

Arizona

UNIFORM APPLICATION

FY 2020 Substance Abuse Block Grant Report

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

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Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

I: State Information

State Information

I. State Agency for the Block Grant

Agency Name Arizona Health Care Cost Containment System (AHCCCS)

Organizational Unit Division of Grants Administration

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III. Expenditure Period

State Expenditure Period

From 7/1/2018

To 6/30/2019

Block Grant Expenditure Period

From 10/1/2016

To 9/30/2018

IV. Date Submitted

Submission Date 12/2/2019 5:17:44 PM

Revision Date

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Footnotes:

II: Annual Update

Table 1 Priority Area and Annual Performance Indicators - Progress Report

Priority #: 1
Priority Area: Youth
Priority Type: SAT
Population(s): Other (Adolescents w/SA and/or MH)

Goal of the priority area:

Increase the percentage of those who are in the behavioral health system diagnosed as having a substance use disorder and received treatment under the age of 18.

Strategies to attain the goal:

The Regional Behavioral Health Authorities (RBHAs) will continue efforts to promote access to substance abuse treatment services for adolescents during meetings with providers and collaborators, and through school and community-based trainings. Trainings provided by the RBHAs have included components screening for substance abuse in the adolescent population, and effective substance abuse treatment such as Adolescent Community Reinforcement Approach (ACRA) and other evidence-based practices targeting the adolescent population. Block grant funds will be available for treatment services while the State Youth Treatment (SYT) grant funds are utilized in this final year for sustainability of the infrastructure created through previous year activities.

Additionally, providers continue to utilize substance abuse screening tools, including American Society of Addiction Medicine (ASAM) and Car, Relax, Alone, Forget, Friends, and Trouble (CRAFT). Arizona Health Care Cost Containment System (AHCCCS) will monitor enrollment number of youth diagnosed with a substance use diagnosis within the system of care.

The RBHAs will continue to collaborate and meet regularly with child/adolescent providers to share information on substance abuse screening, trends and best practices. AHCCCS and the RBHAs will provide and promote access to substance abuse training initiatives available to child/adolescent providers including those employed through other agencies such as the Department of Child Safety (DCS) and Juvenile Justice agencies.

AHCCCS and the RBHAs will educate treatment providers, prevention providers, and coalitions on how to engage community stakeholders in identifying and referring youth to early intervention and substance abuse treatment services. AHCCCS will ensure the availability of a standardized, parent-friendly, screening tool to identify substance use/abuse in children and adolescents.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: The number of persons under the age of 18 diagnosed with SUD and received treatment.
Baseline Measurement: In Fiscal Year 16, 8.9% of those with a substance use disorder and received treatment were under the age of 18.
First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2018), 9.2%
Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2019), 9.5%

New Second-year target/outcome measurement(if needed):

Data Source:

CIS enrollment numbers/data.

New Data Source(if needed):

Description of Data:

CIS data can be stratified by age group, diagnosis, and services received. CIS captures all elements needed to measure outcomes for this population.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

No data related issues anticipated.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (*if not achieved, explain why*)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

AHCCCS has implemented several strategies to achieve the goal of increasing the number of youth in the behavioral health system identified as having a diagnosed Substance Use Disorder (SUD). The goal of 9.2% of those who received SABG SUD services was exceeded, as per CIS data youth under 18 years of age represented 10.45% of the population served in SFY 2018. The Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) are continuing efforts to promote access to SUD treatment services for adolescents during meetings with providers and collaborators, and through school and community-based trainings. Trainings provided by the RBHAs and TRBHAs have included components on how to screen for SUD in the adolescent population, and effective treatment such as Adolescent Community Reinforcement Approach (A-CRA) and other evidence-based practices (EBPs) targeting the adolescent population. Additionally, providers continue to utilize SUD screening tools, including American Society of Addiction Medicine (ASAM) and Car, Relax, Alone, Forget, Friends, and Trouble (CRAFT).

AHCCCS monitors enrollment numbers for youth diagnosed with a SUD within the system of care. The RBHAs and TRBHAs will continue to collaborate and meet regularly with child/adolescent providers to share information on SUD screening, trends and best practices. AHCCCS and the RBHAs provide and promote access to SUD training initiatives available to child/adolescent providers including those employed through other Agencies such as the Department of Child Safety (DCS) and Juvenile Justice. AHCCCS also provides education to providers and teachers. AHCCCS, RBHAs and TRBHAs educate treatment providers, prevention providers, and coalitions on how to engage community stakeholders in identifying and referring youth to early intervention and SUD treatment services. AHCCCS ensures the availability of a standardized, parent-friendly, screening tool to identify substance use/abuse in children and adolescents.

Outreach

The RBHA in Southern Arizona has several outreach initiatives related to transition-aged youth (TAY) to provide support and resources to assist with housing, services and to get youth off the streets. Outreach positions have been established and are dedicated to the youth with substance use disorder and provide assistance with navigating youth to the treatment services they need. These positions also outreach juvenile detention, probation, drug courts, schools, community events, coalitions and other youth providers. Training departments have partnered with schools to provide support to educators on signs and symptoms of substance use and how to refer to treatment. There has been an increase in communication with regard to the use of alcohol, marijuana and prescription drugs among youth through media resources utilizing the Youth Development Program Model. This program recruits youth to serve as peer educators on the dangers of substance use, provides leadership training and advertising/public service announcement (PSA) support for the youth on marketing material to create awareness of the dangers of marijuana, alcohol and prescription drugs in communities.

The clinical training department at the RBHA in Northern Arizona has partnered with local schools districts to provide support to educators on symptoms of substance use and referral to treatment. Ongoing outreach and educational efforts to adolescents have been offered to provide an understanding of the dangers of drugs and alcohol use.

The RBHA in the Central Geographic Service Area (GSA) established a referral process with the Maricopa County Juvenile Probation Department (MCJPD) for youth who are eligible for Medicaid and/or the Substance Abuse Block Grant to be connected to services. In conjunction with a Family Run Organization, the RBHA has worked with the probation department to ensure community and educational resources are readily available to families in places like the lobbies of the detention centers and in the juvenile court buildings. The RBHA's team is also available to help connect families identified from the probation department to services. The RBHA has also focused outreach with the school districts in Maricopa County. The RBHA and providers have participated in community forums and town hall events for various school districts.

Collaboration

Collaboration between Goodwill METRO and other integrated care providers exists to assist youth and young adults navigate various services throughout Pima County. Outreach workers are available at METRO, which is a popular TAY drop-in center located in downtown Tucson every second Tuesday of the month. This initiative has been going for almost a year. Through the year, the second Tuesdays has expanded to having a TAY event every Tuesday of the month. The first Tuesday is dedicated to housing resources for TAY, the second Tuesday includes behavioral health providers, the third Tuesday focuses on employment resources and the last Tuesday is dedicated to holding a dinner for the youth. The RBHA in the southern GSA continues to collaborate with the Juvenile Probation/Detention Centers within their service areas to receive TAY referrals for substance use disorder treatment and recovery services. In Pima County, their Program Development team has structured a program with local providers to deliver SUD treatment for virtually all youth who enter the detention

center needing SUD services. Additionally, they have worked with the Probation Departments to educate contracted providers on the Risk Assessment tools used by probation to identify TAY at moderate to high risk, evaluating criminogenic factors that may lead to continued or increased substance use.

The RBHA has developed a specific program for the opioid use population with a component of Medication assisted treatment for those youth 16-18. Additionally, the RBHA and the Pima County Juvenile Justice system continue to partner after developing a specific program for SABG youth in detention for Pima County made up of a coalition of providers to implement Evidence Based Practices.

In Northern Arizona, the RBHA and the Health Homes (Integrated Physical and Behavioral Health Care Providers) collaborate closely with Department of Child Safety (DCS), Division of Developmental Disabilities (DDD), and the Juvenile Justice System to ensure knowledge of resources, referral to treatment, and addressing any system barriers. The RBHA also collaborates closely with the school system to provide additional resources to educators and school counselors.

In Central Arizona, the RBHA has collaborated with MCJPD and Arizona Department of Juvenile Corrections (ADJC) to connect youth to services and prevent/decrease involvement in the Juvenile Justice System as a result of substance use. The RBHA holds regular collaborative meetings with stakeholder partners such as DCS and MCJPD. During these collaborative meetings the RBHA provides system updates regarding availability of service providers who offer SUD treatment and how these services can be obtained. Collaboration with other community based agencies occurred as well, including local coalitions, hospitals and schools. For example, the RBHA's Network Providers have collaborative agreements in place with 144 schools representing 39 school districts to provide treatment services for youth who are eligible for services under the Medicaid and/or the Substance Abuse and Mental Health Block Grants.

Targeted Interventions

Throughout Arizona the goal is to be able to meet youth and young adults where they are at in the community and immediately connecting them to behavioral health services, as needed. The RBHAs and TRBHAs continues to work with providers as well as the juvenile probation department to identify youth who have been detained and are in need of SUD treatment services, as this population exhibits a higher level of need for SUD treatment services.

All GSAs have providers utilizing A-CRA treatment for adolescents struggling with substance use. Providers utilize other EBPs including, but not limited to the following interventions: Matrix, Cognitive Behavioral Therapy – Substance Use Disorder (CBT-SUD), Multi-Systemic Therapy (MST), Seeking Safety, and Seven Challenges. There is also Medication Assisted Treatment (MAT) programs for adolescents struggling with opioid use disorder (OUD). Adolescents receive a standardized substance use screening, which includes the Substance Abuse Subtle Screening Inventory (SASSI), CRAFFT, or ASAM 3rd Edition.

Other Efforts or Information

There is continued participation in all TAY initiatives in covered service areas. At this time, the main projects are happening in Pima County. Northern Arizona provides trainings to health homes on symptoms of substance use, including coping with depression, shame, trauma, anxiety, and stress. These providers have the ability to screen and refer families to Medicaid and/or SABG funded programs for those uninsured/underinsured youth who have been identified as having an SUD.

Outcomes Measured

In Southern Arizona the Second Tuesday Collaboration is expected to engage with at least a minimum of 5 TAY and get them enrolled into a Health Home. The health homes monitor the success rate of adolescents completing the above mentioned EBP programs and the overall success rate is currently 82%. The RBHA monitors the use of the standardized screening tools on an annual basis. The overall score of the use of appropriate screening and referral is over 90%.

The RBHA in the Central GSA has offered several training options in order to increase the provider networks ability to identify and treat substance use disorder. The RBHA provided CBT –SUD Opioid Training and Advanced CBT-SUD Training to 80 clinicians over this past year. They have also offered a variety of trainings to provider staff, stakeholders and community members regarding Substance Use. These trainings include topics like Substance Use and the Family for Paraprofessionals, Substance Use Disorder Treatment and the LGBTQ Community, Substance Use in the Family and Adolescent Substance Use Disorder Clinical Pathways. The RBHA has also provided training specifically on the Substance Abuse Block Grant to 1002 staff from 40 different agencies from July, 2017 through June, 2018 on various topics related to substance use, misuse and SUD.

Progress/Barriers Identified

In Southern Arizona, the TAY have been receptive to the Second Tuesday events held at the drop-in center. The number of youth who participate in the events has slowly been increasing due to the familiarity & consistency of provider staff engaging with the TAY. The RBHA has developed a specific program for TAY with OUD with a component of MAT for youth aged 16-18. The referral volume for this program over the past fiscal year has been low. To address this issue, the RBHA and the youth treatment providers have increased education in the community to raise awareness of essential needs within this population and address stigma around MAT. Providers in the Central GSA identified their current substance use programs did not offer MAT services as a treatment option for adolescents who have OUD as a barrier. The RBHA has added two providers who offer MAT to meet the needs of youth with an OUD.

Youth are often identified through the collaborative processes in place with the detention center for those needing behavioral health

services. The RBHAs and TRBHAs have not been able to utilize the SABG funding in the past for youth who were in detention to provide treatment services. They have been able to use SABG to connect them to services prior to leaving the detention facility, but this has still posed a barrier. The RBHAs and TRBHAs brought this to AHCCCS attention and AHCCCS is working with SAMSHA to operationalize how services can be provided inside detention facilities that do not meet the definition of correctional institutions.

The RBHAs and TRBHAs continue to utilize the SABG for those youth who are uninsured/ underinsured. Many times during the screening process providers find that the youth qualifies for Medicaid, so the use of the block grant funding often is very short term.

Success Stories

A TAY Native American came into treatment having used alcohol, marijuana, and prescription medication. The youth participated in Intensive Outpatient – Substance Use (IOPSA) services, worked one on one with a recovery coach, and participated in individual and family therapy. Youth was able to successfully complete classes and graduated from high school, obtain admission into college, and maintain sobriety over the period of the program. The youth connected with the talking circle and other cultural components of the treatment program including the Welbriety curriculum.

Another member was admitted in the spring of 2018 and self-referred by the member’s mother. The mom made the referral after hearing about Functional Family Therapy (FFT) from a teacher friend. The member was using marijuana, prescription pain medication, and alcohol as well as struggling with suicidal ideation. Other referral behaviors included physical aggression, verbal aggression, rule non-compliance and leaving without permission. These behaviors were occurring at home, school and in the community. The mom was also often worried about the member using substances and driving. Through doing family therapy with the implementation of the FFT model, the treatment team was able to assess the family’s risk and protective factors and identify relational functions and family dynamics. The FFT was able to develop plans for behavior change for the youth and the family and then generalize these changes and interventions to the larger systems involved such as school.

The family was able to discuss many of the recent losses and changes that had occurred within their family. This youth was able to become closer to the rest of the family and they were able to learn skills to help reduce the conflict in the home and increase positive communication within the home.

The aggression stopped, and the arguments and family conflict decreased substantially. This youth did have some relapses related to substances during treatment, but the family and youth were able to identify ways to get back on track to and use their plans to decrease the risk of using. At discharge, the youth was active in school, had high goals, increased positive peers, started sports again and was active in the church community. The youth and family were able to identify people in their support system that could help them, and the parents felt more confident in their parenting skills and decisions.

Second Year Target: Achieved Not Achieved (*if not achieved, explain why*)

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved (optional):

AHCCCS has implemented several strategies to achieve the goal of increasing the number of youth in the behavioral health system identified as having a diagnosed Substance Use Disorder (SUD). The goal of 9.5% of those who received SABG SUD services was exceeded, as per CIS data youth under 18 years of age represented 35.19% of the population served in SFY 2019. The Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) are continuing efforts to promote access to SUD treatment services for adolescents during meetings with providers and collaborators, and through school and community-based trainings. Trainings provided by the RBHAs and TRBHAs have included components on how to screen for SUD in the adolescent population, and effective treatment such as Adolescent Community Reinforcement Approach (A-CRA) and other evidence-based practices (EBPs) targeting the adolescent population. Additionally, providers continue to utilize SUD screening tools, including American Society of Addiction Medicine (ASAM) and Car, Relax, Alone, Forget, Friends, and Trouble (CRAFT).

The Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) continued efforts to promote access to substance abuse treatment services for adolescents during meetings with providers and collaborators, and through school and community-based trainings. Trainings provided by the RBHAs and TRBHAs have included components screening for substance abuse in the adolescent population, and effective substance abuse treatment such as Adolescent Community Reinforcement Approach (ACRA) and other evidence-based practices targeting the adolescent population. Block grant funds will be available for treatment services while the State Youth Treatment (SYT) grant funds are utilized in this final year for sustainability of the infrastructure created through previous year activities. Additionally, providers continue to utilize substance abuse screening tools, including American Society of Addiction Medicine (ASAM) and Car, Relax, Alone, Forget, Friends, and Trouble (CRAFT). AHCCCS monitored enrollment number of youth diagnosed with a substance use diagnosis within the system of care.

The RBHAs and TRBHAs continued to collaborate and meet regularly with child/adolescent providers to share information on substance abuse screening, trends and best practices. AHCCCS and the RBHAs will provide and promote access to substance abuse training initiatives available to child/adolescent providers including those employed through other agencies such as the Department of Child Safety (DCS) and Juvenile Justice agencies.

AHCCCS, the RBHAs and TRBHAs educated treatment providers, prevention providers, and coalitions on how to engage community stakeholders in identifying and referring youth to early intervention and substance abuse treatment services.

Outcomes

In Southern Arizona, Outreach was done with various Transition Age Youth (TAY) initiatives in the community. The Pima County's Homeless Youth Committee and Youth On The Rise initiative were regularly attended. Goals for these meetings included providing support and resources to help get TAY off the streets and into housing, services as required, etc. Funds were allocated from the State Opioid Response grant to Sin Puertas to increase outreach to the youth population for Opioid Use. Designated providers were identified to receive targeted SABG funding to ensure effective services to Adult populations in jail/detention with children and youth/adult population involved with Family Drug Courts. There was also coordinated effort for providers to ensure populations in need of SUD services who were not eligible for AHCCCS, were being served through SABG funds.

Information, education and treatment were offered to this targeted group in the Gila River Indian Community GRIC. Students at GRIC schools are identified by teachers, as individuals in need of SUD treatment were referred to Behavioral Health Services, as needed. In addition, educational and informational booths were offered at Komatke Outpatient clinics and HuHuKam hospital, throughout the reporting year as another way to reach youth in need.

The Central Arizona RBHA continued to collaborate with the Maricopa County Juvenile Probation Department to connect youth to services and prevent/decrease involvement in the Juvenile Justice System. They are working with probation and detention to ensure community and educational resources are readily available to families in the lobbies of the detention centers. Processes have been implemented for youth who have touched detention to be connected to services. Youth who are Non TXIX Eligible and have been identified to meet the criteria for SABG funding, are connected to a behavioral health services through the JJET Process. The contracted providers continue to provide training and education to school staff in the various districts in an effort to increase their knowledge in areas such as mental health awareness, substance abuse, and suicide prevention. Providers hold formal partnerships with a total of 36 school districts.

In Northern Arizona, the RBHA worked with their Office of Individual and Family Affairs (OFIA) Children's Liaison to ensure SABG information was dispersed and community partners know who to reach out to for further information, questions, and technical assistance.

Collaboration

The Southern Arizona RBHA has continued its work to collaborate with the Juvenile Probation/Detention Centers within their service areas to receive TAY referrals for substance abuse services, as well as specific programming for SABG youth. In Pima County, the Program Development team structured a program with a coalition of providers (COPE, Touchstone, Sin Puertas) to provide SA treatment for virtually all youth who enter their detention center and are in need of SA services. Additionally, they worked with the Probation Departments to educate their contracted providers on the Risk Assessment tools used by probation to identify moderate to high risk TAY; evaluating criminogenic factors that may lead to continued or increased SA behaviors.

Collaboration between Goodwill METRO, Cope and PPEP Integrated Care exists to help youth and young adults navigate various services throughout Pima County. This partnership has now expanded to include El Rio & Pima Community College. They are also providing information about behavioral health services and where to go when in need of substance abuse treatment. Health Homes and outreach workers are available at METRO, which is a popular TAY drop in center located in downtown Tucson every 2nd Tuesday of the month. This RBHA also continues to support the work completed through the State Youth Transition Grant and continues to support these providers in the use of ACRA and continue the successful work of engaging and providing treatment to this population. During this period, the RBHA developed a specific program for the opioid use population with a component of Medication Assisted Treatment (MAT) for those youth 16-18.

Collaborative meetings with stakeholder partners such as Division of Child Safety (DCS) and Maricopa County Juvenile Probation Department (MCJPD) are held with the Central Arizona RBHA. During these collaborative meetings system updates are provided regarding availability of service providers who offer substance use treatment and how these services can be obtained. The adolescent substance abuse treatment providers who have been allocated funding through the SABG have collaborated with Arizona Dept. of Juvenile Corrections (ADJC) and MCJPD to provide treatment services for youth on probation or parole who are not eligible for Title XIX services. A Referral process has been established to ensure these youth are connected as outlined in the Collaborative Protocols. A partnership with Mesa School district and Community Bridges has been coordinated to secure services targeted to youth who are at risk or using substances. In addition, five other provider agencies and Mesa Public Schools came together to develop a shared Partnership model in efforts of covering the 80+ schools that are in the Mesa School District.

The Northern Arizona RBHA has ongoing collaboration with the Juvenile Justice system and is in the process of updating joint protocols with Juvenile Justice. The requirements and responsibilities outlined in the joint protocols apply to all members, including those receiving services through SABG funding.

Targeted Interventions

In Southern Arizona, their goal is to meet youth and young adults where they are in the community and immediately connecting them to behavioral health services, as needed. The continues to work with contracted providers and Juvenile Probation to identify youth who have been detained and are in need of SA services, as this population exhibits a higher level of need for services.

GRHC Oasis youth program has a dedicated youth substance abuse treatment program called 7 Challenges. Traditional counselors are utilized to connect with youth and their families, in a useful way which has helped increase and maintain youth participation as well as decrease community stigma.

In Central Arizona, the RBHA has required the adolescent SABG treatment programs to utilize a community-based Evidenced Based Practice (i.e. A-CRA, MST, Matrix Model, Seven Challenges, etc.) and has implemented screening tools to identify substance use/use in children and adolescents to better meet the needs of this population. There are a variety of programs to allow choice for recipients, referral sources and appropriate matching of services to individualized needs. In addition, training has been provided on several targeted substance use interventions for youth. Some of these interventions are Cognitive Behavioral Therapy Substance Use Disorder, ASAM and Adolescent and Community Reinforcement Approach (A-CRA). Providers also utilize screening tools such as the American Society of Addiction Medicine Criteria – ASAM, Substance Abuse Subtle Screening Instrument (SASSI) and CRAFFT to screen and assess for substance abuse.

Child & Family Support Services, a youth-focused treatment provider, received SABG funding for the first time to increase access to youth services in two separate counties in Northern Arizona. This is particularly important because this provider receives all juvenile probation referrals within these counties. All Health Homes use the ASAM as a screening tool to identify youth with a substance use disorder; some also use the SASSI-A2 or other adolescent-specific tools in conjunction with an ASAM assessment. The Health Homes collectively offer the following evidence-based practices to treat youth identified with a substance use disorder; A-CRA, CBT, CPT, DBT, EMDR, GAIN, Living in Balance, Matrix, Motivational Interviewing, MST, Seeking Safety, Seven Challenges, Strengthening Families, TBRI.

Other Efforts or Information

Continued participation in all TAY initiatives in covered service areas of Southern Arizona has been a continued effort. At this time, the main projects are happening in Pima County.

The Central Arizona RBHA has expanded Medically Assisted Treatment Services (MAT) for youth with an opioid use disorder. At this time, there are four providers that will provide MAT services for adolescents. They have continued efforts with the T4T suicide prevention trainings targeting educators and community members working with children for Central Arizona. During this period, Five ASIST trainings were completed with a total of 50 community, provider and educators trained; four trainings completed with a total of 55 community, provider and educators trained; four trainings were completed with a total of 46 community, provider and educators trained on YMHFA; and focus groups for those who have completed the train the trainers for ASIST, Youth Mental Health First aid and safeTALK to assist with future trainings have continued.

The Northern Arizona RBHA is creating youth-focused marketing materials to distribute to schools and other youth-focused community organizations about SABG funds and available services. The also host Project ECHO focused on SUD & MAT and offer training on these topics to all Health Homes and Providers.

Progress/Barriers Identified

TAY has been receptive to the 2nd Tuesday events held at the drop-in center. The number of youth who participated in the events has slowly been increasing due to the familiarity & consistency of provider staff engaging with the TAY. Southern Arizona RBHA has developed a specific program for the opioid use population with a component of Medication assisted treatment for youth 16-18 years old. The referral volume for this program over the past fiscal year has been low. The RBHA and youth providers have increased education in the community to raise awareness of essential needs within this population.

Gila River Indian Community parental engagement and transportation continue to be ongoing issues/barriers.

The Central Arizona RBHA continues to hold regular meetings surrounding school-based services for all qualified service providers, regardless of their involvement with schools. There has been consistent attendance at this meeting from some of the other Arizona Complete Care has proven to be helpful for them. There are a total of 36 school districts that this RBHA holds formal partnerships with; 254 public schools, 15 Charter schools and 3 Community schools.

