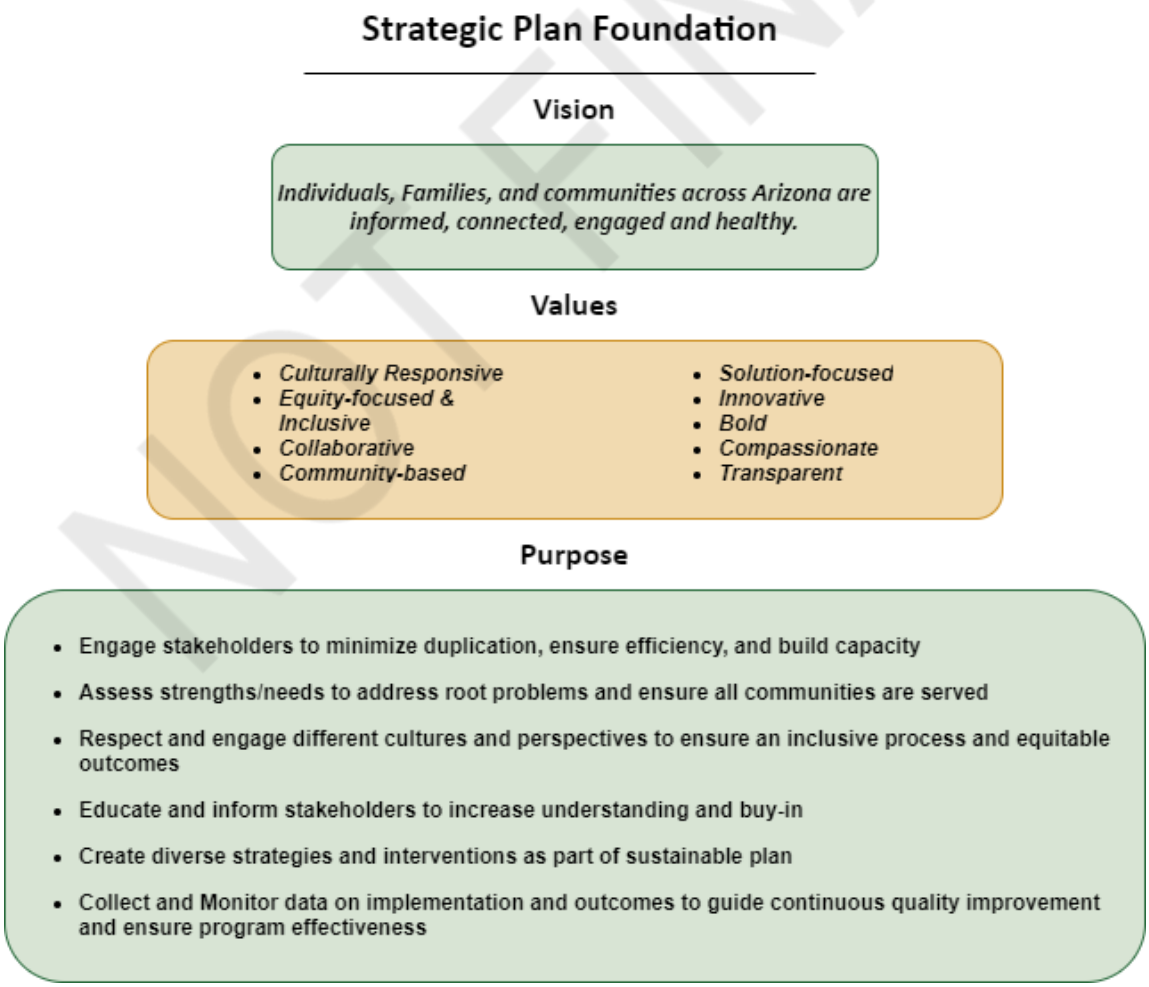


Exhibit 7: Strategic Planning Prevention Logic Model

*Data from the 2017–2018 NSDUH estimates unless otherwise noted. Data is rounded to the nearest percentage. **Opioids includes fentanyl and misuse of prescription pain relievers.

Overview of Logic Model

The development of the AHCCCS Statewide Substance Abuse Prevention Logic Model was informed by data collected throughout the planning process. The first step was to identify the highest priority long-term consequences of substance use in the state and the behavioral health problems that most closely lead to those outcomes. Six long-term consequences were identified as priority areas to address through statewide prevention efforts: 1) criminal involvement, 2) poor socioeconomic outcomes for individuals and families, 3) overdose fatalities; 4) child abuse and family violence, 5) poor mental health outcomes and suicide, and 6) health inequities.

The behavioral health problems that were viewed as most significantly contributing to these long-term consequences are those included in the logic model, with key substances of concern including opioids, alcohol, and methamphetamines for both adults and youth/young adults. According to 2017 and 2018 data from the National Survey on Drug Use and Health (NSDUH), 5% of adults, 3% of youth, and 7% of young adults in Arizona have misused opioids in the past year. Stakeholders viewed opioids as contributing particularly to overdose fatalities in the state, a priority long-term consequence included in the logic model.

As the most widespread substance of concern, alcohol was also identified by stakeholders as a priority substance, with 7% of adults in Arizona identified as having an alcohol use disorder (NSDUH, 2019). Further, 24% of adults in Arizona engage in binge drinking, defined as a man drinking five or more drinks or a woman drinking four or more drinks on the same occasion on at least one day in the past 30 days (NSDUH, 2019). Although NSDUH data suggests methamphetamines are used less frequently among adults and youth/young adults, as 1% of adults and 2% of young adults in Arizona used this substance, it was regarded as a priority substance due to its negative long-term health and socioeconomic consequences.

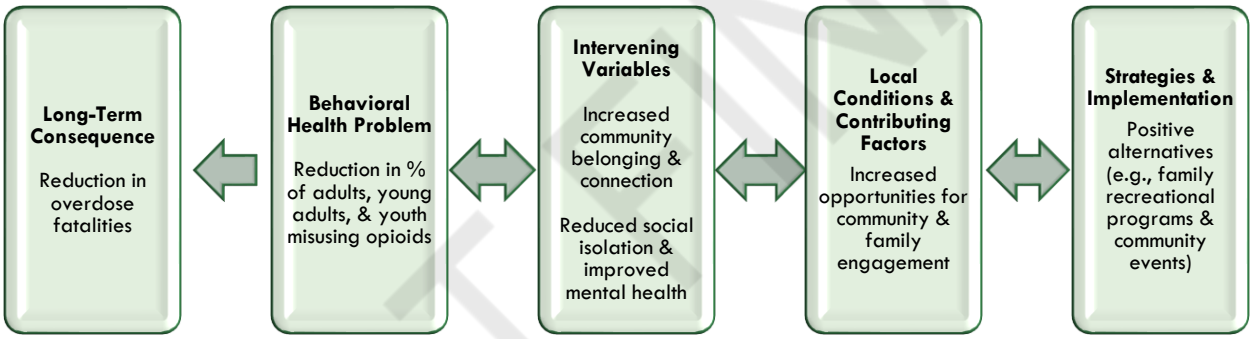
Two additional behavioral health problems, marijuana use and vaping, were identified as behaviors of concern among youth and young adults specifically. Twelve percent of youth and 32% of young adults in Arizona used marijuana in the past year (NSDUH, 2019). With the November 2020 passage of recreational marijuana in Arizona (Prop 207), stakeholders were adamant that the statewide strategic plan prioritize marijuana as a key behavioral health problem, particularly among youth. Vaping was also identified as a key behavioral health problem among youth and young adults. In 2019, 17.9% of high school students reported currently using a vapor product according to the Arizona Youth Risk Behavior Survey (YRBS). It is important to recognize the connection between marijuana use and vaping since vaping devises are used to not only consume nicotine but also marijuana products.

Although stakeholders often discussed behavioral health problems affecting adults and youth/young adults separately, most of the risk factors, local conditions, and contributing factors relating to these problems were the same. Namely, poor mental health, low risk

perception, and accessibility of substances were commonly identified as factors contributing to substance use in general.

Stakeholders also commonly recognized weak interpersonal ties and relationships, particularly with family, as key contributors to substance use regardless of an individual's age. These factors were often discussed in connection to COVID-19, which seems to have expedited the deterioration of interpersonal relationships and community connectedness due to safety measures related to physical distancing. Exhibit 8 illustrates how offering positive alternatives, one of the six CSAP strategies, can impact local conditions by providing youth and adults with opportunities to engage with each other, increasing their sense of belonging to their community and connection with others, reducing social isolation, and improving mental health. This is one strategy that the state will use to reduce opioid misuse in Arizona to reduce overdose fatalities, a key long-term consequence associated with opioid use.

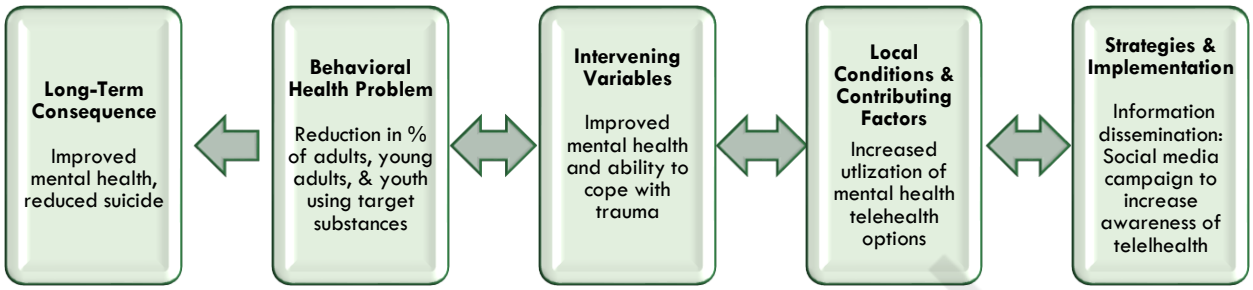
Exhibit 8. Logic Model Highlight on Reducing Substance Use Through Social Engagement



To reduce the statewide prevalence of priority behavioral health problems more generally, stakeholders recognized the importance of using multiple prevention strategies, many of which focus on increasing awareness of risks associated with using specific substances to influence individual behavior and eventually shift social norms. For example, stakeholders recommended using social media campaigns to increase youth's awareness of risks associated with marijuana use that run counter to beliefs that marijuana must be "safe" since it is legal. This shift in risk perception may ultimately lead to a reduction in marijuana use among youth.

Technology is recognized as an essential tool in the implementation of various prevention strategies, as it can be used to inform, educate, and connect people. There is tremendous opportunity around telehealth, as COVID-19 has increased telehealth and other online service options available to support mental health, and it is unlikely these options will go away once the pandemic ends. Exhibit 9 illustrates how information dissemination strategies that embrace technology can improve mental health in the short term, resulting in a reduction in substance use among adults and youth that can prevent chronic mental health conditions in the long term.

Exhibit 9. Logic Model Highlight on Reducing Substance Use Through Strategies Utilizing Technology



Complementing these strategies are those focused on improving mental health by increasing protective factors such as social support and community connection through family- and community-based prevention programming. In some cases, the social benefits of a strategy are not the primary intention, as in the case with a family-based education program focused on building resiliency, but nonetheless, it is an important secondary outcome that relates to other factors associated with substance use.

While stakeholders frequently discussed the importance of addressing social factors associated with substance use, they recognized that environmental strategies, such as policies restricting the sale and marketing of certain substances, are needed to reduce the accessibility of substances. Such environmental strategies also have the potential to impact social factors, such as social norms associated with specific substance-use behaviors, and thus, they are an important strategy because they have the power to change both the social and the physical environment.

Although all six CSAP strategy areas are critical to address the behavioral health problems of interest, as the strategies are complementary in nature and enhance each other's impact, community-based process strategies emphasize the importance of working together to address the root causes of substances use through integrated, multi-sectoral approaches. Community-based process strategies are needed to ensure that all six strategy areas are working together and in alignment to address the risk factors, local conditions, and contributing factors that drive substance in communities throughout Arizona. In the logic model, community-based processes serve as a framework for addressing all factors and conditions contributing to the behavioral health problems of interest.

SAMHSA Framework-Based Strategies

Community-based Process Strategies

SAMHSA Strategy Definition: Strengthen resources such as community coalitions to prevent substance use/misuse. Organizing, planning, and networking are included in this strategy to increase the community's ability to deliver effective prevention and treatment services (SAMHSA 2019).

What is the strategy?

It was clear from participants throughout this planning process, that community-based work is central to effective prevention efforts in Arizona. The very premise for a statewide strategic plan, developed with a diverse body of stakeholders, is that community prevention work requires a shared and multi-faceted approach. No state or local entity alone, can fully complete the work that is required. Doing it together, with alignment of prioritized strategies, has the best likelihood of making an impact on the harmful long-term consequences of substance abuse/misuse.

> "There are a lot of different groups doing lots of different pieces of prevention, but not a lot of coordination. Work [is needed] that can support the community coalition being the nexus of how prevention services get presented in a community, could activate the whole community and get them involved in the conversation."

The specific components to this strategy include:

1) Increase communication and alignment of coalition work at the state and local levels.
2) Share information on evidence-based practices.
3) Address root causes of substance use through integrated approaches with other sectors.
    a) Encourage trauma-informed and resiliency-focused communities.
    b) Build improved pathways to refer individuals in need of services/supports.
    c) Collaborate with entities that support the whole person and address the social determinants of health, including in other fields such as healthcare, social services, education etc. at both the state and local levels.
4) Increase use of shared data for prioritization of prevention efforts and assessment of progress on shared strategies.
5) Increase the cultural and geographic diversity of stakeholders participating at the state level.

Why this strategy?

As indicated in the AHCCCS Statewide Substance Abuse Prevention Logic Model, community-based process is the mechanism by which all sorts of local conditions may be addressed. Specifically, the collaboration and coordination between state and local organization and coalitions will help ensure strategies are strategic, effective, and targeted to local needs and populations. This framework for community-based collaborative work overlays the entirety of this plan.

Population or cultural considerations

During initial planning meetings and throughout the strategic planning process, it was apparent that stakeholders saw the importance of engaging a spectrum of representatives from across Arizona. While certainly this was attempted in this process, continued work in this area may be needed to ensure that those groups and organizations participating, particularly at the state level, reflect the diverse opinions and perspectives of Native American, African American and Hispanic populations; rural and urban communities; counties statewide; and specific groups such as LGBTQ+ and other community and faith-based organizations. Specific engagement strategies may be needed to invite and involve other groups to join the conversation and collaboration work that is proposed.

Proposed implementation priorities

1) Initiate an ongoing statewide substance abuse prevention planning group.
2) Identify and implement specific steps to increase the diversity and representation of this planning group. Ensure that one representative from each coalition in this state working in this area is invited and encouraged to join. This will help to ensure collaboration and integration of efforts at the state and local level.
3) As part of the work of the planning group, identify other entities to collaborate with to focus on supporting integrated supports for families that help address the root causes of substance abuse/misuse.
4) As part of this group, provide a platform/mechanism for sharing evidence-based practices, data and other communications.
5) Encourage this group to continue to utilize this strategic plan and ensure evaluation of the strategies are in place and executed.

Suggested ways to measure progress

- ✓ Number and demographics of planning group representatives
- ✓ Number of collaborative meetings held/year; documented meeting agendas/notes
- ✓ Number and type of partnerships in place
- ✓ Documentation of information and data sharing mechanisms and types/frequency of information shared
- ✓ Annual online survey of all stakeholders in this collaborative planning group to assess the degree of integration and collaboration; document results and achievements

Information Dissemination Strategies

SAMHSA Strategy Definition:

Increase knowledge and change attitudes through communications. This method of learning is mainly one-way, such as through classroom speakers or media campaigns (SAMHSA 2019).

What is the strategy?

> "Messaging to children is needed about setting goals, instilling hope, and countering fear messages aimed at adults."

Prevention providers in the state expressed broad support for information dissemination strategies, and many providers indicated that they are already doing this work. Because information dissemination strategies do not require face-to-face interaction, as these strategies typically use mass media, social media, and other communication channels to distribute information, their potential reach is expansive. Another key benefit of this strategy area is it offers tremendous variability, as campaigns can vary by audience (e.g., youth, parents, prescribers, specific high-risk populations), method of delivery (e.g., pamphlet, billboard, advertisement, public speaker, social media platforms), objective (e.g., behavioral change, cultural change, advocacy for policy support), and scope (e.g., schoolwide prevention campaign, community-wide, and statewide prevention campaigns). To be most effective, prevention messaging must be tailored to the target population and communication channel being used.

The specific components to this strategy include:

1) Embrace social media, particularly to reach youth.
2) Focus on positive messaging to build resiliency and support positive behaviors or behavior change.
3) Design campaigns to reduce, rather than reinforce, stigma surrounding substance use.
4) Complement other prevention strategies with information dissemination to develop a comprehensive, coordinated prevention plan.
5) Pilot test messaging to ensure it is linguistically and culturally relevant to target populations.

Why this strategy?

This particular strategy aligns well with interests expressed by participants throughout the planning process in shifting social norms and risk perceptions of substance use since these strategies can be implemented on a large scale—at the school, community, or state level—potentially reaching a large mass of people as well as priority populations. Information dissemination strategies occurring through online platforms are particularly positioned to reach large populations and address some, but not all, geographic challenges associated with

other prevention strategies that have traditionally occurred through face-to-face interaction. Additionally, information dissemination strategies are often used to increase awareness of substance-use related problems, which can help garner support for policies designed to address problems and influence decisions related to substance use and cessation. Thus, these strategies work well in conjunction with other prevention strategies, such as coupling an information campaign with support for an environmental strategy such as a policy change or to reinforce content delivered through prevention education. Given the potential reach of information dissemination strategies, they also tend to be cost effective.

Population or cultural considerations

This strategy can be effective with diverse populations if messages are tailored to meet the language and cultural preferences of the population, a need acknowledged by participants throughout the planning process. In 2019, 27.2% of Arizonans spoke a language other than English at home (U.S. Census Bureau, 2019), highlighting the critical need for information dissemination efforts to be multilingual. Information dissemination also must reflect best practices in plain language and cultural sensitivity. Finally, it is essential that information dissemination strategies are mindful of person-first language and actively strive to de-stigmatize substance use, as mass media campaigns sometimes further stigmatize individuals, leading to fewer people seeking support or treatment.

Proposed implementation priorities

1) Initiate a working group of the statewide substance abuse prevention planning group charged with identifying and coordinating effective prevention campaigns and other forms of information dissemination. A key first step for the group is to review previous research to identify successful examples of information dissemination strategies addressing similar populations and substance-related behaviors, attitudes, and/or perceptions.
2) Planning working group recommends evidence-based information dissemination strategies aligning with the priority populations and substance-related behavioral health problems. Statewide substance abuse prevention planning group identifies funding for these strategies.
3) Develop campaign messages based on sound research of the target group and pilot test messages during campaign development.
4) Design tailored, culturally relevant campaigns for target populations to raise awareness of substance-related behavioral health problems identified in the logic model, such as campaigns focusing on opioid misuse in communities, particularly among youth.
5) Design campaigns focusing on protective factors, such as resiliency and healthy coping, positive parent/child communication, and telehealth resources, rather than those solely focusing on the negative risks and outcomes of substance use.
6) Implement statewide campaign focusing on shifting norms surrounding marijuana use among youth, delivered through a coordinated state effort in schools.

7) Planning group seeks opportunities to collaborate with other local or statewide prevention efforts to disseminate information in a comprehensive, coordinated approach.

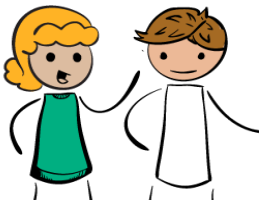
Suggested ways to measure progress

- ✓ Number and demographics of working group representatives.
- ✓ Number of working group meetings held per year.
- ✓ Number of meetings with other planning groups to identify opportunities for collaboration and coordination.
- ✓ Documentation of campaigns conducted and alignment with priority populations, risk and protective factors, and substances.
- ✓ Identify survey methods to assess the impact of key information dissemination efforts.

Prevention Education Strategies

SAMHSA Strategy Definition:

Interactive approach to teaching participants important social skills. These skills can include resisting pressure to use drugs, looking at the intent behind advertising, or developing other skills used in making healthy choices (SAMHSA 2019).



What is the strategy?

Prevention education programs are designed to reduce risk factors and increase protective factors associated with substance use behaviors and patterns in certain populations. Therefore, a key focus is how prevention education programs can strengthen protection or intervene to reduce risks, with a goal to ensure individuals engage in positive behaviors. These programs should address the substance-related behavioral health issues reflected in the local community and target modifiable risk and protective factors. Programs also must be tailored to specific populations and reflect cultural competency. Prevention providers across the state have embraced this strategy and view it as one of the key strategies to incorporate in statewide prevention efforts.

"Prevention education yields the greatest success, especially when delivered in native languages."

The specific components to this strategy include:

1) Increase prevention education in schools through statewide efforts to implement evidence-based curricula to reduce risk factors and bolster protective factors.
2) Expand reach using online strategies to provide prevention education.
3) Identify and deliver prevention education programs that highlight substance-specific risks and consequences of use to shift risk perception.
4) Ensure prevention education programs are evidence based.
5) Ensure prevention education programs reflect a high level of cultural competency and linguistic appropriateness.
6) Provide cultural competency training to individuals delivering prevention education.

Why this strategy?

Prevention providers are already highly engaged in prevention education, as this was the second most reported type of prevention strategy offered among those completing the stakeholder survey, with the first being community-based process strategies. Prevention education, however, was the most frequently recommended strategy area for future funding among those completing the stakeholder survey.

Given this widespread support among prevention providers, this is an important strategy to include as part of the statewide strategic plan. This strategy also provides an opportunity to

address key risk factors associated with substance use, particularly perceptions of risk associated with certain substances, as well as key protective factors, such as healthy coping skills, emotional resiliency, and community connection. There are evidence-based and promising prevention education programs designed for families, youth, and adults that can be implemented in various settings.

Population or cultural considerations

Throughout the planning process, stakeholders stressed the importance of targeting prevention education efforts to families and youth, with several stakeholders stating that a funding priority is providing prevention education programming in schools across the state. To expand the populations reached, particularly during the COVID-19 pandemic, stakeholders suggested prioritizing funding to support prevention programming through online platforms. With respect to cultural considerations, stakeholders acknowledged the importance of providing culturally competent prevention programming to meet the needs and preferences of LGBTQ+ identifying individuals. Stakeholders also stressed the importance of providing prevention programming in the target population's preferred language. Related to these cultural considerations, stakeholders suggested that individuals leading prevention education efforts participate in cultural competency training.

Proposed implementation priorities

1) Initiate a working group of the ongoing statewide prevention education planning group charged with identifying evidence-based, promising, and culturally and linguistically appropriate programs that align with risk and protective factors noted in the logic model. Utilize tools such as the guide from SAMHSA (2018b) on identifying appropriate best practices for various prevention settings.
2) Build relevant systems and capacity, including funding, to provide evidence-based prevention education for grades K–12.
3) Identify evidence-based programs for high-risk groups (e.g., juvenile justice populations) and process/systems for reaching these groups.
4) Identify and include evidence-based programs focused on specific substances, as well as family education programs on building protective factors and resiliency.
5) Provide a platform/mechanism for sharing evidence-based prevention education programs and online trainings with prevention providers and partners.
6) Provide cultural competency training for prevention providers.

Suggested ways to measure progress

- ✓ Number and demographics of working group representatives.
- ✓ Number of collaborative planning meetings held per year.
- ✓ Documentation of mechanisms used to share evidence-based prevention programs.
- ✓ Conduct surveys to assess knowledge gain and attitude changes based on the prevention education programming. Track program fidelity.
- ✓ Ensure use of recommended outcome measures for evidence-based programs

Positive Alternative Strategies

SAMHSA Strategy Definition:

Positive alternatives provide fun, structure activities so people have constructive, healthy ways to enjoy free time and learn skills. These alcohol- and drug-free activities help people—particularly young people— stay away from situations that encourage use of alcohol, tobacco, or illegal drugs (SAMHSA 2019).

What is the strategy?

Positive alternatives programs are primary prevention approachess designed to strengthen bonds with community members, create a rich environment for protective factors, educational opportunities, and skill building. While positive alternatives is not the most common prevention strategy for organizations, its broad applicability offers lots of opportunities. Positive alternatives are designed to strengthen protective factors and help engage individuals in healthy long-term behaviors. These programs can be highly targeted, using population specific tools and cultural competency. Additional outreach and sustainability are essential to expanding the role of positive alternative strategies.

"Older adults may be missing positive alternatives as much as young people."

The specific components to this strategy include:

1) Increase visibility and communication among existing state and local positive alternatives programs to reduce risk factors and strengthen protective factors.
2) Expand reach of existing programs using online platforms and community infrastructure.
3) Increase the cultural, geographic and age diversity of opportunities for community participation.
4) Identify specific positive alternatives that may be needed for certain populations (e.g., parents at home with youth in online school; older adults) given the challenges exacerbated by COVID-19.

Why this strategy?

Positive alternatives are a key strategy that provide adults and youth opportunities for engagement which can reduce isolation and increase community cohesion/belonging. Positive alternatives are often not the focus of prevention providers already highly focused on education and treatment; therefore, this emphasizes the importance of providers sharing information and resources to highlight positive alternative opportunities that are available

more widely in communities. Community focused events and programs can be highly impactful on several risk and protective factors such as social isolation, family connection, mental health, and relationships. For youth specifically, they can also influence academic engagement, a protective factor that minimizes youth substance abuse/misuse. Positive alternatives often focus on strengthening protective factors, and some also include personal development and skill building in topics such as conflict resolution, positive self-imagery, communication, and peer pressure.

Population or cultural considerations

A successful positive alternative strategy requires organizations to engage their specific communities. With the diverse population of Arizona, cultural and population specific engagement strategies show the importance of making a variety of positive alternatives available to Native American, African American, and Hispanic populations; rural and urban communities; all ages; specific groups such as LGBTQ+ and other community and faith-based organizations. Successful positive alternative strategies are most effective with community buy in; it is especially important that programming be culturally competent and delivered in the preferred languages of community members.

Proposed implementation priorities

1) Initiate a working group of the statewide substance abuse planning group focused on best ways to promote positive alternatives that are culturally appropriate at the local level.

2) As part of the work of the working group, collaborate with relevant entities to support positive alternatives and initiatives that focus on well-being for families and address specific local community risk and protective factors.

4) Identify mechanisms for communication at the state level about existing positive alternatives.

5) Inventory existing positive alternative programming that is evidence-based and support promotion of these opportunities; consider innovative online alternatives for various target groups.

Suggested ways to measure progress

- ✓ Number and demographics of working group representatives.
- ✓ Number of collaborative planning meetings held per year; documented meeting agendas/notes.
- ✓ Tracking of communication/messaging regarding positive alternatives.
- ✓ Complete inventory of positive alternative programming.
- ✓ Survey participants about satisfaction and perceived benefits.

Environmental Strategies

SAMHSA Strategy Definition:

Aimed at the settings and conditions in which people live, work, and socialize. These strategies call for change in policies— to reduce risk factors and increase protective factors—for example, tighter zoning restrictions on alcohol outlets or stronger enforcement to prevent underage purchases of alcohol and tobacco (SAMHSA 2019).

What is the strategy?

Environmental strategies are often most effective in addressing risks and promoting protective factors across the socio-ecological model. By implementing policies and ordinances that change the environments in which people live, work, and play, these strategies can ultimately influence community norms and individual behaviors relating to substance use. Stakeholders involved in this planning process indicated that these were the least commonly used strategies by their organizations and were most difficult to garner support to implement. Although environmental strategies were recognized as being important, and critical to changing culture around substance use and addressing the social determinants of health that are often the root cause of substance use, stakeholders did not often identify an environmental strategy as warranting priority funding. The one exception that multiple stakeholders mentioned was the use of environmental strategies to reduce vaping initiation and availability among youth. Stakeholders agreed that strategies were needed at the local level through the passage of ordinances that would restrict the sale of tobacco and vaping productsto individuals who are 21 years old and younger.

> "Each community is at a different level of readiness. In some places environmental strategies might be laughed out of city council."

The specific components to this strategy include:

1) Pursue a combination of community-level and state-level environmental strategies including policy change.
2) Use environmental strategies in conjunction with other prevention strategies, such as developing youth coalitions to lead policy change in schools and communities or ensuring that information dissemination campaigns include a "call for action" that includes supporting environmental change strategies.
3) Advocate for and practice Health in All Policies (HiAP) approaches that address the social determinants of health associated with substance use as an upstream prevention strategy.
4) Prioritize environmental strategies to reduce the availability of substances such as age restrictions, limiting density of stores, limiting days/hours of sale, and increasing taxes to increase the unit price of legal substances.

5) Advocate for regulation of marijuana products given the November 2020 passage of recreational marijuana in Arizona (Prop 207).

Why this strategy?

Of the six prevention strategies, environmental strategies have the most potential to lead to long-term change at the population level. Although they can be difficult to implement as they can be political in nature, they are consistently recognized as recommended prevention strategies by public health experts including the Community Preventive Services Task Force (CPSTF), which recommends multiple environmental strategies to reduce excessive drinking and tobacco use in the Guide to Community Preventive Services, a collection of evidence-based interventions (Guide to Community Preventive Services, 2020). Further, there is strong scientific evidence that environmental strategies work. The evidence is particularly well documented in tobacco research, which has demonstrated that that increasing the price of tobacco products and comprehensive smoke-free policies are effective in reducing smoking rates and shifting norms, especially when combined with communication campaigns.

Although stakeholders in this planning process viewed environmental strategies as the most difficult prevention strategy, they consistently recognized the importance of policy in restricting tobacco and vaping products. Environmental strategies may also be effective in reducing the availability of opioids, another concern among stakeholders, as the Centers for Disease Control and Prevention has identified state-initiated policies designed to curb the rate of inappropriate prescribing of opioids as a "promising" state strategy. Ultimately, there is significant opportunity related to this prevention strategy, which includes cost-effective strategies that can lead to large-scale and long-term positive change.

Population or cultural considerations

It is critically important that environmental strategies, particularly policies, do not perpetuate institutional racism and systemic social and health inequities or further stigmatize certain populations, including those who use substances. Historically, misguided drug laws and disproportionate sentencing requirements have further disadvantaged communities of color. Criminalizing substance can also further stigmatize people who use substances, making it less likely that individuals using substances will seek and access treatment. The intended consequences of policies must be considered through these lenses.

Proposed implementation strategies

1) Initiate an ongoing working group of the statewide prevention education planning group charged with exploring policy efforts aimed at behavioral health factors, including priority substances, and intervening variables identified in the state's prevention logic model. This may include holding additional sub-group meetings during the legislative session each year to review bills that would impact priority behavioral health problems included in the logic model.

2) Build capacity at the local level for prevention providers to engage in environmental strategies, particularly advocacy and policymaking.
3) Build capacity of local coalitions to lead efforts in the passage of ordinances that increase the legal age of tobacco and vaping products to 21 years.
4) Working group develop a white paper summarizing evidence-based environmental strategies, including policies, that align with behavioral health factors and intervening variables included in the state's prevention logic model.
5) Implement environmental strategies, in combination with other prevention strategy areas, that support the use of best practices among health care providers for treating pain with opioids.

Suggested ways to measure progress

- ✓ Number and demographics of working group representatives.
- ✓ Number of collaborative planning meetings held per year; documented meeting agendas/notes.
- ✓ Documentation of capacity building efforts with local providers and coalitions.
- ✓ Method for collection and reporting of impact on local and state level policies.

Identification of Problems and Referral to Services Strategies

SAMHSA Strategy Definition:

Identification of problems and referral to services includes the provision of assessment and referrals when the behavior of people who are at high risk of substance abuse may require education or other intensive interventions (SAMHSA 2019). This strategy does not include any activity designed to determine if a person is in need of treatment.

What is the strategy?

Of the prevention strategies, this may be the most targeted. Bridging the gap from prevention to treatment, this set of strategies targets reaching people who are in need of greater supports in order to prevent likely future or continued use of substances. While the work of assessment and referral is often specific to the individual, establishing the mechanisms by which this can occur is the strategy of interest and was the focus of the planning meetings that discussed this topic. Participants explored, "how do we know what supports are available? How do we recommend people visit them? " Thus, the strategy needs to include development of centralized resources that support referral to services.

> "Intersection between prevention and intervention is needed. Early intervention is the most effective way to prevent substance use disorder and needs to be funded."

It was clear from planning sessions that this is also an area where the line of what is considered primary prevention, and, thus, within the scope of what can be funded by the federal SABG, is unclear. Thus, a component of the strategy is more education and conversation, led by AHCCCS, on the types of work that needs to be done in this area statewide. The remaining focus of this strategy might focus on sharing information designed to encourage individuals to reconsider substance use.

The specific components to this strategy include:

1) Provide more information to the prevention community on best-practices in the strategy of problem identification and referral.
2) Identify a centralized resource that may be used by prevention providers to support referral to support services. While every local resource may not be listed, perhaps links to other local search tools or listings may be included along with statewide resource information.
3) Develop informational campaigns targeting youth and adults who may be at risk for substance abuse or recently engaged in first use. Engage community stakeholders from these populations in developing messaging applicable to specific communities or subpopulations.

4) Collaborate with other sectors (e.g., business, education, early childhood, criminal justice) to encourage the importance of adequate supports for families to minimize the likelihood of future substance misuse/abuse down the road.

Why this strategy?