Central Arizona continues to identify the following barriers to treatment; provider continue to struggle with engaging families and youth in continued treatment and probation/courts can be a barrier to treatment by treating substance use as a criminal issue instead of an addiction having the outcome of the disruption in therapeutic processes.

Not all providers across Northern AZ have specialized tracks for youth substance abuse treatment due to low enrollment of youth members. All providers can and do offer youth treatment, but some providers due to greater enrollment in their area have the opportunity to offer youth groups in addition to individualized services.

Success Stories

COPE and Community Medical Services (CMS) collaborated to assist member in receiving services. A 17 year old showed up at one of CMS adult clinics. CMS Staff outreached COPE and within an hour, the 17 year old was at COPE completing an intake for youth services and evaluation for MAT.

COPE has been able to outreach directly to youth at events like Goodwill METRO and completed intakes onsite, without the grant funding, they report that they would be unable to events such as this.

Three individuals referred by GRIC Drug Court completed the program successfully.

As a result of increased monitoring of utilization of funds, the Northern Arizona RBHA increased provider access to SABG funds and

added a new SABG youth-focused provider. There was also an increased community awareness of SABG funding and services. Many organizations informed the RBHA staff that they were previously unaware of SABG funding for youth, were excited to utilize this funding source.

Priority #: 2
Priority Area: Older Adults
Priority Type: SAT
Population(s): Other ()

Goal of the priority area:

Increase the percentage of those who are in the behavioral health system diagnosed as having a substance use disorder and received treatment aged 55 years and older.

Strategies to attain the goal:

The RBHAs will continue efforts to promote access to substance abuse treatment services for older adults during meetings with providers and collaborators, and through community-based trainings. Trainings provided by the RBHAs have included components on how to screen for substance abuse in the older adult population, and effective substance abuse treatment and other evidence-based practices targeting the older adult population. Block grant funds will be available for treatment services to supplement the targeted efforts of Opioid State Targeted Response (STR) to address the growing population of people over the age of 55 with an Opioid Use Disorder as well as all other substances that are more traditionally associated with this population.

Additionally, providers continue to utilize SA screening tools, including ASAM. AHCCCS will monitor enrollment numbers for older adults diagnosed with a substance use diagnosis who receive substance use disorder (SUD) treatment. The RBHAs will continue to collaborate and meet regularly with providers to share information on substance abuse screening, trends and best practices. AHCCCS and the RBHAs will provide and promote access to substance abuse training initiatives available to Arizona Long Term Care System (ALTCs) providers.

AHCCCS and the RBHAs will educate treatment providers, and coalitions on how to engage community stakeholders in identifying and referring older adults to substance abuse treatment services. AHCCCS will ensure the availability of a standardized, age appropriate, screening tool to identify substance use/abuse in older adults.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: The number of persons 55 years and older diagnosed with SUD and received treatment.
Baseline Measurement: In Fiscal Year 16, 13.1% of those with a substance use disorder and received treatment were 55 years and older.
First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2018), 13.3%
Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2019), 13.5%

New Second-year target/outcome measurement(if needed):

Data Source:

CIS enrollment data.

New Data Source(if needed):

Description of Data:

CIS data can be stratified by age group, diagnosis, and services received. CIS captures all elements needed to measure outcomes for this population.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

No data related issues anticipated.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:



Achieved



Not Achieved (*if not achieved, explain why*)

Reason why target was not achieved, and changes proposed to meet target:

AHCCCS has implemented several strategies to achieve the goal of increasing the number of adults over the age of 55 in the behavioral health system identified as having a diagnosed Substance Use Disorder (SUD). The goal of 13.3% of those who received SABG SUD services was not met, as per CIS data adults over 55 years of age represented 12.8% for SFY 2018, but was an increase from the 12% for the same population served in SFY 2017. AHCCCS has implemented the following strategies to achieve the goal of increased screenings and service provision for adults over the age of 55 with a diagnosed substance use disorder. Statewide there is an effort to ensure people are screened and receive services as appropriate. Below are the activities and strategies currently being implemented.

Outreach

The RBHA in the Southern GSA has an array of contracted agencies which provide outreach to members who are presenting in hospitals but are not enrolled with a Health Home, including individuals who have SUD. Engagement Specialists go into the community, including hospitals and home addresses, to discuss services and facilitate intakes, AHCCCS and marketplace screenings, and transportation if necessary. The RBHA maintains an urgent engagement process where any individual who presents to a detoxification facility will receive a response within one-hour from a Health Home for engagement and enrollment into services. This one-hour timeframe ensures that members in the 23-hour observation chairs are linked with an agency prior to their discharge. During the engagement process, members are involved in establishing a service plan and services are arranged to begin once the person leaves the detoxification facility. The RBHA has increased outreach to the community, hospitals, first responders, and the criminal justice system. All age groups, including those over age 55, have been more effectively engaged through these efforts.

In Northern Arizona, the RBHA has worked with a provider to develop prevention materials focused on the dangers of the misuse and abuse of prescription drugs to older adults. These materials were distributed to senior peer participants, support group members, senior living communities and the general public. Twelve educational presentations at senior living centers, community service group meetings, and senior peer support groups as well as senior expositions. The program assigns Senior Peer Volunteers to provide temporary recovery support to Peer Support participants by weekly visits and phone calls. Six preventative support groups including men's, women's, and special needs support groups to the community facilitated by Senior Peer volunteers. Additionally, in September 2017, the RBHA held an annual grandparent outreach and education conference for the Gila River Indian Community.

In the Central GSA, SABG providers have reported an increase of individuals age 55 and older seeking care for substance use disorders. There has been a focus on providing collaboration of care with each primary care physician/medical practice involved with active patients. This process includes patient information, MAT treatment information, and a service survey. Additionally, they are developing relations with pain management clinics for coordination of care and transfer of members. One provider has engaged the older adult community by expanding community education activities which includes education regarding how to access services and various funding options, including SABG. Another provider has worked to outreach hospitals and the homeless populations as well as word of mouth and educating current patient on the potential for 55+ populations to struggle with medication mismanagement, abuse, and addiction.

Many providers include outreach efforts to the Veteran Affairs Department (VA) to address the needs of those 55 and older. Promotional materials and social media messaging include organizations with older adult populations. Providers continue to outreach to the older adult population as clinically necessary on an individual basis based on member need.

Collaboration

The RBHA in the Southern GSA identified a need for increased outreach from providers to courts, probation and other community legal systems to ensure individuals are being effectively met with services. Data from the community coalitions and from the Justice and Law Enforcement agencies in each county, as well as internal data were used to verify the need to outreach older adults released from jails/facilities that are not eligible for Medicaid and are identified as having a Substance Use Disorder. Each provider receiving SABG funding in each of the counties was tasked with developing a work plan specifying how they would better outreach their courts, legal systems and community to identify older adults that would benefit from SABG funded SUD services. The RBHA has also designated specific providers to receive targeted SABG funding to ensure effective services to the older Adult populations in jail/facilities and population involved with Drug Court.

Gila River Indian Community skilled nursing facility refers identified individuals and Primary Care providers refer individual for review by the pain committee to obtain treatment recommendations through the TRBHA. Additionally, in Northern and Central Arizona, SABG providers are outreaching primary care providers or health homes, pain management practices, residential facilities, and community agencies to ensure those aged 55 and older are able to access services.

Targeted Interventions

The RBHA in Southern Arizona is in the planning stages of development for specialty programs for older adults. In Northern Arizona, the RBHA utilizes Screening, Brief Intervention, and Referral to Treatment (SBIRT), Recover Wellness programs, Matrix Model, Seeking Safety,

and Staying Quit. A Gila River Indian Community addictionologist provides MAT treatment to individuals with Opiate Use disorder (OUD) through the TRBHA. ASAM screenings are completed routinely as an assessment tool to determine treatment needs of those within the older adult population to develop individualized treatment plans to best achieve their goals through treatment.

Targeted interventions through SABG funded providers in Central Arizona include: Living in Balance curriculum, Motivational Interviewing, Family Systems Interventions, Solutions Focused Treatment, MAT services, Matrix Model, Stages of Change, Cognitive Behavioral Therapy, Trauma-Informed Care, Trauma-Based Services, Motivational Enhancement, and Group and individual counseling.

Other Efforts or Information

In the Southern GSA, there is a Program Specialist who is overseeing program development for older adults. Development will include engaging providers in increasing age-specific programming and integrated care for older adults with substance use disorders, increasing collaboration with community service providers for older adults in the service areas, and monitoring outcomes for older adults.

In Northern Arizona, coalitions have partnered with the Emergency Department to ensure a referral to pain management or a Health Home when an individual is presenting with substance use concerns. Two health homes have created centers of excellence (COE) to include a "no wrong door" policy for individuals who may be overusing opioids and need MAT, which has been an increasing segment within the older adult population.

The RBHA in the Central GSA's SABG providers will see individuals who don't qualify for Medicaid or other insurance funded services at no/low cost and sliding scale for dental, medical and behavioral health services that are not covered through the MHBG or SABG. They are also coordinating with other grant providers to ensure all options are assessed to ensure access to care for those who are eligible through the available funding or other community based options.

Outcomes Measured

There are several measures utilized in the Northern Arizona GSA including, website traffic tally, social media and printed materials tracking. The number of community members reached with these materials and presentations, as well as the quantity of drugs collected at each site. The providers collect and evaluate internet traffic on the Senior Peer Prevention web page. The RBHA uses the Adult Connectedness SOM, pre- and post-intervention, to evaluate the changes in our Peer Support participants' feelings about their relationships with family and friends. Contacts between Volunteers and participants are captured monthly and entered into the Senior Peer data base. Use the Adult Connectedness survey twice per year to evaluate our Support Group members' feelings about their relationships with family and friends. Additionally, the providers use the Geriatric Depression Scale pre- quarterly- post following intervention to measure changes in depression levels. Contacts between Volunteers and participants are captured monthly and entered into the Senior Peer data base.

In Gila River, 17 individuals with substance use disorder diagnoses completed an intake and were enrolled in services, during the reporting year. Seven individuals with OUD are currently receiving treatment through Gila River Health Care (GRHC).

In Central Arizona, outcomes for the older adult population can be measured by goals identified by the member and documented in the member's treatment plan. National Outcome Measures (NOMs) can be found in member records to include: employment status, enrolled in school or vocational education program, housing, arrests within 30 days, abstinence from drugs and/or alcohol, and participation in social support recovery 30 days prior. ASAM scores based on ASAM dimensional criteria can also be used to measure outcomes.

Progress/Barriers Identified

The RBHA in the Southern GSA indicated that system development will continue to reshape the need for special services for older adult populations within the service area as well as to continue to outreach to this population.

At the end of June 30, 2018, the Senior Peer Prevention Program had 42 volunteers who made 350 contacts with senior participants, for a total of 879.50 hours of contact. This was the largest team of volunteers in program history, with more growth on the horizon. Plans to add a second Low Vision Support Group are in the works. The Volunteer Training Manual was updated and reorganized, along with a Community Resource Guide for Seniors that volunteers utilize with participants. The Program Manager was a regular speaker on the area Hospital's Speaker Bureau, to include a presentation on Misuse and Abuse of Medications among Older Adults. A barrier/area for improvement would be the "dump the drugs" events targeted at older adults; only one collection was made this year in conjunction with a large Community Health Fair. The level of participation was apparently quite small, causing us to reevaluate how we offer this opportunity in a way that resonates with older adults. Successfully recruiting and retaining male volunteers is an ongoing challenge. In the Gila River Indian Community, elders are more likely to engage in traditional services verses behavioral health.

In Central Arizona, SABG providers consistently report the greatest barrier identified is lack of funding to cover other critical needs for this population – such as physical health, medications, and permanent supportive housing.

Success Stories

In Southern Arizona a male over the age of 55 presented to the COE clinic as the first person to enroll in the after-hours program. He came in for treatment for active use of opiates and meeting criteria for an OUD. Since starting the program he has remained in recovery.

As he was working with the provider he began to titrate from his Methadone as he felt he was past the urges to use opiates. He continued to work as a supervisor at his employer and now works as an advocate for his fellow coworkers. He hopes to fully titrate from Methadone and spend more time with his wife as they get older together.

In Northern Arizona, a member is being followed under the Recover Wellness Program due to having more than 15 ED visits in the past 12 months, diabetes, being prescribed opiates and benzodiazepines for chronic use with a Morphine Equivalent Daily Dose (MEDD) score > 120, and having high risk suicide attempts in the past 12 months. This member was brought to the Integrated Care Manager's attention in the course of a psychiatric inpatient discharge. A review of medical records showed a pattern of going to the ED with blood sugar above 500, stating that he had not taken diabetes medications due to suicidal ideation. Lack of income, homelessness and an inability to store Insulin were identified as barriers to care. The Integrated Care Manager reached out to the treatment team, and member was discharged to temporary housing at an apartment complex managed by the health home, where he has daily staff contact and safe storage of his Insulin. The team has applied for financial benefits and is currently looking for permanent housing. The member now has daily visits with the PCP staff at his Integrated Health Home to support compliance with his diabetes care regimen.

An adult female was referred to residential treatment for OUD. The treatment consisted of MAT, residential and outpatient services. As a result of the treatment, this individual is currently reporting 8 months clean and sober from heroin and is on a maintenance program with Gila River Indian Health Center.

In Central Arizona, a provider has developed a collaborative relationship with the Arizona Ash-line to assist the population served with smoking cessation services.

How first year target was achieved (optional):

Second Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved (optional):

According to AHCCCS Client Information System (CIS) claims data, 48,507 adults aged 55 and older had a Substance Use Disorder (SUD) diagnosis, and of those diagnosed 9,856 (20.3%) received treatment.

OUTREACH

Outreach to identify older adults in need of substance use treatment under the Substance Abuse Block Grant is conducted through the RBHAs and Tribal RBHAs (TRBHAs). Outreach efforts include community forums and meetings such as the Adults & Child Services Committee meetings, Department of Justice Collaborative meetings, and meetings of the AZ Coalition for Veterans and Families, as well as outreach to hospitals, the criminal justice system, and the general community.

Outreach efforts by one TRBHA include providing older adults with education materials at senior centers, referrals by primary care physicians to a pain committee to identify individuals for treatment recommendations. Additionally, skilled nursing facilities refer identified individuals to treatment, and counseling is provided either in-office or on-site. This TRBHA also conducts care coordination with Elderly Services and participates in their events.

One provider reports that 300 members aged 41 and older are diverted from detention into a substance abuse facility (this age category of 41 and older is the closest age category captured to 55 and older from this particular data source).

COLLABORATION

RBHA staff coordinates with contracted community organizations as well as others to ensure SABG treatment information is provided to community partners, and to provide contact information for grant-covered services.

Staff at one particular RBHA identified a need for increased outreach to courts, probation, and other community legal systems, for Non-Title XIX individuals needing SUD treatment. This need was verified through internal data as well as data from coalitions, justice and law enforcement agencies in each county. Each SABG-funded provider in each county was tasked with developing a work plan specifying how they would better outreach their courts, legal systems and community to ID this population and provide treatment under SABG as appropriate.

Coalitions serving older adults under this RBHA also requested that members in their counties complete a Sidewalk Survey to measure community attitudes around substance use. This survey is done quarterly and it includes items related to perceptions of medication misuse, favorable attitudes towards sharing medications, knowledge and use of disposal sites, awareness of messaging regarding medication misuse, and disposal methods. Collaboration between the RBHA, coalitions, and the members themselves was required to complete conduct this survey.

The RBHA participates in a monthly collaboration meeting with system partners to address substance misuse across Pima County, to include overdose and treatments for all ages. They utilize data submitted by the health department that breaks out specific age categories to determine gaps and needs for programming.

For TRBHAs, collaboration between primary care providers and the pain committee and between skilled nursing facilities and treatment providers are useful in identifying older adults to be screened and treated for SED. Collaboration between the TRBHAs and Elderly Services has also been important for SUD treatment.

TARGETED INTERVENTIONS

One RBHA has assisted in policy development within subacute facilities that allow for law enforcement drop off of members, speeding up the process of getting older adults with SUD into behavioral health services.

Some health homes in one GSA offers a "whole health" program for older adults, encouraging the use of exercise, movement, yoga, and other mindfulness activities as alternatives to pain medications. These activities are a proactive strategy to prevent the development of Opioid Use Disorder (OUD) in older adults, a group that commonly deals with chronic pain. One of these health homes offers a Senior Peer Program to address substance abuse in the senior population, while another health home has opened a new Behavioral Health Residential Facility specifically for older adults in May of 2019.

Other providers simply provide SUD treatment including Medication Assisted Treatment (MAT) to individuals with OUD regardless of age.

One RBHA facilitates a quarterly Substance Use Providers meeting, which addresses the 55 and older population specific programming allows the RBHA and providers to determine gaps and needs for programming. This RBHA began working with high risk "against medical advice" (AMA) member population who leave hospitals, and found that 51-75 year olds discharge AMA at higher rates. By identifying this, providers are able to try to wrap these individuals with services for outreach and harm reduction. This RBHA has implemented a chronic pain management program for members, including the older adult (age 55 and older) population, and also continues to partner with a community coalition to assess substance use across generations. While the coalition's work focuses on safe disposal of medication and education for older adults, it also provides a component of provider follow up for treatment for older adults.

OTHER EFFORTS

One RBHA has been active in overseeing programs for older adults and engaging providers in age-specific substance use programming and integrated care for older adults. In addition, they have worked to increase collaboration with community service providers for older adults within the service area, and monitor outcomes.

A provider for older adults distributed and received back 465 surveys during the grant year. Survey results indicated that nearly all respondents believed medication misuse was a problem in the community, nearly 75% were aware of messaging about safeguarding medications, 62% said they safeguarded medications due to the messaging they received. Over 1/3 reported having used medication disposal sites for their medications. Of those who did not use medication disposal sites, more than half responded that they didn't need them, while about 1 in 5 were not familiar with the location of the disposal sites.

Another provider of older adult services received 361 completed surveys. These survey results indicated that 86.8% believed medication misuse was a problem in their community and only about 5% believed it is okay to share medications with others. Just over half of respondents said they were aware of messages about safeguarding medications, and of these 76.4% said they safeguarded their medications because of the messaging. Just over 60.7% reported not using medication disposal sites for their medications, over half (55.1%) of which said they were unaware of drop box locations and 27.5% felt they did not need them.

Although these surveys are more geared toward prevention of SUD, the results were encouraging. Many people see the messaging and either safely store or dispose of medications or due to the messaging efforts.

OUTCOMES

One RBHA reports that, of all members receiving services funded by SABG, 246 (16.6%) of them were over the age of 55 at the time of service within this reporting period.

One TRBHA reports eight elderly individuals with OUD are currently receiving MAT treatment through one provider. In addition, an opioid safety and overdose prevention presentation was offered to all seven district elder service groups and 20 elders participated. Narcan nasal spray education and overdose kits were provided to 25 elders and locking medication bags were provided to 20 elders.

PROGRESS/BARRIERS IDENTIFIED

Progress

One health home has identified that they will open a Behavioral Health Residential Facility specifically for older adults.

One RBHA reports a trend in year to year increase in the number of members served via the crisis system and subacute facilities.

One TRBHA recognizes that tribal elders are more likely to engage in traditional services as compared to behavioral health services.

SUCCESS STORIES

One RBHA reports a success story about an older adult receiving SUD services. After having used substances intravenously for over one year, the patient attended his first induction and assessment. The patient began MAT services, and at the time had 6 days clean. A staff

member who accompanied the patient to his first meeting also met his family during transportation to services. The family had been very concerned, expressing how his substance use had worsened, to the point that the family would not allow him to use the bathroom without being patted down first. The patient was not confident in treatment, as he had an unsuccessful attempt at treatment previously. After starting treatment, including Suboxone and attending groups, he began to look better and feel better and began mending damaged relationships family, rebuilding trust. So far, the patient has been successful in MAT treatment, participating in groups 3 times a week and attends weekly follow up appointments with the doctor.

One program has implemented efforts to increasing diversity and cultural competency across staff members. They recruited a representative member from the Pascua Yaqui/Sewa U'uisim tribal community, and also welcomed a new member from a Hospice program. Staff also participated in the Diverse Voices in Prevention (DVIP) conference, and also scheduled an evidence-based Spanish version of the WISE workshop. This diversity in staffing is an enhancement to the behavioral health workforce, and thus, an enhancement to services provided to the community.

In collaboration with the county health department, a provider presented on medication misuse to a rural retired community of 200 participants and raised awareness of the importance of safe medication use, storage and disposal.

This RBHA and provider also facilitated delivery of Deterra medication disposal bags to the community and engaged the interest and support of the District Supervisor in supporting/promoting safe medication use and disposal in older adults.

Priority #: 3
Priority Area: Suicide Rate
Priority Type: MHS
Population(s): SMI, SED, ESMI

Goal of the priority area:

Reduce the Arizona Suicide Rate to 19.0% per 100,000 by the end of calendar year (CY) 2018.

Strategies to attain the goal:

AHCCCS will work collaboratively with other health agencies to research and implement strategies to reduce the suicide rate. Strategies will include but are not limited to: social media messaging, social market/public awareness, youth leadership programs, gatekeeper trainings, improved data surveillance, and ongoing collaboration with stakeholders or systemic improvement.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement: The suicide rate in Arizona for CY15 was 19.4 per 100,000 population 1320 suicide deaths/6,818,000 population.
First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of CY 2018), 19.0 per 100,000
Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of CY 2019), 18.6 per 100,000

New Second-year target/outcome measurement(if needed):

Data Source:

Arizona Department of Health Services, Division of Public Health and Statistics (ADHS/PHS)

New Data Source(if needed):

Description of Data:

Each Fall, the Arizona Department of Health Services, Division of Public Health and Statistics (ADHS/PHS) calculates the State's suicide rate by determining the number of death certificates of Arizona residents where "Suicide" was indicated by a medical examiner as the cause of death during the second most recent complete calendar year (i.e. CY 2018 data will be made available in Fall 2019). Aggregated across the general population, this number establishes a suicide rate per 100,000 persons.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

No data related issues identified.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (*if not achieved, explain why*)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

The goal of having a suicide rate per 100,000 of less than 19.0 was met as the suicide rate per 100,000 for Arizona was 17.6 per 2016 data based on the most recent, CDC data as cited in the American Foundation for Suicide Prevention's Suicide: Suicide Facts & Figures: Arizona 2018 document. Arizona Health Care Cost Containment System (AHCCCS) continues to implement the strategic direction to achieve the goals in the 2018 End to Suicide in Arizona State Plan focusing on the reduction of the suicide rate across multiple populations of focus across the state.

The 2018 End to Suicide in Arizona State Plan provides recommendations including objectives and strategies specific to our state. The four strategic directions are the same as those given in the National Strategy with the goals, objectives, and strategies closely following the national plan. The statewide strategies identified in the plan are those that can be directly supported by the Arizona Suicide Prevention Coalition and AHCCCS.

An End to Suicide in Arizona 2018 State Plan was written to identify and outline the plan for Arizona to reduce deaths by suicide. The State plan provides a guideline of activities aimed to prevent suicide in Arizona. The State plan is aligned with the 2002 National Strategy for Suicide Prevention: Goals and Objectives for Action, a joint report from the US Surgeon General and the National Action Alliance for Suicide Prevention. The Strategic directions include:

1. Healthy individuals and communities,
2. Ready access to prevention resources for clinicians and communities,
3. Treatment and support services available to clinicians, communities, survivors, and
4. Continued evaluation and monitoring of prevention programing.

During 2018, AHCCCS connected with health care professionals and the community to complete targeted activities. AHCCCS collaborated with groups to promote the best practice, Zero Suicide at public events, organized suicide prevention month events and engaged in positive safe social media activities. AHCCCS worked in partnership with the Be Connected movement to prevent military suicides and joined with community organizations for dialogue of suicide prevention within their own neighborhoods. Additional highlights regarding contractor, provider and Tribal partners funded through the MHBG and SABG are detailed below.