While often viewed as the outlier amongst the other primary prevention strategies, the inclusion of this strategy is critical to ensure that in an integrated world there are tools/supports available no matter where a person is in relation to their use of substances. This important strategy is part individual education and also can include more community-wide information dissemination strategies designed to change consideration around initial use of substances.

Population or cultural considerations

Central to this strategy is an understanding that certain individuals are at increased risk of substance abuse and the resulting harmful outcomes that may occur. Individuals who have experienced more of risk factors and fewer of protective factors, those with past trauma, significant family dysfunction, poor mental health, increased access to substances, may all be at increased risk. Individuals leaving the criminal justice system were also noted as a specific population to consider in ensuring continuity of services and supports to reduce the likelihood of future use.

Proposed implementation priorities

1) Convene a multi-sector working group of the statewide substance abuse prevention planning group to consider ways to improve this area of problem identification resources and referral in Arizona. Bring in resources from SAMHSA or other national experts, as needed, to inform best practices.
2) Topics of discussion this working group may need to address include mechanisms for supporting referrals at the statewide level; how to support people who are in the spectrum between prevention and treatment; multi-sector involvement in preventing future substance abuse; information campaigns needed to support at-risk populations; and harm reduction.
3) Develop a one-page infographic out of this working group to share with prevention providers on ways their work can support this strategy area.
4) Implement several statewide strategies recommended by this working group.

Suggested ways to measure progress

- ✓ Number and demographics of working group participants.
- ✓ Number and type of partnerships in place.
- ✓ Number of collaborative planning meetings held per year; documented meeting agendas/notes.

- ✓ Resources produced by working group (including products and campaigns).
- ✓ Documentation of any revised processes or systems put in place to support this work statewide.

Next Steps

Across these strategies, several overarching implementation recommendations came to light. **First, out of this initial planning effort, it is important to develop an ongoing statewide substance abuse prevention planning group, with multiple working groups addressing specific strategy areas**. Further discussion, collaboration and implementation is needed to advance strategies that are identified statewide. While time-intensive, this type of work is the best way to ensure that strategies are aligned across state and local levels, that they are meeting community needs, and that they are exhibiting a balance of evidence-based and innovative approaches needed to advance prevention in Arizona. This type of collaboration takes time, resources, and a concerted effort to engage diverse representation including geographic, demographic and sector (as applicable). Mechanisms to fund this work are needed to increase participation, enhance statewide efforts with large likelihood of impact, and reduce the siloed work of individual organizations.

Secondly, it will be important to then develop more specific objectives and measurement plans for each SAMHSA strategy area. As implementation evolves and specific actions are undertaken, the methods for evaluating specific objectives for each strategy should be identified. An ongoing data/evaluation working group may be needed to continue to support these efforts along with the evaluation planning that is already underway at the state level. The goal of this overarching plan is to provide framework under which state, regional and local level work may begin to align and move toward common areas of concern and common outcomes of interest. The measurement ideas listed are primarily focused on process measures, with a few outcome measures. It will be important to evaluate overall progress on the behavioral health indicators and other outcomes identified within the logic model.

COVID-19 shed light on many existing issues, and perhaps worsened others contributing to increased substance abuse. **It will be important to continue to watch the data as new information becomes available on substance use, to determine if the pandemic pushed any massive shifts that need to be addressed through prevention work.** Some are highlighted in the resource assessment, but these need to be confirmed with more data and more time for the full implications of the pandemic to be realized. Review and updates to the strategic plan may be needed if major changes are observed. Likely, changes may be made at the level of implementation/evaluation planning conducted by strategy area working groups.

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Appendix A: Participating Organizations in Planning

Exhibit 10. List of Participating Organizations

Organization
Apache Junction Drug Prevention Coalition
Arizona Alliance for Community Health Centers
Arizona Complete Health*
Arizona Department Juvenile Corrections
Arizona Department of Education
Arizona Department of Health Services
Arizona Department of Juvenile Corrections
Arizona Health Care Cost Containment System (AHCCCS)*
Arizona National Guard Counterdrug Task Force*
Arizona Office of the Attorney General
Arizona Prescription Drug Monitoring Project sites within the Board of Pharmacy
Arizona State Board of Pharmacy*
Arizona State University*
Arizona Trauma Informed Faith Community Network Workgroup
Arizona Youth Partnership
Be Awesome Youth Coalition
Casa Grande Alliance
Circles of Peace
Community Bridges, Inc. (CBI)
Community Partners
Division of Social Services - The Navajo Treatment Center for Children and Their Families
Drug Enforcement Administration
Governor's Office of Youth, Faith and Family*
Health Choice Arizona*
Help Enrich African American Lives (HEAAL) Coalition
Inter-Tribal Council of Arizona (ITCA)*
La Frontera Center, Inc.
La Frontera EMPACT-Suicide Prevention Center
Maricopa Community Alliance Against Substance Abuse - MCAASA
MATFORCE
Mercy Maricopa*
Navajo Nation-Division of Social Service
Nexus Coalition-Navajo County
Pascua Yaqui Tribe*
Pinal County Wellness Alliance
SCAT Prevention Program
South Mountain WORKS Coalition
Southern Arizona AIDS Foundation
Southwest Interdisciplinary Research Center at ASU

Tanner Community Development Corporation
The Substance Abuse Coalition Leaders in Arizona (SACLAz)*
University of Arizona
Wellington Consulting Group

*Organizations with representation on the Statewide Substance Abuse Prevention Strategic Planning Steering Committee.

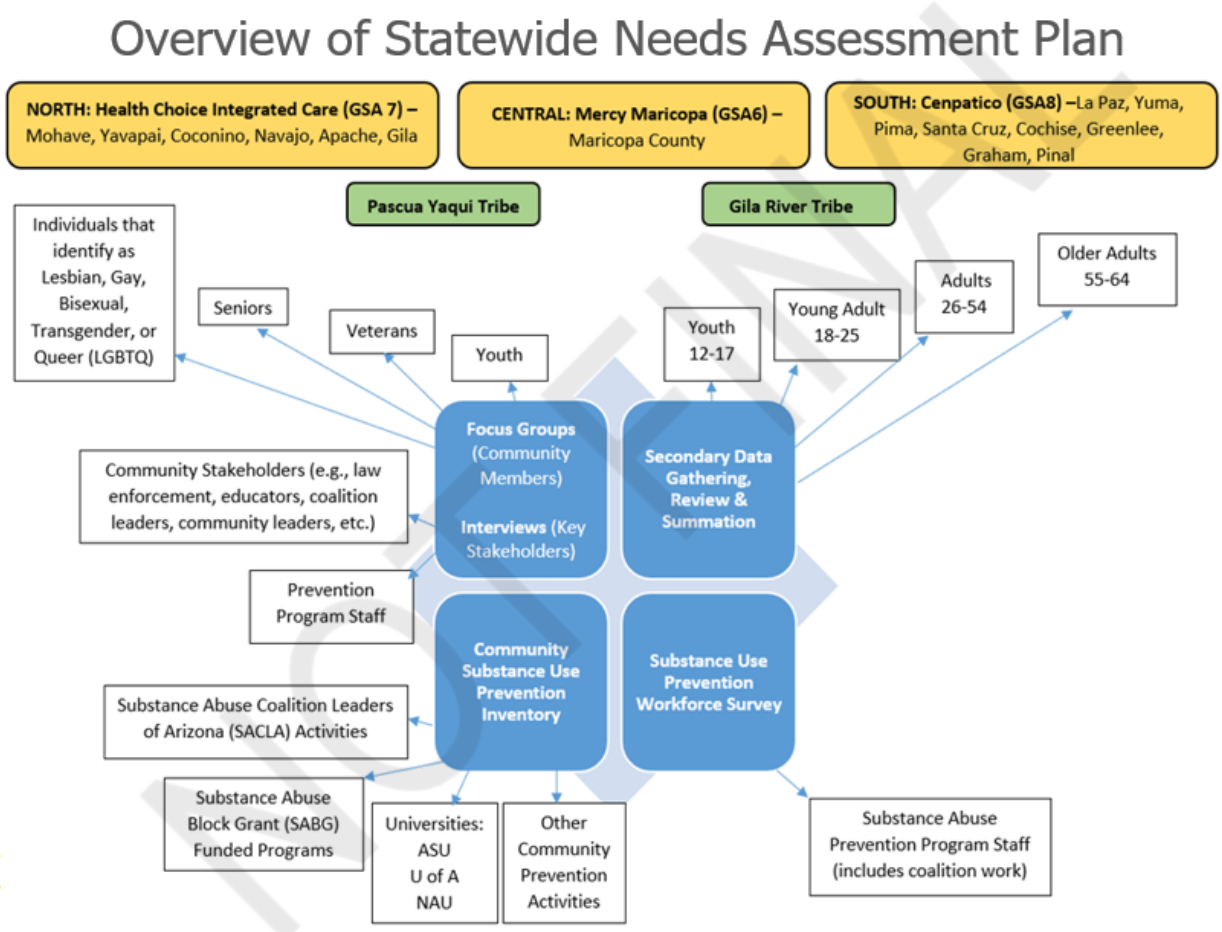
Appendix B: Data Summaries

The following are summaries of key data sources utilized in the development of this strategic plan. Where applicable, the full sources are listed for further review.

Statewide Prevention Needs Assessment: 2018

Excerpt from LeCroy & Milligan Associates (2018).

Exhibit 11. Needs Assessment 2018 Overview



Intended to Look at four Main Questions:

1. What are the current substance use issues in Arizona by region and subpopulation?
2. What substance use prevention programs are active in Arizona?
3. What are the causes for using and/or abusing substances in Arizona?
4. What are the recommendations for the future of substance use prevention in Arizona?

Exhibit 12: Needs Assessment 2018 Key Findings

1) An increasing number of Arizonans of all ages and in all regions are suffering from untreated mental health issues that are leading to substance use and/or misuse.
2) LGBTQ identified individuals in all regions are experiencing significantly more risk factors for, consequences of, and issues with substance use and/or misuse as compared to non-LGBTQ identified individuals.
3) Vaping (e-cigarettes, etc.) is increasing in Arizona for youth in middle and high schools and is significantly higher than national averages.
4) The Counties that are experiencing the most severe consequences of substance use in Arizona are: (1) Gila County, (2) Navajo County, (3) Mohave County, and (4) Pima County.
5) A lack of social support and/or someone to turn to/talk to is a protective factor for substance use and/or misuse to which many Arizonans do not have access.
6) The normalization of marijuana and other substances may be leading to increased substance use.
7) Reductions in funding and resources for schools prohibit effective prevention programs from being delivered to high needs communities.
8) Recent efforts to combat the prescription drug opioid crisis in Arizona are leading to increased street drug use.
9) Prevention programs that are culturally competent, engaging and up to date are more effective and should be prioritized.
10) If basic needs are not being met (e.g., shelter, food, safety, physical health, mental health, social support) then prevention programs and efforts often fail.

Full Needs Assessment available online at: https://www.azahcccs.gov/Resources/Downloads/Grants/ArizonaSubstanceAbusePreventionNeedsAssessment.pdf

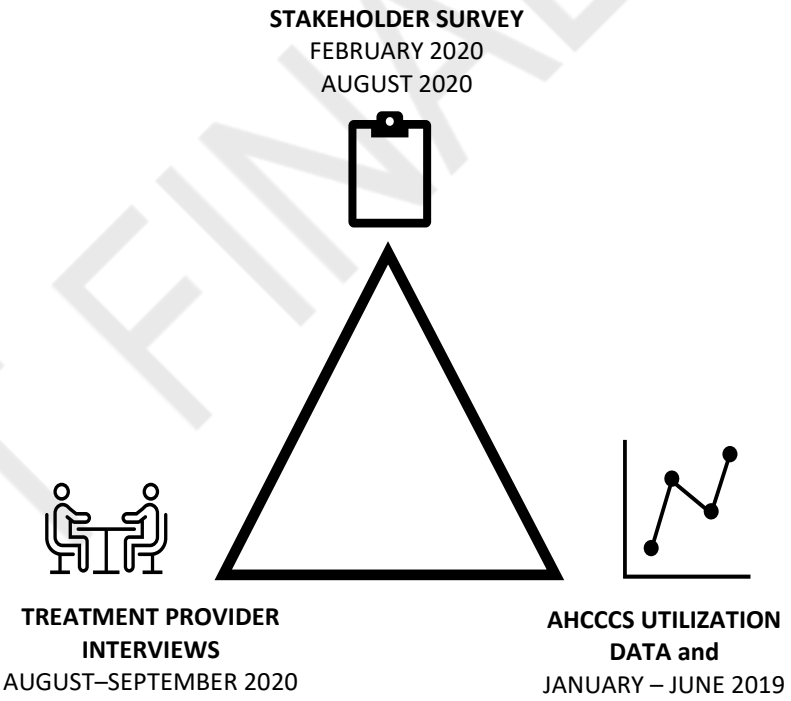
Resource Assessment: 2019-2020

LeCroy & Milligan Associates (LMA) met regularly with Arizona Health Care Cost Containment System (AHCCCS) staff in January and February 2020 to plan a resource assessment as a component of the strategic planning process. The resource assessment survey was ultimately developed with several considerations in mind:

- *A Guide to SAMHSA's Strategic Prevention Framework* was reviewed as it identifies areas where data should be considered in the planning process (e.g., severity and trends of substance abuse/misuse (SAMHSA, 2019).
- The AHCCCS Logic model template (see Appendix A) was considered, and the types of data needed to develop this type of logic model statewide were identified.

- The 2018 Statewide Substance Abuse Needs Assessment was thoroughly reviewed along with the data collection tools used during this needs assessment process.[1] The goal was to enhance or simplify, but not duplicate, existing data.
- The discussions LMA facilitators had with the Strategic Planning Steering Committee which included some of the challenges and considerations around use of data in large group planning efforts.

In March 2020, just after the first resource assessment survey was completed, COVID-19 began to affect Arizona, ultimately impacting many aspects of life across the state. It also impacted the strategic planning process, which was delayed in the hope of continuing in-person. However, it was determined that it was best to go ahead and proceed virtually. Prior to reinitiating this process for the fall of 2020, the LMA team recommended that AHCCCS consider some additional data collection to inform the strategic planning process, given that so much had changed since the time both the Needs Assessment and the initial resource assessment were conducted. This additional effort was approved and included the following:



- Distributing to prevention providers and stakeholders a modified version of the resource assessment survey that was used in February, with additional questions also added specific to the impact of COVID-19.
- Interviews with treatment providers to inform future areas that prevention work may need to focus resources and services. Treatment providers were recommended by the Regional Behavioral Health Authorities (RBHAs) for inclusion and contacted by LMA to be asked to participate.
- A brief review of AHCCCS utilization data to look for preliminary quantitative trends in substance abuse and service provision in Arizona, again that would be informative to developing a statewide substance abuse prevention strategic plan.

[1] https://www.azahcccs.gov/Resources/Downloads/Grants/ArizonaSubstanceAbusePreventionNeedsAssessment.pdf

- AHCCCS provided data for analysis from the Crisis Counseling Assistance and Training Program (CCP), a crisis program funded through FEMA, which was also analyzed on key indicators relevant to this plan. This program provides free and confidential support, education, and resource connection to individuals in the state experiencing negative impacts of the COVID-19 pandemic.

The information below are excerpts from the full Resource Assessment report provided to AHCCCS.

Long-term Consequences Summary

Exhibit 13. Long-term Consequences Summary

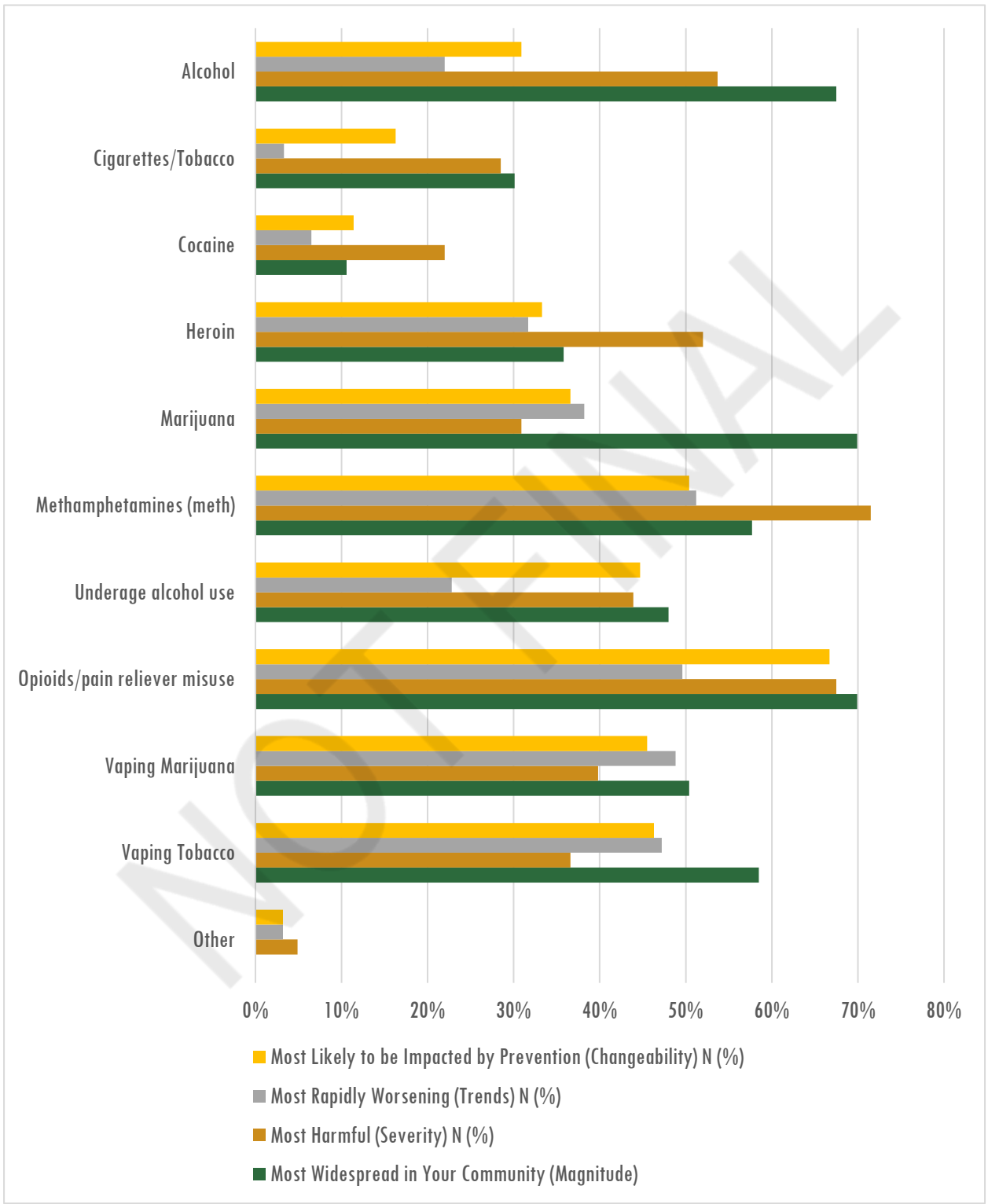
Long-term Consequences of Current Substance Use Issues
Definition: Long-term consequences include outcomes that occur in the long run due to substance use issues (e.g., overdose deaths, substance related health problems; car accidents).
Content Considered for this Section: Long-term consequences of COVID-19 and current substance abuse issues.
Data Sources Utilized: Sample 2 (Post-COVID) Stakeholder Survey; Treatment provider interviews
Key Findings: • Higher drug overdoses and drug-related death rates. • Increased trauma and need for trauma informed care. • Schooling/learning falling behind for many young people, especially those most at-risk. • Increased health inequities. • Increase in number of people struggling with mental health challenges. • Social cost of disconnection and isolation from COVID-19. • More people receiving care through telehealth/virtual options. • Perhaps some increased awareness of health and its importance but also fear. • Domestic violence and child abuse may be increasing.
Limitations of Note: Only minimal questions were asked in this area, due to information already available on these topics, including from the 2018 Needs Assessment. Findings were summarized and focused only on long term consequences as defined. Additional information may be added prior to reviewing this section with the Substance Abuse Strategic Planning Committee. See the Limitations section for additional limitations of all data collected in this report.

Behavioral Health Problems Summary

Data was collected on substance abuse from respondents to both the pre-COVID and post-COVID stakeholder surveys and in the interviews with providers. AHCCCS utilization data

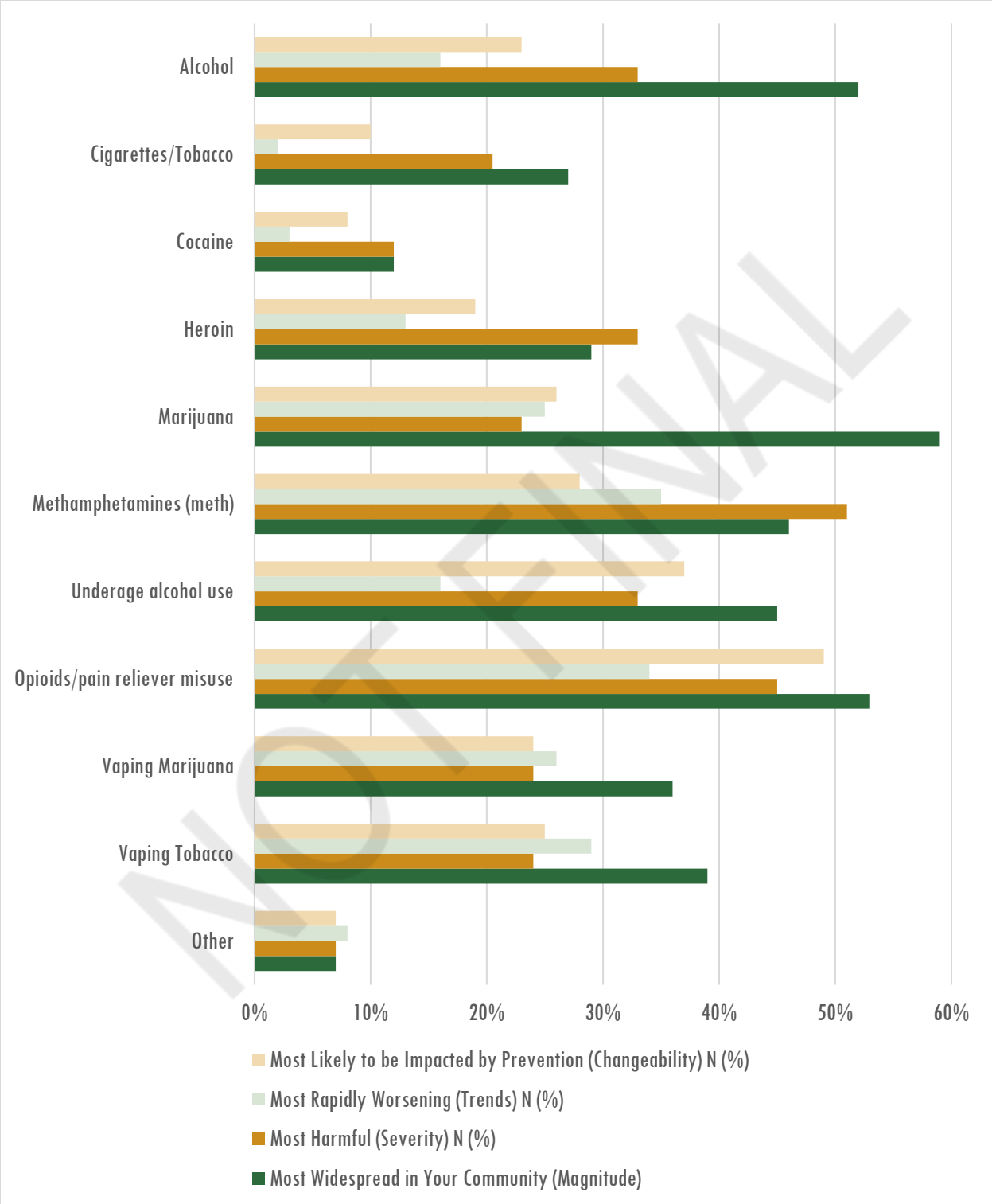
also is available on this topic. Overall, findings suggest that opioids, alcohol, and methamphetamines are the substances of the greatest concern at this time and that all three can be potentially impacted with prevention efforts. Findings based on the stakeholder survey are summarized in Exhibits 14-15, which show which substances were perceived as most likely impacted by four criteria: substance abuse/misuse prevention (changeability), most rapidly worsening (trends), most harmful (severity) and most widespread (magnitude). A summary of key findings in this area are summarized in Exhibit 16.

Exhibit 14. Percent of Respondents Indicating Changeability, Most Rapidly Worsening, Most Harmful, and Most Widespread—By Substance **Pre-COVID** Sample - FEBRUARY 2020*



*Respondents could indicate as many substances as applied for each of these categories, so percentages do not total to 100%.
N=123

Exhibit 15. Percent of Respondents Indicating Changeability, Most Rapidly Worsening, Most Harmful, and Most Widespread—By Substance **Post-COVID** Sample - AUGUST 2020*



*Respondents could indicate as many substances as applied for each of these categories, so percentages do not total to 100%.
N=83

Exhibit 16. Behavioral Health Problems Summary

Behavioral Health Problems
Definition: Specific substance consumption abuse.
Content Considered for this Section: Specific substance abuse data.
Data Sources Utilized: Sample 1 (Pre-COVID) and Sample 2 (Post-COVID) Stakeholder Survey; Sample 2 (Post-COVID) Treatment provider interviews; AHCCCS utilization data

Key Findings:

- All data sources used in this assessment point to an increase in substance use/abuse since the start of COVID-19.
- Many of the same substances continue to be the biggest issues in communities both before and after COVID-19. These include opioids, alcohol, and methamphetamines. Substance specific findings are described below, in an *approximate order of priority* based on the data provided in this resource assessment.
    - **Opioids/pain reliever misuse**—opioids were listed by participants of both survey samples as in the top two of all categories including changeability, most rapidly worsening, most harmful, and most widespread. AHCCCS utilization confirms this substance abuse type is prevalent, with over 86% of members with a substance abuse type listed having an indication of opioid abuse both in 2019 and 2020. All data points to it continuing to increase in use post COVID-19.
    - **Alcohol**—most indicators suggest alcohol use is on the rise. Some of the treatment providers interviewed suggested some were using alcohol to self-medicate during COVID-19 and over half of the post-COVID survey respondents reported observing an increase in use of alcohol. AHCCCS utilization data supports this may be increasing as well or certainly continuing to be prevalent. It was listed as one of the top four most widespread and harmful by survey participants, but not the most rapidly worsening. This supports that perhaps it has been already continuing to increase gradually over time.
    - **Methamphetamines/Stimulants** — Both samples of survey participants suggest that methamphetamines are one of the substances of greatest concern at this time. Fortunately, it was also listed as one of the top four substances in changeability, suggesting it is a good target for prevention efforts. It is one of the top four substances indicated in the categories of rapidly worsening, most harmful, and most widespread. Most of the treatment providers interviewed mentioned methamphetamines as one of the substances on the rise, both prior to COVID-19 and certainly now. Concerns were mentioned with "dirty ingredients" more frequently being mixed in making them even more lethal. As noted above, AHCCCS utilization data suggested stimulants to be potentially increasing in use as well.
    - **Marijuana/Cannabis**—Both samples of survey participants indicated that marijuana was the most widespread in their communities. It was one of the substances that showed some likelihood of changeability. While treatment providers did not call it out specifically as worsening, survey participants post-COVID indicated it as one of the top 3 most increasing substances since COVID-19. This is supported by AHCCCS utilization data which also shows it potentially increasing.
    - **Heroin**—Findings are less definitive when it comes to heroin. It is clearly indicated by survey respondents in both samples as one of the most harmful substances, but not as widespread, preventable, or worsening as many of the other substances. AHCCCS data did not provide specific information on this substance.

- **Underage Alcohol**—Findings in this area are not as definitive. This substance was indicated by survey participants in both samples as the fifth or sixth most harmful and most widespread substance. It was noted as increasing post-COVID by 34% of respondents. Interestingly, nearly 10% of respondents to the post-COVID survey also thought it might be decreasing post-COVID. Thus, the impact of the pandemic on this ongoing substance challenge is not clear. It was also listed as one of the top four substances in changeability, suggesting it is still a good target for prevention efforts. Data on underage drinking was not available from the analysis conducted of AHCCCS utilization data at this time.
- **Vaping Marijuana/Tobacco**—Data was similar for vaping of both types of substances across the two survey samples. About the same percentage of respondents identified vaping as most likely to be impacted, most rapidly worsening, and most harmful. While not in the top four in these categories, quite a few people do appear to perceive them as of concern. They do approach the top four in the category of most widespread. Survey respondents did suggest they thought vaping of both had increased post COVID-19. Vaping was not specifically mentioned by the treatment providers during the interviews and data was not available from the analysis conducted of the AHCCCS utilization data at this time.
- **Cigarettes/Tobacco**— Data does not suggest that this is one of the most critical substances to address with prevention efforts at this time.
- **Cocaine**—Data does not suggest that this is one of the most critical substances to address with prevention efforts at this time.

- Some funding priority recommendations provided in the stakeholder survey also specifically listed substances that should be of focus (though this was not asked for directly). These findings suggest that vaping, opioids, alcohol, marijuana, underage alcohol, and methamphetamines should be considered.

Limitations of Note: It is unclear from the data what is different between the samples and timepoints included. Trends may be attributed to the differences in who participated or other factors. Also, definitions/categories of substance were not the same for this resource assessment and AHCCCS utilization data, limiting some comparability. There is a great deal of geographic variability within these findings. The Appendices include some analyses by GSA, but given the limitations and small sample size, these regional variations are not included in this overall summary; however, they may be reviewed in the planning process. See the Limitations section for additional limitations of all data collected in this report.

Risk/Protective Factors (Intervening Variables) Summary

Overall risk and protective factors for substance abuse are fairly well-established. A preliminary list is provided in Exhibit 1 by level of socioecological model for consideration and use during the planning process.

Survey and interview participants were asked specifically about the impact of COVID-19 on risk and protective factors for substance abuse. Across all the participants, there were fairly consistent responses when asked about the impact of COVID-19. The impact of the economic climate (e.g., unemployment, financial stress, housing), increased mental health challenges (stress, depression, anxiety) and less social and community support/engagement during isolation were primary responses. These and other factors are detailed in the table below.

Exhibit 17. Risk/Protective Factors (Intervening Variables)

Risk/Protective Factors

Definition:

Risk Factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes.

Protective factors are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be viewed as positive countering events.

Content Considered for this Section: Impact of COVID-19 on risk and protective factors.

Data Sources Utilized: Sample 2 Stakeholder Survey; Treatment provider interviews

Key Findings:

- COVID-19 is impacting many of the areas that are considered the social determinants of health (economic stability, education, social and community context, health and health care, neighborhood, and built environment)[2].
- According to participants, specific risk factors most impacted include the following:
  - Worsening mental health including more anxiety, depression, and stress during this challenging time.
  - Increased financial stresses/challenges including more unemployment and housing issues.
  - Increases in violence in the home.
  - Changes in access to substances (more accessibly around the house potentially for some people).
- According to participants, specific protective factors most impacted include the following:
  - Less social and community support during isolation (either because of quarantine and/or out of fear of spreading/catching the illness).
  - Increases in time spent with family (can be a positive or negative impact).
  - Youth without positive engagement in school and other prosocial activities.
  - Perhaps increased health awareness but also fear.
  - Changes in health care system access (can be a positive or negative impact; more virtual, but perhaps new barriers to finding care; less in-person services).

Limitations of Note: An existing list of risk/protective factors commonly associated with substance abuse will also be utilized during the strategic planning process and is included in Appendix G. See the Limitations section for limitations of all data collected in this report.

Local Conditions and Contributing Factors Summary

In order to better understand the conditions across Arizona that may impact substance abuse issues, local conditions and resource availability were assessed. It is clear that COVID-19 has

[2] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

shifted resource access and availability in new ways, with some resources more accessible virtually, and some less so. But either way, the shift has been dynamic, and it appears there is still work to be done to understand what communities need to support substance abuse prevention work post-COVID. Key findings to consider in this process are included in the Exhibit below.

Exhibit 18. Local Conditions and Contributing Factors

Local Conditions and Contributing Factors
Definition: What is specifically happening (or not happening) in communities related to these behavioral health problems and intervening variables. These should be local and short-term.
Content Considered for this Section: Data on resource availability, community readiness, impact on specific populations
Data Sources Utilized: Sample 1 (Pre-COVID) and Sample 2 (Post-COVID) Stakeholder Survey; Treatment provider interviews
Key Findings: • **Resource availability**—Findings are complicated related to resource availability, likely suggesting the changing dynamics of the pandemic, the regional and local variation in the types and availability of resources, and the types of resources considered. o For example, some of the data suggests that there are increased resources available to support basic needs (e.g., food) and protective gear (e.g., masks) as those have been pushed out to communities during this time. o Looking specifically at the data from the post-COVID survey sample, community awareness and fiscal resources had the highest percent of respondents indicating they were not at all adequate or not adequate. These were the main areas identified pre-COVID as well. o Open-ended survey and interview responses provided some additional insight into this resource access complexity, pointing to, at a minimum a shift in the way in which many resources were available. Some were *more* available because offered online, but others, particularly if required or preferred in-person were less available. Technology also became both a door to access and a barrier for those less comfortable or able to access this method for accessing some types of services. And because of these shifts, individuals may or may not have the necessary information on how to access resources in this new and shifting environment. o AHCCCS utilization data points to the likely shift in substance abuse treatment resource access/availability since the start of COVID-19, with more services being offered via telehealth and at community mental health centers. Service claims appear to decrease sizably in independent clinics and FQHCs from Jan-Jun 2020 as compared to the year before. This data was through June 2020, so it is unknown whether some of these changes have shifted or righted themselves with more time for the system to adapt to the pandemic safety protocols, etc. Despite these changes, overall, there were nearly 20% more service claims from Jan-Jun 2020 than the same timeframe the year before. The top five most frequently used service treatment codes for substance abuse all

increased sizably, except for 99407—*smoking and tobacco use intensive counseling, greater than 10 minutes*.