Outreach

Throughout Arizona the RBHAs and TRBHAs as well as the providers participated in and provided information and resources at a variety of community forums, town halls, and events related to suicide prevention, including: Veteran's Administration resource fair, HEAAL Community Forum on Bullying and Suicide 12/17 in Maryvale, "Teen Suicide: Take Action and Save Lives" 5/18 at Mesa Performing Arts Center, "Suicide: the Ripple Effect" Screening in Avondale and Queen Creek, Suicide Prevention Discussion for the Town of Queen Creek 12/17, Community Conversation about Research on Youth Suicide in Phoenix 3/18, and town halls in Gilbert and Queen Creek.

The RBHA in the Central GSA presented an overview of how to access school-based prevention, treatment and crisis services to the Chandler Unified School District. They also met with Tempe Unified School District to describe available prevention programs and discuss district-wide strategic planning including training for staff and students. The RBHA Participated on an ongoing basis with a district-wide Prevention Collaborative in Deer Valley. They presented on Best Practices and Safe Messaging for Suicide Prevention at Northern AZ Suicide Prevention Conference in 8/17, held four Lunch and Learn Presentations for Medical Management staff on Suicide Prevention and Safety Planning 8/17 and Bullying & Self Injury 3/18, presented on Psychological First Aid and Trauma Coping Strategies at the 4th Annual Emergency Preparedness Conference in 9/17, and spoke on a panel for Suicide Prevention at Women's Empowerment Summit at Mesa Community College in 3/18. The RBHA facilitated media interviews with Cronkite News and other local outlets to share information and resources related to suicide prevention efforts and services. Additionally a press conference for suicide prevention was held at the Governor's Office in 1/18.

Prevention Providers conducted outreach within their targeted communities as part of their strategic plans, including health fairs, town halls and community forums, educational workshops and trainings, presentations and collaborations with schools and other organizations. During the reporting period, 1,661 community members, peer/family, staff, stakeholders, faith-based groups, youth and provider agencies participated in suicide intervention gatekeeper trainings in the southern part of the state. The participants nearly double the number reported from last contract year. The participants reported increased knowledge about suicide prevention in the post-tests. Suicide Prevention Specialists worked closely with diverse populations such as: first responders, native communities, school districts, community college staff and students and County Attorney Offices, facilitating trainings in their respective communities. A provider's Senior Peer Program served men and women over the age of 60 in the Prescott and surrounding area who are at risk for depression. A Coalition provided youth and students service referral cards for treatment service and educational information to talk to someone about their feelings which can include suicide ideations. The card includes the suicide hot line phone number.

Over 4000 social media impressions through Facebook and Twitter have provided information about referral phone lines, available 24/7 to those seeking help around the topics of substance abuse, coping and suicide. Created an online awareness program during National Prevention Week through Twitter with a hashtag attached (#NationalPreventionWeek2018) to spread suicide awareness. The providers conducted 20 activities to distribute Yes 2 Life door hangers in neighborhoods throughout the community. Additionally, a TRBHA showed multiple screenings of the Gila River Indian Community produced Yes 2 Life Video. The TRBHA also conducted community events during Suicide Prevention Awareness month with youth as a focus.

Collaboration

The RBHAs, TRBHAs and providers maintained collaborations with the following organizations addressing suicide prevention: Arizona Suicide Prevention, American Foundation for Suicide Prevention AZ Chapter (AFSP-AZ), Teen Lifeline, EMPACT/LaFrontera SPC, Phoenix Indian Center, Tanner Community Development Corporation (TCDC), TERROS, MIKID, Not My Kid, and Project Connect 4. They served as members and partners of Arizona Suicide Prevention Coalition (AZSPC) and its Training Committee for the planning of the annual HOPE Conference, helped sponsor awareness walks for survivors of suicide as well as conferences and events, and helped coordinate care provided to schools and communities following a suicide. Other sponsored community events included the US Vets walk, EMPACT/LaFrontera Rally Point walk, EMPACT/LaFrontera Survivors of Suicide Day and Jeremiah Walk for Survivors of Suicide, and the AZSPC LOSS and HOPE Conferences.

Various contracted providers and community coalitions have collaborated to host ASIST and safeTALK trainings in their communities, lending trainers and facility space to increase access to community members across the central geographic service area. They have achieved a huge success on training provision to a variety of community sectors including schools, faith based organizations, law enforcement, primary care clinics, behavioral health, youth serving organizations, older adult serving organizations, and more. They have conducted eight ASIST trainings hosted at Phoenix Indian Center, Touchstone, Laveen Elementary School District, MARC Community Resources, Native Health, Crisis Preparation and Recovery, Chrysalis, and Childhelp. Additional ASIST trainings were conducted including: Hope Lives, Family Involvement Center, EMPACT/LaFrontera, and Community Bridges In (CBI). The RBHA also provided ongoing support to other stakeholder organizations implementing ASIST, such as Not My Kid, Arizona National Guard, and other agencies.

The RBHAs, TRBHAs and providers also hosted 37 safeTALK trainings for AHCCCS, MIKID, Crisis Preparation and Recovery, Southwest Behavioral & Health Services, Childhelp, Oasis, Southwest Human Development, Arizona Culinary Institute, Mercy Maricopa/The RBHA in the Central GSA, TERROS, Touchstone, Teen Lifeline, Tanner Community Development Corporation, Area Agency on Aging, Phoenix Indian Center, CBI, Jewish Family and Children's Services (JFCS), and Crisis Response Network (CRN) also implemented safeTALK trainings at their organizations. The RBHA provided ongoing support to all trainers in the service area including other stakeholder organizations. A Prevention Specialist also worked with Tucson Pascua Yaqui Tribe Centered Spirit and Tohono O' Odham Native Connections program co-facilitating two day ASIST Trainings quarterly. A Prevention Specialist collaborated to deliver an ASIST training with the Laveen school district following a loss.

The Prevention Specialist served as an active member in the San Carlos Suicide Prevention Task Force to facilitate Question, Persuade and Refer (QPR) trainings and provide technical assistance on best practices and resources, such as the Suicide Prevention Resource Center, SAMHSA, CDC, and community readiness. The RBHA provided the accommodation arrangements and conference registrations for a prevention staff member from the San Carlos Apache Tribe Wellness Center to attend the HOPE conference in 2016. The Southern GSA Suicide Prevention Specialist served a member of the Out of the Darkness Walk Planning Committee.

In the Northern GSA the West Yavapai Guidance Clinic (WYGC) Sr. Peer Program partnered with other agencies such as MATFORCE, Yavapai County Sheriff's Office and Yavapai Suicide Prevention Coalition to execute initiatives that aim to improve connectedness for men and women over the age of 60. The MATFORCE Coalition conducted community trainings to provide information and tools to community members or gatekeepers. Some of the trainings included: Motivational Interviewing in collaboration with Adult Probation where 25 individuals attended, Opioid Overdose: What it Looks Like and How to Respond with 35 attendees, Reentry & Recovery: A Second Chance for Life with 105 attendees, Trauma Informed Care with 19 attendees, and Erase the Stigma with 220 attendees. Additionally, the RBHA Collaborated on Meth and Suicide Prevention Initiative Healing and Hope short film debut in June 2018. Seven youth attended the THRIVE conference which has a focus on suicide prevention through the RBHA as well. The BHS Prevention Program is collaborating with Gila River Health Care staff at the hospital and at behavioral health facilities to enhance processes and educational activities related to suicide prevention. The BHS Prevention Program also collaborates with first responders and schools related to referrals and connections to services.

Targeted Interventions

The RBHAs and TRBHAs led targeted suicide prevention efforts through Help Enrich African American Lives (HEAAL), Maricopa Elder Behavioral Health Advocacy Coalition (MEBHAC), LGBTQ Consortium, Urban Indian Coalition of Arizona (UICAZ), and AZSPC coalitions targeting African Americans, older adults, LGBTQ young adults, Native Americans, and schools throughout the service areas. Prevention efforts included youth peer leadership, alternative activities, education and training, social media and awareness campaigns, information dissemination, and information and referral/screening.

Teen Lifeline had incredible success collaborating with and providing education and awareness events at over 30 schools during TSPAM (Teen Suicide Awareness Month) in September. Teen Lifeline provided workshops on depression and suicide, self-injury, bullying, stress

and coping, Signs of Suicide, and outreached schools to provide education through an online e-learning series on developing postvention policies and procedures. AZSPC, Teen Lifeline, and EMPACT/LaFrontera continued the "Man Therapy" campaign to raise awareness, reduce stigma, and increase help seeking behavior among middle-aged adult males (45-55 and up), a population with rising suicide rates. The "Man Therapy" campaign has been well received and has generated partnerships from law enforcement, military, and veteran-serving organizations. "Man Therapy" strategies included posters and print materials disseminated at health fairs, barber shops, and community sites, billboards, and articles that were featured in male-targeted publications, and an online risk assessment and links for resources.

The Suicide Prevention Specialist and the Supervisor of Tribal Programs attended monthly meetings to support the San Carlos Apache Suicide Prevention Task Force. The Suicide Prevention Task Force enhanced collaboration and resources to reduce and eventually eliminate suicide on the San Carlos Indian Reservation. Additionally, the Sr. Peer Program prepared education materials such as (pamphlets, brochures, display materials, presentation materials, websites) describing the risks of geriatric depression. They distributed educational materials to Sr. Peer participants, support group members, senior living communities and the general public. They conducted 12 educational presentations at senior living centers, community service group meetings, senior peer support groups and senior expositions. Senior Peer Volunteers provided temporary recovery support to Peer Support participants by weekly visits and phone calls. Volunteer monthly reports describe each contact with participant. The volunteers also facilitated six preventative support groups including men's, women's, and special needs support groups to the community.

MATFORCE selective education included 1056 students that were provided with the evidenced based Life Skills ® school-based curricula. Life Skills ® is a 6 session curricula which include educational topics on self-esteem and coping mechanism, providing students with skills necessary to navigate adolescent challenges that can lead to suicidal thoughts. 646 elementary school students participated in the Good Behavior Game ®. The Good Behavior Game ® is an evidenced based program that teaches self-management.

ASIST and youth developed messaging was provided for Pascua Yaqui Tribe Members through the Pascua Yaqui TRBHA. Gila River Health Care BHS Prevention Program staff delivered targeted interventions through three ASIST trainings were delivered with 18 participants, 27 safeTalk trainings were delivered with 403 participants, 33 QPR Trainings were provided with 237 participants, and four Suicide Prevention Strategies for youth were provided with 194 participants.

Other Efforts or Information

The RBHA created an ad-hoc Taskforce this year in response to the rising number of youth suicides, especially in the East Valley of the central GSA. The Taskforce included representation from the Prevention, Children's, and Crisis teams as well as the school-based crisis providers (Teen Lifeline and EMPACT) and AZSPC. There was a designated email created for suicide prevention training requests in the Southern GSA. The RBHA in the southern GSA designed three suicide prevention posters, in English and Spanish, targeting specific populations - youth, adults, and older adults - with the crisis telephone number and Teen Life Line number. The posters were distributed throughout southern Arizona. They also sponsored the Out of Darkness suicide prevention walk in Tucson and had 20 staff members participating, and the 11th Annual Jeremyah Memorial 5K Walk/Run in Tempe to support survivors of suicide.

In the Northern GSA, the WYGC program assigned Senior Peer Volunteers to provide temporary emotional support to Peer Support participants by weekly visits and phone calls as necessary. MATFORCE led 275 students who participated in the 'Say it Out Loud' classroom presentations. This research based program provides information to students on mental health issues. The RBHA sponsored the Yavapai Reentry Project. The project provides support and life skills to individuals returning to Yavapai County from the Department of Corrections. The program provided skills for their transition in gaining the confidence to be successful community members. The northern GSA RBHA's clinical training department partnered with the school system to provide additional training in Youth Mental Health First Aid (YMHFA) and triage options for educators. They provided YMHFA to educators and community members on tribal lands, including Hopi and Havasupai. Crisis counselors have been deployed to the canyon and to the Hopi lands to provide additional support and resources to their community.

The Pascua Yaqui Tribe Lutu'Uria Youth Group, Guadalupe Prevention Partnership (GPP) summer camp each year has presentations on Bullying and suicide prevention. Gila River Health Care BHS Prevention Program contracts with Hoofbeats with Heart to provide Equine Assisted Learning. During the year 9 sessions took place with 87 youth and 126 adult participants. Gila River Health Care is in the process of full implementation of Zero Suicide best practices under the auspices of other funding with 194 participants.

Outcomes Measured

Outcomes are measured on the efforts to reduce the suicide rate through a comprehensive approach including education, social marketing and awareness campaigns, gatekeeper training, screening, increasing access to effective care, increasing collaboration efforts, advocating for policy change, etc. Providers measure outputs in terms of numbers of youth and adults served and number of educational sessions held. School-based suicide prevention outputs (combined data from Teen Lifeline and EMPACT/LaFrontera) included 129 schools served within Maricopa County (148,092 students; 396 workshops; 3,731 students participated in Signs of Suicide); 3,056 youth screened; 198 face to face interventions; 303 referrals to behavioral health for youth, parents, and/or families; 932 staff members and parents trained as gatekeepers (Signs of Suicide, safeTALK); 63 schools participating in ID initiative; and 23 schools, 35 individuals completed postvention e-learning.

The RBHA in the Southern GSA worked with the University of Arizona Evaluation Research and Development (ERAD) Department who

created a database to measure outcomes for the QPR trainings. Suicide prevention training post-tests reflected that the majority of participants "strongly agreed" that they increased their knowledge about suicide prevention. In the Northern GSA, the WYGC Sr. Peer Program measured copies of materials provided including: quarterly reports, website traffic tally, social media and printed materials tracking, community members reached with the materials, community members reached by the presentations, internet traffic on the Senior Peer Prevention web page, the Adult Connectedness SOM, pre- and post-intervention, to evaluate the changes in Peer Support participants' feelings about their relationships with family and friends, contacts between volunteers and participants, and the Geriatric Depression Scale pre- quarterly- post following intervention to measure changes in depression levels.

MATFORCE collected data and outcomes demonstrating that over 90% of the students completing the Life Skills Curricula self-reported an increase in coping skills. Good Behavior Game outcomes were a 60% + decrease in symptoms or negative classroom behavior for the year. They collected utilization data regarding trainings including Motivational Interviewing in collaboration with Adult Probation with 25 individuals attending, Opioid Overdose: What it Looks Like and How to Respond with 35 attendees, Reentry & Recovery: A Second Chance for Life with 105 attendees, Trauma Informed Care with 19 attendees, and Erase the Stigma with 220 attendees.

Through the TRBHA, 91% of youth agreed that they could help a friend after participating in the Gila River Health Care suicide prevention strategies workshop. 85% of participants of ASIST rated their preparation level to help someone who might be thinking about suicide as a 4/5 based on a scale of 1 (not at all prepared) to 5 (very prepared). 92% of QPR participants agreed they felt more prepared to help someone in need. 100% felt they had the knowledge to connect individuals to resources. 89% of safeTalk participants agreed they felt more prepared to help someone in need.

Progress/Barriers Identified

Some of the barriers or concerns regarding suicide prevention included that in this year period there appeared to be an increase in youth suicides around the start of the school year, some "cluster" suicides happened in East Valley schools of the central GSA, and the community demanded action and mobilization engagement as there were some inaccurate and potentially unsafe messages being shared with media and the community. The RBHA worked in partnership with AZSPC, Teen Lifeline, EMPACT, CRN, and others to provide information about resources and efforts. Funding limitations for MHBG and SABG regarding suicide prevention limited the approach and populations that the RBHAs, TRBHAs and providers could use with the funds. Also, data for suicide rates in Guadalupe (as well as other regions of the state) are difficult to determine due to cultural stigmas and reporting.

Progress has been identified given participant numbers nearly doubled between 2016/17 and 2017/18, the awareness of suicide prevention programming is spreading in the southern GSA. MATFORCE identified progress made with raising awareness about the high number of suicides in Yavapai County. The updated health department's community health improvement project plans will include objectives for addressing suicide in all goal areas.

Success Stories

Two great collaborative successes occurred this year including fostering the partnership with Teen Lifeline to provide a series of safeTALK trainings to Tempe Union School District's administration during an in-service week, and connecting TERROS and Touchstone to provide safeTALK for Department of Child Safety, Comprehensive Medical and Dental Program (DCS CMDP) staff. The RBHA continued providing safeTALK for providers and community stakeholders, but a monumental success this year was institutionalizing safeTALK training for RBHA staff who work directly with members. They trained over 600 staff in a 10 month timeframe. This work extended beyond the training room, as it provided opportunities to enhance workplace culture to support employees with thoughts or suicide experience. The RBHA partnered with AZSPC through its Training Committee to receive a grant from LivingWorks Education to support an annual ASIST and safeTALK Trainer Conference in October, bringing trainers together for professional development opportunities.

Overall, one of the most notable successes this year was the increasing success in school-based partnerships. Teen Lifeline's "ID Initiative" to include the crisis hotline on every student's identification badge was a low-cost but innovative strategy that resulted in increased calls to the hotline and opportunities to provide support and education to schools and students. Schools have been increasingly reaching out and requesting training and education services, and we have been working hard to meet this demand and community need.

According to the QPR Annual Report created by University of Arizona ERAD QPR trainings were effective in increasing knowledge across both fiscal years. When asked if they learned new skills 75.3% (2016-17) and 68.0% (2017-18) strongly agreed they had, while 83.7% (2016-17) and 76.5% (2017-18) strongly agreed the training increased their knowledge about suicide prevention. There was broad agreement that the trainer was an expert in conducting QPR. For instance, 88.8% (2016-17) and 89.3% (2017-18) strongly agreed the trainer was knowledgeable about the subject matter, while 89.5% (2016-17) and 88.2% (2017-18) indicated that the trainer communicated the information clearly. Participants strongly agreed the materials were easy to understand (87.7%: 2016-17 – 84.3%: 2017-18) and the length of the session was appropriate (78.6%: 2016-17 – 71.2%: 2017-18).

The West Yavapai Guidance Center's Sr. Peer Program was a recipient of the 2019 Kendall Grant that allowed them to re-examine their process for measuring annual performance indicators.

Second Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved (optional):

Based on Arizona Department of Health Services (ADHS) Vital Health Statistics data, Arizona, achieved this goal with a reported suicide rate of 18% per 100,000 populations in a specified age group, for 2017. Data for 2018 is currently still being tabulated by ADHS and is currently unavailable, but will be reported once it has been finalized.

AHCCCS and its providers implement a myriad of strategies to combat suicide in AZ, targeted at multiple populations. Mental Health First Aid, Question Persuade and Refer, Applied Suicide Intervention Skills Training (ASIST), and SAFE Talk are just a handful of the trainings and events that are implemented statewide, and at AHCCCS for staff and the community, to curb suicide deaths.

Arizona continues to follow the the 2018 End to Suicide in Arizona State Plan, which provides recommendations including objectives and strategies specific to our state. The four strategic directions are the same as those given in the National Strategy with the goals, objectives, and strategies closely following the national plan. The statewide strategies identified in the plan are those that can be directly supported by the Arizona Suicide Prevention Coalition and AHCCCS.

An End to Suicide in Arizona 2018 State Plan was written to identify and outline the plan for Arizona to reduce deaths by suicide. The State plan provides a guideline of activities aimed to prevent suicide in Arizona. The State plan is aligned with the 2002 National Strategy for Suicide Prevention: Goals and Objectives for Action, a joint report from the US Surgeon General and the National Action Alliance for Suicide Prevention. The Strategic directions include:

1. Healthy individuals and communities,
2. Ready access to prevention resources for clinicians and communities,
3. Treatment and support services available to clinicians, communities, survivors, and
4. Continued evaluation and monitoring of prevention programming.

Priority #: 4

Priority Area: IV Drug Users

Priority Type: SAT

Population(s): Other ()

Goal of the priority area:

Increase the availability and service utilization of Medication-Assisted Treatment (MAT) options for members with a SUD. AHCCCS will focus on reaching out to the IV drug use population. Arizona has worked to improve MAT access and availability through provider network monitoring to assess needs, expanding lists of approved MAT medications, and increasing convenience of locations and hours. Providers and their prescribers receive training on the availability and use of MAT services, as well as education on MAT medications. Additionally, there are now Methadone and Suboxone Directories available for Maricopa County to assist in making appropriate referrals. These services and ease of access to services continue to be a collaborative goal of the block grant and additional Opioid focused grants.

Strategies to attain the goal:

AHCCCS will further rollout the expanded MAT services available to those with a substance use diagnoses through additional advertising within the community. AHCCCS and RBHAs will provide education for healthcare practitioners on best practices and availability of MAT services. AHCCCS will update the Behavioral Health page to provide links to locate MATs available throughout the State to assist members in locating appropriate services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators to measure success on a yearly basis.

Baseline Measurement: 2016 measurement of members who report IVDU who received MAT services.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2018), 54%

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2019), 55%

New Second-year target/outcome measurement(if needed):

Data Source:

Client Information System (CIS) data.

New Data Source(if needed):

Description of Data:

CIS report on the number of IVDU members with a SUD receiving MAT services out of number of members receiving MAT services.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

No data related issues anticipated.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

SFY 2018 CIS data shows 9,350 members received one or more medically assisted treatments, out of 14,568 members who reported using substances intravenously, which represents 64.2% of the population, exceeding the goal of 54%. AHCCCS has implemented the following strategies to achieve the goal of increasing availability and service utilization of MAT for individuals that this method of treatment would be clinically indicated, with a special emphasis on those who have intravenous drug use (IVDU). These strategies have been a part of a comprehensive statewide effort to address the opioid epidemic with the resources available through the SABG, Opioid State Targeted Response (STR), Medicaid, and Medication Assisted Treatment Prescription Drug Opioid Addiction (MAT-PDOA). Naloxone training and distribution has been part of a strategic statewide initiative to prevent overdose fatalities. Below is a description of the activities conducted through the RBHAs, TRBHAs and SUD providers.

Outreach

The RBHA in the Southern GSA continues to provide outreach and services through the MAT-PDOA Grant to ensure MAT accessibility for Jail Reach-In efforts in Pima County. These individuals are then connected with services through SABG or Medicaid funding in the community as needed. The main focus of this program is to connect those involved with the criminal justice system to medication-assisted treatment and creating a bridge between incarceration and treatment. The RBHA and providers have increased outreach to the community, first responders, the criminal justice system and hospitals.

In the Northern GSA, the RBHA has provided first responders with Naloxone to decrease the incidence of overdose related fatalities. Through the use of STR funding, SHCA has imbedded care coordinators in jails, EDs, and FQHCs to support the identification of possibly misuse and referral to treatment and eligibility screening for funding for SUD services. The RBHA is in the process of developing informational billboards regarding the dangers of opioid misuse.

The Central GSA SABG providers outreach members in hospitals, jails, homeless campuses, justice initiatives, crisis/first responder services, and through navigation services. Social media is also used to promote MAT services. Gila River Indian Community's general information and education on behavioral health services is provided community-wide to their community members addressing intravenous drug use and medication assisted treatment through the TRBHA.

Collaboration

The RBHA in the Southern GSA has increased Medication assisted treatment availability to members and has successfully increased member participation in these services through education and community outreach. The RBHA has established MAT services in rural areas, such as Nogales, Cochise and Graham counties to ensure MAT accessibility to members through co-locations to provide Buprenorphine through telemedicine. The RBHA also has integrated an Access Point in Pima County through Community Bridges to provide the community and law enforcement 24/7/365 access to urgent and routine behavioral health services. Co-located at the Access Point facility is a Patient Centered Health Home (PCHH) where patients can receive ongoing medical and behavioral health services. The RBHA continues to work with providers to expand and enhance access to medication assisted treatment services for persons with criminal justice involvement that have an opioid use disorder and are seeking or receiving MAT through the MAT-PDOA grant. At the end of this State Fiscal Year the RBHA received accepted allocation from AHCCCS to expand these services in Pima County and into Graham County with the addition of Community Medical Services as a provider.

In Northern Arizona several hospitals and FQHCs are utilizing brief intervention and referral to treatment model to address opioid misuse. MAT services are available in all Health Homes. MAT services have been developed for adolescents 16 and older and collaboration between health homes and jails, EDs, FQHCs, and the community.

The RBHA in the Central GSA providers have collaborative relationships with the Maricopa County Sheriff's Office, Arizona Department of Corrections, Adult Probation, the Governor's Office, and AHCCCS. Several hospitals work with a provider and fast tracks all members who

are pregnant and have an OUD into treatment. The hospital inducts members and then warm-hands them off to a clinic. Collaboration with the Felony Diversion Program in collaboration with the Maricopa County Attorney's office provides treatment in-lieu of incarceration. Maricopa County Jail has a provider that currently manages pregnant incarcerated individuals and accepts warm hand offs from county jails. The Maricopa County Re-entry Center (MRC) for post-release prisoners has Peer Supports who enters MRC once per week and receives members into a clinic for induction. The clinic then delivers MAT to the center 3 times per week and conducts all other services via telemedicine. Maricopa County Drug Court has a provider that attends Drug Court staffing four times per week to provide guidance on those diagnosed with OUD and helps navigate people into treatment with the provider's clinic, other OTPs, or higher levels of care. An OTP is the sole provider for methadone treatment for a number of residential programs throughout Maricopa County. A clinic is the chosen provider to create and implement necessary workflows to fulfill the governor's order to provide Vivitrol to inmates pre-release and transition them into continued services after release for those who elect to participate in the program. The Alhambra (ADC) Transition Center currently transports members daily to a clinic, with the plan to transition to delivering medications to ADC. In Perryville Prison pregnant women are transported weekly to a clinic to see a medical provider and counselor. The clinic then delivers medication once per week to the prison and the prison stores the medication and dispenses them to the inmates. Post-delivery, the inmates are managed with a 30-day withdrawal management protocol.

Targeted Interventions

Throughout Arizona the RBHAs, TRBHAs and providers have established the goal of increasing the number of members receiving access to MAT and substance use treatment as well as to decrease the number of overdoses and deaths due to substance use and opioid use. Targeted interventions statewide include MAT interventions – including Methadone and Suboxone, Matrix Model, Seeking Safety, Naloxone prescriptions with every opioid prescription, HIV prevention and Hepatitis/TB screening.

The TRBHA, Gila River Health Care Addictionologist has clinic hours and provides MAT treatment at GRHC various sites. Some individuals may attend GRHC residential treatment in conjunction with MAT outpatient treatment. The RBHA in the Central GSA has eight MAT providers, all of whom also provide additional individual and group counseling (including IOP). MAT providers primarily utilize Methadone, but are increasingly using Suboxone and some are using Vivitrol. Additionally, Narcan/Naloxone is being increasingly distributed by providers. Terros and Ebony House, both SABG providers, host testing for infectious disease, including HIV, hepatitis C, and tuberculosis and counseling sessions in the community and in partnership with other SABG providers.

Other Efforts or Information

The RBHAs and TRBHAs have submitted budgets to AHCCCS and SAMHSA for the State Opioid Response (SOR) grant to expand and sustain Substance Use Disorder treatment services, peer support, street based outreach, Jail Diversion and Reach In, MAT in rural areas, and workforce development for the opioid use population. With the SOR grant, the RBHAs and TRBHAs will expand access to care for MAT services for IV drug users, and all who need substance use disorder care. Providers will be asked to extend hours to include a second dosing shift, and additional sites will be opened to meet demand. Currently, Arizona has multiple 24/7 MAT locations.

Outcomes Measured

Throughout Arizona, the number of members enrolled with IVDU, members with an OUD and those receiving MAT are identified. MAT accessibility and network capacity are measured as well. The RBHAs have increased MAT prescribers and referrals, as well as developed COEs for opioid treatment and increased Naloxone distribution. During the reporting year, through one of the TRBHAs, 12 individuals completed intake and enrolled in services through the Gila River Indian Health Center. Their addictionologist met with 2 individuals, on average, per quarter.

For the RBHAs and TRBHAs outcomes measured for SABG funded IV drug users include, but are not limited to: discharge status, number of intakes, ASAM level of care throughout service delivery, and achievement of treatment goals as identified by member. National Outcome Measures (NOMs) can be found in member records to include: employment status, enrolled in school or vocational education program, housing, arrests within 30 days, abstinence from drugs and/or alcohol, and participation in social support recovery 30 days prior. ASAM score based on ASAM criteria can also be used to measure outcomes. Providers also report monitoring drug screens, retention, recidivism, and that clients are receiving care prescribed at intervals established in their treatment plans.

Progress/Barriers Identified

The increased outreach and ability of providers to serve this population has resulted in positive outcomes and an increase of the number of members enrolled. A barrier that they often face with this population is transition from the criminal justice system and jails as members often will meet criteria for AHCCCS. SABG providers report the greatest barrier identified is lack of funding to cover other critical needs for this population – such as physical health, medications, and permanent supportive housing.

Gila River Health Center is exploring a comprehensive method to collect, and complete a needs assessment, for this population to identify potential barriers and progress that can be enhanced or sustained.

Success Stories Shared

The Pima County State Targeted Response Team focuses on Opioid and Jail Diversion Outreach. A member's life was saved when two STR

Outreach Specialists were doing street outreach at a local park. They came across a group of people attempting to revive a woman. The group had initially told CBI that she was in diabetic shock, but thankfully one of the men in the group told CBI that she was overdosing on heroin and that he had already administered Naloxone. A provider staff immediately called 911 and began to do chest compressions. A second dose of Naloxone was administered and EMT's stabilized the patient and she was taken to Tucson Medical Center.

A female member came in to a provider in severe withdrawal. The member was feeling very down on herself on top of feeling extremely sick. She stated that she was hoping to feel better because she had a job interview later that day. She also has a son and wanted to get help so she could feel better for him. During her intake process, she received another phone call for another job interview. Even though she was feeling sick and depressed, she completed her intake and started on methadone treatment that same day. Two weeks later the member reported she was offered both jobs. She now says she is feeling a lot better and said she feels ready to start titrating her methadone dose. The member is also still currently working both jobs.

Second Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved (optional):

According to UMC (Unique Member Characteristics) Portal Data 17,159 IV Drug Users had a Substance Use Disorder (SUD) diagnosis, and of those diagnosed 15,324 (89.3%) received treatment.

Outreach

Outreach to identify individuals who have a high risk of IV drug use and to provide referrals and resources to prevent relapse and treatment under the Substance Abuse Block Grant (SABG).

RBHA's were able to peer supports to conduct outreach in the jails to assist in the coordination of care once an individual is released. Providers are also sub-contracted to engage in street outreach to assist in the engagement of individuals into treatment.

RBHA's efforts are being made to coordinate with hospital emergency departments and inpatient units for care coordination for individuals visiting a hospital due to opioid use related medical issues.

One provider that works throughout the state outreaches to substance users and encourage treatment engagement and awareness of services such as MAT, additionally, other MAT providers have been recently added to the network and these providers have multiple funding sources to provide MAT treatment, including SABG.

TBHA's have provided ongoing collaboration with community stakeholders and with off-reservation providers.

Collaboration

RBHA's work with organizations who are funded through SABG and other opioid-specific grants allows the sharing of information surrounding MAT treatment options available. Additionally, peer support services are being encouraged in conjunction with MAT services to increase long-term recovery success in urban and rural areas of Arizona.

One RBHA has integrated an Access Point in Pima County through Community Bridges to provide the community and law enforcement 24/7/365 access to urgent and routine behavioral health services. Co-located at the Access Point facility is a Patient Centered Health Home (PCHH) where patients can receive ongoing medical and behavioral health services.

Another RBHA works with the County Correctional Health Department in giving access to their providers inside the jail setting to help engage the OUD using population (inclusive of the IV Drug Using population) and coordinate into care upon their release from jail with sub-contracted Navigators

TBHA provide ongoing collaboration with community stakeholder and with off reservation providers. Behavioral Health Services and Primary Care staff members work to identify and refer individuals with OUD.

One TRBA reported that they now have 8 Primary Care providers with the ability to prescribe Suboxone at 3 clinics. This TBHA has 2 addictionologists providing OUD treatment at 4 locations.

Targeted Interventions

A concerted effort has been taken to increase access to Medication Assisted Treatment to address the physiological aspects of providing treatment to the target population. Increased monitoring is occurring, and being advanced, to monitor the implementation behavioral health services (i.e. counseling) for individuals receiving MAT services.

Efforts have been enhanced to promote the use of naloxone, as well as network providers offering training/education on naloxone to members (and their families) they are treating.

Other Efforts or Information

RBHA's have been coordinating with Oxford House, Inc. to open homes throughout Arizona. At this time there are 11 Oxford Homes that are currently open since July 1, 2019.

Outcomes Measured

RBHA's and TRBHA's outcomes measured for SABG funded IV drug users include, but are not limited to:

- Discharge status
- Number of intakes
- ASAM level of care throughout service delivery
- Achievement of treatment goals as identified by member

National Outcome Measures can be found in member records to include:

- Employment status
- Enrolled in school or vocational education program
- Housing
- Arrests within 30 days
- Abstinence from drugs and/or alcohol
- Participation in social support recovery 30 days prior

ASAM score based on ASAM criteria can also be used to measure outcomes.

Progress/Barriers Identified

RBHA's have reported that a barrier with IV Drug Use population is the transition from the criminal justice system and jails as members often will meet criteria.

One RBHA reported that not all rural locations in Arizona have MAT providers, therefore in some cases patients are travelling long distances to obtain their daily doses and sometimes have to take the entire day to travel and receive care. This poses a particular problem for patients who are newly employed and have to coordinate around their schedule or take time off work (sometimes without pay) to obtain their MAT doses.

Success Stories

Two brothers were charged with felony possession of heroin while living out of their car where they were using intravenously daily. They had previously been staying with their parents but due to their struggles with substance use, their relationship with their parents had completely eroded. Both were connected with a provider through Felony Diversion referrals and were immediately admitted to Tucson's Toole Access Point, transitioned to Inpatient detox, then transferred to Residential Treatment (one in Tucson and one in Yuma). Neither had established with a PCP despite significant abscesses on their arms and other chronic physical health maladies.

The provider connected both with PCPs and started them on MAT medications while in residential treatment.

Post residential, the brothers were connected with the provider's outpatient clinics where they continued their treatment. Their primary care needs were treated by their PCPs, they continued their MAT, and they engaged in Intensive Outpatient Programming.

As of today, both brothers have reconciled with their parents, and one of the brothers has returned home to live with them.

One of the brothers is tapering off Suboxone and recently accepted a management role at a grocery store. The other brother has completely tapered off Suboxone and was accepted into an apartment with the help of CBI. He has been maintaining his portion of the rent by working in construction.

Both brothers had their felony charges dismissed.

Patient relates the story of having infections due to IV drug use. He came to Intensive Treatment Systems, provider in April 2018 addicted to heroin and methamphetamines. Since that time the member has gained weekend take-home privileges, not used any illicit substances, engaged in our group Intensive Outpatient Program (IOP) and is working with clinic manager to do an art show under the title "Art of Addiction. The art show will feature works displayed by artist in recovery at ITS clinics. Member thanks IOP and staff for their help.

Priority #: 5
Priority Area: Pregnant Women and Women with Dependent Children
Priority Type: SAT
Population(s): PWWDC
Goal of the priority area:

Ensure women have ease of access to all specialty population related substance use disorder treatment and recovery support services.

Strategies to attain the goal:

AHCCCS and the RBHAs will collaborate on ways to expand public awareness campaigns directed towards the priority populations. AHCCCS and the RBHAs will regularly monitor treatment waitlists to ensure access to care. AHCCCS will review encounter codes to ensure pregnant women and women with children receive the full array of covered services. AHCCCS and the RBHAs will monitor the utilization of services for this priority population.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators to measure success on a yearly basis.

Baseline Measurement: Number of those with a substance use disorder and received treatment who were pregnant and/or women with dependent children. SFY15 was 3.9%.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2018), 4.2%

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2019), 4.5%

New Second-year target/outcome measurement(if needed):

Data Source:

Client Information System (CIS) data.

New Data Source(if needed):

Description of Data:

CIS enrollment data on the number of pregnant and parenting women with dependent children receiving SA treatment is capable of stratifying data by gender, diagnosis, service received, number of children, pregnancy, etc.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

No data related issues anticipated.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

Per CIS data, enrollment went up by 10.8% from SFY 2017 to SFY 2018. During that same time period the percent of pregnant women receiving SABG services went down by 7.3% and the percent of women with dependent children receiving SABG services went down by 7.5%, not meeting the second year goal. There was a significant increase in utilization by the pregnant women and women with dependent children (PWWDC) population from 2015-2017, outpacing enrollment increases, so it is likely that the reduction is a balancing of the previous trend.

Additionally, it is reported that because of Medicaid Expansion, there are few individuals who are pregnant or parenting who do not qualify for services through funding sources other than SABG. AHCCCS has implemented the following strategies to achieve the goal of increasing availability and service utilization for the priority populations PWWDC. These strategies have been a part of a comprehensive statewide effort to address the high risk for both the mother and child by treating the family as a whole and having specialized treatment services. Below is a description of the activities conducted through the RBHAs and SUD providers.

Outreach

The RBHAs and TRBHAs have increased outreach to the community, first responders, the criminal justice system and hospitals to identify pregnant and parenting women with an SUD. They communicate frequently with the Department of Child Safety (DCS), children's outpatient programs, and Family Run Organizations. The RBHA in the Northern GSA also created the Parent Support Now program, which involves community stakeholders such as county health departments, courts, and attorneys to support the reunification of families. The RBHAs also maintain a current list of gender-specific providers and programs in their networks.

Gila River Health Center's Behavioral Health workers provide Information, education and refer to services within the community, for this population through the TRBHA. GRHC Behavioral Health response team frequently engages in the Women's clinic for outreach to pregnant and parenting women. The RBHA in the Central GSA providers reach out to coordinate care with OBGYNs. This outreach

includes educating providers about MAT services for pregnant women. Another program offers on-site child care to women who are enrolled in the Center for Hope housing or outpatient clinics so they are able to attend recovery focused services.

Collaboration

The RBHA in the Southern GSA has identified an increased need to ensure pregnant woman (pre and post-partum) and their babies are receiving services while in the hospital and as they transition back to the community. The RBHA in the Southern GSA has worked with Health Homes, Tucson Medical Center (TMC) and the Polysubstance Abuse in Pregnancy and Newborn Task Force. TMC data showed there was a significant population of mothers who are using opiates who were in need of immediate MAT services and treatment. If these Women are identified as OUD or needing MAT assistance in addition to other services, the collaborating Health Homes and MAT OTP's work directly with the hospitals to ensure services. The RBHA in the Southern GSA is also outreaching rural hospitals. PCP's and OBGYN's are outreached for this population to educate them regarding the available services in their community and how to connect the women to services.

One of larger Health Home agencies, a birth – 5 specific treatment provider, and TMC has developed a Memorandum of Understanding (MOU) to serve these women and their babies inside the hospital. The Health Home was given a designated room with in the TMC NICU to complete groups, intakes, and other treatment needs for the women, families, and babies identified needing this service. The RBHA in the Southern GSA, the identified Health Home, Banner Hospital, and St. Joe's Hospital in Tucson have also met and are in the process of developing MOU's for similar services. For those mothers who do not qualify for Medicaid benefits, the provider can access SABG funds to ensure services. Also, if any women and their babies are identified as needing rural area follow up, one of our Medication Assisted Treatment providers have been working with the hospitals to assist with transition.

The RBHA in the Southern GSA has increased MAT availability to members and has successfully increased member participation in these services through education and community outreach. The RBHA has established MAT services in rural areas, such as Nogales, Cochise and Graham counties to ensure MAT accessibility to members through co-locations to provide Buprenorphine through telemedicine.

The RBHA in the Southern GSA has integrated an Access Point in Pima County through Community Bridges to provide the community and law enforcement 24/7/365 access to urgent and routine behavioral health services. Co-located at the Access Point facility is a Patient Centered Health Home (PCHH) where patients can receive ongoing medical and behavioral health services.

The RBHA in the Northern GSA participates regularly in community coalitions that include agencies that provide services to pregnant and parenting women, including Coconino Coalition for Children & Youth (CCC&Y) and the Continuum of Care meeting.

Referrals are accepted from Gila River Indian Community Tribal Social Services and Family Drug (Healing to Wellness) Court. There are weekly meetings with the Healing to Wellness court, for the purpose of reviewing services and accepting referrals. Patient Health Questionnaire two and nine (PHQ2/PHQ9) are administered annually, by medical providers. Referrals are made to BHS for patients who require additional assessment and screening. Specific attention is given to those who indicate moderately severe depression or higher. Gila River Health Center's women's clinic identifies and refers individuals, as needed.

In Central Arizona, Center for Behavioral Health (CBH) Tempe continues to work with current patients as well who become pregnant while in services to continue treatment. Community Medical Services (CMS) collaborates with hospitals and OB/GYNs in the area to provide education and coordination of care for pregnant women. The RBHA collaborates with local correctional health to provide MAT services to pregnant women who are incarcerated. Several Hospitals fast track all pregnant OUD patients into treatment. The hospital inducts patient and warm-hands them off to a CMS clinic. CMS medical providers participate in Grand Rounds at hospitals in Maricopa County.

Targeted Interventions

The RBHA in the Northern GSA assists in care coordination for pregnant and/or parenting women to ensure all women in these priority populations receive the indicated services within the corresponding wait times. Safe Mom Happy Baby program, which is a program developed to partner OB/GYNs with treatment providers when a mother indicates substance use or the infant was born with Neonatal Abstinence Syndrome (NAS). The Parent Support Now program has decreased the length of time for reunification for parents struggling with substance use. Pregnant women and women with dependent children in Gila River Indian Community are offered substance use disorder treatment, while waiting to be reactivated with AHCCCS. A case manager is assigned to assist with this coordination. There is no wait list for this service.

The Central GSA SABG providers focus on working with members in this category to decrease IV use, tobacco use and illicit substance use, and increase access to prenatal care for mother and baby, while treating the opiate issue. The National Council on Alcoholism and Drug Dependence, Inc. (NCADD) provides substance use disorder treatment (IOP/SOP); individual counseling; Dialectical Behavioral Therapy (DBT); trauma group; vocational services; dual diagnosis group; 12 step meetings/sponsor, supportive housing along with wrap around substance use disorder treatment and psychiatric services. There is also a clinic which also provides supportive housing for IV Drug Using pregnant women and women with dependent children.

Other Efforts or Information

The RBHA in the Southern GSA has submitted a budget request to AHCCCS to expanded services to pregnant women and parenting population to include a full continuum of care model with TMC and CODAC Health, Recovery and Wellness for transitional living; OBGYN

and Medication assisted treatment availability. The RBHA in the Northern GSA provided multiple trainings on medication assisted treatment, which included information regarding the efficacy of MAT during pregnancy. The RBHA is looking to develop a specialized residential program for families. Additionally, the RBHA in the Northern GSA has developed a Project ECHO to assist in facilitating improved communication and treatment outcomes for this population. Gila River Health Center Behavioral Health Services is working with their IT department to design a method within their system to help identify those eligible for services. A provider has established a collaborative arrangement with Arizona Ash-line for additional smoking cessation service at no cost to the patient.

Outcomes Measured

In Arizona outcomes are measured by the members ASAM level of care scores based on the ASAM criteria. Treatment plan achievement is another indicator of outcome achievement. The number of women receiving services is another outcome measured. ASAM score based on ASAM criteria can also be used to measure outcomes. The RBHAs, TRBHAs, and providers have been successful in most cases in assisting patients who meet the SABG criteria to obtain insurance through the state to cover all their needs, but historically, for the few patients in this population who could not, they have been able to utilize SABG funding and provide resources. The providers regularly monitors drug screens, retention, recidivism, and clients are receiving care prescribed at intervals established in their treatment plans. The RBHAs and TRBHAs monitor and measure the use of EBPs in treating this population. The RBHA in the Southern GSA has served 55 women and their families through the hospital collaboration with TMC. In Gila River Indian Community there were 16 women, four of which were pregnant, that completed an intake and were enrolled in services through the TRBHA.

Progress/Barriers Identified

The increased outreach and ability of providers to serve this population has resulted in positive outcomes and an increase of the number of members enrolled in Arizona. A barrier often faced with this population is transition from the criminal justice system and jails as members often will meet criteria for AHCCCS. The RBHA in the Northern GSA continues efforts to partner more closely with OBGYNs and Maternal Health programs. Gila River Health Center plans to identify and disseminate informational brochures related to risk associated with drug use, postpartum depression and how to get services.

The Central GSA SABG providers report the greatest barrier identified is lack of funding to cover other critical needs for this population – such as physical health, medications, permanent supportive housing, and access to affordable prenatal services.

Success Stories

A member was struggling with severe alcoholism while being pregnant until May when she medically detoxed. She went to a program that she successfully completed in June. She has since gave birth and is currently meeting all of the Department of Child Safety (DCS) requirements due to her early use in pregnancy and history. She is currently attending IOP for parenting and ongoing relapse prevention. She also receives Doula services through the RBHA once a week. She has done really well even though recently things have been stressful due to the DCS case.

A Family Support Partner (FSP) met a mom at her first court hearing in February this year as part of the Parent Support NOW program. The mom had her three children removed by DCS due to an addiction problem that had led her down a dark path of destruction and wreckage. She was also facing felony charges. The mom was also facing prison time and was scared that she might lose her children to the system. FSP talked with mom about her addiction and was able to assist her to a point of connection due to the FSP's own recovery. The mom slowly began to see her addiction for what it was. She admitted that she had a problem and was willing to go to any lengths for her children and her recovery. She walked away from her old life, boyfriend, friends, job and connections to begin her new journey. The FSP supported the mom in her choices, but would always help mom identify her healthiest options, love others and thank God daily for her new life. The mom engaged in all services with the Health Home and worked with the FSP regularly to assist her in completing her DCS case plan requirements in a timely manner. She also faced the judge for her felony charges. Due to her engagement in services and her willingness to leave her old life and ways behind, she was granted probation with no jail time. The mom has sustained recovery and is working hard to maintain her sobriety. She worked with a provider and was provided housing to help her transition back into society. She also regained custody of her children and the case was dismissed. She reports having a new life now and is grateful to the FSP for supporting and encouraging her when she felt like no one else was on her side.

How first year target was achieved (optional):

Second Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved (optional):

According to AHCCCS Client Information System (CIS) claims data, 12,309 Pregnant Women had a Substance Use Disorder (SUD) diagnosis, and of those diagnosed 3,719 (30.2%) received treatment.

Outreach

RBHA's provide outreach to the community, first responders, the criminal justice system and hospitals for PWWDC.

One RBHA visits all SABG providers with site visits on an annual basis; part of the site visit includes ensures providers have the appropriate posters promoting SABG service availability. Mercy Care has developed a poster specifically targeting pregnant

women/women with dependent children.

Another RBHA uses pregnancy resource centers and prenatal care providers throughout Northern AZ. Providers have been made aware of the SABG grant funding through SHCA and have been given public awareness materials.

TBHA use behavioral health workers provide information, education and refer to services within the community, for this population. Behavioral Health response team frequently engages in the Women's clinic for outreach.

Collaboration

One RBHA is planning the 2nd Annual Opioid Symposium, having a large focus on providing services to pregnant/parenting women. Through the planning process several collaborations were made/enhanced with organizations having key roles in addressing substance use in pregnant/parenting women.

Another RBHA has identified an increased need to ensure our pregnant woman (pre and post-partum) and their babies are receiving services while in the hospital and as they transition back to the community. This RBHA has worked with Health Homes, Tucson Medical Center (TMC) and the Polysubstance Abuse in Pregnancy and Newborn Task Force. TMC data showed there was a significant population of mothers who are using opiates who were in need of immediate MAT services and treatment. If these Women are identified as OUD or needing MAT assistance in addition to other services, the collaborating Health Homes and MAT OTP's work directly with the hospitals to ensure services. This RBHA is also outreaching our rural hospitals. PCP's and OBGYN's are also outreached for this population to educate them regarding the available services in their community and how to connect the women to services.