- **Community readiness** to address substance abuse has *perhaps* decreased slightly post-COVID, but overall, most participants saw their communities as somewhere in the middle on a scale of not ready to very ready. It varies by community.
- **Substance Abuse Impact on Specific Populations**—these findings stayed fairly consistent over time.
    - Homeless individuals and young adults were indicated by both survey samples as the population most significantly impacted by substance abuse and those with the least resources available to help.
    - It appears that adults are the next most significantly impacted group, but they have more resources available than homeless and young adults. These trends held across both survey samples.
- **Populations Experiencing Substance Abuse Increase Post-COVID**
    - The population experiencing the greatest increase in substance abuse since COVID-19 according to survey and interview participants were young adults.
    - Other populations also likely seeing an increase include adults, older adults, and homeless individuals.
    - According to AHCCCS utilization data, it appears there was a greater increase in the number of distinct members with substance abuse diagnoses that identified as Black and Native American, as compared to other categories when looking at Jan-Jun 2019 and 2020 respectively. All populations showed a sizable increase in utilization in 2020, except for Hispanic, however it appears this category may be under-represented in this data as reported, so this is inconclusive about Hispanic service utilization.
    - The percent of distinct members with substance abuse diagnoses who were male increased by about 1.5% more than female when comparing Jan-Jun 2019 and Jan-Jun 2020. It is not known if this represents a significant trend.

Limitations of Note: Data included in this report, while pertaining to local communities across Arizona is primarily summarized by state and region. Large variations in the two survey samples pre- and post-COVID hinder the ability to make assumptions based on comparison of this data (we know geographically the samples are not similar). It will be critical in the strategic planning process to consider what areas may or may not be represented by these findings, and how that impacts state level strategic planning. See the Limitations section for additional limitations of all data collected in this report.

Strategies and Local Implementation Summary

While this will ultimately be the work of the Strategic Planning Committee to identify at the state level, information from this resource assessment provides information on current programming including those in alignment with the SAMHSA prevention categories and the socioecological model. These key findings are included in Exhibit 19 below.

Exhibit 19. Strategies and Local Implementation Summary

Strategies and Local Implementation

Definition: Strategies and programming that fall under one of SAMHSA's primary prevention strategies.

Content Considered for this Section: Substance abuse provider programming; impact of COVID-19 on programming

Data Sources Utilized: Sample 1 (Pre-COVID) and 2 (Post-COVID) Stakeholder Survey—only participants who identified as being able to represent a provider organization or coalition were given these questions.

Key Findings:

- **Programming—**
  - Providers reported offering on average a fairly similar numbers of evidence based, promising, and innovative practices, in the pre- and post-COVID samples, ranging from 1-2 per provider for most indicators and 2-3 per provider for EBPs.
  - A total of 25% of post-COVID survey respondents had implemented a new program and 25% also reported having stopped a program since the start of COVID.
  - Open-ended responses suggest that programming was greatly impacted by COVID-19. In-person programming came to a halt and much of it was adapted to virtual delivery. Program delivery in a virtual model proved challenging with barriers such as internet accessibility and technology.
  - School-based delivery participants felt had been the most impacted as schools have a lot to focus on with just ensuring academics and may not prioritize non-academic programming like prevention.
  - Some providers identified adapting to this new environment with increased community outreach and awareness through virtual mechanisms.
- **Provider Capacity**—providers were asked to indicate the impact COVID-19 has had on several different aspects of capacity.
  - All but one prevention provider reported that their organization is currently open with staff working in full or partial capacity, with 75% indicating the majority of staff are working virtually and 64% indicating their organization is providing virtual services and programming.
  - Fortunately, only a small percentage indicated they have had funding, staffing or other significant reductions from COVID-19. This suggests existing provider capacity.
- **SAMHSA Prevention Categories**—Prevention providers identified the three main categories of prevention programming that they offered out of the six identified by SAMHSA (community-based processes, information dissemination, environmental strategies, prevention education, positive alternatives, and identification of problems and referral to services).
  - Prevention education and community-based processes were the most frequently identified both pre- and post-COVID-19.
  - Data suggests that there was also more information dissemination post-COVID, which supports the open-ended findings that virtual mechanisms were used more to get out information in this new environment.

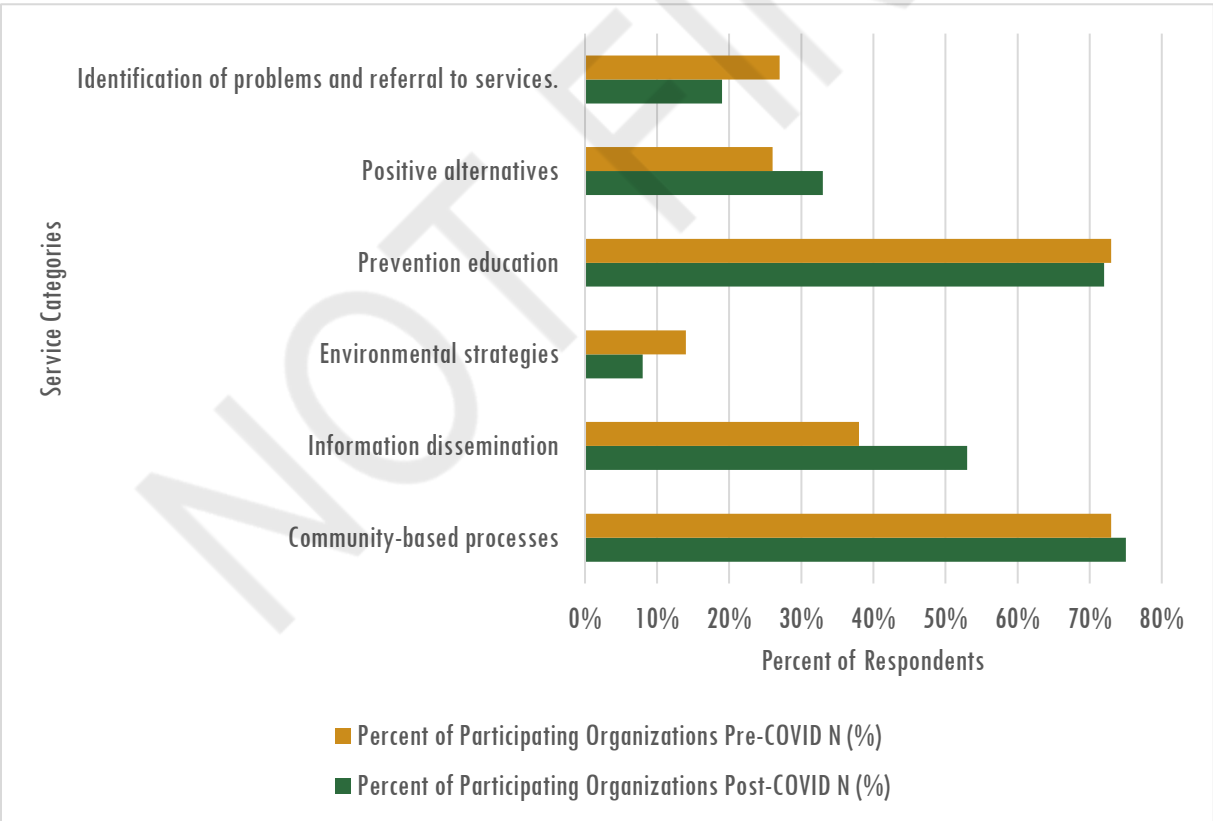
- **Domains Targeted**—Prevention providers were asked to indicate the top two domains they target with their prevention efforts out of society, community, relationship and individual.
    - Interestingly, there is 10-15% variation in each of these from pre to post COVID-19, which is more than on many of the indicators particularly related to programming. As always, this could have to do with the different samples, but is of note.
    - Specifically of interest, it appears that some of the individual/relationship level focus may have shifted to society/community level work. This is an area for further consideration by the Strategic Planning Committee.
- **Disparities**—Providers were asked to comment on what factors might contribute to challenges in serving all the populations in their areas or if they were only focused on specific populations.
    - Both pre- and post-COVID samples indicated that challenges with outreach and recruitment of some populations and also lack of sufficient funding to serve some populations were the main limitations as to why they did not reach all populations. Funding constraints mentioned the need for adequate staffing and long-term program funding. Challenges with collaborating with all populations were noted (e.g., barriers in working with tribes, schools hesitant to share class time or parents suggesting prevention should be done at home; lack of funds/support to do collaborative work).
    - Some organizations choose to focus on specifically serving populations such as youth/young adults, tribal communities, criminal justice involved populations, parents in dependency cases, seriously mentally ill or geographic regions.
    - Populations some noted they wanted to expand to reach more included early intervention, youth/young adults, families, populations that speak other languages, LGBTQ+ identifying individuals, low income, sex offenders, older adults/seniors and homeless).
- **Prevention Provider Demographics**—While clearly not all prevention providers in Arizona participated in the survey at pre or post COVID-19, information on who and where the prevention providers that participated are serving may point to areas for further exploration.
    - **Geographic**—the absence of prevention providers serving specifically Greenlee and La Paz should be considered and may suggest a geographic service gap. Some providers noted that COVID-19 may strain resources further in rural communities, where they are already limited.
    - **Populations Served**—Across both survey samples, over 50% of respondents indicated that children/youth, young adults and adults were priority populations for their organizations. Fewer organizations specifically focus on refugees or serving specific racial/ethnic groups, though the latter appeared higher for the post-COVID sample. Serving youth post-COVID has proved the most challenging since they have not had the ability to attend school or in-person prosocial activities.
    - **Substances Targeted**—Across both samples, marijuana, opioids and alcohol/underage alcohol were the most mentioned as being a substance of current focus for their organization/coalition. Only a few respondents indicated they target steroids, PCP or peyote and less than 10% of respondents suggested that they do not target specific substances. Fewer of the respondents in the post-COVID sample appear to target fentanyl, heroin and cocaine than in the pre-COVID sample. This may or may not be attributable to COVID-related factors. Underage alcohol was the most frequently targeted in the post-COVID sample, with nearly 60% indicating they address this substance. Respondents in the post-COVID sample did suggest in the open-ended responses that their organization had shifted to focus on different substances as the result of COVID.

- **Funding Streams Utilized**—Providers were asked to indicate the funding streams they currently use for substance abuse/misuse programming. The primary funding sources include the Substance Abuse Block Grant (SABG) from AHCCCS and other state grants. Data from the pre-COVID sample suggest that other federal grants and private donations are also commonly utilized; however, these were less common funding sources for respondents in the post-COVID sample. Respondents did not indicate that COVID-19 had significantly impacted funding sources except for a few that experienced a decrease in private donations.

Limitations of Note: Data included in this report, while pertaining to local communities across Arizona is primarily summarized by state and region. It will be critical in the strategic planning process to consider what areas may or may not be represented by these findings, and how that impacts state level strategic planning. See the Limitations section for additional limitations of all data collected in this report.

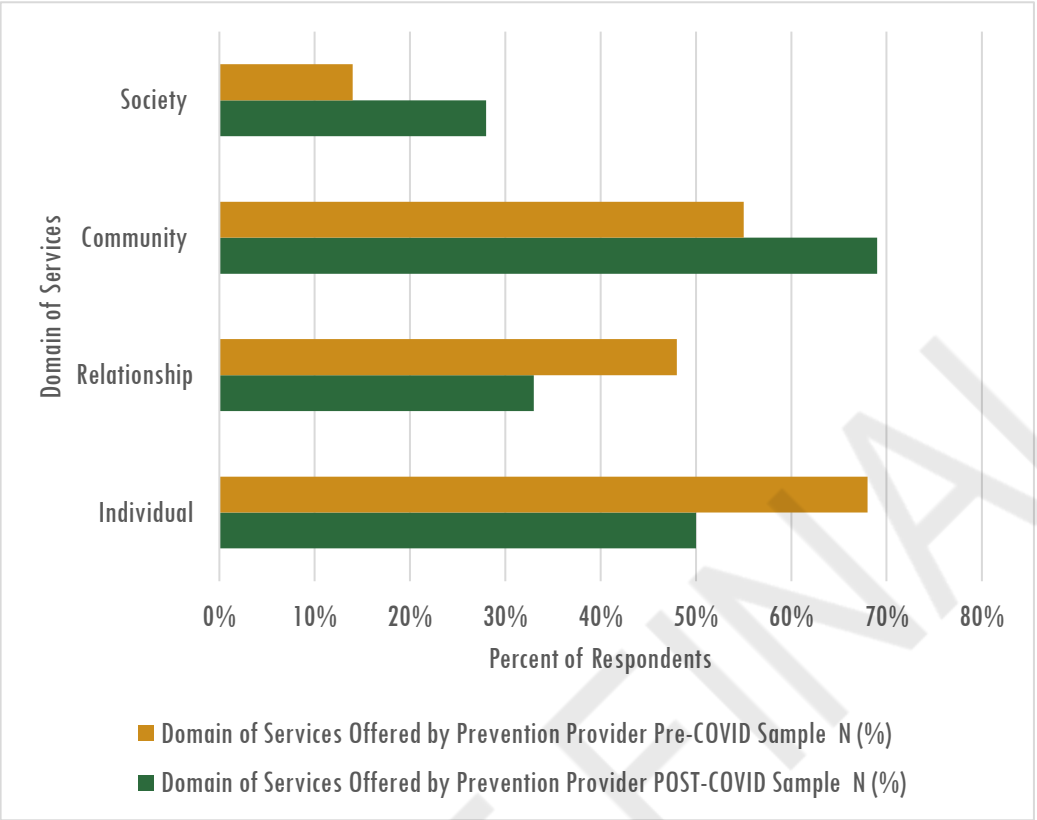
Additional information on the categories of services and domains are included in Exhibits 20 and 21. Please note that the data was collected with different participants in pre- and post-COVID-19 survey timepoints and groups are likely not equivalent. Findings should be interpreted alongside other supporting data.

Exhibit 20. Categories of Services Offered by Participating Prevention Providers/Coalitions by Pre-COVID Sample and Post-COVID Sample *



*Respondents could indicate more than one category, so percentages do not total to 100%. Post-COVID Sample (Prevention Providers only): N=73; Post-COVID Sample (Prevention Providers only): N=36

Exhibit 21. Domain of Services Offered by Participating Prevention Providers/Coalitions by Sample



*Respondents could indicate more than one category, so percentages do not total to 100%. Post-COVID Sample (Prevention Providers only): N=73; Post-COVID Sample (Prevention Providers only): N=36

Funding Priorities Summary

Participants provided recommendations on funding priorities that the Strategic Planning Committee may want to consider. Findings are detailed in Exhibit 22 and 23. There are recommendations across all the SAMHSA prevention categories, by substance, population and overall. Children/youth/young adults were overwhelmingly the most frequently mentioned population that funding priorities should target. Prevention education strategies were the most frequently mentioned, followed by community-based processes and information dissemination. Also, while less directly applicable under SAMHSA primary prevention categories, mental health needs, suicide prevention efforts and technology and internet support were mentioned as key themes and considerations.

Exhibit 22. Funding Recommendations by SAMHSA Prevention Category (Both Pre-COVID and Post-COVID)

SAMHSA Prevention Category and Recommendations
Prevention Education
• Offer programs for families to increase connectedness, heal from trauma, etc. Also support programs and resources for parents in offering prevention to their own kids. • Offer programs for youth (e.g., life skills and decision-making). • Offer drug-specific programming (e.g., heroin, fentanyl, marijuana, alcohol and vaping of substances) including the specific harmfulness and effects of these substances. • Hire staff to do more prevention work and programming in schools (consider whether should be staff internal or external to the schools themselves). Educate whole schools (e.g., like used to do with DARE). • Educate on ways to increase protective factors. Teach healthy coping and emotional resiliency. • Support programs for high-risk age groups and those exposed to traumatic events (including youth and juvenile justice populations). • Provide hands-on trainings for all different stakeholder groups. • Offer peer support programs. • Provide culturally competent prevention programming (including specifically for LGBTQ+ identifying individuals). • Educate from an early age about avoiding all types of addictions and targeting the reasons *why* youth might start using (e.g., handling stress). • Ensure education and training are available for those *delivering* prevention services. • Expand reach for prevention programming in online settings. * • K-12 prevention education in every school across the state. * • New and innovative outreach and education strategies due to COVID. *
Community Based Processes
• Fund and support prevention coalitions. • Increase access to community resources (including affordable housing) and mechanisms to connect people to resources. • Build trauma-informed community. • Build better systems and awareness of those systems within communities. • Establish infrastructure to coordinate prevention efforts. • Mobilize the community. • Address root causes of substance use and use integrated approaches.

Information Dissemination

- Educate the community about specific drugs (e.g., marijuana, THC products, underage drinking).
- Educate about drug use and/or consequences of drug use.
- Educate on public health and risk/protective factors.
- Educate on trauma-informed care and building resiliency. *
- Offer campaigns to reduce stigma around drug use.
- Increase awareness about what substance abuse prevention is all about.
- Use methods like statistics, storytelling and speakers at schools to reach people.
- Tailor campaigns to specific age groups, particularly highlighting resources available by age. *
- Utilize social media to inform parents about talking with youth. *
- Send positive messages to youth that build resilience. *

Problem Identification and Referral

- Identify and help address emerging mental health issues (e.g., depression and anxiety in youth).
- Help those who have faced significant adverse childhood experiences and all forms of abuse (e.g., child abuse, domestic violence, sexual assault, drug endangerment, extreme neglect).
- Support continuity of care for those individuals coming from the criminal justice system.
- Offer harm reduction strategies to reduce death rates from substances.
- Fund early intervention as an important way to prevent substance use disorder.
- Provide intervention resources for all individuals and families at any level of involvement with drugs (e.g., use, abuse, addiction, or family member).
- Offer naloxone education.
- Provide warm lines for those contemplating resuming abuse of substances.
- Suicide prevention services—how to get help.
- Educate older adults on identifying misuse. *
- Fund current resource mapping and development of a centralized referral list. *

Positive Alternatives

- Increase programming to help reduce social isolation.
- Offer health promotion and well-being focused efforts.
- Provide youth with meaningful employment opportunities while still in high school and help with employment skills and job searches.
- Provide more afterschool programs for youth that are little to no cost.
- Fund recreational programs and facilities for youth in communities (e.g., parks, sports complexes, art studios, libraries). *

- Partner with organizations to provide social and job events. *
- Create online environments to provide opportunities for socialization, minimizing isolation. *

Environmental Strategy

- Disrupt the flow of certain drugs into the community (e.g., fentanyl).
- Consider the impacts of marijuana legalization.
- Consider social determinants/intervening variables that effect behavioral health and substance abuse issues.
- Build health-focused public policies in all sectors.
- Improve health systems.
- Change the culture around use of substances (even within the "counterculture").
- Address vaping availability and enforcement.
- Increase funding to increase address the social determinants of health in lower income and minority communities. *
- Funds to revitalize communities. *

*These recommendations were unique to the post-COVID sample.

Recommendations were also categorized according to the substances and populations that were mentioned, since many respondents volunteered their perspectives on these issues in their open-ended responses. Findings are summarized in Exhibit 23.

Exhibit 23. Funding Priority Recommendations by Substance and Population (Pre-COVID Sample and Post-COVID Sample)

Other Recommendations

Drug Focus Areas

- Vaping marijuana and/or tobacco (N=18) *
- Opioids (N=12)
- Alcohol (N=9)
- Marijuana/THC (N=11) *
- Underage alcohol (N=6)
- Meth (N=6)
- Prescription drugs (N=4)
- Fentanyl (N=6)
- Heroin (N=3)

Population Focus Areas

- Children/Youth/Young Adults (60) **
- Families/Parents (15)
- Criminal Justice Involved (7)
- Older adults/seniors (7)
- Other vulnerable/high risk populations (e.g., homeless, rural, sex offenders, LGBTQ+, unemployed, domestic violence victims, veterans, seriously mentally ill) (13)

Other Key Themes

- Mental health needs and services (18)
- General health/wellness efforts (11)
- Suicide prevention efforts (9)
- Support family stability (e.g., financial stability, housing, day care).
- Technology and internet support to increase access and use (3) ***

* Responses that specifically mention vaping marijuana are included in the vaping count and not listed again under marijuana.
**These are grouped together here as it was not clear from open-ended responses which ages of young people were being referenced by the use of these terms.
***Recommendations are from the Post-COVID Sample only.

Strategic Planning Session Summary

The following summarize key themes from discussions held during the strategic planning sessions.

Exhibit 24. AHCCCS Strategic Planning Meeting Notes by Breakout Session Question

OCTOBER 7 SESSION	
Question 1: Are there long-term consequences that are missing that you think are critically important?	
Themes	• Criminal involvement • Family dysfunction/family breakdown • Suicide • Trauma • Unemployment
Question 2: What 2–4 long-term consequences do you think should drive the strategic planning process and why?	
Themes	• Overdose fatalities • Poor education outcomes • Poor mental health outcomes • Domestic violence & child abuse • Health inequities
Question 3: When prioritizing substance misuse/abuse problems, which criterion or criteria do you think are most important to consider in the strategic planning process and why? (Choose 1 or 2)	
Themes	• Changeability and severity most important (Note: this was also reflected in the poll)

Question 4: Which substances rose to the top according to the criterion/criteria you identified as most important? Were they the same top substances?	
Themes	• Opioids • Alcohol • Heroin • Meth • Marijuana
OCTOBER 21 SESSION	
Question 1: What key risk and protective factors are associated with behavioral health problems related specifically to substance misuse/consumption?	
Themes	• Family recognized as both risk and protective factor, as family dysfunction may increase risk while family connection may decrease risk **RISK** • Accessibility of substances • Perceived risk (particularly related to marijuana) • Mental health & stress • Acceptance/norms of alcohol and marijuana **PROTECTIVE** • Community (as protective particularly for Native Americans)
Question 2: Reflecting upon the risk and protective factors that were discussed, which 3–5 are most important (i.e., *key drivers*) to consider and why?	
Themes	**KEY DRIVERS/KEY PROJECTIVE FACTORS** • Family unity • Community connections **KEY DRIVERS/KEY RISK FACTORS** • Isolation/lack of relationships • Unemployment • Access/availability of substances
Question 3: How do current resources align with risk and protective factors (i.e., key drivers) you identified?	
Themes	• These are not many "themes" here, but two groups did mention family-related concerns, stating more attention is needed to be given to the family unit and parents do not have the appropriate tools to assist children, so family/parents could be an area that needs more support/resources.
Question 4: What other conditions must be present in communities across the state in order to address *key drivers*, either by decreasing key risk factors or improving key protective factors?	
Themes	• Main theme here is collaboration.
November 2 Session	
Question 1: Identify which populations are the current focus of participating prevention providers and identify any populations that you believe need more attention/services.	
Themes	• LGBTQ • Young adults • Ethnic and racial minorities, specifically Native Americans, Hispanics, and African Americans. • In one group, several comments pertained to men being a hard-to-reach group needing more intervention.

	• Another group specifically discussed language barriers and fear of deportation making it more difficult to reach/serve Hispanic populations.
Question 2: Identify substances that are the current focus of participating prevention providers and identify where more attention is needed. Discuss if there are important region-specific or county-specific considerations.	
Themes	• Opioids, including fentanyl, and meth were stressed across groups. • Alcohol and marijuana also were concerns. • Recognize that regional and population differences exist/matter.
Question 3: How do we prioritize across SAMHSA strategies? Is it necessary to incorporate all SAMHSA prevention strategies, across all 6 categories, in statewide prevention efforts?	
Themes	• Ensure strategies align with community need and provider strengths. • Prevention education, environmental strategies, positive alternatives, community-based process mentioned most. • Should vary by population and substance. • Need more data to be able to know what each community needs.
Question 4: Review recommended strategies falling under your SAMHSA prevention categories and identify gaps needed to address substance misuse/abuse. What additional strategies do you recommend?	
Information Dissemination and Environmental Strategies	• Trauma informed care, though not sure if this applies outside of tribal communities. Issues of generational trauma. • Priority to get information from the community and build trauma-informed communities. Maricopa county works together on different areas, such as ACES consortium who focus on trauma care. • Social norms campaign, redefining the normal works well with youth. • Adding cultural competency, looking at communities and understanding their experiences. This should be recognized with disseminating information. • Not enough focus on young adults in tribal communities as they transition. • Messaging should have an appropriate cultural lens. • Substance abuse and mental health strategies go hand in hand • List of environmental strategies is comprehensive, add educating parents/guardians. • Harm reduction elements could be added in environmental strategy, such as needle exchange programs. • Family should be viewed as its own environment and you must be knowledgeable about all resources available that can address those areas. Helping people access power in their community, such as referring people to city council, HOA, etc.
Prevention Education Strategies	• Participants noted that the list was comprehensive.
Community based process and Problem Identification or Referrals and services	• Encouraged to use evidence-based programs and approached. The community and area being serviced should be able to weigh in on this. • Flexibility to be creative and strategize is not always possible because there is no funding within the coalition. • Inviting others to bring their skillset, going beyond what these resources entail. This is very important for trauma informed care as it helps identify where a person has come from and where they are going. • Investing in a group with evidence-based approaches helps with an integrated approach.

	• Making sure it is aligned with the needs of the community and knowing who you are serving, make sure it fits with their culture. • Coalition started working with schools and working to go to the legislature. • Levels of prevention, screening for root causes in different setting such as primary care and schools so resources can be given. Does not understand why it is not funded. • Screening family for mental health concerns and influence on the family. • Once people have identified what they need they tend to go for that service, making it difficult to identify and address other needs. • No system for closing the link so one knows that a person got the services. It is hard for families to get connected to services. • Warm lines mentioned, noted that they apply more to mental health. Possibly triggering. • Preventions specialist would refer to hotline and services. • Glad to see prevention moving into referral services, originally told they could not do referrals. • Centralized referral list may be useful. • Trust necessary and must be earned before someone discloses problems. • Evidence based programs have not been written up with cultural backgrounds in mind. • Using a module to see where a community is doing well.
Question 2: Based on the list of strategies falling under each prevention category, list the top 3-5 that you recommend implementing to impact substance misuse/abuse in communities across the state.	
Information Dissemination and Environmental Strategies	• Enforcement of vaping in the community in terms of where and how it can be sold. • Considering social determinants, changing culture around substance use. Consider impacts of marijuana legalization, address vaping, and allocate funds to revitalize communities. • Agreement with social determinants and changing culture. Building health-focused public policy in all areas. • Challenging to determine "how." • How can it be evaluated? Noted they gravitated towards strategies that can be effectively measured.
Prevention Education Strategies	• Offering programs for families for healing, trauma, drug-specific programming, education on ways to increase protective factors, educating at an early age. • Ensuring education and training is available for those delivering prevention strategies, offering hands on training for all stakeholder groups, drug-specific programming, trauma informed care. • Hire more prevention staff and more resources for prevention, not just in schools. Creativity is needed with COVID. Training needed for all groups involved. • Education for parents and grandparents, increasing protective factors, support programs for high-risk age groups, culturally competent prevention programming, education for those delivering services. Possibly credentialing. • Family connectedness and healing trauma, drug-specific programming, educating from an earlier age.

	• Increase connectedness, increase protective factors, culturally appropriate training, drug-specific programs can be effective in some contexts. Would like action-oriented trauma responsive schools.
Community based process and Problem Identification or Referrals and services	• N/A
Question 3: Who have been the key players with respect to each of these SAMHSA prevention strategy areas historically and what opportunities for future collaboration are there? Who is missing?	
Information Dissemination and Environmental Strategies	• Arizona Complete Health does a good job on prevention messaging through billboards, radio, and other PSA's. There are tribal radio stations that have prevention messaging in their native language. • Health departments, AHCCCS, national agencies, CDC, RBHA, and sometimes groups like MADD. • Many different partnerships exist. Sometimes groups can set up sports or art camps that can reach youth at their level. Partnerships with all African American politicians in the state and African American Leadership Conference. • Maricopa county has a recognizable brand (Be Awesome). Agencies can do well to be recognized. Bringing value with your messaging works to generate respect from the community.
Prevention Education Strategies and Positive Alternatives	• Business community, local government beyond departments working with special populations. • Key players are education and behavioral health provider. Opportunities in health care setting and focusing on reducing social isolation through collaboration, agrees that business community is valuable. • Older adults themselves may be missing as well as APS.
Community based process and Problem Identification or Referrals and services	• Religious organizations, fraternal orders, and civic organizations. Law enforcement is absent from collaborations. When they are invited, I can hear their eyes roll. • Some schools do not participate. Youth service organizations are needed. • Arizona Youth Service – access to data on youth. • Universities • Social justice systems. They can help with prevention efforts. • Community volunteers

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

AHCCCS is the agency responsible for matters related to behavioral health and substance use and provides oversight, coordination, planning, administration, regulation, and monitoring of all facets of the public behavioral health system in Arizona. AHCCCS contracts with Arizona Complete Care Regional Behavioral Health Agreements (ACC-RBHAs), Tribal Behavioral Health Authorities (TRBHAs) and Managed Care Organizations (MCOs) to oversee the provision of comprehensive physical and behavioral health services to eligible persons with an Early Serious Mental Illness (ESMI) including First Episode Psychosis (FEP), a Serious Mental Illness (SMI) designation or Serious Emotional Disturbance (SED) designation.

AHCCCS has intergovernmental agreements (IGAs) with the Tribal Regional Health Authorities (TRBHAs) for the coordination of behavioral health services for American Indian members enrolled with the TRBHA. AHCCCS operates the American Indian Health Program (AIHP), a fee for service program that is responsible for care for American Indian members who select AIHP.

There is an array of outpatient covered health services for individuals experiencing symptoms related to SMI, SED, ESMI/FEP or general mental health (GMH) disorders, substance use disorders (SUDs) and/or co-occurring mental health and substance use disorders. A vast majority of the outpatient services are delivered through Integrated Health Homes/Integrated Clinics, Outpatient Treatment Clinics, Outpatient Substance Use Clinics, Medication Assisted Treatment (MAT) Clinics and Federally Qualified Health Clinics (FQHCs). The goal is to serve the whole person and through integrated behavioral and physical health services. Many facilities have Primary Care Physicians (PCP) on site to address physical health needs including Pharmacy and Laboratory services. If a clinic/facility site does not have Primary Care Services on site, it is the expectation that the Health Home integrates the members' care needs by providing coordination of care between behavioral, medical and physical health providers to ensure the needs of the whole person are addressed. This integrated system reduces fragmentation and improves health outcomes for members.

AHCCCS has participated in the Targeted Investment Program which has driven the implementation of integrated care across the state of Arizona. Individuals who are determined to demonstrate symptoms of a qualifying diagnosis and functional impairments as the result of their symptomatology as SMI or SED, ESMI/FEP are offered an array of covered health and community based services, including, but not limited to:

For adult members:
Case Management
Assertive Community Treatment (ACT) as determined by need
Supportive Level of Care as determined by need
Connective Level of Care as determined by need
Evaluations and assessments related to psychiatric services and assignment to a Behavioral Health Medical Provider
Medication/Medication Management
Nursing Services
Rehabilitation Services
Vocational Services
Employment Services
Educational Services
Housing Services and Community Living Support
Applications for housing, rental assistance
Primary Care Services and coordination of care between behavioral health and medical health Providers
Substance Use services, referrals and coordination of care
MAT as indicated
Substance Use Counseling (both individual and group as indicated) provided by Substance Use Specialists/Counselors
Coordination of crisis services as determined by need
As an example; a Crisis Mobile Team visits if a person is experiencing symptoms of their illness. Crisis Mobile Team visits can occur

during the day, evenings, week-ends and can be coordinated 24/7 to ensure a person has the supports to assist them through a challenging time
Counseling services
Individual
Group
Family
Couples
Non-emergent transportation and/or coordination of transportation services
Peer Support Services
Family Support Services
Assistance with applying for benefits
AHCCCS/Medicaid benefits
Social Security
Food Stamps
Public Assistance
Coordination of care/referrals for evidence based practices, as determined clinically appropriate including:
Assertive Community Treatment (ACT)
Cognitive Behavioral Therapy (CBT)
Dialectical Behavior Therapy (DBT)
Applied Behavior Analysis (ABA)
Trauma Informed Care
American Association of Addiction Medicine/ASAM CONTINUUM assessment for persons with substance use challenges to determine levels of care
Motivational Interviewing
Other EBP's as indicated by assessments and treatment planning
Coordination of care and referrals to community based services and natural supports
Overall development of an Individual Services Plan (ISP) to address the unique needs of the whole person

For Children/Adolescents, including the SED population, AHCCCS has implemented the Child and Family Team (CFT) practice model. The CFT practice is utilized with all Medicaid eligible, uninsured or underinsured children, adolescents and young adults under the age of 21, who are receiving services through the children's T/RBHA system.