TRBHA's collaborate with the use of referrals. The referrals are accepted from Tribal Social Services and Family Drug (Healing to Wellness) Court. There are weekly meetings with the Healing to Wellness court, for the purpose of reviewing services and accepting referrals.

Targeted Interventions

RBHA's and TRBHA's utilize multiple specialized service providers who have the ability to accept pregnant or parenting women, with or without their dependent children, into residential treatment exist within the SHCA network. These providers are utilized as necessary to meet the needs of this specialized population.

Other Efforts or Information

RBHA's utilize specialized Oxford Houses are that gear specifically for PWWDC.

Outcomes Measured

Members enrolled into services with in this population. At this time RBHA's and TBHA's monitors outcomes through internal data reports and the monthly performance tracking templates for the grants.

Progress/Barriers Identified

RBHA's One of the primary barriers to providing services to pregnant/parenting women is their reluctance to acknowledge substance use issues due to their concern of having DCS (Department of Child Safety) involvement or children removed from the home. Combined efforts from the provider network additional RBHA staff to educate not only mothers of MAT treatment and substance use disorder treatment, but also careful coordination/communication with DCS will assist in alleviating concern.

There is also a lack of the OB/GYN network that is willing to provide services to pregnant/parenting women using substances, particularly if they are on MAT services.

Another RBHA reports with the rural nature of Northern AZ, providers who are specific to PPW are few and far between. Many locations that can accept PPW are in the Central GSA and although Northern providers can send and "sponsor" their members at these locations, causing PPW to uproot their lives to receive specialized treatment can be a huge barrier to treatment.

Success Stories Shared

A female member entered the Las Amigas program in 8/2018 while she was about 7 months pregnant. Prior to admission, she was using heroin daily, with her methadone dose, but she has been sober since her admission into the program. She gave birth to her daughter while in treatment, and she was able to live with her while she completed the program. She graduated Las Amigas in January 2019, entered the Connie Hillman transitional living program with her daughter, graduated from there, and has remained sober, continues to have her daughter in her care and is now working.

Parenting PATIENT

Navigator received referral from crisis/detox unit. Navigator made contact with PATIENT and offered to assist PATIENT with connecting to outpatient treatment services available including medication assisted treatment. PATIENT had a history of recidivism at crisis unit. PATIENT admitted to suffering from opioid use disorder and expressed interest in medication assisted treatment. Navigator coordinated with CBI outpatient office staff to schedule a full intake assessment and addiction medication consultation appointment. PATIENT missed the scheduled appointment and stated he had recently used heroin but wants to stop. Navigator built rapport with PATIENT by sharing personal experience recovering from opioid use disorder. PATIENT responded well and noted "being the best father I can possibly be for my son" as the primary motivating factor for seeking treatment. Navigator assisted PATIENT with transportation to outpatient appointments and provided peer support services to PATIENT. PATIENT has since maintained recovery, is an active part of his

son's life and regularly attends intensive outpatient treatment groups.

Priority #: 6
Priority Area: Use of Prescription Drugs without a Doctor's Recommendation
Priority Type: SAP
Population(s): PP, Other (Adolescents w/SA and/or MH, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Decrease the percentage of youth who do not perceive use of prescription drugs without a doctor's recommendation as being harmful from the current level of 13.3% of those in the 8th grade, 9.7% of those in the 10th grade, and 11.3% of those in the 12th grade, as measured by the 2016 Arizona Youth Survey.

Strategies to attain the goal:

Through Primary Prevention strategies, conduct youth driven media campaigns to promote positive youth values and community pride. Campaigns will include: youth developed social messaging (radio; PSA poster contests; billboards; murals as well as information on prescription drug abuse).

- Collect samples of youth created posters with anti-drug messages.
- Host a statewide youth prevention media display and recognition event.
- Verify that all prevention programs incorporate education on perception of harm into their prevention programs.

Implement afterschool and leadership programs for youth.

- Host annual statewide and regional conferences/retreats/youth camps.
- Develop a statewide venue for recognition of youth prevention projects and other successes.

Implement an adult targeted media campaign to educate parents about risks.

- Community media campaign
- Proper disposal of medication education
- Resources to safely store and dispose of medications

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement: The current percentage of youth who do not perceive use of prescription drugs without a doctor's recommendation as being harmful from the current level of 13.3% of those in the 8th grade, 9.7% of those in the 10th grade, and 11.3% of those in the 12th grade, as measured by the 2016 Arizona Youth Survey.
First-year target/outcome measurement: Reduce the percentage of youth who do not perceive use of prescription drugs without a doctor's recommendation as being harmful to 13.0% of those in the 8th grade, 9.4% of those in the 10th grade, and 11.0% of those in the 12th grade, as measured by the 2018 Arizona Youth Survey.
Second-year target/outcome measurement: Reduce the percentage of youth who do not perceive use of prescription drugs without a doctor's recommendation as being harmful to 12.7% of those in the 8th grade, 9.1% of those in the 10th grade, and 10.7% of those in the 12th grade, as measured by the 2020 Arizona Youth Survey.

New Second-year target/outcome measurement(if needed):

Data Source:

Arizona Youth Survey (AYS)

New Data Source(if needed):

Healthy Families Healthy Youth: Year Two Final Program Evaluation Report

Description of Data:

Data obtained from the Pre and Post Tests (Adolescent Core Measure) from the AYS

New Description of Data:(if needed)

Program evaluation report from Arizona State University's Southwest Interdisciplinary Research Center prepared for The Governor's

Data issues/caveats that affect outcome measures:

AYS is released every two years so the 2019 numbers will be difficult to evaluate until 2020.

New Data issues/caveats that affect outcome measures:

AYS data is not available before 12/1/2018 for the SABG 2019 report, so the numbers will be used for the SABG 2020 report and an alternative data source will be identified in the upcoming application and plan that has annual outputs.

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

AHCCCS is using an alternative data source to evaluate the goal of Reduce the percentage of youth who do not perceive use of prescription drugs without a doctor's recommendation as being harmful to 13.0% of those in the 8th grade, 9.4% of those in the 10th grade, and 11.0% of those in the 12th grade, as measured by the 2018 Arizona Youth Survey (AYS) due to the data not being available in time for this report. The 2018 AYS data will be used to evaluate the Primary Prevention Goal for the 2020 SABG Report and then an alternative data source will be identified for an ongoing basis due to the AYS being released every two years. Based on the scores for the youth included in the Health Families, Healthy Youth outcome report conducted through the Governor's Office of Youth, Faith, and Family this goal was achieved. On page 66 of the report, the pre-test scores showed 10.4% of the youth did not perceive use of prescription drugs without a doctor's recommendation as being harmful, the post-test scores showed that number was reduced to 6%, and was further reduced to 4.7% at time of follow up. The following sections contain information related to prevention activities from regions that collaborate as a part of the statewide effort that addressed the goal during the current reporting period.

Outreach

In the Central GSA, outreach was conducted in South Phoenix and Maryvale communities that included working with faith based organizations, schools, parents, community members, healthcare organizations, and others through the Tanner Community Development Corporation, Help Enrich African American Lives (TCDC/HEAAL) Coalition. TERROS conducted outreach working with LGBTQ-serving organizations in a variety of community sectors through the Safe Out Youth Coalition. The Phoenix Indian Center (PIC) conducted outreach among schools with Native American youth groups, Native-serving organizations focusing efforts on Mesa, Tempe, and Phoenix areas.

The Southern GSA identified outcomes through comprehensive evaluation using the Strategic Prevention Framework (SPF). The outreach activities conducted included the following components: community surveys in English and Spanish; paper and online Surveys; retrospective post-test community surveys administered at events; detailed implementation plans for coalition work; adolescent instruments administered pre and post-test; coalition assessments; Evidence Based Practices; and data dashboards.

In the Northern GSA, the RBHA worked with the West Yavapai Guidance Clinic Sr. Peer Program outreach activities, which included: recruitment and ongoing training of volunteers age 60 and over to provide one-to-one visits to isolated seniors and facilitate community support groups regarding safe medication practices; securing referrals from relevant agencies of seniors appropriate for programs and providing comprehensive assessments for each; providing referral services by maintaining a Service Providers' Resource Manual to help people who call from the community and for participants; providing ongoing prescription information presentations and classes facilitated by staff and volunteers. While MATFORCE Coalition conducted Lunch 'n Learns on Prescription Drug Misuse; and Walk with Me, Be Drug Free event focusing on Prescription Drug use and misuse. In addition, the Arizona Youth Partnership facilitated presentations and trainings regarding Prescription Drug Use and Misuse; and distribution of prescription medication disposal bags and drug safes for storage of medications. The Southeastern Arizona Behavioral Health Services provided educational community presentations on prescription use and misuse.

The Pascua Yaqui Tribe facilitated the implementation of the RX360 training during National Prevention Network to Elders who also raise grandchildren. Gila River's BHS Prevention Program Staff coordinated and facilitated 61 community events to provide information to community members about the harm of youth substance use (including prescription drugs) and to inform community members about the Gila River Prevention Coalition and related activities. These events included teen workshops, a Veterans' Conference, community Halloween event, wellness fairs, and events at schools.

Collaboration

In the Central GSA the TCDC/HEAAL collaborated with other area coalitions, including the Arizona Suicide Prevention Coalition (AZSPC), Urban Indian Coalition of Arizona (UICAZ), South Mountain Works (SMWORKS) Coalition, and additional stakeholders. Staff of the coalition attended Substance Abuse Coalition of Leaders in Arizona (SACLA) meetings to stay abreast of other coalitions' efforts statewide. Also, the TCDC/HEAAL coalition received Drug-Free Communities (DFC) funding and collaborated with other DFC grantees on shared initiatives and coalition building. Two of the notable partnerships TCDC has are with Walgreens and the Mountain Park Health Clinic. In

addition, TERROS/Safe Out collaborated with other area coalitions, including AZSPC and UICAZ. The staff collaborated with other LGBTQ-serving organizations and worked to provide education to a variety of community sectors that serve LGBTQ young adults. While the PIC partnered with Phoenix Indian Medical Center (PIMC), the City of Phoenix Police Department, the Salt River Pima-Maricopa Indian Community (SRP-MIC) Police Department, and The Inter Tribal Council of Arizona, Inc. (ITCA) on a Take Back event. The PIC staff invited pharmacists as speakers for the event. The PIC also collaborates with the AZSPC and other area coalitions.

In the Southern GSA all coalitions collaborated between agencies and leaders of the community, in order to improve the quality of life while reducing the number youth and families who use or misuse substances. The Northern GSA's West Yavapai Guidance Clinic's Sr. Peer Program partnered with multiple prevention coalitions and county departments to distribute materials and provide presentations. Furthermore, the MATFORCE staff partnered with schools, police departments, county public health departments and state employees to distribute information and resources. While the Southeastern Behavioral Health Services created partnerships with the Gila County Health Department and the Gila County Sheriff's Office. The Pascua Yaqui Tribe partnered with MATFORCE staff and provided training to PYT staff on the RX360 training. The Gila River Indian Community has an active partnership with the Gila River Prevention Coalition that provides the opportunity for collaboration with a variety of sectors throughout the community including health care, behavioral health, education, community elders and community members, the community's governance, first responders and other stakeholders. The coalition participated in community events and participated in planning of community events and other activities.

Targeted Interventions

In the Central GSA TCDC implemented Youth RX360 educational sessions with 384 participants trained during basketball camp, media camp, and other community events. Youth Town Hall events were implemented in partnership with the SMWORKS Coalition (75, 45 youth, 30 adults). Basketball tournament Youth participants (83) and Adult attendees (35), signed anti-substance use pledge forms (79). Adult RX360 educational sessions reached 83 parents and community-faith based organizations. Coalitions conducted the DEA Rx Drug Take back event; and the social marketing "Lock it Up" campaign, which included newspaper ads through the AZ Informant (60000), Billboard South Phoenix (82989), Facebook impressions (1270), and a radio ad through The Beat 101.1 (320000). There were 18 total community events attended for information dissemination, 3550 individuals were indirectly reached. Also in Maricopa County, TERROS completed all four cohorts of youth leadership academy, two at One in Ten, one at the Deer Valley High School, and one at a group home. The reached a total of 278 youth, completed eight prevention education workshops. There were social marketing campaigns, which included social media (Twitter, Facebook, and Instagram), and print articles/ads in Echo magazine. Information dissemination took place at community events including Phoenix PRIDE, Rainbows Festival, and others. The PIC had the Rx360 Presentation/Drug Take Back Day with more than 100 participants. The UICAZ social media campaigns included Facebook page, Twitter, website, Instagram, theatre advertisements, and print literature dissemination (2,647) at 24 community events, and six Rx360 workshops were completed. The coalition retreat and youth leadership day events were held as well.

The Rx 360 program was implemented in 3 Southern Arizona Coalitions including the Southern Arizona AIDS Foundation (SAAF), Youth Empowerment and LGBTQ Leadership (Y.E.L.L.), La Frontera Center (LFC), Refugee and Immigrant Services Provider Network of Tucson (RISP-NET), and Southeastern Arizona Behavioral Health Services, Inc. (SEABHS) in Douglas, AZ. MATFORCE in the Northern GSA had multiple Lunch and Learn events with an average of 75 people attending each event. The staff had a "Community Coach" Training event that focused on developing coaches skills' for working one-on-one in helping provide referrals, and addressing use of prescription drugs without a Doctor's prescription and prevention resources for former inmates.

RX 360 has been implemented in Pascua Yaqui Tribe, and the Gila River targeted interventions including 24 cycles of Life Skills provided with 333 youth participants, 20 cycles of Active Parenting provided with 172 adult participants, and 82 community education sessions. The topics varied from current drug trends, specific substances of which four were focused on prescription drugs including opioids, self-care, parenting as prevention, and mindfulness. A total of 843 participants attended the sessions.

Other Efforts or Information

The Southern GSA had Rx 360 curriculum designed to educate parents, high school, and middle school students on the risks of the misuse and abuse of prescription drugs. The curriculum provided parents with tools to educate themselves about medications that children could be misusing, how to talk to kids about the risks of using drugs, and how to safeguard and dispose medications at home properly. The Gila River Health Care BHS Prevention Program implemented Prescription Take Back events in various locations in the community. Since 2016, eight events have been held and 97 pounds of prescription drugs have been dropped off at events.

Outcomes Measured

The Central GSA had three program outputs as the primary measurement (number of youth, adults served, and number of trainings held.). RX360 pre/post-tests were administered as well. The 2018 AYS data also will provide outcome data for youth perception of harm for prescription drugs, but this data is not yet been available.

In the Southern GSA the RBHA measured outcomes included comparing changed in knowledge from prior to after participation, there were significant changes on approximately all of the items from the Rx360 survey. For instance, there were significant gains in knowledge about where there were permanent drop box locations (96.0%) and awareness of "take back" events (71.2%). The only area that did not indicated a significant change was in the importance of communicating with prescribers on understanding medication though the change was positive. Lastly, there was a significant decrease of -14.3% in agreeing it is "OK" to share prescription drugs with others,

however this is typically the direction desired.

The Northern GSA RBHA's outputs were measured by information distributed and community members participating in Prescription Drug Misuse and Education events or services through the Coalition efforts including: the number of attendees at events; pre and post-test on events and training; copies of materials provided, website traffic tally, social media and printed materials tracking; number of community members reached with these materials and presentations, internet traffic on the Senior Peer Prevention web page, and the number of RX360 and other Prescription Drug Use and Misuse trainings or presentations.

Pascua Yaqui reported that 11 elders completed Rx360 training. Gila River measured that during the For EL Life Skills training, 88% of participants indicated that they learned ways to say no and 92% indicated that they now have a goal not to use drugs; for MS Life Skills, 90% of participants indicated they know more about the negative impacts of drug use and 88% reported that they now have a goal not to use drugs. For Active Parenting, 96% of participants reported that the program was valuable, and 97% indicated that they learned new skills about communicating with their children about not experimenting with drugs. 90% of individuals who participated in substance use prevention focused community education indicated they intended to talk with their children or children they interact with about the information they learned in the workshop.

Progress/Barriers Identified

In the Central GSA, providers indicated that workforce adequacy and development were barriers to expanding prevention services in addressing the opioid epidemic in addition to the other prevention efforts taking place. In the Southern GSA, a barrier included low participation in RX360 presentation by families. While in Northern areas a barrier was identified of stigma associated with substance use disorder that continues to impact the amount of people who reach out for services. Some community members have a lack of knowledge on accessing resources, and a significant number of individuals with substance use disorders refused to access treatment services that were available to them.

Pascua Yaqui indicated progress as the staff obtained specific knowledge in the area of Rx misuse prevention. A barrier identified was the stigma attached to prescription drug abuse in elder community causes lack of engagement. The Gila River Indian Community reported progress as an active prevention coalition for many years. Each year prevention efforts have become more coordinated and supporting each other. As an example, as life skills occurs, Active Parenting is also offered to provide parents with information that will support what their children are learning. In addition, community events are wrapped around those activities to reach the broader community. Regular meetings take place with community elders to inform them about prevention strategies and engage their support. Coalition members are active in planning and participating in community events.

Success Stories

In the Central GSA, TCDC developed posters, post cards, banners, wrist bands, t-shirts, etc. with Lock It Up prevention messaging that was combined with Rx Disposable Pouches and disseminated at area pharmacy, health care facilities and community information settings. TERROS' Safe Out continued to meet and engaged in coalition work, creating the renamed Safe Out LGBTQ Youth Coalition and building activities and coalition infrastructure specifically around supporting LGBTQ youths' health. The Coalition was able to re-establish previous relationships and create new relationships, while continuing meeting as a community coalition at TERROS Health locations. A notable success was the decision of a prevention program to expand efforts to target opioid use/misuse. The PIC's successful partnership with Phoenix Indian Medical Center on Opioid use/misuse, created a roll-out plan to address Opioid Misuse in the Tribal communities. In Northern Arizona, schools continued to be willing and open to partnerships with prevention coalitions covering prescription drug use and misuse education. Lastly, Gila River Health Care received funding to build infrastructure and develop education for Opioid Use Disorder through the State Target Response and Tribal Opioid Response.

Second Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved (optional):

Based on 2018 Arizona Youth Survey (AYS) data, Arizona achieved this goal. Data shows that when asked about 30 day use of prescription drugs ("In the last 30 days, have you used prescription pain relievers without a doctor telling you to take them (e.g., codeine, Oxycontin, Vicodin, Percocet, Hydrocodone, fentanyl)?"), 8th graders reported use at 3.2%, 10th graders at 3.0% and 12th graders at 12%. When asked about prescription sedative use ("In the last 30 days, have you used prescription sedatives without a doctor telling you to take them (e.g., bars, Valium, Xanax, Klonopin, Ambien, Lunesta)?"), 8th graders reported use at 1.1%, 10th graders at 1.7%, and 12th graders at 1.5%.

Based on 2018 Arizona Youth Survey (AYS) data, Arizona achieved this goal. Data shows that when asked about 30 day use of prescription drugs ("In the last 30 days, have you used prescription pain relievers without a doctor telling you to take them (e.g., codeine, Oxycontin, Vicodin, Percocet, Hydrocodone, fentanyl)?"), 8th graders reported use at 3.2%, 10th graders at 3.0% and 12th graders at 12%. When asked about prescription sedative use ("In the last 30 days, have you used prescription sedatives without a doctor telling you to take them (e.g., bars, Valium, Xanax, Klonopin, Ambien, Lunesta)?"), 8th graders reported use at 1.1%, 10th graders at 1.7%, and 12th graders at 1.5%.

Outreach

Service providers throughout Southern Arizona under contract with Arizona Complete Health-Complete Care Plan (AzCH-CCP), worked with community coalitions to address substance use and misuse among youth. The framework guiding these efforts is the Strategic Prevention Framework (SPF). The SPF is a data-driven planning process that is comprised of five stages, including assessing needs, building capacity, planning, implementing, and evaluating. Prevention programs responded to community needs identified by local data. By reducing risk factors, increasing protective factors, and changing community norms, service providers and community coalitions strategically developed prevention efforts to meet the needs of the community in addressing substance use among youth. Outreach strategies included:

community-based processes, youth leadership, public information, social marketing, personal and cultural development, mentoring, life skills, community education, and environmental strategies.

Central Arizona providers conducted outreach to faith based communities, LGBTQ serving organizations, Native youth groups, and schools throughout the provider's targeted areas.

Tribal prevention providers utilized youth RX prevention campaign with Rx abuse message and instilling cultural pride, which is currently airing at local movie theaters until February 2020. Quarterly newsletters delivered to 2500 community members shared messages about opioid prevention as well as informed the community about opportunities for education and prevention activities. Students at Gila River Indian Community (GRIC) schools are identified by teachers, as individuals in need of substance abuse (SA) treatment and then referred to Gila River Health Care (GRHC) Behavioral Health Services (BHS), as needed. Educational and information booths were offered at Komatke Outpatient clinics and HuHuKam hospital, throughout the reporting year. Referrals are accepted by anyone in the community such as Primary Care physicians, Teachers, Tribal social services and Probation Department. GRIC drug court will refer identified individuals to GRHC BHS.

Northern Arizona service providers utilized a plethora of methods to conduct outreach, which included: social media campaigns, radio PSAs, open coalition meetings, attending and tabling at health fairs and related community events, newsletter dissemination, school assemblies and related events, as well as "Lunch and Learns" open to the community.

Collaboration

All AZ prevention providers actively work to retain and recruit members of the community to serve on their coalitions, following the CADCA 12 Sectors for coalition membership. These sectors include: youth, parents, businesses, media, schools, youth-serving organizations, law enforcement, religious or fraternal organizations, civic or volunteer groups, healthcare professionals, state, local, or tribal governmental agencies with expertise in substance misuse, and other organizations involved in reducing substance misuse (treatment providers). In addition, all provides work to involve other populations that may experience health disparities (such as the LGBTQ population) within their collaboration efforts

Targeted Interventions:

In Southern AZ, Five coalitions work with youth focusing on refusal skills around substances. These groups are in Ajo, Yuma, Douglas, Sierra Vista and Maricopa. In Pima County, Youth Empowerment and LGBTQ Leadership (Y.E.L.L) aims to support LGBTQ youth and their allies in identifying risk reduction techniques around substance use. Refugee Integrated Services Provider Network (RISP-NET) illuminates issues influencing the successful acculturation of refugee families in Tucson, including youth substance use. Two coalitions focus on older adults. The vision is to educate older adults and their caregivers about the safe use, storage and disposal of medications. Often youth can access medication from a grandparent or older adult in their life. The coalitions located on tribal land in GuVo and San Carlos, utilize effective prevention strategies, activities, and evidence based curriculum to promote healthful behaviors, decisions, and environments that will reduce, postpone, or eliminate the problematic use of alcohol and illicit substances.

In Central AZ, providers utilized the following targeted interventions: youth leadership events and council, life skills development, LGBTQ specific life skills development and leadership development, Rx 360 training and education, take back and safe storage events and interventions, and alternative activities such as basketball tournaments and drug free dances.

Northern AZ utilized similar strategies as their Southern and Central Counterparts, as well as education strategies for youth, parents, and families, hosting and implementation regional trainings and conferences, and trauma informed approaches to preventing substance abuse in their region.

Outcomes Measured

In Southern AZ, the Community Survey is a brief community-level instrument designed to gauge attitudes and behaviors around substance usage by youth. The questionnaire is administered on a quarterly basis and is available to all residents within a service provider or coalition's target area. It is available in paper format and online. The survey is confidential and voluntary. Topics covered by the Community Survey include the severity of problems associated with various substances use in the community, ease of access, awareness of substance use messaging, perceptions of risk and harm, methods of obtaining substances, and medical marijuana items. During FY 2019, 2716 surveys were completed.