The behavioral health service provider is responsible for oversight of the CFT model in practice; a facilitator for the child and family with complex needs has the specialized training and skill set to perform this function. The team identifies and determines a consensus in the development of the child/adolescents' service plan goals and interventions. The child/adolescent, their family members (biological, foster parents, other individuals of support, as determined appropriate for each child), Department of Child Safety (DCS) case manager/s, behavioral health case manager/s, the Division of Developmental Disabilities, education, juvenile justice, other child serving organizations, and advocates can also learn to lead CFTs.

In the Arizona CFT practice model, it is the child's and family's complexity of needs that drive the development, integration, and individualization of service delivery. The level of complexity is determined individually with each child and family. One variable that is considered when determining complexity of needs for children is the involvement of other child-serving agencies, such as Juvenile Justice (Probation or Parole), Division of Developmental Disabilities (DDD), Department of Child Safety (DCS), and Education (Early Intervention or Special Education). The number of system partners involved and invited to participate in CFT practice by the child and family will contribute to the level of integrated service coordination required, as well as consideration by team members of the individual mandates for each agency involved.

A child's and family's overall health status also contributes to their complexity of needs and subsequent level of service intensity. For children with a SED and/or chronic physical condition, symptoms associated with their physical or behavioral health condition can impact their level of functioning in multiple life domains and may result in the use of medications that are monitored through a Behavioral Health Medical Practitioner (BHMP) and/or Primary Care Physician (PCP). Thus, the intensity of service integration through the CFT model is dependent on the level of coordination necessary to support the child and family in making progress toward identified goals in their Individual Service Plan (ISP). Several stressors/risk factors are considered by the CFT when reviewing the child's and family's level of complexity, including environmental stressors such as changes in primary caregiver, inadequate social support, housing problems, mental health or substance use concerns. The team also considers out-of-home setting (group home, therapeutic foster care, etc.) and use of crisis or inpatient services.

One method for determining complexity of needs and intensity of service delivery is through the application of the CALOCUS for children ages 6 to 18. This instrument consists of six dimensions for assessment of service intensity: risk of harm, functional status, co-occurrence of conditions, recovery environment, resiliency, and/or response to services and involvement in services.

For individuals with co-occurring mental health and substance use disorders, outpatient providers provide MAT services, prevention, treatment, on-going SUD counseling, coordination of care and referrals to community based services; this also includes natural supports and resources such as Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, etc.

MAT is the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders. For those with an opioid disorder (OUD), medication addresses the physical challenges that one experiences when they

stop taking opioids. MAT can help to re-establish normal brain function, reduce substance cravings and prevent relapse. The longer a person engages in the treatment, the more the individual will be able to manage their dependency and move forward toward recovery.

An important piece of the MAT approach is that the medications are "assisting" other components of treatment. To increase the benefit that individuals receive from psychosocial intervention, services should be best practice. Some examples of best practice for persons who have substance use disorders include, Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Moral Reconation Therapy, Peer and Recovery Support Services, Twelve Step Facilitation, and Contingency Management. Arizona has 24/7 Access Point Locations providing opioid treatment services 24 hours a day, 7 days a week to serve individuals seeking treatment.

MAT services are offered in various settings including Opioid Treatment Programs (OTPs) and Office-Based Opioid Treatment (OBOTs). An OTP is any treatment program certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide medication-assisted treatment for persons diagnosed with OUD. These programs are authorized to administer and distribute all forms of MAT; methadone, buprenorphine (Suboxone/Subutex) and naltrexone. Additional support services within the OTP may include case management, peer support, individual counseling, group counseling and other types of support services identified by the individual being served.

An OBOT program allows for a qualified primary care physician (PCP) to provide opioid treatment services in their office based settings. Federal guidelines allow qualified physicians in the OBOT to prescribe medications for OUD in their office setting although it is required that the physician has the ability to connect their patients to the appropriate level of counseling and other appropriate services, as indicated by the needs of the individual and their treatment plan.

AHCCCS also supports evidence-based Permanent Supportive Housing (PSH) models, including Housing First, for serving persons who are experiencing unsheltered homelessness, persons with behavioral health needs including mental illness or substance use disorders (SUD) and is premised on: 1) access to and availability of both affordable housing subsidies and capacity, and 2) individualized wrap around housing focused supportive services to support housing placement, stability and coordination with member's other service goals and resources. Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

AHCCCS addresses transitions from the Arizona State Hospital through the screening of members to be discharged and, if they are not already connected with a behavioral health home including case management services in their geographic service area, they are matched with an appropriate team to coordinate support services including, but not limited to, vocational services, psychiatric medication management, counseling, housing, and Peer Recovery Support.

AHCCCS has partnerships and an Interagency Service Agreements(ISA) with the Rehabilitation Services Administration (RSA) Vocational Rehabilitation (VR) to connect members to employment, educational support and opportunities, or other vocational services determined to promote individual success. The VR program provides a variety of services to persons with disabilities and, with the ultimate goal to prepare for, enter into and/or retain employment. The VR program is a public program funded through a Federal/State partnership and administered by the RSA, which in Arizona falls under the Arizona Department of Economic Security (ADES).

Additionally and not related to the ISA, RSA/VR has assigned one of their offices to work with individuals transitioning to the community from the Arizona State Hospital and also has a VR Counselor assigned to the Human Services Campus in Phoenix. The VR Counselor at the Human Services Campus assists people who are experiencing unsheltered homelessness and/or housing insecurity who are wanting to re-enter the workforce. The Human Services Campus is Maricopa's largest homeless service provider.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No

k) Services for persons with co-occuring M/SUDs (●) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

AHCCCS' System of Care is a spectrum of effective integrated community-based services and supports for individuals with, or at risk of mental health or other challenges and their families. The spectrum is organized into a coordinated network that builds on the strengths of members and their families. AHCCCS strives to meet the families' cultural and linguistic needs to achieve the best possible outcomes at home, in school, in the community, and throughout life.

Providers, MCOs and FFS Programs are required to ensure delivery of services is consistent with the following values, principles, and goals:
1. Timely access to care,
2. Culturally competent and linguistically appropriate care,
3. Identification of the need for and the provision of comprehensive care coordination for health service delivery,
4. Integration of clinical and non-clinical health care related services,
5. Education and guidance to providers on service integration and care coordination.
6. Provision of chronic disease management including self-management support,
7. Provision of preventive and health promotion and wellness services,
8. Adherence with the Adult Behavioral Health Service Delivery System-Nine Guiding Principles, and the Arizona Vision and Twelve Principles for Children Behavioral Health Service Delivery,
9. Promotion of evidence-based practices through innovation,
10. Expectation for continuous quality improvement,
11. Improvement of health outcomes,
12. Containment and/or reduction of health care costs without compromising quality,
13. Engagement of member and family members at all system levels,
14. Collaboration with the greater community,
15. Maintenance, rather than delegation of, key operational functions to ensure integrated service delivery,
16. Embrace of system transformation, and
17. Implementation of health information technology to link services and facilitate improved communication between treating.

AHCCCS has developed an Integrated System of Care (ISOC) encompassing the spectrum of services for our individuals. The ISOC is organized into a comprehensive network to create opportunities to foster recovery and improving health outcomes by:

1. Building meaningful partnerships with individuals served
2. Addressing the individuals' cultural and linguistic needs and preferences
3. Assisting the individual in identifying and achieving personal and recovery goals

Adult services follow the Nine Guiding Principles to promote a recovery focused continuum of coordinated community and facility based services and supports for adults with, or at risk for, behavioral health challenges. Utilizing the Adult Recovery Team (ART), individuals are served by an integrated network of professional and community/social support in treatment planning, decision making, and communicating their voice and choice throughout the planning and service process. Within the Children's System of Care, Arizona's Child and Family Team (CFT) practice model blends shared concepts of the 12 Arizona Principles for children's services with the 10 Principles of Wraparound: family voice and choice, team based, natural supports, collaboration, community based, culturally competent, individualized, strengths based, unconditional, and outcome based. The CFT considers involvement of the child in Juvenile Justice (Probation or Parole), Division of Developmental Disabilities (DDD), Department of Child Safety (DCS), and Education (Early Intervention or Special Education). The number of system partners involved and invited to participate in CFT practice by the child and family, contributes to the level of service coordination required, as well as consideration by team members of the individual mandates for each agency involved. Providers are required to incorporate the model in all aspects of service delivery to children and families at all levels of need/acuity as well as children with complex needs or who are determined SED.

In collaboration with the child and family and others, MCOs are required to provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services are tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's family's cultural heritage.

AHCCCS further requires that MCOs develop, manage, and monitor provider use of Evidence Based Programs and Practices (EBPP) including, but not limited to:
1. Intake, assessment, engagement, treatment planning, service delivery, inclusion of recovery interventions, discharge planning, relapse prevention planning, harm reduction efforts, data and outcome collection, and post-discharge engagement,
2. EBPPs used by all providers for the treatment of SUD, including MAT, integrated into services as appropriate,
3. Trauma Informed Care,
4. Gender based treatment,
5. LGBTQIA+,
6. Culturally appropriate,
7. Criminal Justice Involvement,
8. Adolescent specific, and

9. Development and use of Promising Practices if no EBPP is available.

3. Describe your state's case management services

AHCCCS covers provider case management as a supportive service intended to improve treatment outcomes and meet individuals' Service or Treatment Plan goals. Examples of case management activities include but are not limited to:
Assistance in maintaining, monitoring, and modifying behavioral health services.
Assistance in finding necessary resources other than behavioral health services.
Coordination of care with the individual/Health Care Decision Maker (HCDM), designated representative (DR), healthcare providers, family, community resources, and other involved supports including educational, social, judicial, community, and other State agencies.
Coordination of care activities related to continuity of care between levels of care (e.g. inpatient to outpatient care) and across multiple services (e.g. personal care services, nursing services, and family counseling) and providers.
Assisting individuals in applying for Social Security benefits when using the SSI/SSDI Outreach, Access, and Recovery (SOAR) approach.
Outreach and follow-up of crisis contacts and missed appointments.
Provider case managers are responsible for monitoring the individual's current needs, services, and progress through regular and ongoing contact with the individual. The frequency and type of contact is determined during the treatment planning process, and is adjusted as needed, considering clinical need and individual preference, though generally falls within one of the following categories
1. Assertive Community Treatment (ACT) Case Management (Adult): One component of a comprehensive model of treatment based upon fidelity criteria developed by the Substance Abuse and Mental Health Services Administration. ACT case management focuses upon individuals with severe and persistent mental illness that seriously impairs their functioning in community living, in conjunction with a multidisciplinary team approach to coordinating care across multiple systems (e.g. social services, housing services, health care).
2. High Needs Case Management (Children/Adolescents): Focuses upon providing case management and other support and rehabilitation services to children with complex needs and multiple systems involvements for whom less intensive case management would likely impair their functioning. Children with high service intensity needs who require the assignment of a high needs case manager are identified as:
a. Children 0 through five years of age with two or more of the following:
i. Other agency involvement; specifically: Arizona Early Intervention Program (AzEIP), DCS, and/or DDD, and/or
ii. Out of home placement for behavioral health treatment (within past six months), and/or
iii. Psychotropic medication utilization (two or more medications), and/or
iv. Evidence of severe psycho-social stressors (e.g. family member serious illness, disability, death, job loss, eviction), and
b. Children six through 17 years of age: CALOCUS level of 4, 5, or 6.
3. Medium Level of Intensity Case Management (Adult): Focuses upon individuals for whom less intensive case management would likely impair their functioning. Supportive case management provides assistance, support, guidance and monitoring in order to achieve maximum benefit from services. Caseloads may include individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.
4. Low Level of Intensity Case Management (Adult): Focuses on individuals who have largely achieved recovery and who are maintaining their level of functioning. Case management involves careful monitoring of the individual's care and linkage to service. Caseloads may include both individuals with an SMI designation as well as individuals with a general mental health condition or substance use disorder as clinically indicated.
In addition to the levels of Case Management as listed above, Forensic Assertive Community Treatment Teams (FACT) function in Maricopa County to address the unique needs of people determined SMI and have had involvement with the criminal justice system. The goal of the FACT teams is to reduce recidivism and assist members with high needs through an array of integrated, community based services, resources, and supports.
The FACT team utilizes evidence-based practices to:
1. Identify and engage members with complex, high needs.
2. Remove barriers to services and supports.
3. Address the whole person and provide a full range of community-based services and supports wherever and whenever they are needed.
4. Reduce hospitalizations and contact with the criminal-justice system, improve health outcomes and help establish and strengthen natural community supports.
FACT team staff have experience in psychiatry, nursing, social work, rehabilitation services, substance-abuse interventions, employment support, independent-living skills and housing. A key member of the team is a peer support person who has lived experience with behavioral health challenges and prior interaction with the criminal justice system likened to the members served. The team assists members with adhering to treatment plans, activities of daily living, employment-related services, finding and maintaining affordable housing, budgeting, obtaining benefits, and engaging in community activities through delivering services in accordance with SAMHSA evidence-based practices (EBP/s).

AHCCCS (currently within Maricopa County) also offer Medical Assertive Community Treatment Teams (MACT). The difference between a regular ACT team and the MACT team is that the individuals not only have a SMI qualifying diagnosis but also have significant medical comorbid conditions. MACT employees have experience in Psychiatry (Behavioral Health Provider), nursing, social work, rehabilitation services, and licensed substance use specialists who provide individual and group counseling, interventions/supports, employment support, independent living skills and housing supports. The MACT team additionally employs a Primary Care Medical Provider and closely monitor the medical and physical condition of the member along with their behavioral health condition providing integrated care for the unique challenges the combination of these conditions can present.

MCOs are required to submit an annual Provider Case Management Plan that addresses how the Contractor will implement and monitor provider case management standards and caseload ratios for adults and children. The Provider Case Management Plan includes performance outcomes, lessons learned, and strategies targeted for improvement. MCOs must also ensure that provider sites where provider case management services are delivered have regular and ongoing member and/or family participation in decision making, quality improvement, and enhancement of customer service. The AHCCCS Medical Policy Manual (ACOM) Chapter 500 is dedicated to outlining care coordination requirements with Policy 570 - Provider Case Management (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/570.pdf) responsibilities outlined, including Attachment A - Case Management Caseload Ratios and Review Cycle (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/570_AttachmentA.pdf) to identify maximum caseload ratios and contact requirements. AMPM Policy 590 - Behavioral Health Crisis Services and Care Coordination (https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/590.pdf) outlines the required provision of crisis services in addition to care coordination requirements for aftercare and wraparound services.

4. Describe activities intended to reduce hospitalizations and hospital stays.

AHCCCS's System of Care includes an integrated and comprehensive continuum of coordinated community and facility based services/supports for adults and children with, or at risk for, behavioral health challenges. Case managers are responsible for monitoring the individual's current needs, services, and progress through regular and ongoing contact with the individual. The frequency and type of contact is determined during the collaborative CFT and ART treatment planning process and is adjusted as needed, considering clinical need and individual preferences. The goal is to serve individuals in the least restrictive environment by providing individualized outpatient services and engaging community and natural support to divert crisis situations and inpatient admissions.

Arizona is often referenced as an example among Medicaid programs for its innovative approach to behavioral health crisis services. Its comprehensive array of services are available to any resident of the state, regardless of insurance coverage. Crisis services are required to be recovery-oriented, person focused, and work to stabilize the individual as quickly as possible to assist them in returning to their baseline of functioning. All interventions are required to be offered in a clinically and culturally appropriate manner that respects the preferences of the individual in crisis, while recognizing the need to maintain safety.
Arizona's crisis services encompass the full timeline of care and intervention as outlined below:
Crisis Prevention and Early Intervention
Wellness Recovery Action Plan (WRAP) Crisis Planning
Psychiatric Advance Directives
Family Engagement
Safety Planning
Peer-Operated Warm Lines
Peer-Run Crisis Respite Programs
Suicide Prevention
Crisis Interventions/Stabilization
Assessment/Triage (Living Room Model)
Open Dialogue
Crisis Residential/Respite
Crisis Intervention Team/Law Enforcement
Mobile Crisis Outreach
Collaboration with Hospital Emergency Departments and Urgent Care Systems
Post Crisis Intervention/Supports
Peer Support
Follow-up Outreach and Support
Family-to-Family Engagement
Connection to care coordination and follow-up clinical care for individuals in crisis
Follow-up crisis engagement with families and involved community members
Recovery community coaches/peer recovery coaches
Recovery community organization
AHCCCS utilizes the ACC-Regional Behavioral Health Agreements (ACC-RBHAs) as the Managed Care Organizations (MCOs) responsible for the full continuum of crisis services to all individuals within their assigned Geographical Service Area (GSA) to prevent a potentially dangerous condition, episode, or behavior. Crisis services include crisis telephone response, mobile crisis teams, and facility-based stabilization (including observation and detox), and all other associated covered services delivered by crisis service providers within the first 24 hours of a crisis episode for Title XIX/XXI individuals.

RBHAs ensure the provision of regular Crisis Intervention Team (CIT) training and Mental Health First Aid for Law Enforcement (LE) and other community partners, including federal and tribal entities. RBHAs encourage two-way connections with LE and behavioral health providers in their communities to enhance relationships and better support individuals experiencing behavioral health crises who become involved with law enforcement. Additionally, RBHAs deliver police culture training to crisis providers to enhance system collaboration.

Case management services, home visits (in person or virtual depending on the situation), appointments with the Behavioral Health Medical Provider, Counseling and other supports are available. These services are intended to address the treatment needs of a

person to assist them in the community and have an impact on reduced hospitalizations and crisis situations. Regular and on-going contact with the person, their family or other persons of support is essential to assisting them during their recovery journey.

Beginning in 2016 and renewed in 2021, AHCCCS's Targeted Investment (TI) Program supports participating providers (including hospitals) in delivering integrated and coordinated care at the provider-level. The program reduces fragmentation between physical and behavioral health providers, increase efficiencies in integrated service delivery, and improve health outcomes for adults and children with behavioral health needs who are at high risk for complex care including those experiencing ESMI/FEP, SED, SMI, Substance Use Disorders (SUD), and co-occurring MH/SUD disorders, including justice involved individuals. The TI program incentivizes requirements aimed at building the necessary infrastructure to enable an integrated and high-performing health care delivery system that enhances care coordination, improves health and financial outcomes, and supports a comprehensive approach to integrated care in any setting in which a member may receive either physical or behavioral health services. Improvements in physical and behavioral health integration as the result of AHCCCS's Targeted Investment (TI) Program that support the provision of person-centered, integrated care such as:
Integrated care plans for members with behavioral health needs
Primary Care screening for behavioral health using standardized tools for depression, substance use disorders, anxiety and suicide risk
Primary Care screening, intervention and treatment for children with developmental delays, including early childhood cognitive and emotional problems
Protocols for behavioral health providers to identify physical health concerns and to effectively connect the member to appropriate physical health care
High risk registries, health risk assessment tools, predictive analytic systems and other data mining structures to identify individuals at high risk of a declines in acute and/or behavioral health status
Trauma-Informed Care protocols including screening for Adverse Childhood Events (ACEs), referral processes for children that screen positive, and use of Evidence Based Practices (EBPs) and trauma-informed services.
Protocols to send and receive core Electronic Health Record (EHR) data with the state's Health Information Exchange (Health Current) and receipt of Admission, Discharge, and Transfer (ADT) alerts to notify providers when their patients are hospitalized.
Based on the success of the initial five-year initiative, AHCCCS renewed the TI Program in 2021 to expand provider participation, sustain the integrated point of care infrastructure and protocols, and enable more members to receive greater levels of point of care coordination and integration, especially as the public health emergency intensified the need.

In the event of a hospitalization, MCOs, ACC-RBHAs, and Providers are required to track inpatient admissions, lengths of stay, and discharge dates. MCOs and ACC-RBHAs have Care Managers that track and monitor the status of individuals in hospitals/inpatient facilities to ensure coordination of care and discharge planning occurs to assist members to reintegrate back to the community. Inpatient protocols are in place for Case Managers/Providers to have ongoing contact with the inpatient Social Workers and Behavioral Health Medical Providers while the person is inpatient to ensure coordination of care and appropriate discharge planning occurs.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	311,559	.12%
2.Children with SED	102,928	.24%

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

The process used to calculate prevalence and incidence rates is used to determine the number of members served who meet the designation requirements of SMI or SED, and then compare those numbers to the overall population of the state within that demographic. Members served are determined through standardized reporting based on expenditure and demographic data. The prevalence and incidence rates are used for allocation of resources throughout the state, in structuring service provision through the RBHAs and TRBHAs, and targeting specific areas of need.

Please indicate areas of technical assistance needed related to this section.

none at this time

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care*?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDEA	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such systems	(•) Yes ( ) No

Please indicate areas of technical assistance needed related to this section.

None at this time.

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

AHCCCS contracts with ACC-Regional Behavioral Health Agreements (ACC-RBHAs) to cover over 1 million Arizonans throughout the state including rural and tribal areas. For the purposes of ACC-RBHA coverage, Arizona is divided into three Geographic Services Areas (GSAs) to serve the unique needs of each region of the state. While all three GSAs include rural areas, the Northern and Southern GSAs include most of the rural counties and regions characterized by low general population and population densities. A significant portion of Arizona's geography consists of reservation and tribal lands and similar to the ACC-RBHA structure, there are four Tribal Regional Behavioral Health Authorities (TRBHAs) that fulfill similar roles for their designated tribal groups. Each of these groups is responsible under contract with AHCCCS to establish a services network that meets the contractual requirements for all RBHA's while allowing the RBHA or TRHBA to address the specific needs of their GSA including delivery of services in a rural context. Within this service network, AHCCCS has Non-Title XIX/XXI state general funds to provide housing subsidies for persons experiencing homelessness who have been determined to be Seriously Mentally Ill (SMI). As with other AHCCCS programs and services, these housing subsidies and supports are also allocated to each GSA and provide housing to both urban and rural populations. According to the October, 2022 Arizona Department of Health Services Biennial Report, 82 of Arizona's 126 Primary Care Areas (PCAs) are designated as medically underserved areas. The Health Resources and Services Administration designates the geographic majority of Arizona, particularly (but not exclusively) the rural areas, as Health Professional Shortage Areas (HSPA) in behavioral health. Approximately forty percent of Arizonans live in a Mental Health Professional Shortage Area while, during and since the pandemic, there is an increased need for mental health and substance use treatment for both adults and children. To address these challenges, the Arizona Department of Health Services collaborated with multiple public health, community partners, subject matter experts, and dedicated stakeholders at the state and local levels, including the then AHCCCS Director, Jami Snyder, to create the Arizona Health Improvement Plan (AzHIP) for 2021-2025. The plan outlines action steps and tactics to increase access to mental health management resources, with a particular focus on remote options (telehealth therapy/psychiatry/addition support appointments, virtual support groups, mental health first aid, etc.); increase awareness and utilization of population-based mental health and wellness resources/outreach where they exist and develop strategies to close gaps, and increase the number of public facing/front line staff who receive an approved evidence based suicide prevention training by identifying organizations to receive the training and expand the statewide training capacity in a manner that ensure cultural humility in health equity are a priority. They prioritized addressing health professional shortage by building a diverse healthcare workforce employing multiple tactics including: developing strategies to reduce financial and other barriers for underserved students in health professional education programs, build/grow health care workforce which is representative of the communities served, quantifying healthcare professional shortages in rural and urban underserved areas, developing a curriculum to address local community priorities/concerns, and implementing curriculum with consideration of tribal communities' needs and cultural understanding. AHCCCS is actively involved in these initiatives to overcome these challenges to ensure all Arizonans receive integrated care.

Homeless coordination is one way in which the ACC-RBHA/TRBHA structure meets the needs of rural communities and how collaboration and coordination with other systems have directly improved care and services for members in rural areas. AHCCCS Contractor Operations Manual Policy 448 (Housing) policies require all RBHA and TRBHA contractors and their networks of clinics, services and housing programs to participate in the local HUD Continuum of Care (CoC) for their jurisdiction. This includes participation, when possible, in local case conferencing, homeless coordinated entry systems, care coordination and regional homeless planning efforts. For RBHAs and TRBHAs serving rural or tribal Arizona areas, participation is in the Balance of State CoC (BoSCoC covers the 13 rural counties of Arizona outside of Maricopa County/Phoenix and Pima County/Tucson) and HMIS system. In addition to the aforementioned participation in regional planning and other coordination efforts, RBHA and their providers have established innovative partnerships to increase services to SMI and other persons with behavioral health needs in rural areas. For example, many rural Arizona counties lack homeless service sites, shelters or facilities to serve as HUD CoC Coordinated entry sites for purposes of connecting homeless persons, including those with mental health needs, to HUD homeless programs and housing. To address this, Arizona Complete Health (AZCH) requires all of their health homes and housing providers to serve as CoC Coordinated Entry sites for persons with behavioral health needs. This includes conducting CoC required housing assessments, HMIS data entry and enrollment on the local by name list of persons seeking CoC housing. The site can also enroll the individual, if eligible, in AHCCCS housing programs in addition to other Medicaid covered services. Similarly, rural communities and counties in Arizona access the Project for Assistance to Transition from Homelessness (PATH) grants. PATH teams serving the BoSCoC also coordinate with the regional CoCs and serve as coordinated entry points to enroll members in CoC services and housing lists especially in rural areas where homeless shelters, service sites or access points may be limited. PATH utilizes federal and state funding dollars to contractors who serve as a point of contact for food, clothing, water, blankets, shelter, and other basic living skills individuals require to reduce homelessness for individuals determined to have a Serious Mental Illness (SMI). PATH funding is critical in creating linkages with the behavioral health crisis system, aiding enrollment into the behavioral health system, obtaining medical records, picture ID and social security cards. PATH funding also allows for affordable housing options and conducting outreach and in-reach to adults 18 and over who are chronically homeless and have a Serious Mental Illness determination..

PATH services are provided in Coconino, Mohave, & Yavapai counties through Catholic Charities; in Maricopa County through Community Bridges Inc; Cochise County through Good Neighbor Alliance; and in Pima County through La Frontera. Of those counties where services are provided, the majority of the population served is rural. The targeted services provided by PATH providers are Outreach services (i.e. case management, peer support, housing services, individual living skills, etc.); Screening and diagnostic treatment (i.e. SMI determinations); Habilitation and rehabilitation; community mental health (i.e. create linkages with behavioral health system); Substance use treatment; Referrals for primary healthcare, job training, educational services, and housing services, and SOAR.

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

AHCCCS is awarded the Project for Assistance to Transition from Homelessness (PATH) funding from SAMHSA. Arizona finalized a competitive Request for Proposal (RFP) to PATH contractors in May 2020. These current contracts are for three (3) initial years with two (2) one-year options to extend, not to exceed a total contracting period of five (5) years. The PATH grant to provide outreach services to persons who are homeless, at risk of becoming homeless, and those determined to have a SMI, including those with a co-occurring substance use disorder to six out of the fifteen counties in Arizona; Maricopa, Pima, Cochise, Coconino, Yavapai, and Mohave. The PATH grant provides an array of services, which include; community health screening, case management, and outreach to locations where homeless individuals commonly gather, (i.e. food banks, parks, vacant buildings and the streets). PATH staff provides community education, field assessments and evaluations, hotel vouchers in emergent situations, assistance in meeting basic needs such as: food stamps, health care, and applying for Medicaid and/or SSI/SSDI. The PATH contractors utilize best or promising practices to target street outreach and case management to serve the most vulnerable adults who are literally and/or chronically homeless. Once the individual is enrolled into the PATH program, the PATH Contractor will assist with applying for mainstream services such as SSI/SSDI, Housing, Temporary Assistance for Needy Families, Food Stamps, medical resources, etc. Services are documented within the individual's case plan and the case plan will be updated as needed or at least every three (3) months. Additionally, PATH staff can assist individuals in obtaining behavioral health case management, medications, moving assistance, and referrals for transitional and permanent housing. Services are documented within each individual's case plan and the case plan is updated as needed, or every six months.
AHCCCS works with the aforementioned state partners, health plans and other stakeholders to provide needed services to homeless individuals. Statewide PATH teams are integrated into CoC HMIS coordination activities including coordinated entry, case conferencing and use of By Name List to prioritize housing for most vulnerable at risk persons. On an annual basis, funded contractors, volunteers perform a point-in-time street shelter count to determine the number of individuals in Arizona, those with serious mental illness, or co-occurring illness substance disorder.

The table below is 2022 broken out by each county within Arizona.
County/Total Homeless Count
Maricopa (Phoenix) / 9,026 /
Pima (Tucson) / 2,227 /
Balance of State / 2,300 /

The AHCCCS Housing Program (AHP) consists of both permanent supportive housing and supportive services. The majority of AHCCCS available housing funding is reserved for members with a designation of Serious Mental Illness (SMI), although limited housing is provided for some individuals without an SMI designation who are considered to have a General Mental Health and/or Substance Use Disorder (referred to as "GMHSU") need. For persons with GMHSU needs, housing priority is focused on persons identified with increased service utilization including crisis or emergency services and/or services addressing complex chronic physical, developmental, or behavioral conditions. For a limited number of units within the program, eligibility is further based upon receipt of specific behavioral health services such as an Assertive Community Treatment (ACT) Team.
The AHP is community-based permanent supportive housing where a member should have a renewable lease, the right of entry and exit (not restricted by program), and can voluntarily select services. Housing subsidies are provided for permanent supportive housing scattered site units (Scattered Site Program), dedicated site-based units (Community Living Program), and in projects where a portion of the units have been set aside to serve AHP members (Project Based Vouchers). All subsidized rental units must meet or exceed all federal minimum Housing Quality Standards (HQS) of health and safety, as well as any additional State requirements, and have a reasonable rent based on market standards. Members are expected to pay up to 30% of their income toward their rent while the balance is subsidized by the program. This subsidy is paid to the landlord directly by the contracted AHP Housing Administrator on behalf of the member/household. AHP funding can also provide for housing related supports and payments such as deposits, move-in assistance, eviction prevention, and damages related to member occupancy. Funds for these purposes are limited based on budget availability. Behavioral Health Residential Facilities, Group Homes, or other licensed clinical residential settings are not eligible for AHP participation.

AHCCCS recognizes that supportive services are critical to housing stability. Therefore, AHCCCS and the AHP promote a Housing First model in accordance with best practices as defined by the Substance Abuse and Mental Health Service Administration (SAMHSA). Supportive services for members in AHCCCS subsidized housing are funded by Medicaid and supplied by the managed care health plans' provider network.
The State allocation for AHP is for approximately 2,700 members throughout Arizona. Arizona's State Legislature allocates Non-Title XIX/XXI General Fund money to AHCCCS annually to provide permanent supportive housing.
AHCCCS requested an amendment to the 1115 Research and Demonstration Waiver for waiver and expenditure authority to implement the AHCCCS Housing and Health Opportunities (H2O) demonstration. The goal is to enhance and expand housing services and interventions for AHCCCS members who are homeless or at risk of becoming homeless. Under this demonstration, the agency seeks to:
Increase positive health and wellbeing outcomes for target populations including the stabilization of members' mental health conditions, reduction in substance use, improvement in the utilization of primary care and prevention services, and increased member satisfaction, reduce the cost of care for individuals successfully housed through decreased utilization of crisis services, emergency department utilization, and inpatient hospitalization, and to reduce homelessness and improve skills to maintain housing stability.

The AHCCCS H2O demonstration targets individuals who are experiencing homelessness or at risk of homelessness and who have at least one or more of the following conditions or circumstances:
Individuals with a Serious Mental Illness (SMI) designation or in need of behavioral health and/or substance use treatment,
Individuals determined high risk or high cost based on service utilization or health history,
Individuals with repeated avoidable emergency department visits or crisis utilization,
Individuals who are pregnant,
Individuals with chronic health conditions and/or co-morbid conditions (e.g., end-stage renal disease, cirrhosis of the liver, HIV/AIDS, co-

occurring mental health conditions, physical health conditions, and/or substance use disorder),
Individuals at high risk of experiencing homelessness upon release from an institutional setting (e.g., Institutions for Mental Disease/IMDs, psychiatric inpatient hospitals, correctional facility),
Young adults ages 18 through 24 who have aged out of the foster care system, and
Individuals in the Arizona Long Term Care System (ALTCS) who are medically able to reside in their own home and require affordable housing in order to transition from an institutional setting.

AHCCCS' MHBG team works in tandem with PATH efforts to ensure PATH enrollees are receiving the entire continuum of services they may need for recovery. Within the Division of Grants and Innovation at AHCCCS, the MHBG Grant Administrator also serves as administrator for the PATH grant. PATH subrecipients are required to have Memorandums of Understanding (MOUs) with local ACC-RBHAs and TRBHAs to ensure information sharing and referral resources as needed between the PATH subrecipients and other administrators of Arizona's behavioral health systems. MHBG subrecipients are held to contractual and policy language regarding the outreach of homeless populations to ensure services are being provided to Arizona's most vulnerable populations. AHCCCS monitors the adherence and compliance to these parameters through various reporting mechanisms, including annual Operational Reviews (ORs). If subrecipients do not meet the requirements through the OR process, AHCCCS develops a Corrective Action plan for the subrecipients and offers technical assistance as needed to the subrecipients.

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

The 2022-2023 AHCCCS Delivery System Integration information outlines that all members have equitable coverage for physical, behavioral, rehabilitative, or long term care services. (https://www.azahcccs.gov/shared/Downloads/2022_Delivery_SystemIntegration_10012022.pdf) AHCCCS' Arizona Long Term Care System (ALTCS) program has specific health plan Contractors that manage care for members who are Elderly and/or have a Physical Disability (E/PD) . The health plans provide services to AHCCCS members who are elderly (65 and over), blind, or disabled and at risk of institutionalization. ALTCS E/PD members receive all their medical care under the long term care program, including doctor's office visits, hospitalizations, prescriptions, lab work, long term services and supports, and behavioral health services. The ALTCS E/PD program is recognized as a national model for its success in supporting a high percentage of individuals who receive services in their own home or in the community rather than in institutional settings. In an effort to ensure that members have the opportunity to receive services in their own home, the ALTCS health plans, consistent with other health plans, are required to have a Housing Administrator to identify homeless members and/or members with affordable housing needs and leverage community partnerships or other resources to meet those needs. AHCCCS aligns systems for members who are dually-eligible for Medicare and Medicaid. Being its own distinct and complex system of care with little to no interface with state Medicaid programs, the over 180,000 Arizonans with dual-eligibility can be overwhelmed by navigating these two separate systems and are more likely to fall through the cracks, receive inefficient care, and not achieve optimal health outcomes. As part of integrated care efforts, AHCCCS contracts with Medicare Advantage Dual Special Needs Plans (D-SNPs) that are each affiliated with its partner AHCCCS Complete Care Medicaid Health Plan. Requiring each ACC Medicaid health plan to offer a partner Medicare D-SNP promotes the enrollment or alignment of dual eligible members in the same health plan for both Medicare and Medicaid services to the greatest possible extent and allows dual eligible members to receive all of their health care services, including prescription drug benefits, from a single, integrated health plan. https://www.azahcccs.gov/AHCCCS/Downloads/Initiatives/CY23_DSNP_ReferenceTables.pdf

Please indicate areas of technical assistance needed related to this section.

none at this time

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

AHCCCS leverages several financial resources and funding streams to provide for a well-supported network of behavioral health providers to deliver covered services under the various contracted health plans. Although the Division of Grants and Innovation oversees administration of grants and other Non-Title XIX/XXI funding, AHCCCS staff work collaboratively across divisions to leverage county, state, and federal dollars (Title XIX/XXI and Non-Title XIX/XXI) effectively and appropriately for services included in the state plan. Title XIX/XXI funds provide care for members' physical and behavioral health care needs, including behavioral health prevention/promotion, treatment, recovery, and other support services under one Managed Care or Fee For Service health plan. Non-Title XIX/XXI funds provide coverage for additional mental health services not covered by Title XIX/XXI and also for certain members who are not eligible for Title XIX/XXI but meet other eligibility criteria including both uninsured and underinsured members. These other funding sources may include the Children's Behavioral Health Fund for children's services including SED, the Mental Health Block Grant (MHBG) for SED, SMI, and ESMI/FEP, Maricopa County, Pima and Coconino County funds for certain children's or SMI services and/or Court Ordered Evaluation/Pre-Petition Screening, SMI General Fund, SMI Housing General Fund, Supported Housing General Fund, SMI Housing Trust Fund, Emergency COVID-19 grant for members with co-occurring illness, COVID-19 Emergency Response for Suicide Prevention, and state crisis service dollars. Each funding source may have its own staffing or training requirements, while larger system training requirements are described below. In accordance with ACOM Policy 407, AHCCCS requires that Contractors establish and maintain a Workforce Development Operation (WFDO) and employ a Workforce Development Administrator. The WFDO works with the MCO's Network and Quality Management functions to ensure the provider network has sufficient workforce capacity, and is staffed by a workforce that is interpersonally, clinically, culturally, and technically competent in the skills needed to provide services. The WFDO is the organizational structure MCOs utilize to monitor and assess current workforce capacity and capability, forecast and plan future workforce capacities and capabilities, and when indicated, deliver technical assistance to provider organizations to strengthen their Workforce Development (WFD) programs. AHCCCS further requires all MCOs to participate in a Single Learning Management System (LMS), and to collaborate with all other AHCCCS MCOs in using the LMS to administer the delivery, documentation, tracking and reporting of all required education and training programs. AHCCCS requires that Contractors provide, at a minimum, annual training/s to support and develop law enforcement agencies' understanding of behavioral health emergencies and crises. Contractors are also contractually required to have regular and ongoing training for providers to assist members with how to access both Medicaid compensable services as well as Non-Medicaid funded services.

AHCCCS is committed to workforce development and support of the medical residency in the State of Arizona and expects MCOs to support these efforts. AHCCCS also requires that MCOs attempt to contract with graduating residents and providers that are opening new practices in/or relocating to Arizona, especially in rural or underserved areas. AHCCCS encourages MCOs to contract with or otherwise support the many Graduate Medical Education (GME) Residency Training Programs currently operating in the State and to investigate opportunities for resident participation in medical management and other committee activities.

In 2018, AHCCCS required all ACC Health Plans and the three RBHA Health Plans to jointly fund a contract between the AZ Association of Health Plans (AzAHP) and a learning management system (LMS) provider. The provider is responsible for operating a single, statewide LMS for the physical and behavioral health workforces. RELIAS was selected as the LMS provider and remains under contract to provide LMS support to the MCOs, RBHAs and Providers. The system is used by the workforces of provider organizations delivering physical and behavioral health services.

AHCCCS requires the use of an LMS in order to accomplish three goals:

1. To disseminate computer assisted policy and best practice education and training content to provider organizations across Arizona.
2. To collect and store training program transcripts and skill competency evaluations for provider staff and to ensure the transcripts and evaluations are available to staff and their employers upon request.
3. To report training or competency requirements compliance for all AHCCCS policies or mandated practices requiring specific staff training or competency demonstrations.

The RELIAS LMS automatically collects and stores individual staff training and evaluation records for computer disseminated training content. In addition, the LMS has the capability of supporting traditional in-person training and evaluation events and generating required compliance reporting. Included in the Relias LMS platform are training opportunities for the staff employed at the MCOs, RBHAs and providers to learn about the Mental Health Block Grant and services for members with SED, SMI, and/or ESMI/FEP.

AHCCCS continually assesses and updates training requirements based on identified areas of needs and to maintain current best program and practice expectations for all providers. Most recently, AHCCCS is contracting with Arizona's Peer and Support Training Academy to create and implement a mandated clinical supervisor training for all programs employing Peer Support Specialists within their programs to ensure this unique and necessary group of providers receive the clinical supervision required to successfully fulfill their job expectations.

AHCCCS divisions are sensitive and responsive to staffing and training needs for behavioral health services providers. For example, the AHCCCS Division for Fee for Service Management (DFSM) employs staff responsible for provider trainings, inclusive of behavioral health trainings. Some behavioral health trainings are posted online for ease of access for providers. If a provider has questions regarding billing and coding, they are routed to the AHCCCS coding team. Additionally, the AHCCCS Division of Community Advocacy and Intergovernmental Relations (DCAIR) conducts educational sessions for individuals in the system, ACC-RBHA staff/provider staff and other stakeholders on various topics. AHCCCS DCAIR and the Office of Individual and Family Affairs (OIFA), have also established training requirements and credentialing standards for Peer and Recovery Support Service (PRSS) providing Peer Support within the AHCCCS programs, including qualifications, supervision, continuing education, and training. These are a few examples of additional mechanisms by which AHCCCS may ensure training for mental health providers.

Additional training is available at the health plan level through their Workforce Development Administrators, and other staff or departments. Some Contractors utilize Project ECHO for optimizing performance and spreading new medical knowledge throughout the provider network in a manner allowing community providers to learn from specialists, from each other, and for specialists to learn from community providers as well.

CALOCUS/LOCUS/ECSII
AHCCCS implemented the Child and Adolescent Level of Care Utilization System (CALOCUS) as the standardized mechanism for determining the level of intensity in case management supports necessary for children age 6-18. Service intensity assessment and planning is a critical independent element of overall person and family-centered service planning and is a collaborative process between the person or family served and their service providers. Cultural considerations and social determinants of health impact all these dimensions, and the CALOCUS systematically matches individuals and families' dimensional ratings to specific defined levels of case management support to ensure that their needs are met.

The CALOCUS is considered best practice for assessment of service intensity across multiple dimensions, as follows:
1. Risk of Harm
2. Functional Status
3. Medical, Addictive and Psychiatric Co-Morbidity as well as Developmental Disabilities
4. Recovery Environment:
A-Stressors
B-Supports
5. Treatment and Recovery History
6. Engagement and Recovery Status
ASAM

AHCCCS has implemented the ASAM CONTINUUM® assessment tool across the state of Arizona to improve treatment outcomes with greater assessment fidelity and proper level of care placement. This assessment tool provides the entire treatment team with a computerized clinical standard decision support system for assessing members with substance use disorders and co-occurring conditions. This is an evidenced based practice (EBP) established by the American Society of Addiction Medicine (ASAM) to assist clinicians in determining levels of care for persons who have substance use disorders.

AHCCCS has collaborated with the with the Managed Care Organizations (MCO) Workforce Development Administrators, ASAM, FEI Systems and the Arizona Association of Health Plans (AzAHP) to have the ASAM CONTINUUM® assessment training videos hosted on the Relias Learning Management System (LMS) platform. This will assist with "ease of access/use" for clinicians and providers and allow for standardized training reports. Providers are expected to ensure that all staff completing the ASAM are trained prior to conducting the assessment.
Mental Health First Aid

AHCCCS has also implemented Mental Health First Aid Training in Arizona. Mental Health First Aid is an eight (8) hour training that

is available to anyone age 16 and older interested in learning about mental health. Each session can accommodate 25-33 participants. Participants learn a valuable five (5) step process to assess a situation, select and implement appropriate interventions and help a person experiencing a crisis or who may be exhibiting the signs and symptoms of mental illness. AHCCCS offers the training for employees at AHCCCS and there are also several trainings available in communities throughout the state.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

Arizona currently has over 100 companies offering a statewide spectrum of behavioral health and integrated health care services in telehealth format. Telehealth services are provided not only from individuals' immediate location, but also a variety of other settings including correctional facilities, rural hospitals, urban hospitals, educational institutions, Urgent Care Centers, and emergency departments. If an individual determined SMI, SED, ESMI/FEP or a SUD does not have access to the necessary technology, transportation to a location in which the technology is available is a covered service under both MHBG and SUPTRS. AHCCCS is currently assessing the need and capability to establish additional locations with telehealth capability in remote communities in rural Arizona further reducing the need and/or distance for transport. The Arizona Telemedicine Program at the University of Arizona and the Southwest Telehealth Resource Center was recently recognized as a "trendsetter in distance learning" by the United States Distance Learning Association and provides a service provider directory, telemedicine training, webinars, and updates regarding telehealth services throughout the state. Anyone can connect with these resources via Facebook, Instagram, LinkedIn, YouTube or at their website: https://telemedicine.arizona.edu/

In 2021, Arizona created the Telehealth Advisory Committee tasked with identifying best practice for telehealth in our state. In June 2022, the committee unanimously voted to adopt the Telehealth Advisory Committee Teleheath Best Practice Guidelines for Health Care Providers and provided the guide to the Arizona Governor, Arizona State Senate President, and Arizona House of Representatives Speaker of the House as required. This report is found here: https://www.azahcccs.gov/AHCCCS/Downloads/TelehealthAdvisoryCommittee/Presentations/TAC_BestPracticesRecommendations2022.pdf. The Telehealth Advisory Committee continues to evaluate the need for revisions to this best practice guidelines list at a minimum of annually, including the ongoing review of national and other standards for telehealth best practices and relevant peer-reviewed literature.

AHCCCS Medical Policy 320-I Telehealth https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/300/320-I.pdf outlines the expectations in regard to telehealth services. In Arizona, there are no geographic restrictions for Telehealth; services delivered via Telehealth are covered by the Contractor and FFS programs in rural and urban regions. The Contractor and FFS programs may not limit or deny the coverage of services provided through Telehealth and may apply only the same limits or exclusions on a service provided through Telehealth that are applicable to an in-person encounter for the same service, except for services for which the weight of evidence, based on practice guidelines, peer-reviewed clinical publications or research or recommendations by the Telehealth advisory committee on Telehealth best practices established by A.R.S. § 36-3607, determines not to be appropriate to be provided through Telehealth.

Please indicate areas of technical assistance needed related to this section.

none at this time

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	◉ Yes	○ No
ii)	Education	◉ Yes	○ No
iii)	Brief Intervention	◉ Yes	○ No
iv)	Assessment	◉ Yes	○ No
v)	Detox (inpatient/residential)	◉ Yes	○ No
vi)	Outpatient	◉ Yes	○ No
vii)	Intensive Outpatient	◉ Yes	○ No
viii)	Inpatient/Residential	◉ Yes	○ No
ix)	Aftercare; Recovery support	◉ Yes	○ No

b) Services for special populations:

i)	Prioritized services for veterans?	○ Yes	○ No
ii)	Adolescents?	◉ Yes	○ No
iii)	Older Adults?	◉ Yes	○ No

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

AHCCCS contracts with ACC-RBHAs to administer behavioral health services. ACC-RBHAs contract with a network of service providers similar to health plans to deliver a comprehensive array of services as outlined in the Non-Title XIX/XXI contract between AHCCCS and the ACC-RBHAs as well as the AHCCCS Medical Policy Manual (AMPM).

Programmatic oversight of the grant by AHCCCS provides an opportunity to receive information about PPW services and provide feedback on any concerns AHCCCS may have. Contracts between AHCCCS and the ACC-RBHAs include language for preferential access to care and provision of interim services, as needed which highlights the requirements for serving PPW.

ACC-RBHAs hold quarterly meetings with their providers about SUD. AHCCCS staff attends the meetings to monitor program compliance for the priority populations, and additional block grant requirements. These meetings serve as collaborative opportunities to disseminate information, address provider concerns, ensure that priorities of the block grant are met, and address any potential compliance issues promptly. AHCCCS sets expectations for prenatal providers to connect women who are pregnant to community resources, as outlined in AMPM 410, which is the AHCCCS policy for maternity care. The AHCCCS PPW SME as well as other subject matter experts (SMEs) including clinical and grant staff review policies annually and continuously improve the policies to ensure expectations are up to date, evidence-based, and clear for the ACCs, ACC-RBHAs, TRBHAs, and provider staff. The 2023 policy review and feedback includes additional guidance for PPW w/ SUD.

Deliverable related to PPW, SABG, and Non-Title XIX/XXI requirements include the SABG Performance Progress Report, the Priority Population Waitlist Report, the SABG/MHBG annual plan, and SABG/MHBG annual report to AHCCCS.

AHCCCS fiscal and program staff also review planned and actual expenditures to ensure that the system is meeting requirements related to SABG women's services.

The AHCCCS Division of Grants and Innovation also employs a Compliance Manager that assists the SABG team in ensuring ACC-RBHAs and TRBHAs are in compliance with contract, agreement, and policy requirements. The Compliance Manager holds ACC-RBHA compliance meetings every 2 months, while the SABG team meets regularly with ACC-RBHAs as well as TRBHAs for oversight and monitoring as well as technical assistance and support. This may be as frequently as every 2 weeks for some, or as needed for others, depending on the needs between AHCCCS, the ACC-RBHAs, and the TRBHAs. The Compliance Manager also assists the SABG team to deliver Corrective Action Plans as needed. In the case of a compliance concern with a TRBHA, the SABG team works with the AHCCCS Division for Fee For Service Management (DFSM), the division that is responsible for overseeing the

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(•) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs, if applicable	(•) Yes ( ) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	( ) Yes (•) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (•) No
c)	Use of peer recovery supports to maintain contact and support	(•) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)?	(•) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

AHCCCS Oversight of ACC-RBHAs

AHCCCS contracts with ACC-RBHAs to administer behavioral health services. ACC-RBHAs contract with a network of service providers similar to health plans to deliver a comprehensive array of services as outlined in the Non-Title XIX/XXI contract between AHCCCS and the ACC-RBHAs as well as the AHCCCS Medical Policy Manual (AMPM).
Programmatic oversight of the grant by AHCCCS provides assurances that programs that serve PWID are following best practices for strategies and services such as outreach, syringe service programs, HIV prevention/early intervention programs, person-centered and customized treatment services, and recovery supports. Contracts between AHCCCS and the ACC-RBHAs include language for preferential access to care and provision of interim services, as needed which highlights the requirements for serving PWID. AHCCCS monitors for compliance with preferential access standards, including review of data submitted by health plans to the Medicaid claims and encounters system, ACC-RBHA, TRBHA, and other contractor deliverables, and implementing corrective action plans as appropriate. Language continues to be expanded to specifically match the block grant requirements through contracts between AHCCCS and the RBHAs and referenced in the AHCCCS Contractors Operations Manual (ACOM), and AMPM.

ACC-RBHAs hold standing meetings with their providers about SUD. AHCCCS staff attends the meetings to monitor program compliance for the priority populations, and additional block grant requirements. These meetings serve as collaborative opportunities to disseminate information, address provider concerns, ensure that priorities of the block grant are met, and address any potential compliance issues promptly.
Sonoran Prevention Works (SPW) harm reduction program serves PWID through the following activities:
Naloxone distribution, education, and training for prescribers, pharmacists, AHCCCS members, and the general public.
Provide onsite access or immediate referral/linkages to healthcare, treatment, and wrap-around supports through a SSP in strict accordance with state and local law and SAMHSA guidance, or other evidence-based programming supporting the overall purpose of the harm reduction program.
Fentanyl testing strip distribution, education, and training for AHCCCS members and the general public.
Relationship and capacity building with key community stakeholders to promote the program and services offered to Arizonans in need of harm reduction strategies utilizing peer support and individuals with lived experience to assist Arizonans in their recovery journey.
Tailor harm reduction programming to meet the unique needs of women, including pregnant and parenting women.

AHCCCS Oversight of Sonoran Prevention Works (SPW)

SPW prioritizes PWID via direct distribution of naloxone education and training. SPW has developed dozens of original trainings related to overdose, opioids, stimulants, supporting pregnant women who use drugs, and other harm reduction topics. SPW has provided education on fentanyl exposure, fentanyl testing strips, and overdose prevention upon fentanyl detection in a

substance since 2017. This education has historically been targeted to PWID, encompassing regular and casual users as well as SABG priority populations. In 2018, SPW founded the Kingman Harm Reduction Program (KHRP) in response to the CDC designating Mohave County as one of 220 U.S. counties vulnerable to HIV and HCV outbreaks due to injection drug use. Through KHRP, certified peer support staff provide harm reduction counseling, supplies such as syringes and outreach kits (wound care, hygiene, safer use, etc.), made referrals to ancillary services, and received overdose reversal reports. KHRP is a wraparound program in line with CDC recommendations - including sterile syringe disposal, rapid HIV/HCV screening, referrals and navigation to substance use and mental health treatment, naloxone and other overdose prevention supplies, connection to community services that impact the social determinants of health, and peer support.

SPW is required to conduct advisory board meetings, team meetings, and submit expenditure reports and deliverables to AHCCCS quarterly. Monthly expenditure reports present a way for AHCCCS to assure fiscal responsibility as SPW provides an accurate and detailed report along with back up documentation for allowable reimbursement of SABG grant fund expenditures. Deliverables serve as another way to monitor programmatic compliance as SPW is required to report with the following: include the number and type of training conducted includes county and city/town, the number of Naloxone doses and/or kits, fentanyl test strips, and harm reduction material distributed into the community. This includes the number of doses and/or kits distributed, the number of people reached with trainings, kits, and harm reduction material distribution, the number of reported opioid overdose reversals using Naloxone, fentanyl test strips, and other harm reduction material; and the number of individuals outreached/engaged, referred, and connected to treatment. In tandem, deliverables and monthly expenditure reports allow AHCCCS to ensure accountability and monitor compliance over SPWs activities during the funding period.

In addition, SPW has also incorporated an evaluation design into their method of approach to measure project performance, identify best practices, and facilitate continuous program improvement. Using the RE-AIM framework, SPW gathers data from program staff and participants through monthly programmatic reports and electronic health records. The data will track all measurable objectives, required reports, and reports for use by the advisory committee and executive team to ensure compliance with subcontractors.

Other Oversight Efforts

Reimbursement Process
In addition to these programmatic efforts to conduct oversight efforts, programs funded by the COVID-19 Supplemental funds (otherwise known at AHCCCS as the Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA)) and SABG American Rescue Plan Act (ARPA) have an additional layer of oversight because they are paid to the subrecipients on a reimbursement basis. This means that AHCCCS program and finance staff have the opportunity to review and approve (or not approve) the expenditures requested for reimbursement by the Contractor before they are paid out. This provides an opportunity to flag questions of programmatic and fiscal concern that may relate to services provided to PWID and therefore address concerns with the Contractor.

Operational Review: An annual requirement to ensure Contractors satisfactorily meet AHCCCS requirements as specified in contract.

AHCCCS Medical Policy Manual (AMPM): Manual for covered services for NT-XIX/XXI populations, referenced by AHCCCS and Providers to ensure appropriate use of services. Updated annually.

Contracts & Deliverables: AHCCCS employs multiple contracts and service agreements to ensure appropriate use of SABG funds. Providers are required to regularly submit deliverables related to program progress, financial standing, and/or ad-hoc information as requested by AHCCCS.

Deliverables allow AHCCCS to monitor programmatic and fiscal compliance. With regularly submitted deliverables and expenditure reports, AHCCCS works to hold Contractors accountable to spend down allocated funds timely and ensures appropriate programmatic progress. Deliverables also provide a mutually beneficial relationship between AHCCCS and Contractors as it becomes a way of communication to better understand programming, community and organizational needs, clear expectations, and offers a channel of additional support throughout the project term.

Independent Peer Review:
The Annual Independent Peer Review assesses the quality, appropriateness, and efficacy of treatment services provided in the State. Although not specific to PWID, there is crossover between Opioid Use Disorder (OUD) and PWID in the following measures within the ICR: opioid specific treatment services: such as if the member's file documents a diagnosis of OUD, was provided Medications for Opioid Use Disorder (MOUD) education and referral, overdose education. Through this process, AHCCCS staff is able to extract data and information pertaining to PWID and use the results to identify barriers, opportunities, and work with ACC -RHBAs for process improvement and grant compliance.

For the SFY22 report, Mercer added a qualitative data collection component through the use of focus groups. These focus groups were conducted with ACC-RBHAs, providers, and members who received services and their loved ones. To inform and facilitate the focus groups, Mercer used findings from the ICR to frame and guide discussion. This addition to the ICR provided valuable insight and context to the review findings from the case file reviews. Although the ICR process typically is to assess the larger system and

identify improvements for the system overall (not specific to provider compliance efforts), AHCCCS received feedback that the results of the ICR would be most useful if the results could be stratified at the provider level. In order to maintain the purpose of the ICR to be for process improvement, and not compliance, Mercer provided a special report to AHCCCS only, allowing AHCCCS to review internally for consideration of identifying specific and actionable concerns to be addressed with the ACC-RBHA.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Business agreement/MOU with primary healthcare providers ( ) Yes (●) No

b) Cooperative agreement/MOU with public health entity for testing and treatment ( ) Yes (●) No

c) Established co-located SUD professionals within FQHCs ( ) Yes (●) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

AHCCCS supports TB services making them available to individuals receiving SUD treatment through partnerships with the ACC-RBHAs, TRBHAs, and Arizona Department of Health Services (ADHS). Respectively, TB services are outlined in the Non-Title XIX/XXI contract, AMPM 320-T1, and in the Interagency Service Agreement (ISA) with ADHS. AHCCCS monitors program compliance through a deliverable required for the ACC-RBHAs, called a SABG TB Services Treatment Procedure and Protocol, through the ICR, Operational Reviews, and regular and ad hoc meetings with subrecipients of the grant.
Pursuant to the 45 CFR Part 96 Sect. 127, AHCCCS is required to routinely make available tuberculosis services as defined in §96.121 to each individual receiving treatment for substance use, implement infection control procedures including the screening of patients, and identify those individuals who are at high risk of becoming infected. AHCCCS passes this requirement down into contracting language to ensure all parties involved are aware and in compliance with TB requirements.
In the past, ADHS would securely provide to AHCCCS an annual deliverable listing members with tuberculosis cases, which AHCCCS would then use to pull data from the AHCCCS claims and encounters system for members with SUD. The data report is then used as an oversight tool to determine if members with TB had received behavioral health services. AHCCCS and ADHS reviewed this deliverable requirement in summer of 2023, and determined that is not the best way to conduct the oversight anymore, and AHCCCS will be working with an epidemiologist on a better mechanism to check the offering and administration of TB services among the SUD population in accordance with this requirement
The Independent Case Review (ICR) also measures what percentage of case files reviewed include a documented screening for TB. AHCCCS uses this data source to communicate with the ACC-RBHAs about system improvement needs.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas ( ) Yes ( ) No

b) Establishment or expansion of tele-health and social media support services ( ) Yes ( ) No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ( ) Yes ( ) No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)(F)? (●) Yes ( ) No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? (●) Yes ( ) No

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? (●) Yes ( ) No

If yes, plese provide a brief description of the elements and the arrangement

According to the CDC, Syringe Services Programs (SSPs) are a public health strategy for persons who inject drugs (PWID). SSPs aim to reduce PWID's risk of getting and transmitting HIV, viral hepatitis, and other blood-borne infections by using new or sterile injection equipment for each injection.

In accordance with ARS § 36-798.51 and SAMHSA requirements, the objectives of the SSP are to reduce the spread of viral

hepatitis, HIV and other bloodborne diseases in AZ, to reduce needle-stick injuries to law enforcement officers and other emergency personnel, to encourage individuals who inject drugs to enroll in evidence-based treatment, to increase proper disposal of used syringes and to reduce the occurrence of skin and soft tissue wounds and infections related to injection drug use.
An SSP arrangement shall offer disposal of used needles and hypodermic syringes, needles, hypodermic syringes, and other injection supply items at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supply items are not shared or reused. It is important to note that federal SABG funds may not be used to purchase syringes or needles. The SSP will also provide educational materials on all of the following: overdose prevention, peer support services, the prevention of HIV, viral hepatitis transmission and the incidence of skin and soft tissue wounds and infections, education and referrals for mental illness, treatment and referrals for substance use disorder, education and resources for individuals with co-occurring disorders and harm reduction strategies.

Access to kits that contain naloxone hydrochloride or any other opioid antagonist that is approved by the United States Food and Drug Administration (USFDA) to treat a drug overdose, or referrals to programs that provide access to naloxone hydrochloride or any other opioid antagonist that is approved by the USFDA to treat a drug overdose. For each individual who requests services, personal consultations from a program employee or volunteer concerning mental health or substance use disorder treatment or referrals for evidence-based substance use disorder treatment, as appropriate. Pursuant to State and local law and SAMHSA requirements, the SSP shall develop standards for distributing and disposing of needles and hypodermic syringes based on scientific evidence and best practices. The number of needles and hypodermic syringes disposed of through a program shall be at least equivalent to the number of needles and hypodermic syringes distributed through the program. (ARS § 36-798.51, Subsection C.). Collect all data required for the SABG report to include the number of unique individuals served with: HIV testing (onsite and referred), treatment for substance use conditions (onsite and referred), treatment for physical health (onsite and referred), STD testing (onsite and referred), and Hep C (onsite and referred.)

According to SAMHSA guidance and approval from AHCCCS and the SAMHSA Project Officer, the following are allowable uses of federal funds to support SSPs: personnel to support SSP implementation and management, supplies to promote sterile injection and reduce infectious disease transmission, testing kits for viral hepatitis and HIV, syringe disposal services, navigation services to link to prevention, testing, treatment, and care services, educational materials, male and female condoms, referral to hepatitis A and hepatitis B vaccinations, communication and outreach activities designed to raise awareness about and increase utilization of SSPs and SSP planning and non-research evaluation activities.

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — ( ) Yes (●) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MOUD — (●) Yes ( ) No
  - **ii)** Tele-Health — (●) Yes ( ) No
  - **iii)** Social Media Outreach — (●) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (●) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — (●) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (●) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No

c) Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

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3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — (●) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes ( ) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☑ Other (please specify)

NCQA Accreditation of all ACCs is currently underway.

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ◉ Yes ○ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ◉ Yes ○ No

c) Performance-based accountability: ○ Yes ◉ No

d) Data collection and reporting requirements ○ Yes ◉ No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ◉ Yes ○ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ◉ Yes ○ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ○ Yes ◉ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ◉ Yes ○ No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? ◉ Yes ○ No

b) Mental Health TTC? ◉ Yes ○ No

c) Addiction TTC? ◉ Yes ○ No

d) State Targeted Response TTC? ○ Yes ◉ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

Arizona Administrative Code Title 9. Health Services.
Chapter 21. Department of Health Services Behavioral Health Services for Persons with Serious Mental Illness
https://qa.azsos.gov/public_services/Title_09/9-21.pdf
Chapter 10. Department of Health Services - Health Care Institutions: Licensing https://apps.azsos.gov/public_services/Title_09/9-10.pdf
Arizona Revised Statute Title 36 https://www.azleg.gov/arsDetail/?title=36
Chapter 1 State and Local Boards and Departments of Health
Chapter 2 State Health Institutions and Agencies
Chapter 5 Mental Health Services
Chapter 18 Alcohol and Drug Abuse
Chapter 28 Controlled Substances Prescription Monitoring Program
Chapter 34 Behavioral Health Services

If the answer is No to any of the above, please explain the reason.

Allocations regarding women - not needed, we anticipate we will meet the requirement
Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus - not needed, we anticipate we will meet the requirements
Additional Agreements - not needed, we anticipate we will meet the requirements

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ○ Yes ○ No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

[2] *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	Yes No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	Yes No
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	Yes No
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	Yes No
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	Yes No
6.	Does the state use an evidence-based intervention to treat trauma?	Yes No
7.	Does the state have any activities related to this section that you would like to highlight.	
	Please indicate areas of technical assistance needed related to this section.	

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- ☐ Coordination across mental health, substance use disorder, criminal justice and other systems
- ☐ Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- ☐ Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- ☐ Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- ☐ Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- ☐ Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- ☐ Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- ☐ Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- ☐ Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- ☐ Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- ☐ Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- ☐ Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- ☐ Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- ☐ Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- ☐ Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe. ○ Yes ○ No

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? ○ Yes ○ No

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?

- **a)** ☑ Methadone
- **b)** ☑ Buprenophine, Buprenorphine/naloxone
- **c)** ☑ Disulfiram
- **d)** ☑ Acamprosate
- **e)** ☑ Naltrexone (oral, IM)
- **f)** ☑ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

The SUBG supports MOUD and MAT as a part of the continuum of care for SUD. Many MAT and MOUD programs under SUBG or in the SUD system use braided funding to ensure coverage of SUD treatment services to eligible members. Braided funding includes but is not limited to SUBG, SUBG Supplemental funding sources such as COVID-19 Funding (CRRSAA) and ARPA, State Opioid Response (SOR) funds, and Pregnant and Postpartum Women Diagnosed with Substance Use Disorder (PPW-PLT).

According to the Annual Report of Substance Use Treatment Programs for SFY22, a total of 23,890 members were served with MAT.

Of those, 23,138 were served with medical services, 19,458 were served with support services, and 16,677 were served with treatment services. Other services provided to members undergoing MAT treatment include inpatient services, crisis intervention, rehabilitation services, residential services, and others. The report can be found here https://www.azahcccs.gov/shared/Downloads/Reporting/2023/FY23SubstanceUseDisorderReport.pdf

MAT providers under SUBG, SUBG COVID-19 supplementals (CRRSAA and ARPA) include but are not limited to: BAART, Center for Behavioral Health, Community Bridges, Inc. (CBI), Community Medical Services (CMS), Crossroads, Intensive Treatment Systems (ITS) including a mobile MAT unit, New Hope Behavioral Health, Southwest Behavioral & Health Services, Terros, Valle del Sol, CODAC Health & Wellness 24/7 Center of Excellence integrated MAT OTP, Spectrum including a mobile MAT unit. MAT and MOUD providers commonly offer wrap around services in addition to the medication to treat the substance use disorder. Additional details on some of these programs are outlined below.

The Barbell Saves program is a special program that implements holistic health and wellness for members with SUD by partnering with CMS clinic which includes MAT services. The program provides peer support to members with SUD and engages them in health and fitness instruction as a part of SUD recovery. 137 of the 550 members served under Barbell Saves were on MAT in FY23.

About $1,500,000 of SUBG COVID-19 Supplemental funds were budgeted under the ACC-RBHAs and their contracted providers for treatment services, which included MAT services.

Under PPW-PLT, CODAC Behavioral Health and Wellness in Tucson, Arizona, implemented the direct service component providing treatment of Pregnant and Postpartum Women Diagnosed with Substance Use Disorder). Under this program, CODAC has created a hub-and-spoke treatment program for women who are either pregnant, or delivered their last baby within the previous 12-months, and are diagnosed with a substance use disorder. For example, under the PPW-PLT CODAC program, women and their children are able to live in Casitas on site when housing is needed to support their successful treatment, as well as participate in a wide variety on therapy groups and sessions, parenting and child development classes, and community resources to meet the psychosocial needs of the families involved.

Under SOR III, Arizona supports and subsidizes four Opioid Treatment Program (OTP) 24/7 access points in the central and southern areas of the state. These centers are critical to providing ongoing access to MOUD, as well as linking clients to recovery support services, while concentrating on high-risk groups by connecting correctional health facilities, transitional housing programs, residential programs, and programs for pregnant women with OUD.

There are four mobile units that have been launched using grant funding in the northern, central and southern (2) parts of Arizona. These units will serve to target individuals in rural and underserved areas, connecting them to MOUD services, as well as providing naloxone, counseling, urine drug screening, and other supportive components of care.

Programming is underway to provide MOUD to individuals who are currently justice involved. Under this arena, individuals are not only dosed while incarcerated, but also connected to resources including recovery support and naloxone, and are provided with direct referrals upon release.