Results common to all 4 Counties:

- Problem medication misuse increased
- Marijuana and meth use increased
- Adults think it is easy for youth to obtain substances – youth think it is not easy

- Adults view use as more severe

Messaging:

Most messages come from social media and live events
 Awareness that it is harmful to use others' medications

Additional Trends:

- Binge drinking has shown increased perception of risk
- Adults view meds and e cigarettes as risky

In the Southern Native Coalitions on the San Carlos and Tohono O'Odham nations, a Cultural Identity Survey is conducted. Family and link to native culture and community are the focal points of this survey. It is a multi-item instrument designed to gauge community member's attitudes around their own community. In FY 2019, 312 surveys were completed. Research supports that native populations who feel linked to culture and community have lower rates of substance use and misuse.

Results from San Carlos:

- 92.3% said they have a lot of pride in their heritage and accomplishments and had a strong sense of belonging to their own culture.

Results from GuVo:

- Over half (58.1%) strongly agreed they had a strong sense of belonging to their culture
- Regarding youth using medications, over half (54.1%) viewed it with great risk.

In Central and Northern AZ, outputs are the primary measurement (number of youth, adults served, number of trainings held, etc.). Some RX360 pre/post tests administered but no analysis conducted due to limited evaluation resources.

Tribal prevention providers track their activities related to Problem ID and Referral, include the number of referrals made to treatment for youth. Other outcomes tracked include the number of views for targeted messaging through various mediums and forms, as well as the number of those at trainings and community events.

Progress/Barriers Identified

Throughout AZ, similar barriers have been identified, including the following: staffing changes at the sub-state and coalition levels, member recruitment from certain sectors, lack of physical resources (such as internet connection) in some rural areas of the state, engaging youth in meaningful ways, transportation, parental engagement, time taken to negotiate and implement contracts for services, and the need for additional prevention funding.

Success Stories Shared

After youth attended the University of Arizona's NNI Youth ACT training they were inspired to learn how to create their own film regarding opioid abuse and gang activity. When asked by the facilitator why they chose this topic they said they were tired of seeing these problems in the community and wanted to do something about it. Due to conflicts with contracts and other internal systems they got a late start in the fiscal year but they are currently wrapping up the filming of this project and will be hosting a screening in the community next year.

Phoenix Indian Centered partnered with Phoenix Indian Medical Center and Tohono O'odham Nation Police Department on October 20, 2018 to provide a Drug Take Back event. The goal for the event was provide education and awareness regarding breast cancer, women's wellness check, sex trafficking, and prescription drugs use and abuse. There were approximately 500 adults and 150 youth at the event.

Priority #: 7
Priority Area: 8
Priority Type: MHS
Population(s): SMI, SED, ESMI

Goal of the priority area:

Increase the number of members served with FEP EBPs.

Strategies to attain the goal:

AHCCCS will work collaboratively with RBHAs, Behavioral Health Service Providers, and communities to assist in increasing knowledge related to FEP and the resources available for treatment following a FEP. Strategies will include but are not limited to: social media messaging, social market/public awareness, provider outreach, strategic partner identification, improved data surveillance, and ongoing collaboration with stakeholders and systemic improvement.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual Performance Indicators to measure success on a yearly basis.

Baseline Measurement: The utilization and expenditure rates for SFY 2017.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2018), by increasing utilization and expenditure rates by 2% above SFY 2017 rates.

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2019), by increasing utilization and expenditure rates by 2% above SFY 2018 rates.

New Second-year target/outcome measurement(if needed):

Data Source:

CIS data and RBHA reports.

New Data Source(if needed):

Description of Data:

CIS data is collected related to demographics and expenditures, which will be cross-referenced with reports that are due from the RBHAs annually.

New Description of Data:(if needed)

Data issues/caveats that affect outcome measures:

No data related issues identified.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target: Achieved Not Achieved (*if not achieved, explain why*)

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved (optional):

SFY 2017 CIS data shows a 79% increase in utilization of First Episode Psychosis (FEP) services compared to SFY 2016, exceeding the goal of a 2% increase. The number of providers of FEP providers actively engaging members has also significantly increased reaching all three GSAs throughout Arizona. This significant increase can be attributed to a ramping up period of developing expertise and infrastructure regarding the EBPs for FEP to ensure appropriate quality of care to members who have recently experienced a first episode of psychosis. AHCCCS has implemented the following strategies to achieve the goal of increasing accessibility and service utilization of FEP services for eligible members. These strategies have been a part of a comprehensive statewide effort to reach and treat members with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) in addition to FEP. Below is a description of the activities conducted through the RBHAs and MHBG funded providers.

Outreach

FEP providers conduct outreach to multiple venues throughout the state. FEP contractors communicate with crisis providers, first responders, schools, PCPs, and hospitals in an effort to increase awareness of FEP services, and to better educate potential referral sources. Additionally, FEP providers in Arizona outreach their other lines of business and community partners as referral sources.

In addition to traditional outreach activities, FEP providers are also conducting intensive clinical trainings for rural providers, and Ending the Silence classes in schools. The intensive clinical trainings help disseminate FEP practices and treatment modalities to rural providers that would not otherwise receive this material. The Ending the Silence classes help to build relationships with schools, and work to destigmatize seeking mental health treatment as well as encourage students and teachers to refer others for FEP services.

Collaboration

Arizona FEP providers collaborate with their internal and external providers throughout the state. Likely referral sources are communicated with to help identify members who may benefit from FEP services. Additionally, FEP contractors that utilize the case management model to address their communities' FEP needs collaborate with health homes and other clinic settings in order to ensure all

aspects of the person is addressed. Lastly, FEP contractors collaborate with stakeholder interest groups in an effort to permeate FEP resources into the community, and to decrease stigma around seeking services.

Targeted Interventions

The RBHA and FEP providers have targeted public and private schools, colleges, and juvenile correction facilities as a way to reach new populations that may need FEP services. They remain committed to creating new ways to target the uninsured and underinsured, and getting them engaged in services. Additionally, they have targeted various EBPs related to FEP services including DBT, CBT, Cognitive Remediation, and Dealing with Psychosis curriculum.

Several FEP providers in Arizona have implemented the Coordinated Specialty Care (CSC) program. CSC emphasizes shared decision making as a means for addressing the unique needs, preferences, and recovery goals of individuals with FEP. CSC services are also highly coordinated with primary medical care, with a focus on optimizing a client's overall mental and physical health.

Other Efforts or Information

The RBHAs and FEP providers developed their program models to positively impact the members' perception of their recovery, member engagement in employment or school, and reduce member reported suicidal ideation or hospitalizations. Additionally, community engagement, and identifying new systems or contacts to increase the number of members enrolled in FEP services is always an ongoing effort. Satisfaction surveys are also an effort practiced by FEP contractors to help ensure satisfaction and adequacy.

Specifically, there are current efforts to provide a follow up training to Ending the Silence (ETS) called Text, Talk, and Act (TTA). The benefits of having a 2-part training are that it allows young people time to absorb and understand the information offered through the ETS component, and the TTA discussion activity reinforces the information learned. Lastly, there are efforts in place to develop and implement more FEP providers across the state. As the referrals continue to increase, additional capacity will be needed. FEP contractors continue to monitor this and proactively identify areas of heightened need.

Outcomes Measured

The RBHAs monitor and measure member populations (SMI, SED, and FEP), number of referrals and discharges, living and employment status, hospital and jail admissions, counseling and medication utilization, and member and family engagement. Contractors that provide trainings monitor outcomes based on how many trainings were held, pre-test/post-test evaluations and how many community members were reached.

Progress/Barriers Identified

Creating new partnerships with community members and providers has been identified as a barrier statewide. Additionally, the expenditure of training dollars was also identified as a barrier. Also, since many of the trainings are provided through the school system, the summer months tend to yield lower numbers.

Success Stories

One young adult being served in the FEP program who was homeless at the time of enrollment was able to move into supported housing. Another individual went from experiencing acute psychosis, to being able to fully manage their symptoms with medication and support services and is now employed. Another young adult being served in the FEP program is employed in a vocational program through the Health Home. Several members have successfully completed FEP programs, as they felt they no longer needed the intensity of services provided by the FEP team. Several members with FEP, who identify as LGBTQ+ youth/young adults have been engaged in LGBTQ+ focused groups.

For additional success stories, please see the following links:

<https://kjzz.org/content/636662/first-episode-center-avondale-trying-catch-psychosis-early>

<https://tv.azpm.org/p/azill-recent/2018/7/13/133189-epicenter-of-hope/>

Second Year Target: Achieved Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved (optional):

AHCCCS has implemented the following strategies to achieve the goal of increasing accessibility and service utilization of FEP services for eligible members. Many strategies have been a part of a comprehensive statewide effort to reach and treat members with Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) in addition to FEP. Below is a description of the activities conducted through the RBHAs and MHBG-funded providers.

FEP OUTREACH

Regional Behavioral Health Authorities (RBHAs) and their subcontractors conduct outreach for First Episode of Psychosis (FEP) programs through a variety of methods. Mental health trainings and suicide awareness/prevention trainings have been an opportunity for RBHAs to provide information on MHBG-funded programs such as FEP programs. School-based trainings and collaborations with school districts are particularly useful in educating about programs and service availability, as they can impact students, staff, as well as parents. School staff in Flagstaff Unified School District were trained specifically on early psychosis through a partnership with the RBHA and given information on FEP programs in the region.

RBHAs also conduct outreach to the crisis system, police and fire departments, health centers, hospitals, and among inpatient teams. The Hearing Voices training on psychosis was provided to law enforcement professionals in four counties, as well as to university police. At least one RBHA participates in the crisis collaborative meeting to inform about FEP services. Additionally, RBHAs and their subcontractors reach the general community through community presentations, health fairs, community forums, town halls, and other events to educate on the signs of early psychosis.

One notable outreach effort is collaboration between one RBHA and the National Alliance on Mental Illness Southern Arizona (NAMI-SA) that brings mental health trainings to middle schools, high schools, and communities across Southern Arizona. NAMI-SA delivers a two-part training series titled "Ending the Silence" and "Text Talk Act". Through 50-minute presentations, these trainings teach participants mental health warning signs, facts, statistics, and how to get help for themselves or a friend, student, or family member, and has been shown to be effective in changing knowledge and attitudes about mental health conditions and reaching out for help. Participants receive take-home materials to share with their families. The presence of these trainings in schools not only increases education and awareness of mental health issues among students and staff, but also creates a relationship which functions as a resource and referral pathway between schools and community-based mental health services. Each Ending the Silence and Text Talk Act training specifically includes an element dedicated to educating trainees and community members on the region's Early Psychosis Intervention Center (EPICenter) program and services. This program has expanded into reach wider geographic areas, both urban and rural. Between July 1, 2018 and June 30, 2019, over 100 trainings were implemented, training about 8,000 youth and young adults in the school and/or community setting.

Finally, Connections Access "Early Connections" Program, a new Coordinated Specialty Care program for FEP clients has opened in Southern Arizona, with a licensed clinician team lead, a Family, Education, and Employment Support Specialist, an Outreach Coordinator/Therapist, and a Nurse, and plans for a Behavioral Health Medical Practitioner. Connections Access places outreach staff in the Crisis Response Center, managed by Connections Access. Brochures and referral packets have been created for the new program, and program staff has begun conducting outreach to local hospitals, health homes, and other community providers. At the time of the report ending June 30, 2019, the Early Connections program had begun accepting new patients.

FEP COLLABORATION

Arizona's RBHAs collaborate with school districts, community colleges, law enforcement, contracted behavioral health and FEP providers, crisis services, and the National Alliance on Mental Illness. For example, many of the outreach activities for FEP services are done in collaboration with these partners (Hearing Voices training with law enforcement, trainings and presentations in school). Successful outreach and problem identification and referral relies on successful collaborations.

TARGETED INTERVENTIONS

RBHAs contract with providers to serve individuals with FEP with targeted interventions, particularly the Coordinated Specialty Care (CSC) model, delivered by a team of specialists who offer psychotherapy, medication management, family education and support, case management, and work or education support, depending on the individual's needs and preferences. Arizona has 3 EPICenters, 5 health homes, and 1 new FEP program (Connections Access) that all utilize the CSC model for interventions for FEP. These FEP programs utilize the evidence-based programs NAVIGATE, OnTrack, and Fast Forward, and often utilize consultation services from these programs in order to implement with fidelity and maintain up-to-date knowledge on the programs. Additionally, the RBHAs utilize other EBPs such as cognitive remediation, CBT, CBT-p, CET for individuals with FEP.

One RBHA also utilized funding to target minority groups such as African Americans, Native Americans, LGBTQ young adults, and older adults to provide education, information dissemination, risk assessment, referral/screening, and other resources related to mental health.

OTHER EFFORTS

One RBHA has planned and has begun preparation to implement the Early Psychosis Intervention (EPI) Project ECHO program. The goal of this program is to provide additional support and resources to the region's FEP programs and other providers that currently do not have a dedicated FEP program, and to further enhance the knowledge, skills and abilities of the staff who implement the FEP program.

Another RBHA has developed its own process for step-down from CSC services. This process moves clients to an integrated community mental health clinic which is conveniently co-located with the FEP program. Clients stepping down from CSC services are offered a variety of group therapies that focus on continued social skills building, socialization, expressive arts, vocational support, case management and peer support as well as health-focused activities and medication management. Individual therapy becomes optional after this step-down transition, and many opt for group therapy and peer support. In addition, this FEP program has expanded services to address extensive family needs and also provides family and couples therapy.

FEP OUTCOMES

FEP program providers track service utilization and outcomes for individuals in their programs. Examples of services and outcomes

tracked include education, employment, and housing status, utilization of medication, individual therapy, group therapy, and crisis services, as well as hospitalizations, emergency department (ED) visits, and incarcerations. Additionally, providers may measure levels of social functioning, family involvement, family functioning, perception of symptoms and recovery, and member satisfaction of services.

Among two EPICenters in one GSA, 83% (90/108) program participants reported participating in either individual therapy, group therapy, or both, and 76% (81/106) reported receiving medication treatment. The vast majority of participants either lived at home with family, or independently. The majority are students or employed, 28% unemployed, and 9% disabled.

In another GSA, the RBHA reported that most of the FEP enrolled members reported improvements in at least tracked one area. Again, the vast majority of participants lived at home with family or independently. The most common outcome reported was engagement in school or work (37/51 or 75% in one quarter), and in one quarter, 22% (10/46) reported improvements in social functioning. Although generally, number of ED visits and hospitalizations was low as we would hope, the highest number of reported ED visits and hospitalizations in any given quarter was 5% (3/56) and 8% (5/59), respectively. Even though a few members reported suicidal ideation, there were no suicide attempts reported among participants throughout the year.

Additionally, one of the FEP providers in another GSA examined the medical impact (outcomes) for EPICenter program participants compared to individuals with early psychosis who were not EPICenter program participants (non-participants). The analysis found the following outcomes: 1) medical claim costs for program participants was lower after enrollment compared to before enrollment, 2) program participants had fewer ED visits after enrollment compared to before enrollment, 3) medical claim costs was lower for program participants compared to non-participants, and 4) program participants had fewer psychotic related claims compared to non-participants.

PROGRESS/BARRIERS IDENTIFIED

Progress

In an effort to increase services, one RBHA has begun implementing a process to increase enrollment by identifying more Non-Title XIX individuals and also identifying children ages 12 and up that may be eligible for services. One strategy for this has been to establish internal ID and referral processes such as during the intake process at a health home.

Another item identified as progress and success in the existence of FEP team meetings at health homes, which specifically, in which BHMPs and prescribers are reportedly actively involved. This weekly touch base is an important opportunity for team members to conduct case consultation, collaborate, and provide comprehensive care coordination.

Barriers

In one case, a challenge was low participation in family psychoeducation families. The providers addressed this challenge by utilizing a NAVIGATE training. After consideration, the providers decided to focus more on 1:1 family psychoeducation which is what the families seem to prefer. Another challenge in this region was a lack of success engaging families for all age ranges of members. Although the families of child members were engaged, older members' families were less engaged. This was also addressed in the NAVIGATE training.

One provider reportedly struggled with implementation of one program model and has since switched from the Breitborde model to CSC model. The provider is anticipating that more services, including case management, will be provided with the CSC model.

Although scheduling had been an issue for some FEP contractors and providers to implement trainings to law enforcement and teachers, this is being addressed by the RBHA working to create an online training track for FEP to overcome the scheduling issue. This is anticipated to allow for more services and more or better care coordination to be provided to members. Scheduling issues were further identified as a barrier to due summer schedules, vacations, and holidays have reportedly been a barrier to implementing some trainings.

SUCCESS STORIES

Story 1

One individual began services at an EPICenter in March 2018, referred for symptoms of psychosis. He was hospitalized several times, once during his current episode of care. Upon his release from the hospital, he began FEP services including metacognitive therapy, symptom management, and parent education program (multifamily group). He attended therapy twice a week, focused on cognitive remediation and after completing the program, showed improvements in at least 4 areas out of 7 assessed by the MATRICS Consensus Cognitive Battery (MCCB). He continues to maintain stability and has not been hospitalized. He will continue services 2 times per month for maintenance and continued symptom management, with the goal of returning to school and seeking part-time employment.

Story 2

An individual was referred to an EPICenter program in April of 2019 as he had been petitioned due to paranoia, psychosis as well as received several legal charges in the community while experiencing his first break. He was discharged from the hospital May of 2019. Shortly after he was discharged from the hospital, his family had to move abruptly. Despite the last-minute move, he returned to his job while he maintained the requirements of his court order. He began participating in Cognitive Enhancement Therapy at an EPICenter to sharpen his cognitive skills that had been dampened during his untreated psychosis. He obtained a 6-month gym membership which he uses as a positive outlet. He continued to have the stressor of legal charges involving several court dates in which his team specialist accompanied him for advocacy and support, and eventually his case was sent to community court as he was also facing losing his job if the charges were upheld. At his first court date in community court he learned of the death of a close family member. The staff surrounded him with support and offered grief counseling, in spite of this loss, he continued his treatment plan, including therapy sessions, meeting with a psychiatrist, exercising, and working full time. Recently a judge ruled that all charges and all fines be

dismissed, given a glowing report from the EPICenter. He received a certificate of completion from community court, which he has presented to his employer and now his job is no longer in jeopardy. This individual is a great role model to his younger brothers and his peers at the EPICenter. He plans to return to college and provide a better life for himself and his family.

FEP ENROLLMENT AND EXPENDITURE RATES

According to AHCCCS Client Information System (CIS) claims data, 3,605 individuals ages 12-35 with eligible FEP diagnoses were served under the Mental Health Block Grant (MHBG) between in State Fiscal Year 19 (SFY19: July 1, 2018 and June 30, 2019). This is about level with the numbers served during the previous year, State Fiscal Year 18 (SFY18: July 1, 2017 – June 30, 2018), which totaled 3,622 of the same age range and diagnoses.

Priority #: 8
Priority Area: TB Screenings
Priority Type: SAT
Population(s): TB

Goal of the priority area:

Increase the number of tuberculosis screenings for members entering substance abuse treatment.

Strategies to attain the goal:

Focus on developing mechanisms to document and verify TB screening of those entering substance abuse treatment that were implemented this past year.

Strategies that providers are and will continue implementing include: integrating education on TB (along with other communicable diseases) into member orientations, providing educational materials on TB to members, providing members with referral handouts for TB and HIV testing at specified locations, as well as including elements to capture TB screening documentation in contractors' audit tools.

In addition, AHCCCS will provide guidance to the RBHAs regarding accurate documentation on screening and referrals for TB services. Communications on block grant CFR requirements related to TB are more specific to RBHAs and providers.

In addition, AHCCCS will provide guidance to the Regional Behavioral Health Authorities (RBHAs) regarding accurate documentation on screening and referrals for TB services. Block grant CFR requirements related to TB is being communicated more specifically to RBHAs and providers.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement: FY16 data on the number of members receiving substance abuse treatment with documentation of TB services documented in their chart. Current baseline is 24.6%
First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2018), 25.6%
Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2019), 26.6%

New Second-year target/outcome measurement(*if needed*):

Data Source:

Independent Case Review

New Data Source(*if needed*):

Description of Data:

A random sample of charts will be pulled and scored based on pre-determined elements that include documented evidence of screenings and referrals for TB services.

New Description of Data:(*if needed*)

Data issues/caveats that affect outcome measures:

No data related issues anticipated.

New Data issues/caveats that affect outcome measures:

Report of Progress Toward Goal Attainment

First Year Target:



Achieved



Not Achieved *(if not achieved, explain why)*

Reason why target was not achieved, and changes proposed to meet target:

How first year target was achieved *(optional)*:

Based on the 2017 Independent Case Review (ICR), the percent of clients entering substance abuse treatment who are screened for tuberculosis increased from 37.3% in FY16 to 50% in FY17, which exceeds the goal of 25.6%. The Arizona Health Care Cost Containment System (AHCCCS) partners with the contractors and provides technical assistance as well as identifies available resources to enhance the management of the SABG implementation of early intervention programs with specific emphasis on Tuberculosis in addition to HIV and Hepatitis B & C. These efforts include:

Outreach

The RBHAs throughout Arizona continue to complete training and audits in addition to ICR Peer Reviews to ensure completion of TB testing and referrals. The RBHAs meet regularly with network providers of SUD services and provides information and feedback about policies and initiatives. Individuals referred to substance use residential programs are required to complete TB screens, as criteria of admission in the Gila River Indian Community. Providers have direct contact with the county health departments and if there are any concerns for TB positive patients and provide testing upon intake. Additionally, they provide TB screening and test for all patients served. Providers have enhanced internal data reporting to be able to identify individuals in need of TB screenings and they have implemented TB screening services across the Patient Centered Medical Home clinics. TB screening is done for all intakes. Screening is explained to every client during the initial history and physical exam.

Collaboration

The RBHA in the Southern GSA met with, and will continue to meet with, health homes to collaborate on improving TB screenings and documentation for TB screenings. The Health Homes in the Northern GSA partner with the county health departments to create informational handouts on HIV and TB. The RBHA's medical management, quality management and clinical services department work actively with providers to provide support and technical assistance to provide and enhance service provision. Gila River primary care provides TB screenings, upon request of individuals referred to SUD treatment. Behavioral health staff has access to these medical records, for coordination of care. Providers refer members for a chest x-ray if they have a positive PPD (skin test) throughout Arizona. If there is an issue, the provider coordinates care with their primary care physician. Any abnormal results are referred to the client's primary care provider or other resource for further testing and treatment.

Targeted Interventions

Throughout the RBHAs, TRBHAs and providers additional training and communication have been targeted to increase the number of members receiving TB testing and information. The RBHA in the Northern GSA ensures TB testing for all individuals that enter SUD residential treatment services. The RBHAs, TRBHAs and providers have focused on engagement with at risk individuals for screening of other communicable diseases like HIV and Hepatitis B&C in addition to TB. Gila River Health Care counselors and case managers assist to identify individuals with obtaining TB screenings, through coordination with GRHC primary care. SABG providers test each member as they enter treatment and provide resources to obtain chest x-ray if needed.

Other Efforts or Information

The RBHA in the Southern GSA continues to hold substance use disorder and medication assisted treatment meetings to exchange information and collective strategies that also address communicable disease testing, treatment, and prevention. In the Central GSA, the RBHA's members are educated on the symptoms of TB and the importance of being tested and having a chest x-ray. Members are tested at intake and during their annual physical.

Outcomes Measured

All of the RBHAs, TRBHAs and providers identify the number of members receiving TB testing and/or information on TB testing and referrals. They ensure all members that complete intake are successfully tested for TB and there have been no active TB cases during the reporting period. Additionally, the Independent Case Reviews conducted measure the documentation of compliance with the TB referral and testing requirements.

Progress/Barriers Identified

Progress has been identified by the RBHA in the Northern GSA, which has been able to expand Hepatitis C screening throughout Northern Arizona.