Funding helps support the Overdose Assistance and Referral Line (OAR Line) for the state which not only provides resources to people who use drugs directly, but also serves as an invaluable resource to providers who may call in for expert consultation through virtual case management regarding prescribing opioids and managing high-risk patients.

West Valley – OBGYN, the University of Arizona, and the Arizona Women's Recovery Center (AzWRC) all provide programming to directly support and provide integrated care to pregnant and parenting women with an opioid or stimulant use disorder. These programs provide resources in the areas of housing, long term vocational counseling, peer support, and indefinite postnatal care. These providers also offer education in areas such as labor pain management, contraception, and parenting.

Hushabye Nursery implements two distinct programs; they are a newborn detoxification facility focusing specifically on newborns diagnosed with Neonatal Opioid Withdrawal Syndrome (NOWS), and an outpatient behavioral health provider encompassing care for the whole family. Hushabye centers both of their programs on a family-based model of care, reaching the entire family beginning in pregnancy through labor and delivery, inpatient care of the newborn immediately after delivery with the family at the bedside 24/7 utilizing the Eat, Sleep, and Console mode of infant care for babies with Neonatal Abstinence Syndrome (NAS), and into the postpartum period. Families remain engaged with Hushabye as long as they want and need the support. Hushabye partners with any OTP engaged with their clients, and with many of the homeless shelters, supportive and transitional housing programs, residential behavioral health facilities, and outpatient opioid treatment clinics.

The Ability360 Opioid Reduction Program, run through a funded provider, which incorporates physical activity to address chronic pain leading to less need for opioids. Ability360 defines itself as advocating "responsibility – by, and for, people with disabilities – as a means to independence," and aims to have individuals, especially those with disabilities, work toward self-sufficiency. Complementary to this, there is also programming that targets individuals statewide who are at risk for or experiencing addiction in the disability community, focusing on, but not limited to, cognitive impairment.
The Opioid Services Locator allows the public to search for MOUD and other OUD services throughout the state using zip codes.

Service types currently available to search for on the locator include naloxone distribution, office based opioid treatment, opioid treatment programs, and residential programs.

A recent AHCCCS report on SUD treatment services identified that rural areas do not have the same access to care and availability of MAT and MOUD services. AHCCCS and its partners are seeking ways to increase this effort such as increasing the use of mobile MAT and MOUD units, such as the new Spectrum mobile MAT unit and CMS expansion of MAT availability to rural areas. Additionally, AHCCCS and its partners are communicating with SAMHSA and the DEA about the challenge and barrier caused by the DEA requirement that mobile MAT units must return to its home location each day, limiting the area that can be covered in a day and the efficiency of reaching people in rural and remote areas.

Another barrier for members on MAT and MOUD is that some residential treatment programs do not accept members on MAT or MOUD as they are abstinence based programs. AHCCCS is aware of this issue and is actively working to identify strategies to remove this barrier to treatment, which is based on an outdated and not evidence-based view of abstinence vs MAT and MOUD services.

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Footnotes:

Environmental Factors and Plan

15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

Arizona's Medicaid programs have gained recognition for their innovative approach to behavioral health crisis services. The AHCCCS crisis care continuum encompasses a comprehensive range of services, including crisis telephone response, mobile crisis team intervention, facility-based stabilization (including observation and detox), and all other covered services available to any Arizona resident, regardless of insurance coverage. Ensuring recovery-oriented and person-focused care, the crisis services aim to stabilize individuals promptly, enabling them to return to their baseline of functioning.
To oversee the crisis care continuum, AHCCCS utilizes the Regional Behavioral Health Agreements (RBHAs) as the Managed Care

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis lifeline network

ii. Not in the suicide lifeline network

b. Number of Crisis Call Centers with follow up protocols in place

c. Percent of 911 calls that are coded as BH related

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of first responder structures (police, paramedic, fire)

b. Integrated with first responder structures (police, paramedic, fire)

c. Number that employs peers

3. Safe place to go or to be:

a. Number of Emergency Departments

b. Number of Emergency Departments that operate a specialized behavioral health component

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☐	☑
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to go or to be	☐	☐	☐	☐	☐	☑

b. Briefly explain your stages of implementation selections here.

The Arizona crisis system is presently in the program sustainment phase of implementation. Over the years, the utilization of crisis services in Arizona has exhibited a consistent upward trend, with a notable surge following the introduction and promotion of the national lifeline, 988. The growing recognition of the advantages offered by crisis services, coupled with a reduction in stigma, suggests that the demand for such services will likely continue to escalate. In response to this, AHCCCS is committed to enhancing our system by diligently monitoring network sufficiency, service quality, and individual outcomes. Moreover, we are dedicated to allocating resources strategically, with a focus on fostering innovation and facilitating increased access to care.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

According to SAMHSA's National Guidelines for Behavioral Health Crisis Care, The Arizona crisis system is currently in the program sustainment stage. During this phase Arizona's efforts will focus on maintaining and continuously improving the system's effectiveness and outcomes.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

Proposed/planned activities utilizing the 5% MHBG Crisis set aside include:
1. Crisis Hotlines and Helplines: Enhancing or maintaining access to state operated crisis hotlines and helplines that provide 24/7 support for individuals in crisis, ensuring they have immediate access to trained professionals via call, text, or chat options.
2. Mobile Crisis Response Teams: Bolstering mobile crisis response teams that can quickly respond to crisis situations in the community, providing on-site support and de-escalation.
3. Crisis Stabilization Centers: Creating or improving crisis stabilization centers as an alternative to emergency room admissions,

Please indicate areas of technical assistance needed related to this section.

None at this time.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	(•) Yes ( ) No
b)	Required peer accreditation or certification?	(•) Yes ( ) No
c)	Use Block grant funding of recovery support services?	(•) Yes ( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(•) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (•) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

SAMHSA, the Substance Abuse and Mental Health Services Administration define recovery as “the process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.” In Arizona, we have Peer-Run Organizations, Family-Run Organizations, and Specialty Providers that provide services to these populations based on the principles of recovery and resiliency. Recovery support services are for all AHCCCS members including adults with a serious mental illness designation. AHCCCS requires all members with a designation of SMI or SED be offered recovery support services during the initial planning process. These services are provided to many specialty populations including members involved in the justice system, dual diagnosis, in tribal communities, and faith-based organizations and include peer support and credentialed family support. Individuals providing peer support and/or family support are credentialed as Peer Recovery Support Specialists (PRSS) through an AHCCCS approved training program. Credentialed family support training is established in AHCCCS policy including elements for children with SED. Credentialed family support (CFSS) is provided by family members of children with SED who have completed training and credentialing with state approved curricula. This applies the peer principal to family support which traditionally can be provided by individuals without "lived experience." CFSS ensures that those providing the service can relate to those they are serving as peers with shared lived experience of raising children with SED.

AHCCCS Policy AMPM 100 establishes the 9 Guiding Principles of Adult System of Care and Arizona Vision and 12 Principles for Children's System of Care as outlined below. These principles came directly from members and family members to guide us as the State Medicaid Authority in the fundamental values of recovery in the adult system and resiliency in the children's system.

The following Nine Guiding Principles to promote recovery in the adult behavioral health system and for engaging with adults who have a serious mental illness:
1. RESPECT: Respect is the cornerstone. Meet the person where they are without judgment, with great patience and compassion.
2. PERSONS IN RECOVERY CHOOSE SERVICES AND ARE INCLUDED IN PROGRAM DECISIONS AND PROGRAM DEVELOPMENT EFFORTS: A person in recovery has choice and a voice. Their self-determination in driving services, program decisions, and program development is made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the “informed consumer” and the broadest possible palette from which choice is made. Persons in recovery should be involved at every level of the system, from administration to service delivery.
3. FOCUS ON INDIVIDUAL AS A WHOLE PERSON, WHILE INCLUDING AND/OR DEVELOPING NATURAL SUPPORTS: A person in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual’s social community.
4. EMPOWER INDIVIDUALS TAKING STEPS TOWARDS INDEPENDENCE AND ALLOWING RISK TAKING WITHOUT FEAR OF FAILURE: A person in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.?
5. INTEGRATION, COLLABORATION, AND PARTICIPATION WITH THE COMMUNITY OF ONE’S CHOICE:
A person in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscores one’s role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.
6. PARTNERSHIP BETWEEN INDIVIDUALS, STAFF, AND FAMILY MEMBERS/NATURAL SUPPORTS FOR SHARED DECISION MAKING WITH A FOUNDATION OF TRUST: A person in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants, and lead to the creation of optimum protocols and outcomes.
7. PERSONS IN RECOVERY DEFINE THEIR OWN SUCCESS: A person in recovery – by their own declaration – discovers success, in part, by quality of life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Persons in recovery are the experts on themselves, defining their own goals and desired outcomes.
8. STRENGTHS-BASED, FLEXIBLE, RESPONSIVE SERVICES REFLECTIVE OF AN INDIVIDUAL’S CULTURAL PREFERENCES: A person in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and mores. A person in recovery is the source of his/her own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for

generating greater autonomy and effectiveness in life.
9. HOPE IS THE FOUNDATION FOR THE JOURNEY TOWARDS RECOVERY: A person in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. A person in recovery is held as boundless in potential and possibility.

In addition, Arizona/AHCCCS collaborated with the child, family, and others to provide services that are tailored to meet the needs of children with serious emotional disturbances and their caregivers. The goal is to ensure that services are provided to the child and family in the most appropriate setting, in a timely manner, in accordance with the best practices and respecting the child, family and their cultural heritage.

The Twelve (12) Principles for Children's in the Behavioral Health Service Delivery System:
1. COLLABORATION WITH THE CHILD AND FAMILY: Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. FUNCTIONAL OUTCOMES: Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
3. COLLABORATION WITH OTHERS: When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented. Client centered teams plan and deliver services. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, DCS and/or DDD caseworker, and the child's probation officer. The team (a) develops a common assessment of the child's and family's strengths and needs, (b) develops an individualized service plan, (c) monitors implementation of the plan, and (d) makes adjustments in the plan if it is not succeeding.
4. ACCESSIBLE SERVICES: Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need. Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided. Behavioral health services are adapted or created when they are needed but not available.
5. BEST PRACTICES: Competent individuals who are adequately trained and supervised provide behavioral health services. They are delivered in accordance with guidelines adopted by ADHS that incorporate evidence-based "best practice." Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in class member's lives, especially class members in foster care. Behavioral Health Services are continuously evaluated and modified if ineffective in achieving desired outcomes.
6. MOST APPROPRIATE SETTING: Children are provided behavioral health services in their home and community to the extent possible. Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.
7. TIMELINESS: Children identified as needing behavioral health services are assessed and served promptly.
8. SERVICES TAILORED TO THE CHILD AND FAMILY: The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided. Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.
9. STABILITY: Behavioral health service plans strive to minimize multiple placements. Service plans identify whether a class member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk. Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops. In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and criminal justice system. Behavioral health service plans anticipate and appropriately plan for transitions in children's lives, including transitions to new schools and new placements, and transitions to adult services.
10. RESPECT FOR THE CHILD AND FAMILY'S UNIQUE CULTURAL HERITAGE: Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family. Services are provided in Spanish to children and parents whose primary language is Spanish.
?11. INDEPENDENCE: Behavioral health services include support and training for parents in meeting their child's behavioral health needs, and support and training for children in self-management. Behavioral health service plans identify parents' and children's need for training and support to participate as partners in assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, will be made available.
12. CONNECTION TO NATURAL SUPPORTS: The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents' own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

Recovery support services are offered to members in all stages of treatment and all levels of care. Outpatient clinics, residential facilities, inpatient facilities, and MOUD facilities all have necessary recovery support services to help ensure the best chance at recovery. These services are provided both in office and in the community. Recovery support services can help provide support and assistance in gaining and growing a community support system as well as teach important independent living skills. Peer recovery support services are available to all individuals we serve, including those with substance use disorders, with specialty training and support specifically to members with opioid use disorders. Peer and Recovery Support Specialists (PRSS) serving members with SUD, have substantial representation within Arizona's recovery support workforce. PRSS who serve members with SUD are employed in many settings including within Medication for Opioid Use Disorder (MOUD) programs.

The AHCCCS Medical Policy Manual (AMPM 310-B) outlines coverage for PRSS Medicaid members including children and adults while the AMPM 300-2B outlines covered services for Non-Medicaid funding such as SABG, which includes Peer Services. AMPM 963 Peer and Recovery Support Service Provision Requirements such as qualifications for the PRSS, continuing education, supervision of PRSS by a BHT or BHP, training standards, and the approval process, among others.

In addition to the coverage of recovery and peer support through both Title XIX/XXI and Non-Title XIX/XXI funding streams, the SABG funds additional recovery efforts through the ACC-RBHAs, TRBHAs and the Sonoran Prevention Works harm reduction program. Examples include:
Oxford House - a democratic, self-run, peer-run sober living environment that provides a housing option with an environment conducive to recovery for members in recovery from SUD
The Barbell Saves Project - a gym for and by people in recovery from SUD that implements recovery programming around physical fitness and holistic health, highlighting the impacts that the support of peers and health and fitness focus can have on maintaining sobriety
Supporting to expansion of PRSS through hiring and training additional PRSS across the BH provider network and system, including placement of PRSS in the crisis system
Funding to AZ Peer and Family Academy to enhance and increase training to PRSS and their supervisors
Community Medical Services' pilot implementation of the Recovery Path application
Valle Del Sol's implementation of recovery coaches re-engaging member when they no-show to the clinic
Connie Hillman house implementing programs for supporting parenting individuals in recovery
Engagement specialists provision of recovery toolbox groups

5. Does the state have any activities that it would like to highlight?

All policies overseeing Recovery services are informed and guided directly by stakeholders including behavioral health service providers, RBHAs/TRBHAs, and members who receive said services and their professional and personal support systems.

Please indicate areas of technical assistance needed related to this section.

None at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	○ Yes	○ No
Home and community-based services	○ Yes	○ No
Peer support services	○ Yes	○ No
Employment services.	○ Yes	○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED?	(•) Yes	( ) No
b) The resilience of children and youth with SED?	(•) Yes	( ) No
c) The recovery of children and youth with SUD?	(•) Yes	( ) No
d) The resilience of children and youth with SUD?	(•) Yes	( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare?	(•) Yes	( ) No
b) Health care?	(•) Yes	( ) No
c) Juvenile justice?	(•) Yes	( ) No
d) Education?	(•) Yes	( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization?	(•) Yes	( ) No
b) Costs?	(•) Yes	( ) No
c) Outcomes for children and youth services?	(•) Yes	( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?	(•) Yes	( ) No
b) Mental health treatment and recovery services for children/adolescents and their families?	(•) Yes	( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system?	(•) Yes	( ) No
b) for youth in foster care?	(•) Yes	( ) No
c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems?	(•) Yes	( ) No
d) Does the state have an established FEP program?	(•) Yes	( ) No
Does the state have an established CHRP program?	( ) Yes	(•) No
e) Is the state providing trauma informed care?	(•) Yes	( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

AHCCCS requires all health plans, regardless of the type, amount, duration, scope, service delivery method, and population served to ensure that their service delivery systems:
1. Coordinate and provide access to high-quality health care services informed by evidence-based practice guidelines in a cost-

effective manner
2. Coordinate and provide access to high-quality health care services that are culturally and linguistically appropriate, maximize personal and family voice and choice, and incorporate a trauma-informed care approach
3. Coordinate and provide access to preventive and health promotion services, including wellness services
4. Coordinate and provide access to comprehensive care coordination and transitional care across settings; follow-up from inpatient to other settings; participation in discharge planning; and facilitating transfer from the children's system to the adult system of health care
5. Coordinate and provide access to chronic disease management support, including self-management support
?6. Conduct behavioral health assessment and service planning following a Health Home model
7. Coordinate and provide access to peer and family delivered support services, based on member's needs, voice, and choice
8. Provide covered services to members in accordance with all applicable Federal and State laws, regulations, and policies
9. Coordinate and integrate clinical and non-clinical health-care related needs and services across all systems
10. Implement health information technology to link services, facilitate communication among treating professionals and between the health team and individual and family caregivers
11. Deliver services by providers that are appropriately licensed or certified, operating within their scope of practice, and registered as an AHCCCS provider.?
AHCCCS further requires that at all ACC Plans work in partnership to meet, agree upon, and create in writing joint collaborative protocols with each County, District, or Regional Office of:
1. Administrative Office of the Courts
2. Juvenile Probation and Adult Probation
3. Arizona Department of Corrections and Arizona Department for Juvenile Corrections
4. Arizona Department of Child Safety (DCS)
5. Tribal Nations and Providers
6. The Veterans Administration and
7. The County jails.

In order to coordinate the delivery of services to members served by both/all involved entities, ACC plans must ensure that each collaborative protocol addresses, at a minimum, the procedures for each entity.

AHCCCS ACC plans are contractually required to report on performance measures that consider underlying performance, performance gaps, reliability and validity, feasibility, and alignment. These performance measures are also evaluated based on several demographics to reduce, to the extent practical, health disparities based on age, race, ethnicity, sex, primary language, and disability status. These measures are used to evaluate whether ACC Plans are fulfilling key contractual obligations and are an important element of the agency's approach to transparency in health services and Value Based Purchasing (VBP). ACC Plans performance is publicly reported on the AHCCCS website (e.g., report cards and rating systems), as well as other means, such as the sharing of data with state agencies and other community organizations and stakeholders. ACC Plans performance is compared to AHCCCS requirements, with the national NCQA Medicaid Mean (for NCQA HEDIS ® measures) and the CMS Medicaid Median (for CMS Core Set Only measures) for the associated measurement period serving as the performance target for each contractually required performance measure. ACC-RBHAs providing SABG and MHBG services are contractually required to submit quarterly, bi-annual and/or annual reports which are reviewed by the prospective teams and discussed at monthly meetings as needed.

7. Does the state have any activities related to this section that you would like to highlight?

MHBG-Specific Examples

For the youth population identified as experiencing First Episode Psychosis (FEP) or Serious Emotional Disturbances (SED), AHCCCS ensures providers are coordinating with an array of community services, including but not limited to: treatment services including outreach, engagement/reengagement, peer support, individual, family and group therapies, educational support, medication management, medical services, Federally Qualified Health Centers (FQHCs), school-based service programs, case management, suicide prevention and ideation services, crisis intervention, skills training and development, and family preservation services. AHCCCS is collaborating with and supporting all ACC-RBHAs as they expand and/or bolster FEP services throughout the state including additional treatment locations in highly populated areas and efforts for mobile FEP service delivery, training, and technical assistance for previously underserved frontier areas of Arizona.

AHCCCS has recently contracted with The Innovations Institute, a founding member of the National Wraparound Initiative (NWI) and the National Wraparound Implementation Center (NWIC) to develop and procure an Arizona based Center of Excellence in the implementation of Wraparound, FOCUS, and MRSS installation. NWIC provides training, coaching, systems level technical assistance, research/evaluation and enhances distance coaching options to states and organizations implementing Wraparound. Wraparound is an evidence-based model of care coordination that is utilized for children diagnosed with SED and/or CALOCUS score of 4 or higher; FOCUS modernizes traditional case management models and operationalizes values within a system of care framework for youth with lesser complex needs than the intensity of Wraparound but remain at risk of intensified system involvement including custody/involvement with Department of Child Services (DCS) or juvenile justice involvement or whose needs exceed the resources of a single organization or a family's capacity to gain access to needed supports and services. Mobile Response and Stabilization Services (MRSS) is a child, youth, and family specific crisis intervention model that meets a parent/caregiver's sense or urgency with a child/youth demonstrates escalating behavioral health and/or substance use symptomatology with the goal of in home de escalation and intervention reducing the need for immediate higher level of care.

Within the next year, all First Episode Psychosis programs throughout Arizona will be actively utilizing the Coordinated Specialty

Care (CSC) model for treatment to standardize expectations for service delivery and to improve member outcomes statewide. AHCCCS is collaborating with and supporting all ACC-RBHAs as they expand and/or bolster FEP services throughout the state including additional treatment locations in highly populated areas and efforts for mobile FEP service delivery, training, and technical assistance for previously underserved frontier areas of Arizona.

AHCCCS providers also focus on services and programs that address school violence related to mental health through Youth Engagement Specialists that are trained to outreach and assess the needs of these youth populations and ensure refer to services are occurring as needed. The Youth Engagement Specialists are trained in assessment and suicide prevention and work with students referred by schools for behavioral health services. These supportive services are offered to students through tele-health and in-person appointments. AHCCCS providers continue to build relationships with school districts within each Geographic Service Area (GSA), with many partnerships within local schools already in place to ensure coordination of services between youth identified as at risk.

AHCCCS is currently utilizing supplemental MHBG funding to expand services within these vulnerable populations through the building and identification of additional services and providers for children and adolescents. AHCCCS will ensure providers are building partnerships with key stakeholders for these populations to ensure youth services are inclusive of all areas of need. These additional projects include the following items:

Children/Adolescents with SED/FEP
Implementation of a statewide standardized process for early identification and referral for SED assessment.
Implementation of an SED assessment and determination process to standardize identification and utilization statewide
Implementation of co-located models of care and strengthening of evidence-based practice delivery for justice involved youth.
Implementation of a Child Psychiatry Access Program (CPAP) to expand access to child and adolescent psychiatrists for Primary Care Providers (PCPs)
Creation of electronic crisis services locator and bed registry
Expansion of the availability of parent and family support services, Child and Family Team (CFT) coaches, and professional development opportunities to support the behavioral health workforce.
Development of 23 hour crisis child and adolescent observation units in Central and Northern Arizona
Development of statewide intensive crisis wraparound teams
Wraparound, FOCUS, and MCSS Center of Excellence

SABG-specific examples

To better serve youth who are most at risk for substance use disorder, AHCCCS is utilizing SABG funding to launch several new projects within the continuum of care that target adolescents.

Service providers are developing opportunities to cultivate youth with lived experience to serve as peer support as adults. AHCCCS is referring to this as pre-peer support. Programming includes mentorship programs, youth-led community projects, and youth development programs collaboratively implemented with American Indian tribes, justice system partners, and youth diversion.?
Detention Centers employ Behavioral Health Technicians and Clinicians to administer assessments for youth without an existing community-based treatment relationship. This improves continuity of care for youth in detention settings.
Expansion of Juvenile Justice Engagement Team (JJET) Liaisons to include services for juveniles in qualified detention facilities. JJET's primary purpose is to resolve service barriers and other concerns for Probation, families, or other treatment stakeholders while juveniles temporarily reside in detention facilities.
AHCCCS' plan also includes non-billable outreach and coordination staff for qualified detention centers and billable Covered Services to include substance use disorder treatment and support services. Individual therapy, case management, and Teen AA classes are most offered to juveniles in a detention setting.

Building upon the work of the PPW-PLT learning collaborative, AHCCCS is using SABG funding to support programs that integrate SUD treatment with health and family service agencies with a focus on pregnant and postpartum women and their babies and children.

Service providers are offering maternal mental health programs that support the complex OB and substance use disorder needs of pregnant and postpartum women in recovery. Services include the provision of MAT (Medication Assisted Treatment) modalities through data-waivered, office-based opioid treatment counselors, expanding both perinatal and postpartum depression programs and family support services.
Detoxification programs for substance-exposed newborns and supportive services to their mothers are being offered together, serving the mother/baby dyad. Parenting courses are a key component of programming.
Supported independent living programs utilize outpatient services for women in substance use disorder who are living with their children while in recovery. In these programs, treatment is designed to replicate a full-time job. Women are engaged in services 40 hours per week and childcare is provided. Case management, group processing, individual counseling, life skills (budgeting, scheduling, meal planning etc.), vocational services, and 12 step meetings are offered.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

In Arizona, our state suicide prevention team is housed within our sister agency, the Arizona Department of Health Services (AZDHS). AZDHS partners with multiple stakeholders, including AHCCCS, in creating and implementing recommendations outlined in the Suicide Prevention Action Plan. This plan is updated bi-annually and can be located here: https://www.azdhs.gov/prevention/tobacco-chronic-disease/suicide-prevention/index.php

The primary goals of our state plan to address suicide in Arizona include ensuring suicide prevention resources, crisis support, and treatment services are universally available to clinicians, communities, families, and survivors; utilizing current community trends in order to best address emergent threats and direct future efforts; supporting disproportionately affected persons and populations with focused interventions that are appropriate and delivered with cultural humility and respect; supporting state prevention efforts by serving as a focal point for internal and external coalitions and partnerships; and improving the resilience of individuals and communities.

AHCCCS implements, oversees, and supports multiple programs and projects to carry out the goals outlined in the Suicide Prevention Plan. Initiatives and activities intended to reduce incidents of suicide are imbedded into all elements of our behavioral health delivery system.

An integral part of suicide prevention is accessible, high quality intervention in times of crisis. Arizona's crisis services are often referenced as an example among Medicaid programs. SAMHSA recently described Arizona as a "pace car" state in regard to our innovative approach to behavioral health crisis services. The AHCCCS model approaches crisis care with a "no wrong door" policy and offers a comprehensive array of ancillary crisis services that are available to any Arizona resident, regardless of insurance coverage, and exemplifies SAMHSA's guidelines of "someone to call, someone to respond and a safe place to receive help." Crisis services are required to be recovery-oriented, person focused, and work to stabilize the individual as quickly as possible to assist them in returning to their baseline of functioning. All interventions are required to be offered in a clinically and culturally appropriate manner that respects the preferences of the individual in crisis, while recognizing the need to maintain safety.

Arizona's crisis services utilize a braided funding model including Medicaid, State Appropriated, Block Grant, and other funding that allows our Managed Care Organizations (MCO's) with Regional Behavioral Health Agreements (RBHAs) to support this no wrong door model throughout Arizona's crisis care continuum. This braided funding prioritizes immediate service provision and funding can be assigned after a crisis has been resolved.

AHCCCS utilizes the Regional Behavioral Health Agreements (RBHAs) as the Managed Care Organizations (MCOs) responsible for the full continuum of crisis services to all individuals within their assigned Geographical Service Area (GSA) to prevent a potentially dangerous condition, episode, or behavior. AHCCCS Medical Policy 590 - Behavioral Health Crisis Services and Care Coordination - https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/500/590.pdf specifies how AHCCCS defines a crisis and outlines RBHA's responsibilities in providing the continuum of crisis care. The crisis care continuum includes crisis telephone response, mobile crisis teams, facility-based stabilization (including observation and detox), and all other associated covered services delivered by crisis service providers. AHCCCS and the RBHAs contract with a single provider, Solari, to ensure consistency in the crisis call center process by utilizing a single provider as opposed to coordinating services through several agencies.

Arizona's State Crisis Line and the 988 National Suicide Prevention Lifeline are integrated to provide a live answer response to all callers 24 hours a day, 7 days a week. AHCCCS and the Arizona Department of Health Services partnered to fund a substantial media campaign to increase awareness and encourage use of the 988 Suicide and Crisis Prevention Lifeline. Call center staff are qualified behavioral health professionals (BHP) and/or behavioral health technicians (BHT) under the supervision of a BHP and are trained to assess caller needs, provide de-escalation support, and connect callers to additional supports such as crisis mobile teams or crisis stabilization facilities if the caller's crisis cannot be resolved by phone. By operating the call center as a hub, call center staff are able to maintain contact with the callers while establishing a warm hand off to other services providers including directly dispatching crisis mobile teams and arranging transportation for callers who prefer to go to a 24/7 crisis stabilization facility. For individuals who disclose their identity and are already enrolled in an AHCCCS Medicaid program, the call center is required to provide notification to the plan of enrollment within 24 hours to ensure follow up and support during and after the crisis episode. For individuals not actively enrolled in an AHCCCS Medicaid program who may be uninsured or underinsured, the RBHA is required to ensure the provision of continued support to the individual for up to 72 hours to confirm that the crisis is

resolved and ensure the person is connected to community support and services available in their area (e.g. behavioral health services, counseling, support groups, faith based organizations, food banks, housing support and/or other resources dependent upon member's needs). Call centers are required to adhere to SAMHSA's National Guidelines for Behavioral Health Crisis Care, National Suicide Lifeline Policy for Helping Callers at Imminent Risk of Suicide, and partner in Zero Suicide efforts. Call center counselors are also able to connect callers to Warm Lines operated by credentialed peers for ongoing connection and support if requested.

Crisis Mobile Teams (CMT) dispatched by the call center use GPS technology to identify the team closest to the caller. CMT's are available to respond to all areas of the state 24 hours a day, 7 days a week. CMT composition is outlined in contract and policy including a requirement to employ no less than 25% credentialed peers. The RBHAs are required to ensure that CMTs respond to requests for assistance from Law enforcement within 30 minutes of request, community members in urban areas within 60 minutes of request, and to community members in rural areas within 90 minutes of request. Data verifying response times are provided to and monitoring by AHCCCS via monthly deliverables. Crisis Mobile teams that are not able to support a person in resolving the crisis in the community are able to coordinate directly with a crisis stabilization facility and provide transportation to a facility when needed. This direct coordination ensures a warm hand off and minimizes the amount of duplication a person has to endure when moving through the crisis continuum.

RBHAs are required to establish and maintain crisis stabilization settings that provide 24-hour SUD/psychiatric crisis stabilization services and 23-hour crisis stabilization/observation capacity, crisis stabilization services that provide access to all Food and Drug Administration (FDA) approved MAT options covered under the AHCCCS Drug List, short-term crisis stabilization services in an effort to successfully resolve the crisis and return the individual to the community instead of transitioning to a higher level of care, accept all referrals adhering to a "no wrong door" approach, and ensure streamlined practices for swift and easy transfer of individuals from law enforcement and public safety personnel.

The RBHAs are additionally required to provide community information about crisis services and develop and maintain collaborative relationships with community partners including: fire, police, emergency medical services, hospital Emergency Departments (EDs), AHCCCS Health Plans, Tribal partners and other providers of public health and safety services. RBHAs provide regular Crisis Intervention Team (CIT) training and Mental Health First Aid to law enforcement (LE) and other community partners, including federal and tribal entities. RBHAs encourage two-way connections between LE and behavioral health providers in their communities to enhance relationships and better support individuals experiencing behavioral health crises who engage with law enforcement.

Recognizing that consistent, proactive, and ongoing quality behavioral health care to address factors leading to a behavioral health crisis reduces the risk of suicide, AHCCCS requires that RBHA Contractors ensure individuals receive a Post-Crisis Care Plan and ensure that post-crisis care coordination and service delivery occur to address the individual's ongoing needs and ensure resolution of the crisis. AHCCCS Policy 1040 - Outreach, Engagement, and Re-Engagement for Behavioral Health: https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/1000/1040.pdf outline essential elements of clinical practice and mandate the provision of critical activities regarding service delivery with the AHCCCS System of Care including:

1. Establish expectations for the engagement of members seeking or receiving behavioral health services.
2. Determine procedures to re-engage members who have withdrawn from participation in the behavioral health treatment process.
3. Describe conditions necessary to end re-engagement activities for members who have withdrawn from participation in the treatment process, and
4. Determine procedures to minimize barriers for serving members who are attempting to re-engage with behavioral health services.

The policy also outlines requirements for ensuring providers are eliciting active engagement in treatment planning policies, following up after significant and/or critical events (including member involvement in the behavioral health crisis system within 72 hours and member discharge from inpatient services no later than 7 days following discharge), refusal to adhere to prescribed psychotropic medication schedule, when a member changes location or when there is a change in the individual's level of care.

The ability of an individual to access and obtain transportation to integrated services to address their needs also reduces suicide risk. As such, AHCCCS Contractor Operations Manual Policy 417 - Appointment Availability, Transportation Timelines, Monitoring, and Reporting: https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/400/417_Appointment_Availability_Monitoring_and_Reporting.pdf establishes appointment accessibility and availability standards and establishes a common process for Contractors to monitor and report appointments accessibility and availability including provision of a comprehensive provider network and standards to validate adequacy of their established network, written policies and procedures about educating its provider network regarding appointment time requirements, and general appointment standards for all contractors. Urgent Need General Behavioral Health appointments need occur "as expeditiously as the member's health condition requires but not later than 24 hours from identification of need" and Routine Care Appointments as follows:

1. Initial assessment within seven calendar days of referral or request for service
2. The first behavioral health service following the initial assessment as expeditiously as the member's health condition requires but, for members ages 18 years or older, no later than 23 calendar days after the initial assessment, and for members under the age of 18 years old, no later than 21 days after the initial assessment.
3. All subsequent behavioral health services, as expeditiously as the member's health condition requires but no later than 45 calendar days from identification of need.

In 2019, the Arizona State legislature passed ARS 15-120: https://www.azleg.gov/ars/15/00120.htm also known as the Mitch Warner Act, mandating that all public school staff who interaction with students grades 6 through 12 be trained in suicide prevention that includes: training in suicide prevention, training to identify the warning signs of suicidal behavior in adolescents and teens, and appropriate intervention and referral techniques. Jake's Law requires that schools have a policy for behavioral health referrals and a process for obtaining parental consent and post it on their website. The Arizona School Board Association

has created a policy with assistance from AHCCCS and ADE to assist school districts with the statutory requirements for Jake's Law. AHCCCS, in coordination with the Arizona Department of Education (ADE) and Arizona Department of Health Service, select multiple school suicide prevention training curricula from which schools can choose to train their staff. These, along with additional resources for schools, are posted annually on the AHCCCS website with direct links to curriculum information and a request form for schools who want to receive training. The ADE prioritizes training to school staff, however, also offers training to community members across the state.
In March 2020, the Arizona Legislature charged ADHS with establishing a Suicide Mortality Review (SMR) to develop a data collection system and evaluate the incidences and causes of death by suicide within the state. AHCCCS leadership serve on the team to examine and evaluate circumstances surrounding a death by suicide in order to:
1. Identify specific barriers and service systems issues experienced in suicide deaths.
2. Identify significant risk factors and trends in suicides.
3. Identify potential protective factors that may decrease suicide risk.
4. Improve the delivery of services to individuals, families, and community members.
5. Analyze the adequacy of state and local laws, trainings, and services to recommend what changes are needed to decrease the occurrences of preventable suicides and, as appropriate, take steps to implement these changes.
6. Inform local and state suicide prevention strategies.
7. Educate the public regarding the incidences and causes of suicide as well as the public's role in preventing suicide deaths.