Second Year Target:



Achieved



Not Achieved (if not achieved, explain why)

Reason why target was not achieved, and changes proposed to meet target:

How second year target was achieved (optional):

Based on the 2018 Independent Case Review (ICR), the percent of clients entering substance abuse treatment who are screened for tuberculosis increased from 50.0% in FY17 to 69.4% in FY18, exceeding the goal of 26.6%. The Arizona Health Care Cost Containment System (AHCCCS) partners with the contractors and provides technical assistance as well as identifies available resources to enhance the management of the SABG implementation of early intervention programs with specific emphasis on Tuberculosis in addition to HIV and Hepatitis B & C. These efforts include:

Outreach

The Southern Arizona RBHA completes audits and ICR Peer Reviews to ensure completion of Tuberculosis testing and referrals. As a criterion of admission, Gila River Indian Community substance abuse residential programs are required to complete TB screens on all members. The Northern Arizona RBHA providers educate members on the risk of communicable disease due to substance use at intake and prior to admission to any CDR or inpatient facility. TB testing is available and encouraged. Outreach occurs with hospitals, crisis teams, and schools in the Central Arizona RBHA as well as with Maricopa Integrated Health System inpatient teams, schools, as well as health centers. The Central RBHA TB testing is completed for members receiving residential services, particularly if they are placed on the waitlist.

Collaboration

The Southern Arizona RBHA meets with health homes to collaborate on improving TB screenings and documentation for TB screenings. The primary care provides TB screenings, upon request of individuals referred to substance use treatment. Behavioral health staff has access to these medical records for coordination of care. The Central Arizona RBHA providers collaborate with Maricopa County and Primary Care Physicians to assist with TB screenings and/or referrals for positive TB tests. Many providers are also transforming to becoming integrated facilities.

Targeted Interventions

Counselors and case managers assist to identify individuals with obtaining TB screenings, through coordination with Gila River Health Center's primary care. All RBHAs conduct TB screenings for members in residential services and refer positive screenings to the appropriate medical providers as necessary. Screenings include PPD skin testing and chest x-rays. If TB is found, treatment interventions begin immediately and the member is referred to an appropriate medical provider for TB treatment services prior to admittance into an inpatient or residential treatment facility.

Other Efforts or Information

If a member who tests positive for TB also qualifies for a specialized care or disease management program they will be referred to the appropriate program.

Outcomes Measured

Outcomes measured include screening all members receiving a residential level of care. Further, referrals are provided for members having a positive TB screen result.

Progress/Barriers Identified

The Health Homes have demonstrated improvement with TB referrals from the Quarterly Audit to the Bi-Annual. Challenges with TB testing are three-fold. SABG covers substance use treatment, but does not cover medical needs. If a member tests positive for TB, they do not have the means to receive medical care for their positive test. Coordination with PCP's can be difficult for providers. Lastly, members do not always follow-up 72 hours after the initial test to have their results read, making it difficult to ascertain the actual prognosis.

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Arizona Healthcare Cost Containment System (AHCCCS) State Report for SABG/MHBG Administrative Supplement for Technical Assistance

Notice of Award: 3B08TI010004-18S2

The Arizona Healthcare Cost Containment System (AHCCCS) utilized the SABG Administrative Supplement for Technical Assistance for various technical assistance (TA) and training needs as decided by AHCCCS and SABG subrecipients throughout the state. Utilizing a collaborative approach through existing SABG provider monitoring meetings and information provided to AHCCCS through the latest SABG/MHBG core reviews and site visits from the Substance Abuse and Mental Health Services Administration (SAMHSA), AHCCCS designated the TA supplement to be focused on the following areas:

1. **SABG and MHBG** - Data collection through integrated care providers utilizing the Social Determinants of Health ICD-10 codes.
2. **MHBG** - Integration of MHBG Serious Emotional Disturbance (SED) funding into AZ's children's System of Care.
3. **SABG and MHBG** - Allowable activities for suicide prevention/intervention related to individuals eligible for block grant funding.
4. **SABG and MHBG** – Provide assistance to AHCCCS and its contractors with development of standard work policies, protocols and systems to manage and meet SABG and MHBG grant requirements.

AHCCCS identified vendors to complete these TA requests through a competitive bidding process. The TA vendors, Mercer and Navigant, were identified and started work in July 2019. Activities related to this TA Supplemental award are outlined below.

Technical Assistance Priorities

1. **(AWARDED TO NAVIGANT) SABG and MHBG - Data collection through integrated care providers utilizing the Social Determinants of Health ICD-10 codes.**

Data collection through integrated care providers utilizing the Social Determinants of Health (SDoH) ICD-10 codes.

Population: Statewide behavioral health recipients include: Serious Emotional Disturbance (SED), Serious Mental Illness (SMI), youth, adults, co-occurring populations, general mental health, and tribal population at the tribe's discretion.

Data Sources: National, Statewide

Deliverables and Vendor Activities:

- Complete a thorough survey and review of national best practices, including journals, literature reviews, and other state's best practices, in relation to data collection through integrated care providers utilizing the Social Determinants of Health ICD-10 codes. Review will include how other states are addressing this topic, as well as the organizational structure of other state's agencies (i.e. other states may have dedicated bureaus/offices to this topic). Survey recipients should include all behavioral health service types, tribal partners, and related behavioral health partners as appropriate.
- Utilizing data collected from national best practices report, prepare a comparison report related to current Arizona efforts. Report to include a complete review of AHCCCS's

Arizona Healthcare Cost Containment System (AHCCCS) State Report for SABG/MHBG Administrative Supplement for Technical Assistance

current data collection protocol, current SDoH initiatives, as well as recommendations for improvement and current strengths in Arizona.

- Utilizing data collection, develop an Arizona specific SDoH Report. SDoH Report will include potential ways for AHCCCS to build agency policy to strengthen SDoH data collection efforts. Addressing the following areas of emphasis in addition to the general information:
 - Capturing SDoH data that are representative of the member’s status at the beginning of treatment as well as at time of entering into maintenance stage of change to show change over time for the individual member as well as the aggregate of the population.
 - The use of incentives or increased rates for providers who meet benchmarks of using the ICD-10 Z Codes.
 - Quality measures to ensure that the use of codes are accurate and consistent.
 - How to demonstrate change by the absence of the use of a Z Code following the use of it at a prior interval.
 - Identification of alternative forms of data other than ICD-10 Z Codes to utilize in the measurement of SDoH.
 - Methods of combining different data sources to ensure accuracy and prevent duplication.
 - Provide an analysis of the current data collection efforts of ICD-10 Z Codes, the DUGless, and other data sources used by AHCCCS for efficiency and areas for improvement.
- Provide recommendations for the consistent use of specific codes and the possible addition of new Z Codes to address any potential gaps in the existing available options to obtain SDoH data. Develop a presentation for AHCCCS staff and related providers regarding report findings and recommendations for enhanced data collection. Presentation materials shall be informed by the data collected and reports developed. Presentation shall be developed in a PowerPoint format.

3. (AWARDED TO MERCER) SABG and MHBG - Allowable activities for suicide prevention/intervention related to individuals eligible for block grant funding.

SABG and MHBG - Allowable activities for suicide prevention/intervention related to individuals eligible for block grant treatment.

Population: Statewide youth, general mental health, co-occurring, Substance Use Disorder (SUD), tribal populations at the tribe’s discretion.

Data Sources: National, Statewide

Deliverables and Vendor Activities:

- Provide AHCCCS with a review of national best practices, other state practices, and approaches that SAMHSA has deemed allowable for SABG and MHBG funding. The review shall include, but is not limited to: innovative approaches, approaches that use media dissemination for suicide prevention/education, and approaches that utilize the

Arizona Healthcare Cost Containment System (AHCCCS) State Report for SABG/MHBG Administrative Supplement for Technical Assistance

integration of interventions in schools, including the process of referring children in need of services.

- The report shall include a comparison of AZ suicide prevention/intervention programming with other western states programs (SAMHSA region 9), with an emphasis on Medicaid expansion states. Report will include the following:
 - How other states work to shift the culture of suicide prevention/intervention,
 - How states try to reduce the stigma associated with suicide,
 - What methods states use to identify technical assistance needs in high risk populations (i.e. American Indian/Alaska Natives),
 - How states provide suicide prevention/intervention services to SABG and MHBG eligible populations,
 - How states utilize programming that focuses on dual outcomes related to SUD treatment and Mental Health to implement suicide prevention/intervention programming,
 - Other state’s infrastructure for billing of suicide prevention/intervention related activities to the block grants, and
 - Other state’s methods for sustainability for suicide prevention/intervention efforts, including non-grant dollars allocated by states for suicide prevention.
- Provide AHCCCS with a comprehensive review of available online trainings, resources, education available both nationally and with other states and/or organizations. The review will include a document that can be disseminated to AHCCCS contractors, providers, and the general public regarding resources that are available. Resources should be broken out into sections by high-risk populations, and frontier vs. rural vs. urban areas.
- Review current AHCCCS policy guidance documents as they relate to suicide prevention to ensure alignment with SAMHSA requirements, best practices, and needs of contractors, and provide recommendations for AHCCCS to achieve better alignment to these items.
- Prepare a presentation incorporating all findings geared towards AHCCCS, stakeholders, and contractors as applicable. Presentation shall be developed in a PowerPoint format.

4. (AWARDED TO NAVIGANT) SABG and MHBG – Provide assistance to AHCCCS and its contractors with development of standard work policies, protocols and systems to manage and meet SABG and MHBG grant requirements.

SABG and MHBG – Provide assistance to AHCCCS and its contractors with development of standard work policies, protocols and systems to manage and meet SABG and MHBG grant requirements.

Population: *Statewide SABG and MHBG providers, and tribal population at the tribe’s discretion.*

Data Sources: *National, Statewide*

Arizona Healthcare Cost Containment System (AHCCCS) State Report for SABG/MHBG Administrative Supplement for Technical Assistance

Deliverables and Vendor Activities:

- Have a demonstrated knowledge of AHCCCS funding structures related to SABG/MHBG expenditures, as well as tribal spending, fee for service and capitated funding models, and current AHCCCS programs and policies and procedures. Contractor shall also have a background in organizational development, business management, and/or project management.
- Develop an inventory and timeline of all SABG and MHBG grant requirements to be used as a tool for AHCCCS and contractors. The inventory will include all levels of requirements (AHCCCS, Tribal and Regional Behavioral Health Authorities (T/RBHAs), and providers).
- Research and develop a document of findings related to best practices that are being used nationally and at other states to operationalize standard work policies. The document shall include, but is not limited to, the following:
 - A subset of practices that have been reviewed and deemed acceptable by SAMHSA, as applicable,
 - Data collection methods and/or data management systems that are currently being used,
 - Accounting policies and procedures that are being used to manage SABG/MHBG spending and reporting,
 - Employee level policies currently implemented as it relates to SABG/MHBG spending and reporting tracking,
 - Description of how each practice/protocol relates to the different block grant funding sub-recipients including RBHAs, TRBHAs and other contractors,
 - Sample policies and procedures templates, as applicable, and
 - A review of past and current templates used for SABG/MHBG deliverables and provide recommendations for improvement.
- Develop training(s) related to SABG/MHBG deliverables and how to operationalize standard work protocols to meet deadlines. Training(s) shall include a “mapping” to current scopes of work for SABG and MHBG contractors and provide a link to deliverables and federal requirements. Contractor shall survey the field for preferred training modalities, utilizing the most popular option(s). Trainings shall use any/all modalities as appropriate, including but not limited to in person and online. Contractor will record at a minimum one (1) training for future training purposes. Contractor will provide AHCCCS with all training materials no more than two (2) weeks before the training(s) for review.
- Provide AHCCCS with a document that shows “mapping” to current scopes of work for SABG and MHBG contractors and provides a link to deliverables and federal requirements. This document will be provided in addition to training materials developed.

Monitoring and Oversight of Vendor Activities

AHCCCS actively monitored and was a collaborative partner throughout the implementation of services related to this supplement. AHCCCS staff served as project managers, Subject Matter Experts (SMEs), and utilizing current partnerships with the current workforce in Arizona to ensure the information gathered and reported was comprehensive in nature. AHCCCS held weekly meetings with both vendors to discuss progress made towards project deliverables, as well as used meeting time to mitigate

Arizona Healthcare Cost Containment System (AHCCCS) State Report for SABG/MHBG Administrative Supplement for Technical Assistance

challenges or barriers that were encountered by vendor staff. All deliverables are scheduled to be finalized and submitted to AHCCCS on 9/30/19, with many deliverables having already gone through multiple rounds of review with AHCCCS staff and SMEs. Once final deliverables are submitted, AHCCCS will utilize the information gathered and the reports to influence needed system changes as necessary, and share the information through the appropriate channels (i.e. tools and deliverables may be posted on AHCCCS' website to ensure the information is disseminated throughout the system and community). AHCCCS will be holding trainings and information sessions on the reports as needed during the coming year to ensure broader information dissemination throughout the system.



Arizona Statewide Prevention Needs Assessment

September 2018



LeCroy & Milligan
ASSOCIATES, INC.

Arizona Statewide Prevention Needs Assessment September 2018



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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 Block 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 Cenicato 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.



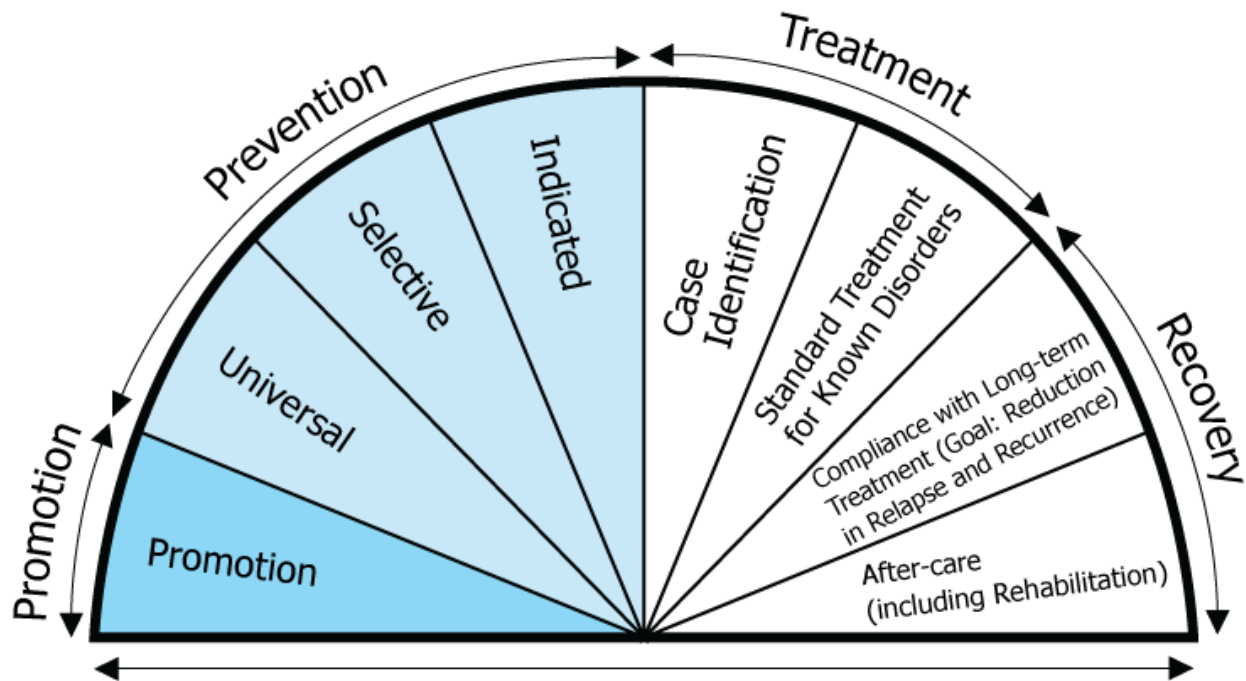
5. **Reliant on a team approach:** Each step of the SPF requires – and greatly benefits from – the participation of diverse community partners.

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, Gyll & 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 \$9.60 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.

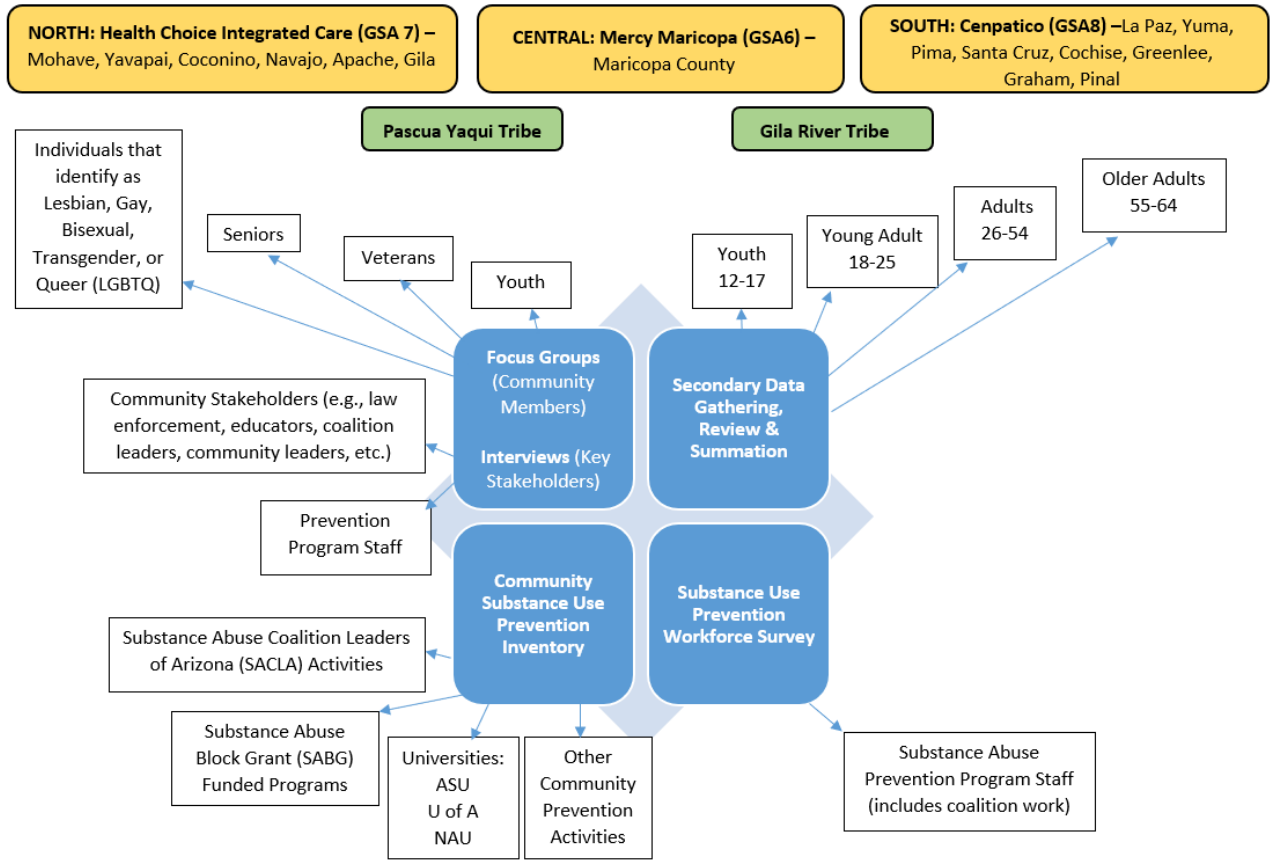
Project Overview

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 inconsistencies, 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)

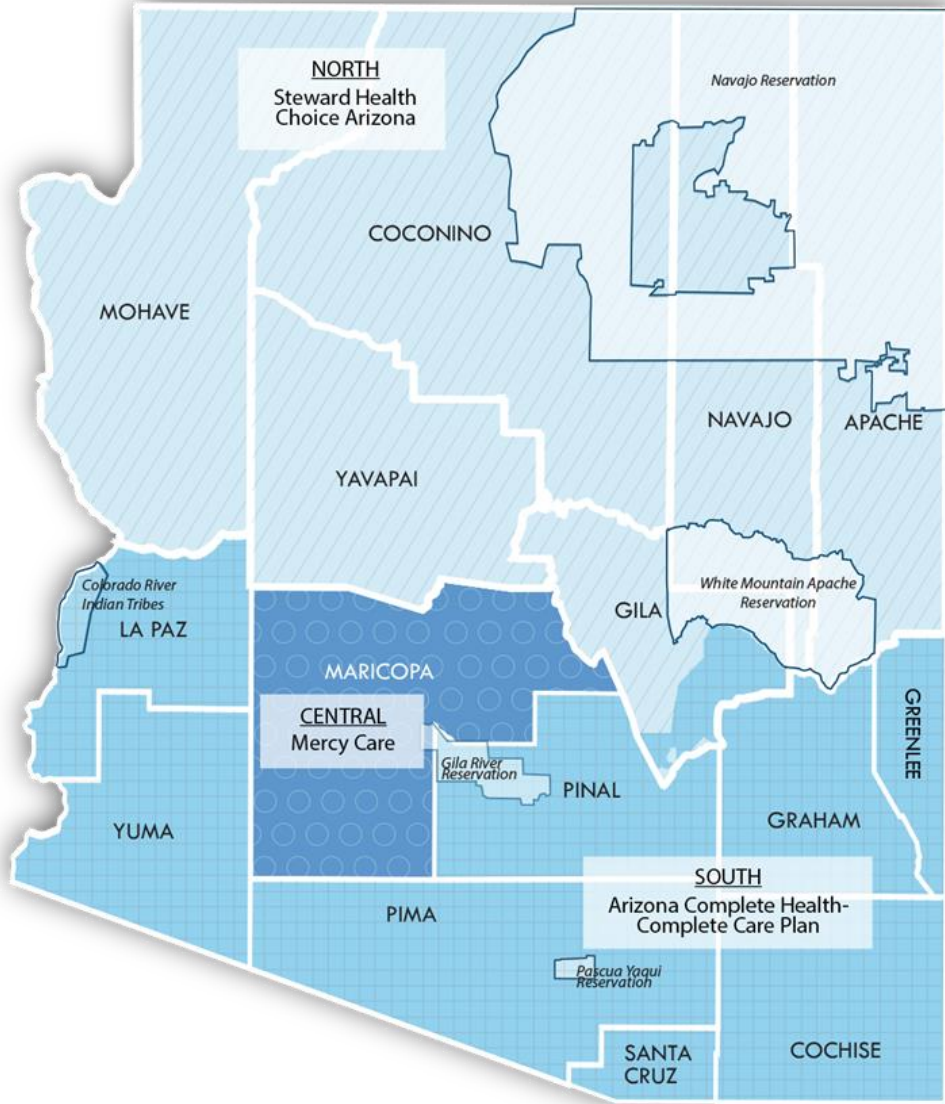
The Arizona Health Care Cost Containment System (AHCCCS) is the Single State Agency (SSA) that contracts with the Regional Behavioral Health Authorities (RBHAs), the Tribal Regional Behavioral Health Authorities (TRBHAs), and the Governor's Office of Youth, Faith and Families (GOYFF) to provide prevention 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.



RBHA/TRBHA and Crisis Services Map Effective October 1, 2018



Note: Zip codes 85542, 85192, 85550 representing San Carlos Tribal area are included in the South GSA.

Source: Map provided by AHCCCS 02/22/19; Produced by AHCCCS October, 2018.