Additionally, the state SMR Team is charged with developing standards and protocols to assist with the formation of local multi-disciplinary suicide mortality review teams to better understand and address county-level needs and make recommendations and take appropriate actions to reduce the number of preventable suicides. AHCCCS utilizes the information to influence policy and protocol revisions in addition to innovative use of all funding sources to eliminate barriers and service system issues identified.

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

Based on a historical lack of available transitional services serving youth in the Northern region of the state, AHCCCS has partnered with and allocated MHBG ARPA funding to our Regional Behavioral Health Agreement in that GSA, Care 1st, to establish short term transitional residential facilities for youth transitioning out of crisis. The project is underway with facilities in Mohave and Coconino counties being renovated to house two dually licensed facilities providing crisis stabilization and short term transitional residential services for youth. The project also provides additional funding for local behavioral health home providers to increase crisis intervention, care coordination, and high needs care management services for this population.

Recognizing that uninsured or underinsured individuals with suicidal ideation being admitted/discharged from inpatient units and/or emergency departments face barriers to fluid and/or timely transition to outpatient services based on a lack of medical coverage, AHCCCS is revising policies, procedures, and NTIX contracts to expand the utilization of MHBG set-aside funding for Early Serious Mental Illness (ESMI). These revisions will provide coverage to individuals with a recently diagnosed SMI for up to 90 days allowing for additional professional assessment, monitoring, medication management and case management during the time it takes to complete/process both a Medicaid application and a SMI Determination (qualifying a person for long-term SMI coverage in Arizona) in addition to concurrent planning for ongoing service provision should the individual not qualify for Medicaid or be determined SMI. Ensuring fluid access to care during this critical time reduces suicide risk not only in the short term due based on accessibility to less restrictive intervention in this high-risk time of need, but also improves long-term outcomes as people learn that when they come to the system for help, the system effectively provides them with what they need to manage symptoms. This confidence in the system's dependability decreases the discouragement, solitude, and hopelessness related to managing symptoms including suicidal ideation.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

AHCCCS has increased utilization of population-based suicide prevention science. AHCCCS partnered with the Arizona Coalition for Military Families (ACMF) on the Be Connected Initiative to further suicide prevention resources to those who are served in the military and their families, including the development of a gun hygiene tool kit called "Secure Your Weapon." This toolkit is used statewide at gun ranges and with Veteran groups to reduce the rate of suicide by firearm.

The Suicide Prevention Team has worked to identify potential health and behavioral health clinics hospitals and other partners that could adopt or have already adopted the Zero Suicide Model and is promoting adoption of the ZSM in Arizona hospitals and behavioral health clinics. ADHS established internal and external workgroups, including AHCCCS, with the intent of soliciting input and creating buy-in across the state. Foundational planning for ZSM is ongoing with possible inclusion into Arizona's medical infrastructure as a priority for the 2023-2025 Suicide Prevention Action Plan.
A statewide initiative to reduce access to lethal means has been implemented through sharing take-back information on the ADHS Suicide Prevention website as well as beginning community level listening sessions to identify recommendations for reducing the number of firearm-related suicides in Arizona.

AHCCCS partnered with ADHS to fund a campaign advertising the availability of 988 crisis services throughout Arizona. The rollout of this statewide marketing campaign is underway in order to increase public awareness of the crisis services.

In partnership with the American Foundation for Suicide Prevention, AHCCCS contributed funding and expanded distribution of Local Outreach to Survivors of Suicides (LOSS) materials to all Arizona's counties to raise community awareness and support survivors of suicide in addition to identifying volunteers in high priority rural counties to help lead LOSS activities including counseling.

Please indicate areas of technical assistance needed related to this section.

None at this time.

Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

Since the last planning period, AHCCCS has begun working with Arizona State University (ASU), University of Arizona (UA), Northern Arizona University (NAU) for substance use primary prevention services. Under the Emergency COVID-19 grant, AHCCCS collaborated with Arizona Department of Veterans Services (ADVS) to coordinate and provide treatment services for members with co-occurring disorders not otherwise having access to treatment. AHCCCS staff also collaborated with Arizona Department of Juvenile Correction (ADJC) to explore primary prevention options in the juvenile justice system. While a direct contract/agreement was not yet developed, the SABG provided PAX Tools training to ADJC staff. AHCCCS staff collaborated with the DEA Opps Engage team in Yavapai County as well as Yavapai College.

AHCCCS also partners with the Substance Abuse Coalition Leaders of Arizona (SACLAz) to implement direct primary prevention services and media campaign work under the SABG. This partnership is also leveraged to enhance reach of communications and stakeholder engagement to the larger AZ substance use prevention field.

In collaboration with the Arizona Department of Education (ADE) and Arizona Department of Health Services (ADHS), AHCCCS has

worked to increase the awareness of schools on funding sources available in the state for covering behavioral health services for students. This work has been accomplished through presentations and maintenance of a guide that helps schools to establish comprehensive school mental health programs that include referrals to community behavioral health providers for services. AHCCCS requires that the ACC plans and ACC-RBHAs post contact information on their website for schools to outreach for assistance with establishing partnership with community behavioral health providers. AHCCCS also holds two quarterly meetings with ACC plans, ACC-RBHAs, ADE, and other system partners to report on activities to increase awareness, build relationships between school and providers, and ensure access to care for students. AHCCCS has also established a feedback form that allows schools to report both the successes and barriers that they are experiencing when making referrals to providers. Our partnerships with ADE and ADHS have been key in disseminating, both the feedback form as well as a universal referral form that was developed to reduce burden on the schools when making referrals.
The Arizona Revised Statute (ARS) 15-120, known as the Mitch Warnock Act, went into effect for the 2020-2021 school year. This act Mandates school professionals who interact with students grades 6-12 to be trained in suicide prevention once every three years. Project AWARE facilitates partnership and collaboration between ADE, ADHS, and AHCCCS to review and post annual suicide curriculums for training of school professionals. This year two additional training will be added to the suicide list.
Per the statute, the training must include:
1. Training in suicide prevention,
2. Training to identify the warning signs of suicidal behavior in adolescents and teens, and
3. Appropriate intervention and referral techniques.
The key aspect to #3 is that all suicide prevention curriculums are going to tell school staff to refer students when they identify the warning signs of suicidal behavior. Therefore, the staff member is going to refer the student to a BH community provider. Signing multiple partnerships between LEAs and BH providers (such as La-Frontera, Not My Kid, Resilient Health, Bayless, Open Hearts etc.) has been very helpful in assisting multiple students. The primary goal of Project AWARE is to facilitate and ensure a multiplicity of partnerships so that students receive the treatment they need.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

State and local entities coordinate services in a number of ways that impact the efficiency, effectiveness, quality, and cost effectiveness of services as well as outcomes. For information on coordination with local school systems, see response to question #2.

One mechanism for ensuring this coordination is through contract requirements. AHCCCS requires that all ACC plans work in partnership with all other ACC plans, ACC-RBHAs and TRBHAs in its Geographical Service Area(s) to meet, agree upon and establish MOUs and/or joint Collaborative Protocols with other state agencies and system partners. Protocols and/or MOUs represent robust and meaningful collaborative processes and relationships to meet members' specific needs (e.g., adult, child, SMI, GMHSU, justice-involved). Each collaborative protocol, at a minimum, is required to address:
1. Procedures for each entity to coordinate the delivery of covered services to members served by both entities.
2. Mechanisms for resolving problems.
3. Information and data sharing.
4. Resources each entity commits for the care and support of members mutually served.
5. Procedures to identify and address joint training needs.
6. Where applicable, procedures to have providers co-located with jails, prisons, and detention facilities or other agency locations as directed by AHCCCS.

Additionally, the Non-Title XIX/XXI contact includes language for coordination of care and services, including but not limited to continuity of care for members in court ordered treatment, coordination of housing subsidies and supportive services, coordination of treatment and early intervention services with other appropriate services (including health, social, correctional, criminal justice, educational, vocational rehabilitation, and employment services), coordination of benefits and third party liability, coordination with the Title XIX/XXI funding/payors, private insurance, tribal payors, and providers.

AHCCCS policies for Covered Behavioral Health Services under Title XIX/XXI (AMPM 310-B) and the Non-Title XIX/XXI funds (AMPM 300-2B) are posted on the AHCCCS website.
The Non-Title XIX/XXI requires a "no wrong door" model to maximize access to the SUD treatment system and the monitoring provider interventions that serve a variety of populations of focus.

AHCCCS also implements requirements and systems around case management and referral processes that contribute. AHCCCS implements requirements for ACC-RBHAs to have established processes in place to receive referrals for, and refer members to, Non-Title XIX/XXI services, and also requires most primary prevention providers to have MOUs with ACC plans, ACC-RBHAs, TRBHAs, and/or providers as applicable to their local jurisdiction, for referrals to appropriate care. Additionally, the Closed Loop Referral System is a new platform that AHCCCS launched in late 2022,known as CommunityCares. The CLRS supports members' health-related social needs, which have a direct impact on their physical and mental health. CommunityCares is an electronic tool that AHCCCS health care providers can use to screen and refer members for health-related social needs. The system contains preloaded screening tools like the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) which allows providers to quickly screen members for gaps in care and immediately provide referrals to local community based organizations to

address their health-related social needs. The tool supports streamlined care coordination between health care providers and community based organizations, where there has historically not been a connection. The tool is free of cost for AHCCCS-registered health care providers and community-based organizations, which is a cost-effective way of addressing critical needs that impact our members' physical and mental health.

Case management services are a covered service for all members, and AHCCCS implements additional requirements for case management for Tuberculosis and HIV/AIDS services SABG members.
Additionally, services among those at increased risk for behavioral health problems and those disproportionately impacted by substance use, related risk factors, etc. are another way that services are implemented in a way to enhance effectiveness, efficiency, and outcomes. Service provision is often targeted toward members and populations that experience the highest need, thereby addressing the most vulnerable and most impacted populations. When services are implemented among these populations, successful treatment results in better health outcomes that reduce the cost of health care.
An example is behavioral health supports in the criminal justice system. AMPM 320-T1 and AHCCCS' SAMHSA-approved plan for use of block grants the juvenile justice system outlines the requirements and program efforts for this work. As outlined in the policy, services shall be provided:
1. Only to voluntary members,
2. By qualified BHPs/BHTs/BHPPs,
3. Based upon assessed need for SUD services,
4. Utilizing EBPPs,
5. Following an individualized service plan,
6. For a therapeutically indicated amount of duration and frequency, and
7. With a relapse Prevention plan completed prior to discharge/transfer to a community-based provider.
These interventions facilitate the provision of services either before, during, or after engagement in the system. Tools such as telehealth services can be leveraged to efficiently provide certain behavioral health and related services.

Please indicate areas of technical assistance needed related to this section.

None at this time.

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Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? ○ Yes ○ No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? ○ Yes ○ No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Please indicate areas of technical assistance needed related to this section.

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Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
No Data Available				

*Council members should be listed only once by type of membership and Agency/organization represented.
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Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	0	
Parents of children with SED	0	
Vacancies (individual & family members)	0	
Others (Advocates who are not State employees or providers)	0	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**0**	**0.00%**
State Employees	0	
Providers	0	
Vacancies	0	
Total State Employees & Providers	**0**	**0.00%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	0	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	0	
Total Membership (Should count all members of the council)	**0**	

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Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ○ No

b) Posting of the plan on the web for public comment? ○ Yes ○ No

If yes, provide URL:

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

c) Other (e.g. public service announcements, print media) ○ Yes ○ No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Revision Request:
Web Block Grant Application System (WebBGAS)
FY 2022-2023 Combined Behavioral Health Assessment and Plan Submitted (SABG Plan)
Section IV. Environmental Factors and Plan
Item 23. Syringe Services (SSP)

March 7, 2022

March 7, 2022

Theresa Mitchell Hampton, DrPH, M.Ed.
Public Health Advisor/State Project Officer / COR II / FAC-P\PM
Substance Abuse and Mental Health Services Administration (SAMHSA)
5600 Fishers Lane, Station 13N16–E, Rockville, MD 20857 (courier/overnight use 29000)
O: (240) 276-1365
E: theresa.mitchell@samhsa.hhs.gov

RE: FY 2022-2023 Combined Behavioral Health Assessment and Plan Submitted (SABG Plan), Section IV. Environmental Factors and Plan, Item 23. Syringe Services (SSP)

Dear Dr. Theresa Mitchell Hampton:

Thank you for the opportunity to submit a Revision Request through the WebBGAS portal to support our efforts to utilize the Substance Abuse Block Grant (SABG) to fund elements for a statewide Syringe Service Program (SSP) throughout Arizona. The Arizona Health Care Cost Containment System (AHCCCS), which serves as the Single State Authority, has worked to develop, bid, and subsequently award a statewide contractor, herein known as "contracted provider," "statewide provider," or "Sonoran Prevention Works (SPW)." We aim to implement the program through the following strategies to reduce the rates of overdose, drug-related deaths and injuries, and the transmission of infectious diseases; improve the health and wellness of people who use drugs (PWUD); and reduce costs and burden associated with substance use/misuse on public systems:

1) Naloxone distribution, education, and training;
2) Statewide Syringe Service Program;
3) Trainings for professionals and the broader community;
4) Peer support program to facilitate linkages to treatment and wrap-around supports;
5) Fentanyl testing strip distribution, education, and training;
6) Tailored programming and services for women, especially pregnant and parenting women (SABG Priority Population);
7) Culturally appropriate services and resources; and
8) Stakeholder relationship and capacity building to ensure long-term program sustainability.

As part of this request we included a detailed AHCCCS work plan, timeline for implementation, copies of existing SSP protocols (Arizona Senate Bill 1250), budget and budget justification – *SSP budget portions highlighted in yellow* – including plans for disposal of injection equipment, description of current training needs, location of SSP related activities to be supported with federal funds, SSP metric information, and a few attachments to support the overall request.

The overall aim of this Revision Request is to receive SAMHSA approval to implement our comprehensive, evidence-based, statewide SSP for Arizona to meet the needs of those most vulnerable to overdose and other drug-related consequences.

With your approval, AHCCCS can increase and improve access to care for Arizonans in need of critical support services. I welcome any further questions or requests for additional information.

Sincerely,

K. Cole Challacombe

Kristen Challacombe, Deputy Director for Business Operations

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1. BACKGROUND

Description of proposed model(s) and plans, including MOUs with SSP providers who can supply needles; the grantee will need to maintain documentation showing that any needle/syringe purchases were made with non-federal funds;

Note: The work plan and accompanying attachments submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA) were developed and adapted from the Arizona Health Care Cost Containment System's (AHCCCS) Substance Abuse Block Grant (SABG) proposal submitted for bid by and subsequently awarded to Sonoran Prevention Works (SPW). Portions of the proposal by SPW are included in this work plan, as the proposal is the workplan to be implemented.

On May 24, 2021, Governor Doug Ducey signed into law Arizona Senate Bill 1250, Short Title: overdose; disease prevention; programs, allowing a city, town, county or non-governmental organization, including a local health department or an organization that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors, to establish a Syringe Service Program (SSP) and supports. In addition, on October 26, 2021 – through a Determination of Need (DON) request to the Centers for Disease Control and Prevention (CDC) from the Arizona Department of Health Services (ADHS) – the CDC determined that the State of Arizona is at risk for a significant increase in viral hepatitis infection or HIV outbreak due to injection drug use.

Sharing unsterile injection equipment contributes to the transmission of Hepatitis C (HCV), HIV, and Hepatitis B (HBV) among people who inject/use drugs (PWID/PWUD).[1] SSPs are proven and effective community-based programs supporting a range of services including access to and disposal of sterile syringes and injection equipment, naloxone and fentanyl test strip (FTS) education and distribution, testing for HCV, HBV, and HIV, and linkages to substance use, mental health, and infectious disease care and treatment. SSPs provide services to the most marginalized individuals within our communities, many of whom are often served through SABG funds (i.e., uninsured/ underinsured individuals), and often rely on SSPs as their only source for health care.[2] [3] Decades of research has shown that SSPs provide low-barrier support to PWUD, are safe and cost-effective, reduce healthcare related costs to hospitals/health care systems (e.g., AHCCCS), and increase the likelihood of an individual entering substance use treatment.

Substance Use Disorder (SUD) in the United States is at epidemic levels and has had a disproportionate and long-lasting impact in the State of Arizona. Between June 15, 2017 to November 26, 2021, Arizona experienced 11,235 suspected opioid related deaths and 81,100

[1] Journal of Infectious Diseases: https://doi.org/10.1080/23744235.2020.1727002
[2] Journal of Acquired Immunodeficiency Syndrome: 10.1097/QAI.0000000000001792
[3] Centers for Disease Control and Prevention: https://www.cdc.gov/ssp/syringe-services-programs-summary.html

suspected overdoses.[4] In addition, data from the Arizona Department of Health Services (ADHS) showed that "HIV infections with injection drug use reported as a risk factor have remained relatively stable, yet high, since 2014. In 2020, 15.8 percent of all prevalent cases, and 11 percent of incident cases report IDU as a risk factor. Additionally, opioid-related morbidity and mortality continue to increase with a 198 percent increase in suspected opioid deaths between 2012 and 2019."[5]

Although there is ample literature demonstrating evidence behind treatment for SUD, drug use prevention and treatment efforts are often unable to meet the full spectrum of needs (i.e., wraparound supports) to help reduce the prevalence of chaotic drug use. For many SABG recipients, traditional drug treatment is not always viable or successful due to access barriers, limited availability, rigorous requirements, and personal preferences. According to a report analyzing utilization among Medicaid enrollees with a SUD diagnosis to understand service utilization patterns revealed that only 20 percent of females and 25 percent of males with SUD are receiving community-based services specific to treating their SUD or behavioral health condition.[6] These alarmingly low rates indicate that many individuals with SUD are not receiving the needed treatment and support through the current models of care in our communities. Though the data is specific to Medicaid enrollees, AHCCCS can generalize the data to recipients of SABG funds (N-TXIX/XXI) as services have been historically underutilized across the state. As such, a comprehensive approach that goes beyond naloxone education, training, and distribution is needed to adequately address the needs of substance users across Arizona.

Through this, AHCCCS seeks to expand the current Overdose Education and Naloxone Distribution (OEND) statewide contract to include elements of SSPs to its provision of services to engage the hardest-to-reach Arizonans who use drugs – those who are most medically complicated, and the highest cost to public systems. This new initiative includes the following strategies to reduce the rates of overdose, drug-related deaths and injuries, and the transmission of infectious diseases; improve the health and wellness of PWUD; and reduce costs and burden associated with substance use/misuse on public systems:

1) Naloxone distribution, education, and training;
2) Statewide Syringe Service Program**;
3) Overdose education and trainings;
4) Peer support and wraparound services;
5) Fentanyl testing strip distribution, education, and training;
6) Tailored programming and services for women (SABG Priority Population) **;
7) Culturally appropriate services and resources; and

[4] Arizona Department of Health Services: https://www.azdhs.gov/prevention/womens-childrens-health/injury-prevention/opioid-prevention/index.php
[5] Arizona Department of Health Services: Determination of Need Request, dated October 26, 2021.
[6] Burns & Associates, A Division of Health Management Associates: Delivery of Services to AHCCCS Members with Substance Use Disorder in Calendar Years 2018, 2019 and 2020.

8) Expanded network of key community stakeholders**.

***Indicates new service not previously funded through SABG.*

2. WORKPLAN

Adapted from SPW's bid proposal effective January 1, 2022:

AHCCCS, through the statewide contractor, SPW, aims to develop and implement comprehensive, evidence-based treatment strategies for the State of Arizona to meet the needs of the most vulnerable to overdose and other drug-related harms. *Figure 1* below displays the conceptual model developed for this project, illustrating the relationship between the interventions, immediate outcomes, and long-term outcomes.

Figure 1. Conceptual Model

Intervention	Immediate Outcomes	Long-term Outcomes
1) Naloxone distribution, education, and training 2) Syringe Service Program 3) Education and training 4) Peer support and wraparound services 5) Fentanyl testing strip distribution, education, and training 6) Tailored programming and services for women 7) Culturally appropriate services and resources 8) Expanded network of key community stakeholders	• Increased initiation, continuation, and coordination of evidence-based treatment for individuals who use drugs • Increased harm reduction behaviors such as reduced or safer use, supply testing, and overdose prevention kits • Increased proper disposal of used syringes • Increased public awareness and community engagement	• Reduced rates of overdose, drug-related deaths and injuries, and transmission of infectious diseases • Improved health and wellness of people who use drugs • Reduced costs and burden associated with substance use/misuse on public systems

To achieve the listed outcomes, our strategy consists of eight (8) overarching strategies/interventions:

1) **Naloxone distribution, education, and training:** Expand a comprehensive, statewide naloxone distribution, education, and training initiative for PWUD, prescribers, pharmacists, AHCCCS members and the public. Through the subcontracted provider, we aim to achieve the following objectives:
   - **a.** Distribute Narcan doses via kits to communities across Arizona through targeted street and community outreach.
   - **b.** Conduct in-person and web-based training sessions for prescribers, pharmacists, AHCCCS members, and the public, emphasizing evidence-based responses to opioid overdose and post-overdose support.
   - **c.** Provide naloxone training and technical assistance to the correctional system to at least 50 percent of Arizona jails and 75 percent of state prisons distributing naloxone upon release.

d. Train 10 percent of Arizona group homes for transition-age youth on overdose prevention, recognition, and response.

2) A statewide SSP: Through SPW, AHCCCS aims to implement the following elements for a statewide SSP:

a. Develop and expand needle and hypodermic syringe disposal education and options for the State of Arizona to reach at least 25 percent (5,640) of individuals who have injected drugs in the past year. In order to maximize our reach among our target population, we have developed four strategies to deliver supplies to PWUD: 1) fixed sites, 2) mobile units, 3) mail order programs, and 4) kiosks. Supplies include syringes, safe disposal containers, hygiene and wound care kits, internal and external condoms, rapid home HIV tests, and other associated supplies.

b. Implement a statewide SSP with sites in Yavapai, Maricopa, Pinal, Pima, Yuma, Mohave, Cochise, Navajo, Santa Cruz, and Graham counties (in partnership with Southwest Recovery Alliance, Southern AZ AIDS Foundation, and Community Medical Services). The statewide provider will also create new and expanded mobile and delivery based SSP services to reach PWUD across Arizona. In this project period, we aim to reach at least 25 percent of Arizonans who have injected drugs in the past year (an estimated 5,640 people in 2020).

c. Coordination navigation services and treatment referrals for mental illness, substance use disorder, and other co-occurring disorders for SSP participants, as appropriate. SSPs provide an excellent opportunity to engage PWUD in a community setting with peer support from people with lived experience with substance use. Individuals seeking needles or other supplies may also be offered referrals to navigation services, treatment referrals, or additional services as appropriate. Individuals receiving services from the SSP will be referred into the peer support program as appropriate.

d. Develop and disseminate educational materials to at least 5,640 individuals through the SSP. Educational material may include the following topics: Overdose prevention, peer support services, infectious disease and transmission prevention, education, referrals, and treatment referrals for mental illness, SUD, and co-occurring disorders.

e. Develop and distribute evidence-based standards for distributing and disposing of needles and hypodermic syringes. Currently, the statewide provider, in collaboration with AHCCCS, in the planning phases of developing a statewide SSP standards board in collaboration with people who inject drugs and individuals who work and volunteer at SSPs.

3) Training for professionals and the broader community; Through SPW, AHCCCS aims to implement the following stigma reduction trainings for professionals and the broader community:

a. Develop and distribute educational material to at least 30,000 people through print and electronic distribution. With AHCCCS guidance, SPW will review and adapt existing educational material targeted at PWUD, the general public,

providers, pharmacists, AHCCCS members, and other specific populations as appropriate.

b. Provide at least 20 free, training sessions for community members and the broader public. SPW's training sessions are typically geared toward community members, resource organizations, and medical/behavioral health professionals, with specialized curricula for numerous populations and professions. In coordination with AHCCCS and the program officer, SPW will review and update all training curricula and materials for free general training sessions geared toward community members. Current training topics include overdose prevention and naloxone use, opioid use disorder, stimulant use disorder, stigma, injection-related complications, and other relevant issues. These general trainings are offered in-person or virtually, including virtual video workshops or self-paced online courses.

c. Provide at least 15 training sessions to medical, behavioral health, and social service providers. SPW will develop or enhance trainings on overdose prevention, fentanyl test strip use, stimulants, and other emerging topics and deliver to drug treatment providers, substance use prevention coalitions, health care providers, AHCCCS members, SABG priority populations, organizations who serve women who use drugs, and other groups who engage with PWUD.

d. Conduct at least three trainings each year in each Geographic Service Area (GSA) in Arizona to the Department of Child Safety regional offices on overdose prevention and harm reduction. SPW will adapt existing curriculum to specifically address the unique needs of transition-age youth struggling with substance use/misuse.

e. Provide training to at least 50 percent of Community Corrections offices on overdose prevention. Due to the disproportionate impact of opioid overdoses on criminal-justice involved individuals, we will make a concerted effort to train those that work in the criminal justice system with specialized content for this population.

4) Peer support program to facilitate linkages to treatment and wrap-around supports; Through SPW, AHCCCS aims to implement the following peer support program through the following strategies:

a. Develop and implement a network of at least 75 provider organizations to facilitate linkages to evidence-based care navigation services for individuals requiring a higher level of care. Peer support staff, or Harm Reduction Outreach Workers (HROWs) at SPW work at SSPs and conduct street outreach in order to identify new clients and facilitate referrals to CMS and other organizations.

b. Provide at least 1,500 referrals to treatment through peer support staff for individuals requiring a higher level of care. Referrals may include treatment for: SUD, mental illness, mental health and harm reduction-based counseling, screening and treatment for HIV, viral hepatitis, and STIs, medical treatment and basic wound care. HROWs are peer-certified and specially trained to provide intensive case management services to include support around drug treatment,

medical care, mental health, housing, criminal justice involvement, identification replacement, and other services.

c. Disseminate risk reduction material through peer support staff to 5,000 individuals. Supply kits may include condoms, hygiene products, naloxone kits, fentanyl test strips, and other necessities.

d. Promote awareness through in-depth training for 2,700 individuals about the relationship between injection drug use and communicable diseases, recommended steps for disease transmission prevention, and options for treatment. Through syringe services and rapid HIV/HCV screening, peer support specialists will provide education on prevention, risk mitigation, and treatment for HIV, HCV, and other communicable diseases including hepatitis A and B, COVID-19, and STIs.

5) **Fentanyl testing strip distribution, education, and training;** Through SPW, AHCCCS aims to implement the following strategies:

a. Distribute 120,000 rapid fentanyl testing strips (FTS) to communities across the State of Arizona in Year 1. Distribution will be prioritized to people who use drugs (all drugs, including heroin, stimulants, and pills), their friends and family, and organizations who can effectively distribute test strips to people at risk for overdose. SPW maintains the lowest available cost-effective pricing agreement with pharmaceutical companies for FTS in Arizona and will continue to do so for this project. Our budget for this proposal includes resources to purchase 120,000 FTS for statewide distribution.

b. Develop and distribute FTS training materials and modules. FTS educational material will include content such as the use of FTS; alleviating fears and stigma; education on harm reduction and how it relates to using the testing strips to test for the presence of fentanyl; and information regarding use and/or disposal of substances that test positive for fentanyl. This content will be made available to PWUD, families, AHCCCS members, community-based organizations, and the general public.

6) **Tailored programming and services for women, especially pregnant and parenting women (SABG Priority Population);** Through SPW, AHCCCS aims to implement the following strategies for this SABG Priority Population:

a. Provide outreach and care coordination services to at least 200 women who use drugs, prioritizing pregnant and parenting women. Tailored programming and services for women who use drugs may include pediatric medical treatment and care, child welfare, Arizona Department of Child Safety (DCS) coordination, legal assistance, early childhood education, and family counseling, in addition to other services needed by all PWUD. We aim to serve a minimum of 30 women in each region.

b. Staff the statewide SSP with at least one staff member who specializes in supporting women who use drugs, particularly pregnant and parenting women. The staff member will travel throughout the state to provide services, as well as training and education for project staff and partners.

c. Prioritize the delivery of services and training to SABG priority populations. In compliance with SAMHSA and AHCCCS regulations for the use of SABG funds, all services provided through the resources requested for this project will prioritize the following SABG populations: 1) pregnant women/teenagers who use drugs by injection, 2) pregnant women/teenagers with a SUD, 3) other persons who use drugs by injection, 4) women/teenagers with a SUD, with dependent children and their families, including women who are attempting to regain custody of their children, and 5) all other individuals with a SUD, regardless of gender or route of use. With respect to naloxone distribution, education and training, we aim to increase the utilization of SPW services among SABG priority populations by at least 10 percent during the three-year project period.

d. Participate in statewide groups to conduct provider education on decreasing stigma and utilization of evidence-based practices for pregnant and parenting women who use drugs. Along with Objective 3C, we will make concerted efforts to train providers who treat women who use drugs, as well as incorporate gender-informed principles in our general training.

7) Culturally appropriate services and resources; Through SPW, AHCCCS aims to implement the following:

a. Provide Spanish translations and culturally sensitive versions of services and resources. SPW has provided Spanish translations of educational and outreach materials, as well as offered peer support services in Spanish since 2019. SPW currently has Spanish-speaking outreach staff in five Arizona counties. All printed educational materials will be available in English and Spanish, and additional materials will be revised for cultural sensitivity when working with tribal nations. In the event that our outreach staff do not speak the same language as the participants that they encounter, we will offer a telephone translation service to ensure that all participants are able to effectively communicate with SPW staff.

b. Host at least 20 training sessions in Spanish and distribute materials to at least 1,000 Spanish-speaking clients.

8) Stakeholder relationship and capacity building to ensure long-term program sustainability. Through SPW, AHCCCS aims to implement the following:

a. Convene an Advisory Board consisting of leadership representatives from across the health and social service systems. Potential Advisory Board members include PWUD people with lived experience, SSPs, state and local government agencies, Substance Use Disorder and behavioral health treatment providers, health departments, health clinics and systems, correctional health, first responders, community-based organizations, mutual aid groups, local businesses, schools, colleges and universities, and neighborhoods. The Advisory Board will provide overall project guidance, promote the program and services, build collective capacity, and reduce stigma amongst the public. Utilizing a

collective impact model[7] for this project, SPW will act as this initiative's backbone, bringing CMS, ASU CHS, and many of our other partners together with the shared goal of preventing overdose and increasing harm reduction infrastructure in Arizona.

b. Evaluate and continuously improve the services provided through our program through regular data monitoring, performance reports, and quality improvement methods. With the support of ASU CHS, a system of evaluation that measures the project's impact across all partners will be created. Peer support will be used not only to provide low-barrier harm reduction services to participants, but to gauge community need and response to ensure that we are including community voices and adapting interventions to evolving community needs. A critical part of this project is collecting reliable data to assess performance, evaluate progress, and continuously improve services and internal control systems. Additionally, we will maintain and expand SPW's inventory tracking system to monitor the supply and distribution of naloxone, FTS, and related outreach supplies purchased with SABG funds.

c. Identify and disseminate best practices and recommendations for sustaining and expanding the program. All project processes, protocols, tools, evaluations, publications, and reports will be documented for dissemination to sustain and expand our collective efforts.

Acquiring Syringes and Needles through Non-Federal Funds: The SPW, submits an annual letter attestation to AHCCCS affirming they will not utilize federal funds to purchase syringes/needles. AHCCCS will continue this practice to ensure compliance with state and federal regulations. SPW is dedicated to ensuring that participants have access to all the supplies they need to stay as safe and healthy as possible, including syringes and needles. In support of this project, SPW will continue to fund the purchase of syringes and needles through a combination of grassroots fundraising methods as well as grant funding from a diverse range of private and public funders. SPW has a long history of utilizing grassroots fundraising methods, including one-time and monthly sustaining donations and program service revenue to support the work and help to fund the purchase of program supplies. SPW is committed to seeking out a diverse range of funders who share our values, and can support the purchasing of lifesaving supplies, such as syringes and needles, for participants. For years, SPW has worked to build and maintain relationships with funders dedicated to supporting health and harm reduction services to people impacted by substance use, including Broadway Cares, the Gilead Foundation, AIDS United, and more. SPW has also received funding from county health departments, hospital systems, and foundations across Arizona. Additionally, SPW proactively seeks out and applies to new funding opportunities that can further support the purchase of syringes and needles.

Applicable MOUs with SSP Providers who can supply needles: SPW is the acquirer of the syringes and needles needed for their program, we do not have a signed MOU in place. In lieu of

[7] Sagrestano LM, Finerman JCR. COLLECTIVE IMPACT MODEL IMPLEMENTATION. J Health Hum Serv Adm. 2018;41(1):87-123. https://www.jstor.org/stable/26974591.

an MOU, we have an executed contract that we can submit as part of this request outlining how SPW will acquire syringes and needles through non-federal funds.

3. TIMELINE FOR IMPLEMENTATION

Please refer to **Attachment A** at the end of this document for the timeline for implementation.

4. COPY OF EXISTING SSP PROTOCOLS OR GUIDELINES

AHCCCS, in consultation with SPW, will utilize the following protocols/guidelines, and applicable state law such as:

a. Arizona Revised Statutes (ARS) Title 36, Chapter 6, Article 15: *Title 36, chapter 6, Arizona Revised Statutes. ARTICLE 15. OVERDOSE AND DISEASE PREVENTION. 36-798.51. Overdose and disease prevention programs; requirements; standards*
b. Centers for Disease Control and Prevention: *Syringe Service Programs, A Technical Package of Effective Strategies and Approaches for Planning, Design, and Implementation (published 2020)*
c. NASTAD: *Syringe Services Program (SSP) Development and Implementation Guidelines for State and Local Health Departments (published 2012)*
d. National Harm Reduction Coalition: *Guide to Developing and Managing a Syringe Service Program (published 2010, updated 2020)*

5. BUDGET, BUDGET JUSTIFICATION, AND PROPOSED ACTIVITIES, INCLUDING A PLAN FOR DISPOSAL OF INJECTION EQUIPMENT

Budget/Budget Justification: Please refer to **Attachment B** for the budget justification at the end of this document.

Proposed Activities:

1) Naloxone distribution, education, and training;
2) A statewide SSP;
3) Trainings for professionals and the broader community;
4) Peer support program to facilitate linkages to treatment and wrap-around supports;
5) Fentanyl testing strip distribution, education, and training;
6) Tailored programming and services for women, especially pregnant and parenting women (SABG Priority Population);
7) Culturally appropriate services and resources; and
8) Stakeholder relationship and capacity building to ensure long-term program sustainability.

Plan for disposal of injection equipment: Because Arizona recently legalized SSPs, there is a gap in the development and distribution of evidence-based standards for distributing and disposing of needles and hypodermic syringes. AHCCCS, in collaboration with the contracted provider, Sonoran Prevention Works, is in the planning phase of developing a statewide SSP standards board in collaboration withPWID and individuals who work and volunteer at SSPs. SPW aims to follow applicable Arizona law regarding the disposal of injection equipment (*SB 1250: Article 15: 36-798.51. Overdose and disease prevention programs; requirements; standards*):

> *"A program established pursuant to this section shall develop standards for distributing and disposing of needles and hypodermic syringes based on scientific evidence and best practices. the number of needles and hypodermic syringes disposed of through a program shall be at least equivalent to the number of needles and hypodermic syringes distributed through the program."*

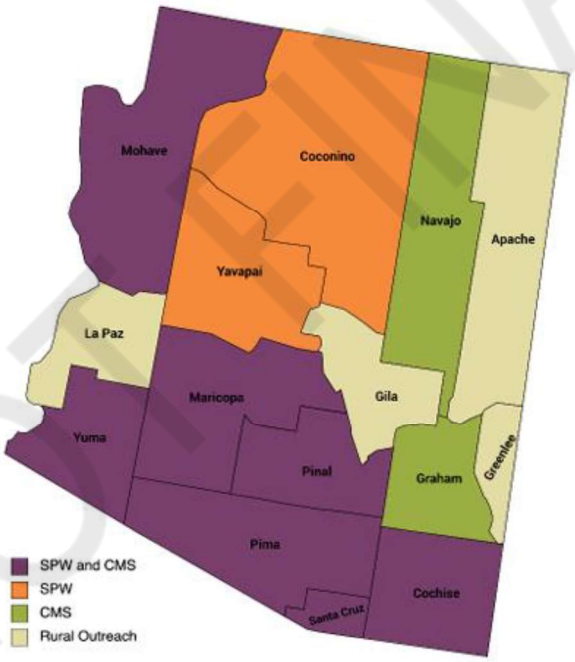
6. DESCRIPTION OF CURRENT TRAINING AND TECHNICAL ASSISTANCE NEEDS

Training/Technical Assistance Item	Description	Resource
Data & Evaluation	Arizona needs a comprehensive method to track and evaluate key performance indicators (KPIs), basic demographics, etc. KPIs include Naloxone (intranasal, intramuscular) Education & Distribution, Fentanyl distribution/testing, syringes received/distributed, etc.	SAMHSA Technical Assistance: https://harmreductionhelp.cdc.gov/s/

7. LOCATION OF SSP RELATED ACTIVITIES TO BE SUPPORTED WITH FEDERAL FUNDS

AHCCCS will implement a statewide SSP to adequately address the needs of PWUD across the Arizona community. *Figure 2* (below) shows the statewide reach of our program, with SPW and Community Medical Services (CMS) presence both in 9 separate counties (covering a combined 11 counties). Our strategy also includes extensive plans to adequately address the needs of the four counties without physical SPW or CMS presence through rural outreach, mobile clinics, virtual services, and main-in programs. (covering a combined 11 counties) throughout Arizona: Mohave, Yuma, Maricopa (most populous), Pinal, Pima, Santa Cruz, Cochise, Coconino, Yavapai, Navajo, and Graham counties.

Figure 2



8. SIGNED STATEMENT (I.E., ANNUAL CERTIFICATION)

Signed and included as part of this request (**Attachment C**).

9. SSP METRIC INFORMATION

SABG sub-recipients,)i.e., community-based organizations), implementing new or expanding existing SSPs will need to collect basic SSP metrics information (e.g., number of syringes

distributed, estimated number of syringes returned for safe disposal, number of persons tested for HIV or viral hepatitis, and referrals to HIV, viral hepatitis and substance use disorder treatment).

AHCCCS developed an evaluation design into the method of approach to measure project performance, identify best practices, and facilitate continuous program improvement. Using the RE-AIM framework, the contracted provider, SPW, will gather data from program staff and participants at SPW and CMS through monthly programmatic reports and electronic health records. The data will track all measurable objectives, required reports, and reports for use by the advisory committee and executive team. All data collection methods will take into consideration the language, norms and values of the focus populations. All data collection, data storage, and data analysis procedures will be approved by the Institutional Review Board (IRB) at Arizona State University. Data sharing and transfer agreements will be developed with all partners and sub-awardees pursuant to IRB approved processes. All data will be protected and stored according to IRB approved protocols.

In compliance with SAMHSA guidance for State Block Grants, AHCCCS will collect the following information related to SSPs:

- Number of syringes distributed,
- Estimated number of syringes returned for safe disposal,
- Number of persons tested for HIV or viral hepatitis,
- Referrals to HIV/Viral Hepatitis testing and treatment, and
- Referrals to substance use disorder treatment.

10. ATTACHMENTS A – E:

Attachment A: Timeline for Implementation

Milestones	Lead	Year 0 (Administrative)				Year 1 (2022)				Year 2 (2023)				Year 3 (2024)				Year 4
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Develop SABG RFP	AHCCCS																	
RFP out for Bid	AHCCCS																	
RFP Proposal Evaluation & Contractor Selection	AHCCCS																	
Receive Determination of Need for SSP in AZ (obtained Oct-21)	AHCCCS																	
Contract Executed (December 1)	AHCCCS																	
Develop SABG-SSP Metrics for Contractor	AHCCCS																	
Receive Approval for SABG Funds for SSP Activities	AHCCCS																	
Naloxone Distribution, Education, and Testing (ongoing)	Contractor																	
Syringe Service Program (pending SAMHSA approval)	Contractor																	
Fentanyl Testing Strip Distribution, Education, and Testing	Contractor																	
Programming for Pregnant and Parenting Women (SABG)	Contractor																	
Contract Close-Out for Statewide Vendor	Contractor																	
Final Deliverable for Statewide Vendor	Contractor																	

Attachment B: Budget Justification

AHCCCS/Sonoran Prevention Works (SPW)
Syringe Service Program (SSP)
Budget and Justification
01/01/2022-12/31/2022

A. Personnel:

Position (1)	Key Staff (3)	Annual Salary/ Rate (4)	Level of Effort (5)	Total Salary Charged to Award (6)
Syringe Services Program Manager	x	$60,000	100%	$60,000
Syringe Services Team Lead		$21/hr	100%	$43,680
SSP Trainer		$20/hr	100%	$41,600
Women's Health Peer Support Specialist		$21/hr	100%	$43,680
Syringe Service Program Specialists (5)		$19/hr	100%	$197,600
Operations Associate		$22/hr	25%	$11,440
Naloxone and Fentanyl Test Strip Distribution Coordinator		$19/hr	100%	$39,520
FEDERAL REQUEST				**$437,520**

JUSTIFICATION:

- Syringe Services Program Manager will oversee the in-person syringe services to include Yavapai, all of Mohave, Maricopa, Pinal, Cochise, and Pima counties, and ensure that supply delivery occurs for individuals unable to reach those physical programs. The position requires a background in outreach, managing remote teams, operationalizing new programs, and ensuring cross-program collaboration to leverage SPW's existing staff and programming to support the statewide syringe service program. They will oversee the five Syringe Service Program Specialists.
- Syringe Services Team Lead will provide support to the SSP Manager in day-to-day staffing of the five SSPs. They will be the first line of defense in cases of conflict, sharps exposure, and scheduling, and will serve as a backup for any staff who will be on extended leave.
- Trainer will deliver online and in-person training for AHCCCS patients, community members, pharmacists, drug treatment organizations, medical providers, and others to increase knowledge of overdose prevention, naloxone, fentanyl test strips, and other harm reduction topics.
- Women's Health Peer Support Specialist will conduct outreach to women who use drugs (particularly pregnant and parenting women) and organizations who serve them. They will be the resident expert on supporting women who use drugs and train the rest of the staff on interventions and resources to support women who use drugs in all three GSAs.

- Syringe Service Program Specialists are peer-support certified individuals who will run SSPs in Mohave, Yavapai, Pinal, Cochise, and Yuma counties. In partnership with other SPW staff, volunteers, and community partners, they will conduct fixed site distribution, home delivery, and mobile syringe services in line with AZ statute and the expectations of this SSP.
- Operations Associate will run SPW's Harm Reduction by Mail program to ensure that individuals unable to access services through our 5 SSPs can still receive supplies, referrals, and peer support by mail.
- Naloxone & Fentanyl Test Strip Distribution Coordinator will manage organizational requests for naloxone and fentanyl test strips, distribute them equitably and timely, and oversee inventory management.

- **Fringe Benefits:**

Position (1)	Name (2)	Rate (3)	Total Salary Charged to Award (4)	Total Fringe Charged to Award (5)
All	FICA, worker's comp, health insurance, state unemployment insurance	see table below	$437,520	$96,886
FEDERAL REQUEST				**$96,886**

JUSTIFICATION:

Fringe Category	Rate
Retirement	n/a
FICA	7.65%
Insurance (worker's comp)	1.26%
Health insurance	$7500 per FTE
State unemployment insurance tax	6.18% on first $7000
Total	26.53%

B. Travel:

Please note: All travel expenditures will require itemized receipts and will not exceed the State allowable rates which can be found in the State of Arizona Accounting Manual (SAAM) https://gao.az.gov.publications/saam.

Purpose (1)	Destination (2)	Item (3)	Calculation (4)	Travel Cost Charged to the Award (5)
Statewide travel	In state	Mileage	10,000 miles x .445	$4,445
	In State	Lodging	State of AZ allowable reimbursement rate	$3.000
	In state	Meals	State of AZ allowable reimbursement rate	$1,500
FEDERAL REQUEST				**$8,945**

JUSTIFICATION:

Local travel needed to conduct outreach, support staff, attend training events, and conduct other SSP project activities. Local travel rates not to exceed allowable rates in SAAM.

C. Equipment (Over $5,000 per item):

Item(s) (1)	Quantity (2)	Amount (3)	% Charged to the Award (4)	Total Cost Charged to the Award (5)
				n/a

JUSTIFICATION:

D. Supplies (Items costing less than $5,000 per unit):

Item(s)	Rate	Cost
Fentanyl test strips	$0.70 x 50,000	$35,000
Intramuscular naloxone	$35,000	$35,000
SSP Supplies (excluding syringes) see justification	$15,000 x 12 months	$180,000
Leased Vehicle (Dedicated 100% for SSP_	$4,800 per year	$4,800
Laptops	$500 x 6.25 FTE	$3,125
Cell phones	$350 x 6.25 FTE	$2,187
Office supplies	$100 x 12 months	$1,200
Office Furniture	$500 per employee x 6.25 FTE	$3,125
Printing	Varied	$3,125
SSP advertisement	Varied see justification	$5,000
FEDERAL REQUEST		**$272,562**

JUSTIFICATION:

1. Fentanyl test strips - SPW will purchase and distribute 120,000 strips to decrease overdose and increase awareness of safer drug use among people who use drugs. These will be primarily offered to SABG priority populations and organizations who reach those populations.
2. Intramuscular naloxone - SPW will purchase and distribute naloxone to decrease overdose and build relationships with people who use drugs. These will be offered to SABG priority populations, organizations who reach those populations, AHCCCS members, and the general public.
3. SSP Supplies include tourniquets, hygiene products, wound care supplies, food kits (less than $3/person), cottons, sharps containers, bags, alcohol wipes, and more to be distributed at the SSPs in accordance with Arizona statute, federal law, and the expectations of this proposal. Grant funds will not be used to purchase hypodermic syringes or needles.
4. Leased vehicle to be utilized in Cochise and Pinal counties by the Syringe Service Program Specialists for countywide coverage and deliveries. Vehicle will not be used for purposes outside the scope of this award.
5. Laptops and cell phones to be purchased for the 6.25 FTE to collect data, provide referrals, coordinate with team members, and support participants.
6. Office supplies & furniture to be purchased for the 6.25 FTE. Items include pens, paper, notebooks, mice, chairs, desks, and other related items.
7. Printing to distribute educational materials to participants and community members, print posters, brochures, data collection forms, and other related materials.

8. SSP Advertisement of program to include digital advertising, billboards, bus shelter ads, and other related efforts to increase awareness and utilization of the program.

Contractual:

COSTS FOR CONTRACTS MUST BE BROKEN DOWN IN DETAIL AND A NARRATIVE JUSTIFICATION PROVIDED. A SEPARATE ITEMIZED BUDGET IS REQUIRED FOR EACH CONTRACTOR. IF APPLICABLE, NUMBERS OF CLIENTS SHOULD BE INCLUDED IN THE COSTS.

Name (1)	Service (2)	Rate (3)	Other	Cost (4)
Southern Arizona AIDS Foundation	Pima County Syringe Services	$93,200	700 unique individuals to be reached annually	$93,200
Southwest Recovery Alliance	Maricopa County Syringe Services	$480 x 104 outreach events	1,500 unique individuals to be reached annually	$49,920
ASU College of Health Solutions	Evaluation	$106,426	n/a	$106,426
Community Medical Services	24/7 supply provision and Statewide systems change coordination	$175,002	1,370 unique individuals to be reached annually	$175,002
Tory Howell	Graphic & web design	$80/hr x 10 hrs	n/a	$800
Kurt Clark	IT	$80/hr x 10 hrs	n/a	$800
TBD	Medical waste disposal services	$600/mo x 12 months	n/a	$7,200
FEDERAL REQUEST				$433,348

JUSTIFICATION:

1. **Southern AZ AIDS Foundation** will administer a syringe service program three days/week in Tucson to benefit this project with an approximate X projected individuals to be reached. The program will meet the requirements set out in Arizona statute and in this RFP's scope of work.

Item	Rate	Total cost
Bilingual Health Education & Testing Specialist	$38,854/yr @ 0.75 FTE	$29,141
Health Education & Testing Specialist	$36,774/yr @ 0.75 FTE	$27,581
ERE	$56,722 * 27.0%	$15,315
State travel	Allowable state rates	$534
Direct program costs	$2,700 x 1.5 FTE	$4,050
Allocable program support	$1,397 x 1.5 FTE	$2,095

Occupancy costs	1.10% x $84,600	$931
Indirect costs	17.00% * $79,647	$13,553
Total		$93,200

2. **Southwest Recovery Alliance** will administer a syringe service program two days/week in Phoenix to benefit this project with an approximate 1500 individuals to be reached. The program will meet the requirements set out in Arizona statute and in this RFP's scope of work.

Item	**Rate**	**Total cost**
Outreach events	$480 x 104	$49,920
Total		**$49,920**

3. ASU College of Health Solutions (ASU CHS)

Item	**Rate**	**Total cost**
Personnel	See below	$56,580
ERE	See below	$17,122
Indirect Costs	See below	$32,724
Total		**$106,426**

ASU CHS Personnel

Position (1)	**Name (2)**	**Key Staff (3)**	**Annual Salary/Rate (4)**	**Level of Effort (5)**	**Total Salary Charge to Award (6)**
(1) Site PI	William Riley	Yes	$199,300	15%	$29,895
(2) Project Manager	Kailey Love	No	$84,099	15%	$12,615
(3) Data Analyst	Megan Phillips	No	$67,000	21%	$14,070
Total					$56580

1. The Site PI will be responsible for providing regular oversight of all the ASU-related activities for the grant. This includes evaluation design, data design, data collection, performance assessment, development of performance measures, quality improvement, data management, tracking, analysis and reporting. The Site PI will also oversee and ensure the completion of evaluations to assess program performance and internal organizational controls and management.
2. The Project Manager will coordinate project service and activities, including implementing project activities, internal and external coordination, developing materials, and conducting meetings. The Project Manager will work closely with SPW leadership to develop an

organizational project management plant to ensure the goals and objectives of the project are completed in a timely manner and within budget.

3. The Data Analyst will be responsible for implementing all data collection policies and procedures, including working directly with SPW and CMS staff to audit current processes and develop recommendations to improve data accuracy. The Data Analyst will also work with the ASU team to develop monthly performance reports that will be disseminated to the project team for broader discussion. The Data Analyst will support SPW staff in preparing data and evaluation sections for grant reports to AHCCCS and SAMHSA.

ASU CHS ERE

Position (1)	Name (2)	Rate (3)	Total Salary Charged to Award (4)	Total Fringe Charged to Award (5)
(1) Site PI	William Riley	27.3%	$29,895	$8,161
(2) Project Manager	Kailey Love	33.58%	$12,615	$4,236
(3) Data Analyst	Megan Phillips	33.58%	$14,070	$4,725
Total				$17,122

Arizona State University defines fringe benefits as direct costs, estimates benefits as a standard percent of salary applied uniformly to all types of sponsored activities, and charges benefits to sponsors in accordance with the Federally-negotiated rates in effect at the time salaries are incurred. An estimated cost escalation has been included and is consistent with ASU policy for both fringe rates and IBS. The current Rate Agreement was approved April 20, 2021. The estimated cost of ERE is $17,122 for the personnel effort allocated in this project, which is based upon the following rates for FY 2023 and thereafter:

ASU CHS Indirect Cost Rate

ERE Rate Estimates	Faculty	Staff
FY 2023 Estimated Rates	27.3%	33.58%

Organization's Indirect Cost Rate for Other Sponsored is 44.4% of Modified Total Direct Costs MTDC (44.4% of $73,702). Indirect costs are calculated using rates approved by US Department of Health and Human Services (DHHS). The University's Current Rate Agreement was approved on April 20, 2021.

MTDC includes salaries and wages, fringe benefits, materials and supplies, services, publications, rental/equipment/software fees, travel, and the first $25,000 of each sub-award. Exclusions from MTDC include graduate student tuition remission, participant support, sub-awards over the first $25,000, capital equipment, and scholarships/fellowships.

4. **Community Medical Services** will oversee state systems coordination – Arizona Department of Corrections, jails, Community Corrections, and Arizona Department of Child Safety. They will also provide low barrier public access to harm reduction supplies at each of their clinics, and provide peer support staff in each Geographical Service Area to offer treatment and linkage to care for those accessing supplies and support with conducting public trainings.

Item	Rate	Total cost
Program Supervisor - Tina Braham	$93,600 x 0.05 FTE	$4,680
Peer Support x 3	$41,600 x 3 @ 0.50 FTE ea	$62,400

ERE	8.65% x $67,080 $480/mo x 1.5 FTE	$14,442
Local travel	State rate	$1,980
Contractual - supply kiosks + maintenance	$3,500 x 25 $4000 maintenance	$91,500
Total		**$175,002**

5. Tory Howell will provide hourly rate graphic and web design service to support the promotional and educational goals of the project.
6. Kurt Clark will provide hourly rate IT assistance to staff on the project as needed.
7. Heinfeld Meech will conduct SPW's required single audit. This contract makes up 20% of SPW's federal contracts.
8. Medical waste disposal services to pay for the safe and sterile disposal of syringes collected through the program.

E. Construction: NOT ALLOWED

JUSTIFICATION:

F. Other: (Include Other Consultants):

Item	Rate	Cost
Phoenix office	$22,800/yr x 30%	$6,840
Tucson office	$14,400/yr x 43%	$6,192
Phoenix & Tucson utilities	$18,000 x 37% (average)	$6,660
Storage	$9,000 x 75%	$6,750
Office maintenance & repairs	$2,400 x 37% (average)	$888
Cell service	$503/yr x 6.25 FTE	$3,144
FEDERAL REQUEST		**$30,474**

JUSTIFICATION:

1. Phoenix and Tucson offices will be allocated by staff FTE to grant. Offices are necessary for in-person work, supply receiving, and kit assembly.
2. Utilities for Phoenix and Tucson offices allocated by staff FTE to grant.
3. Storage units required for Phoenix, Tucson, Prescott, Kingman, Yuma, Bisbee, and Casa Grande to store SSP supplies, fentanyl test strips, and naloxone. Units will be allocated by staff FTE in the region to the grant.
4. Office maintenance and repairs to include plumbing, electrical, sterilization, and other standard repairs.
5. Cell service to ensure staff are able to communicate with each other, community partners, and participants.

G. Total Direct Charges: $1,279,735

H. Indirect Cost Rate or Administration (See Footnote below):

Calculation (1)	Indirect Cost Charged to the Award (2)
16.3%	$208,596

FEDERAL REQUEST	$208,596

JUSTIFICATION: Admin overhead is the rate requested for all federal grants. The costs include payroll and accounting software, accounting fees, WiFi, CPA, and other administrative costs associated with the harm reduction program.

K. Total Project Costs: $1,488,331

L. BUDGET SUMMARY (should include future years, as applicable to the grant, and projected total):

Category	AHCCCS?SP W SSP 1/1/2022-12/31/2022
Personnel	$437,520
Fringe	$96,886
Travel	$8,945
Equipment	$0
Supplies	$272,562
Contractual	$433348
Other	$30,474
Total Direct Charges	$1,279,735
Indirect Charges or Administration	$208,596
Total Project Costs	$1,488,331

Attachment C: Signed statement (i.e., Annual Certification)

March 7, 2022

Theresa Mitchell Hampton, DrPH, M.Ed.
Public Health Advisor/State Project Officer / COR II / FAC-P\PM
HHS Region VIII (MT and UT), and IX (AZ; HI; and NV), and (CNMI, FSM, GU, and PU)
U.S. Department of Health and Human Services (DHHS)
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
Division of State and Community Assistance (DSCA)
Performance Partnership Grant Branch (PPGB)
5600 Fishers Lane, Station 13N16–E
Rockville, MD 20857 (courier/overnight use 29000)
O: (240) 276-1365
E: theresa.mitchell@samhsa.hhs.gov

Dear Dr. Theresa Mitchell Hampton:

In accordance with the Consolidated Appropriations Act, 2016, Division H, the Arizona Health Care Cost Containment System (AHCCCS) respectfully submits the following attestation.

> *SEC. 520. Notwithstanding any other provision of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, That such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

For programmatic questions, please contact José Echeverría Vega at (602)417-4743 or jose.echeverriavega@azahcccs.gov.

Sincerely,

K. Colter Challacombe

Kristen Challacombe, Deputy Director for Business Operations

CC:
Alisa Randall, AHCCCS
Hazel Alvarenga, AHCCCS
Nereyda Ramirez, AHCCCS
Emma Hefton, AHCCCS
Christopher Shoop, AHCCCS
José Echeverría Vega, AHCCCS

Attachment D: CDC Determination of Need for Arizona 10/26/2021

Attachment E: Arizona Revised Statute: Article 15: 36-798.51. Overdose and disease prevention programs

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Due to formatting, Attachments D and E can be found in the next two pages.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

October 26, 2021

Kristen Herrick, MPH, CHES
Chief, Office of Disease Integration & Services
Arizona Department of Health Services
150 North 18th Avenue, Suite 110, Phoenix, AZ 85007
Email: kristen.herrick@azdhs.gov

Dear Ms. Herrick,

The Arizona Department of Health Services (ADHS) submitted a determination of need request to the Centers for Disease Control and Prevention (CDC) with data examining whether the state is experiencing or at risk for an increase in viral hepatitis or HIV infection due to injection drug use (IDU). Consulting with CDC to determine need is a requirement in the process of seeking approval to use federal funds to support syringe services programs (SSPs). All such requests are reviewed by a panel of CDC subject matter experts who evaluate submitted data in accordance with the *U.S. Department of Health and Human Services (HHS) Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016.*

The Arizona Department of Health Services provides persuasive data that the state is at risk for a significant increase in viral hepatitis or HIV infections due to injection drug use. HIV infections with injection drug use reported as a risk factor have remained relatively stable, yet high, since 2014. In 2020, 15.8% of all prevalent cases, and 11% of incident cases report IDU as a risk factor. Additionally, opioid-related morbidity and mortality continue to increase, with a 198% increase in suspected opioid deaths between 2012 and 2019.

Arizona also provides supporting evidence that their state is at risk. CDC's Vulnerability Assessment (2106) identified Mohave County as being at risk for rapid dissemination of HIV or HCV infections among persons who inject drugs. Importantly, while syringe services programs were not officially sanctioned by the state until May 2021, several SSPs operating prior to the change in policy report large numbers of participant interactions, syringe provision, and naloxone distribution, with 435 reported overdose reversals.

Taken together, Arizona's request for a determination of need presents compelling data that the State is at risk for significant increase in viral hepatitis or HIV infections due to injection drug use.

This notice may be used by state, local, territorial, or tribal health departments or eligible HHS-funded recipients to apply to direct federal funds to support SSPs. As there is no expiration date for this notice, ADHS may elect to either (1) immediately request to direct current federal funding to support SSPs or (2) delay requests to direct funds to support SSPs until a subsequent fiscal year. The State is strongly encouraged to discuss plans to direct funds for SSPs with your federal funding agencies. Only CDC directly-funded, eligible awardees should submit a request to CDC to direct funding for SSP activities.

Thank you for your interest in the public health implications of injection drug use in Arizona. If you have any questions or require further technical assistance, please do not hesitate to send an email to SSPCoordinator@cdc.gov.

Sincerely,
CDC SSP Determination of Need Panel

Senate Engrossed

REFERENCE TITLE: overdose; disease prevention; programs

State of Arizona
Senate
Fifty-fifth Legislature
First Regular Session
2021

CHAPTER 382

SENATE BILL 1250

AN ACT

AMENDING TITLE 36, CHAPTER 6, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 15; RELATING TO PUBLIC HEALTH.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 36, chapter 6, Arizona Revised Statutes, is amended by adding article 15, to read:

ARTICLE 15. OVERDOSE AND DISEASE PREVENTION

36-798.51. Overdose and disease prevention programs; requirements; standards

A. A CITY, TOWN, COUNTY OR NONGOVERNMENTAL ORGANIZATION, INCLUDING A LOCAL HEALTH DEPARTMENT OR AN ORGANIZATION THAT PROMOTES SCIENTIFICALLY PROVEN WAYS OF MITIGATING HEALTH RISKS ASSOCIATED WITH DRUG USE AND OTHER HIGH-RISK BEHAVIORS, OR ANY COMBINATION OF THESE ENTITIES, MAY ESTABLISH AND OPERATE AN OVERDOSE AND DISEASE PREVENTION PROGRAM. A PROGRAM ESTABLISHED PURSUANT TO THIS SECTION SHALL HAVE ALL OF THE FOLLOWING OBJECTIVES:

1. TO REDUCE THE SPREAD OF VIRAL HEPATITIS, HIV AND OTHER BLOODBORNE DISEASES IN THIS STATE.

2. TO REDUCE NEEDLE-STICK INJURIES TO LAW ENFORCEMENT OFFICERS AND OTHER EMERGENCY PERSONNEL.

3. TO ENCOURAGE INDIVIDUALS WHO INJECT DRUGS TO ENROLL IN EVIDENCE-BASED TREATMENT.

4. TO INCREASE PROPER DISPOSAL OF USED SYRINGES.

5. TO REDUCE THE OCCURRENCE OF SKIN AND SOFT TISSUE WOUNDS AND INFECTIONS RELATED TO INJECTION DRUG USE.

B. A PROGRAM ESTABLISHED PURSUANT TO THIS SECTION SHALL OFFER ALL OF THE FOLLOWING:

1. DISPOSAL OF USED NEEDLES AND HYPODERMIC SYRINGES.

2. NEEDLES, HYPODERMIC SYRINGES AND OTHER INJECTION SUPPLY ITEMS AT NO COST AND IN QUANTITIES SUFFICIENT TO ENSURE THAT NEEDLES, HYPODERMIC SYRINGES AND OTHER INJECTION SUPPLY ITEMS ARE NOT SHARED OR REUSED.

3. EDUCATIONAL MATERIALS ON ALL OF THE FOLLOWING:

(a) OVERDOSE PREVENTION.

(b) PEER SUPPORT SERVICES.

(c) THE PREVENTION OF HIV, VIRAL HEPATITIS TRANSMISSION AND THE INCIDENCE OF SKIN AND SOFT TISSUE WOUNDS AND INFECTIONS.

(d) TREATMENT FOR MENTAL ILLNESS, INCLUDING TREATMENT REFERRALS.

(e) TREATMENT FOR SUBSTANCE USE DISORDER, INCLUDING REFERRALS FOR SUBSTANCE USE DISORDER TREATMENT.

4. ACCESS TO KITS THAT CONTAIN NALOXONE HYDROCHLORIDE OR ANY OTHER OPIOID ANTAGONIST THAT IS APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION TO TREAT A DRUG OVERDOSE, OR REFERRALS TO PROGRAMS THAT PROVIDE ACCESS TO NALOXONE HYDROCHLORIDE OR ANY OTHER OPIOID ANTAGONIST THAT IS APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION TO TREAT A DRUG OVERDOSE.

5. FOR EACH INDIVIDUAL WHO REQUESTS SERVICES, PERSONAL CONSULTATIONS FROM A PROGRAM EMPLOYEE OR VOLUNTEER CONCERNING MENTAL HEALTH OR SUBSTANCE USE DISORDER TREATMENT OR REFERRALS FOR EVIDENCE-BASED SUBSTANCE USE DISORDER TREATMENT, AS APPROPRIATE.

C. A PROGRAM ESTABLISHED PURSUANT TO THIS SECTION SHALL DEVELOP STANDARDS FOR DISTRIBUTING AND DISPOSING OF NEEDLES AND HYPODERMIC SYRINGES BASED ON SCIENTIFIC EVIDENCE AND BEST PRACTICES. THE NUMBER OF NEEDLES AND HYPODERMIC SYRINGES DISPOSED OF THROUGH A PROGRAM SHALL BE AT LEAST EQUIVALENT TO THE NUMBER OF NEEDLES AND HYPODERMIC SYRINGES DISTRIBUTED THROUGH THE PROGRAM.

36-798.52. Immunity

A. NOTWITHSTANDING TITLE 13, CHAPTER 34, AN EMPLOYEE, VOLUNTEER OR PARTICIPANT OF A PROGRAM ESTABLISHED PURSUANT TO SECTION 36-798.51 MAY NOT BE CHARGED WITH OR PROSECUTED FOR POSSESSION OF ANY OF THE FOLLOWING:

1. A NEEDLE, HYPODERMIC SYRINGE OR OTHER INJECTION SUPPLY ITEM OBTAINED FROM OR RETURNED TO A PROGRAM ESTABLISHED PURSUANT TO SECTION 36-798.51.

2. A RESIDUAL AMOUNT OF A CONTROLLED SUBSTANCE CONTAINED IN A USED NEEDLE, USED HYPODERMIC SYRINGE OR USED INJECTION SUPPLY ITEM OBTAINED FROM OR RETURNED TO A PROGRAM ESTABLISHED PURSUANT TO SECTION 36-798.51.

B. SUBSECTION A OF THIS SECTION APPLIES ONLY IF THE PERSON CLAIMING IMMUNITY PROVIDES VERIFICATION THAT A NEEDLE, HYPODERMIC SYRINGE OR OTHER INJECTION SUPPLY ITEM WAS OBTAINED FROM AN OVERDOSE AND DISEASE PREVENTION PROGRAM ESTABLISHED PURSUANT TO SECTION 36-798.51.

APPROVED BY THE GOVERNOR MAY 24, 2021.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 24, 2021.

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
Sonoran Prevention Works (Contractor)	2211 S 48th St STE B, Tempe, AZ -85282	$2,091,359.00	No	7	Yes

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

7/31/2023: SAMHSA approved for AZ to use SUBG funding to support SSPs in 2022. Since the plan was approved, a couple small changes have occurred (page 7): 1) Serving Coconino County instead of Pinal County, 2) Added Cochise Harm Reduction as a subcontracted SSP provider.

Funds are allocated on a calendar year rather than a state fiscal year.