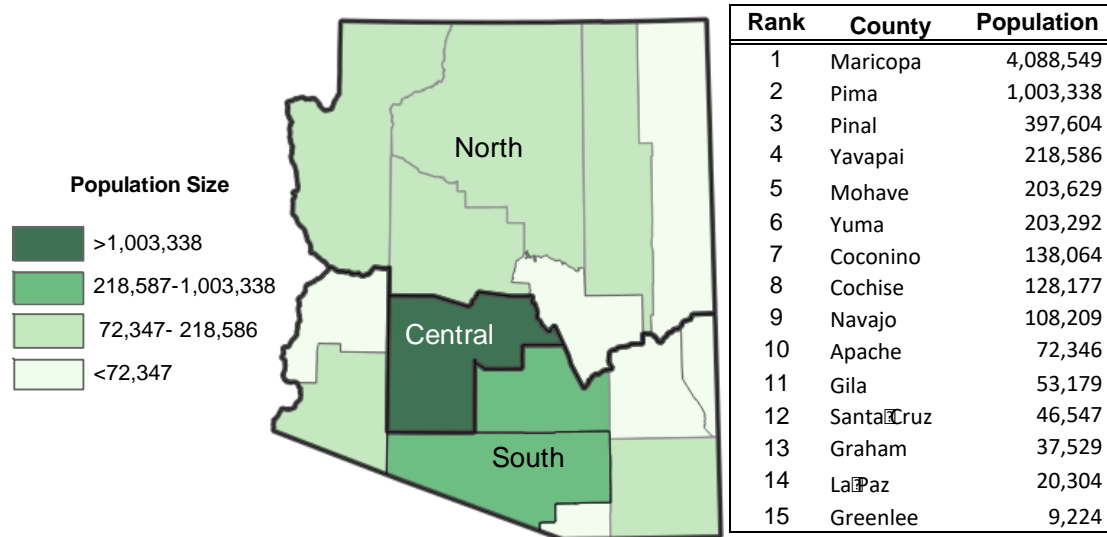
**This updated map is not reflective of the RBHA/TRBHAs that were providing services during the time of the needs assessment data collection. Since the assessment took place during a time of transition to AHCCCS Complete Care Plans, this map should be used going forward when determining RBHA/TRBHA designations 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 2012-2016²



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

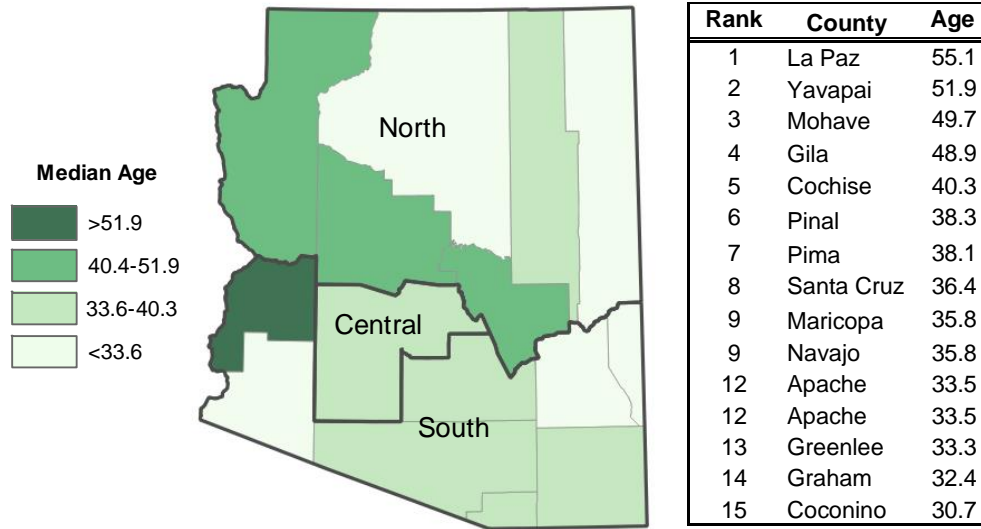
The median age in Arizona is 37.1 years, compared to 37.7 years nationally. The age profile differs by County (See Exhibit 4). La Paz, Yavapai and Mohave counties have the oldest populations. Over one-third of residents in La Paz (36.1%), and more than one-quarter of residents in Yavapai (28.3%) and 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



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).

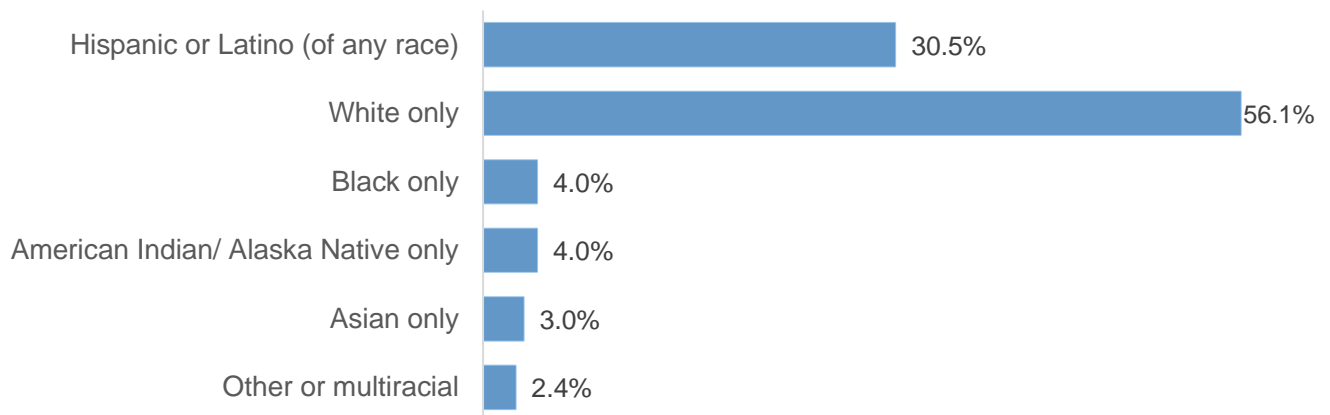


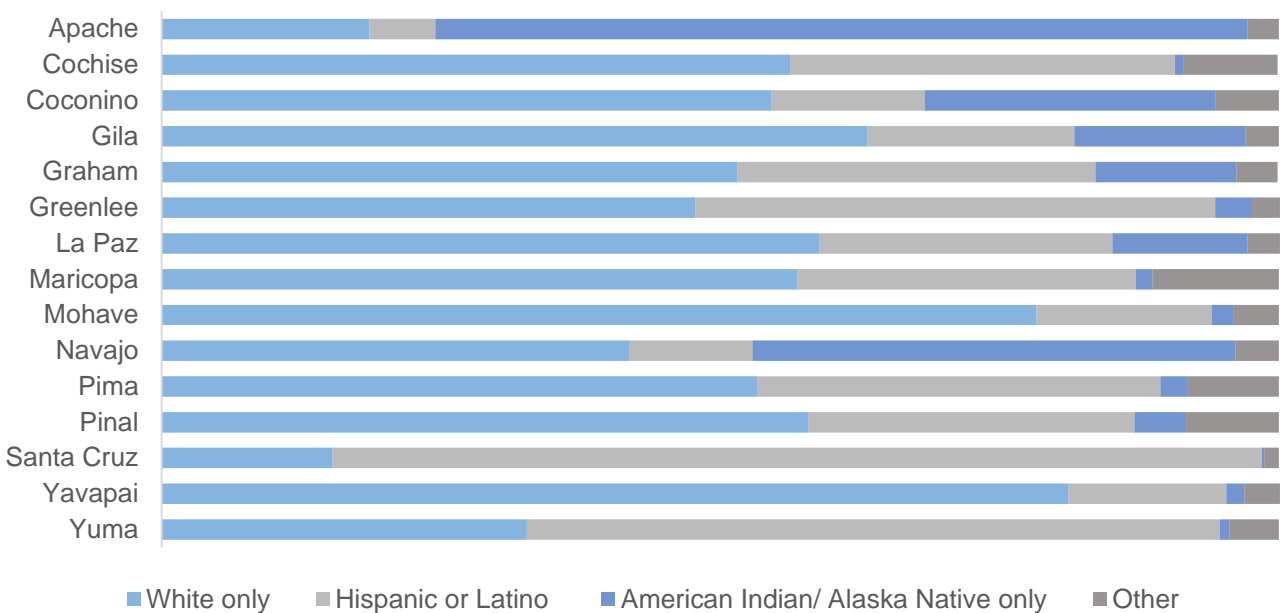
Exhibit 5. Race/Ethnicity in Arizona, 5-Year Estimates from 2012-2016

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



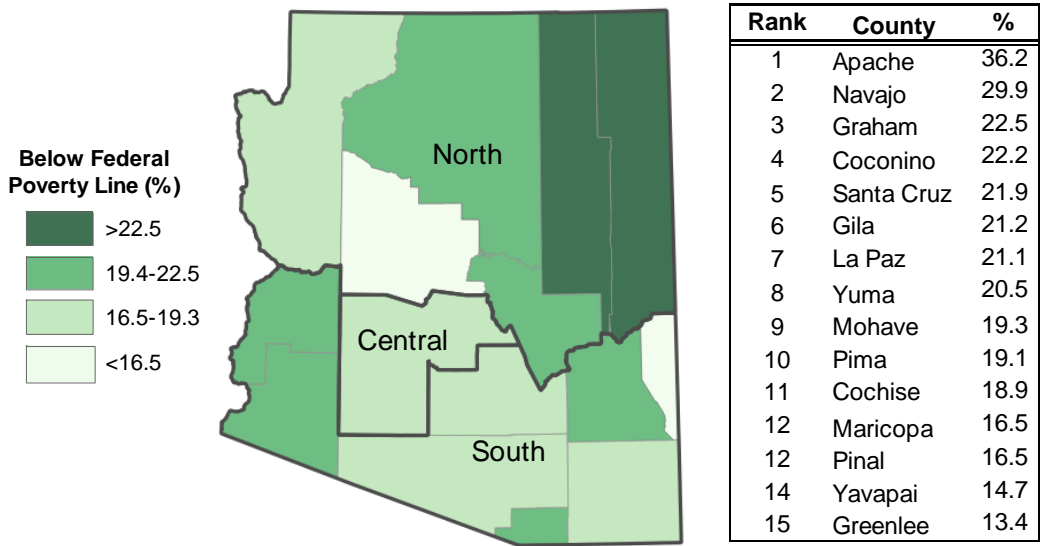
Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates

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



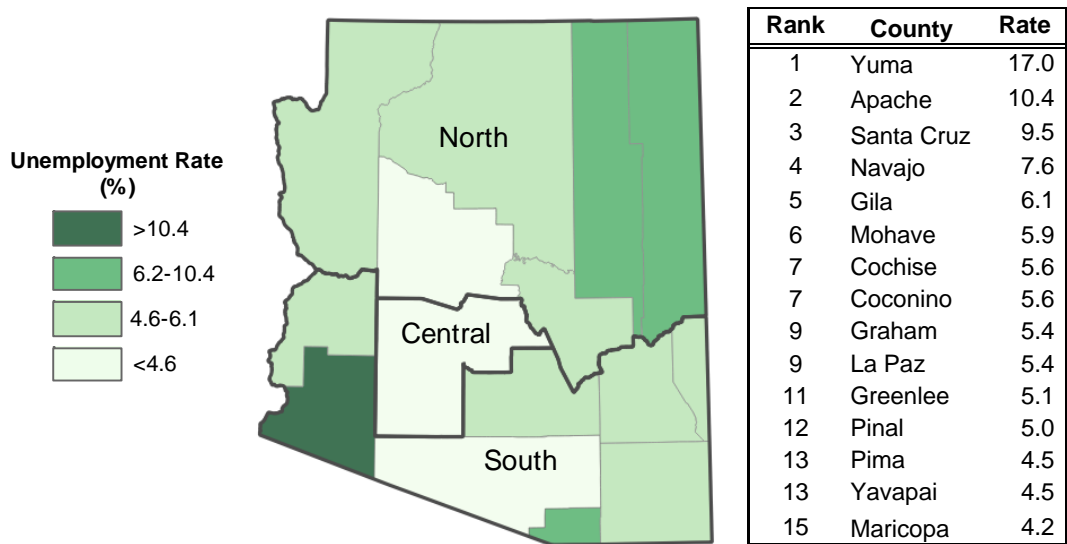


Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-year estimates

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



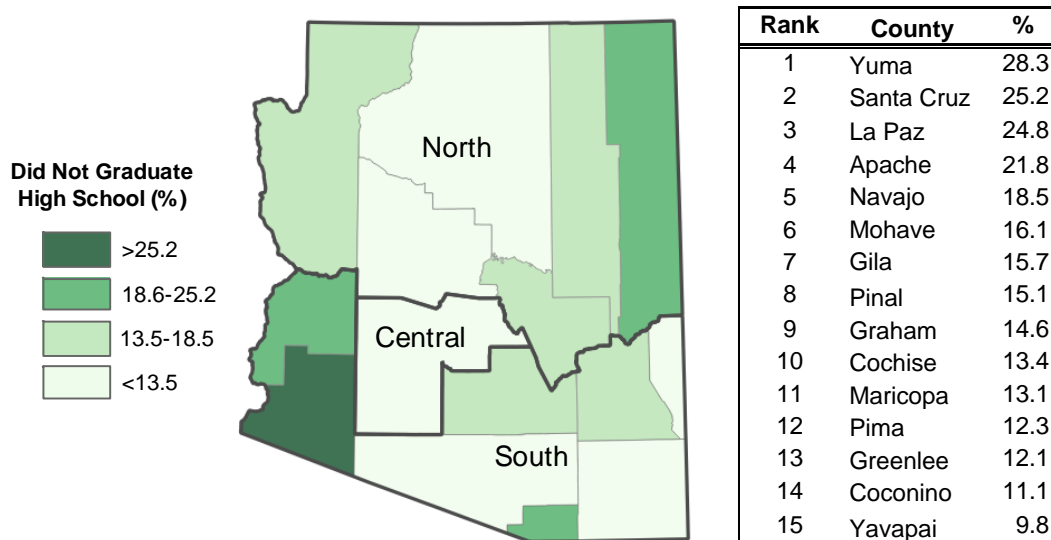
Source: Bureau of Labor Statistics, Current Population Survey, 2017

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



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 2016³. 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

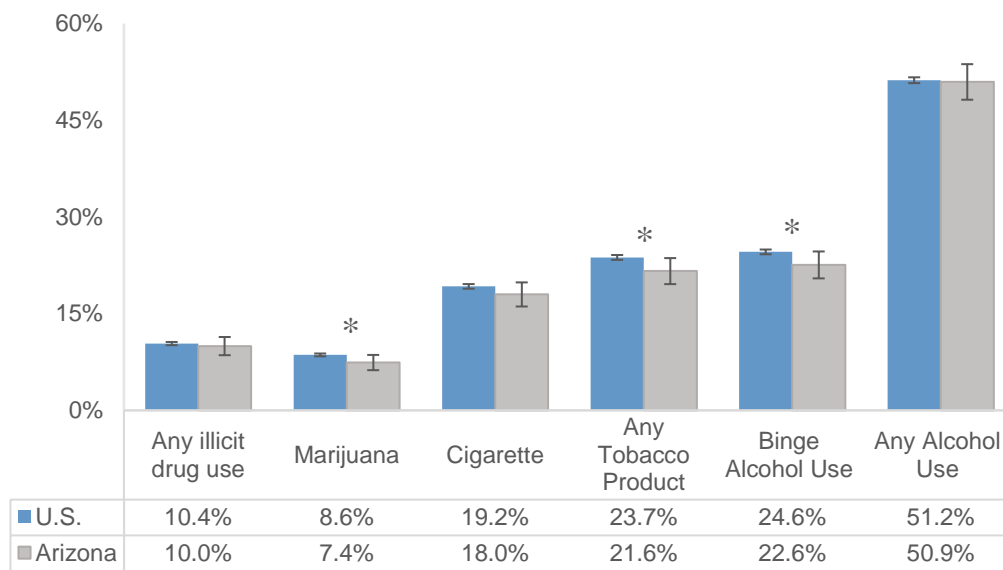
³ State-level prevalence estimates are based on two years of combined NSDUH data (2015,2016); estimates by RBHA are based on three years of combined NSDUH data (2014, 2015, 2016). NSDUH data are pooled in order to increase the precision of state and regional estimates, and to detect changes overtime 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



* 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:

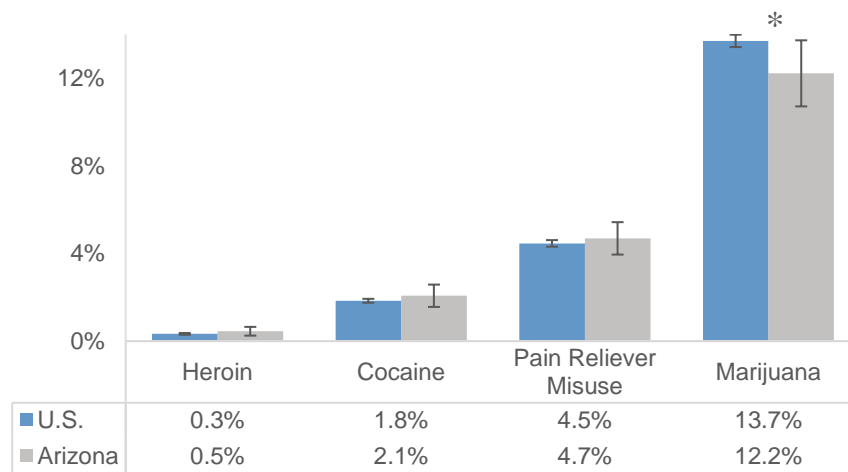
- marijuana,
- heroin,
- cocaine, and
- pain reliever misuse, which includes misuse of opioid pain relievers such as hydrocodone (e.g., Vicodin®), oxycodone (e.g., OxyContin® and Percocet®), and morphine. This misuse is defined as “use in any way not directed by a doctor, including use without a prescription 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.

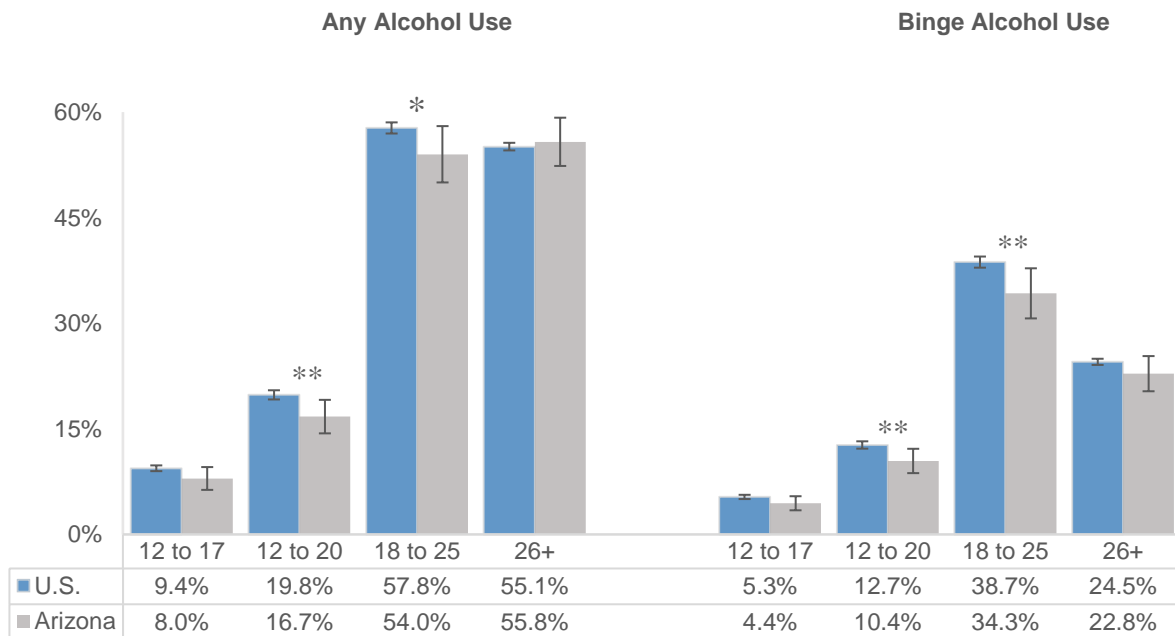


Youth Prevalence

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



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.

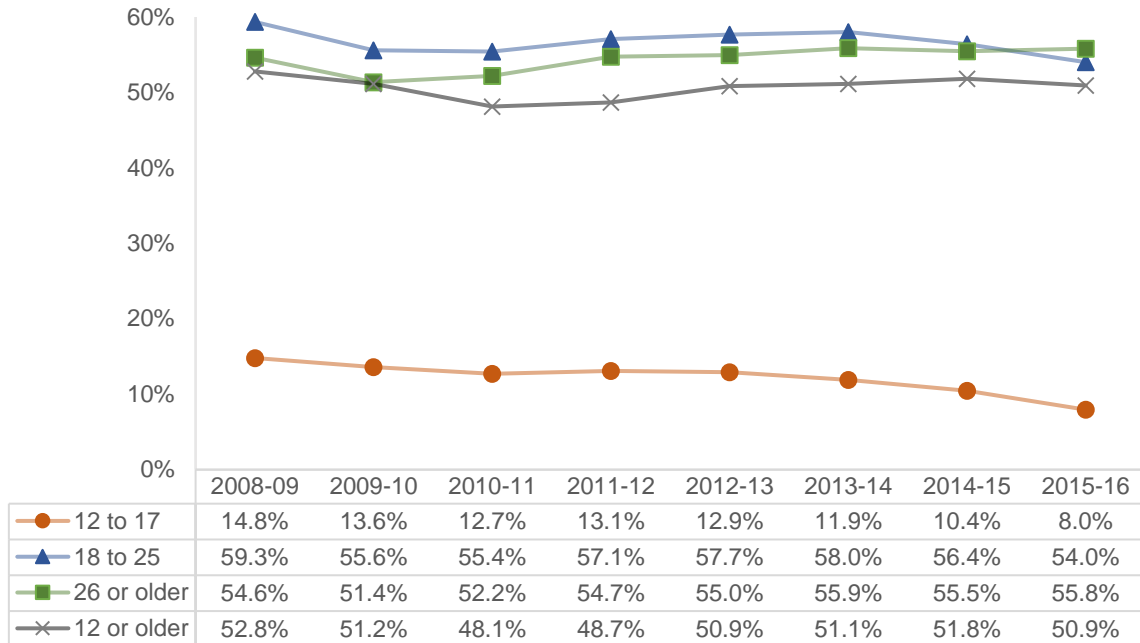
Youth Trends

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).

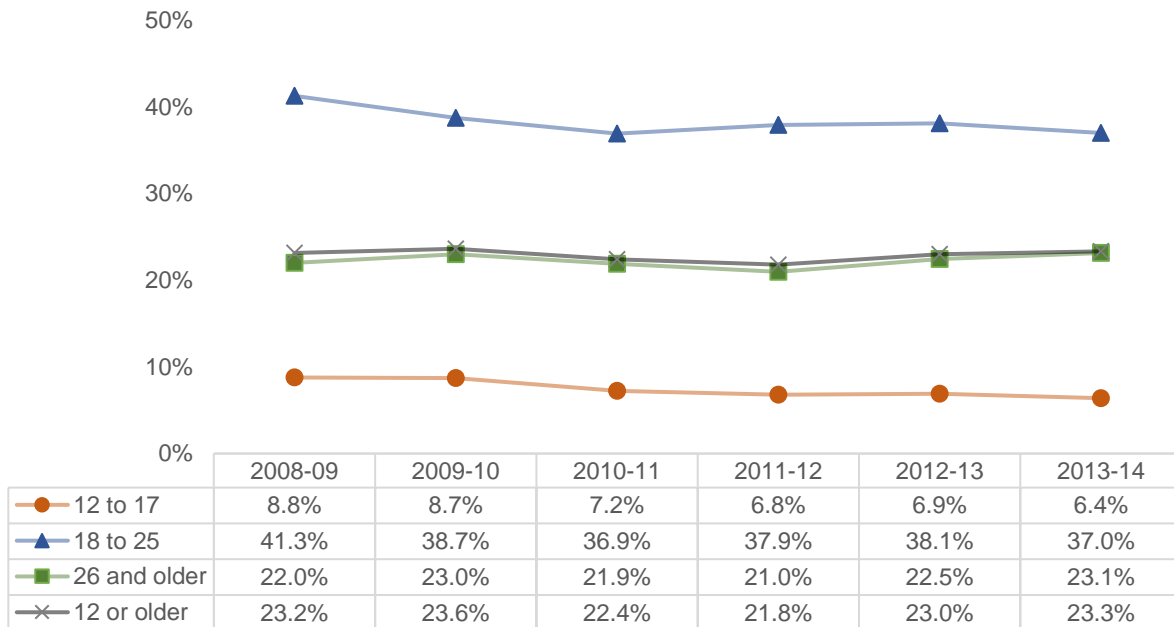


Exhibit 13. Trends in Prevalence of Past Month Alcohol Use in Arizona by Age Group, 2008-2016



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

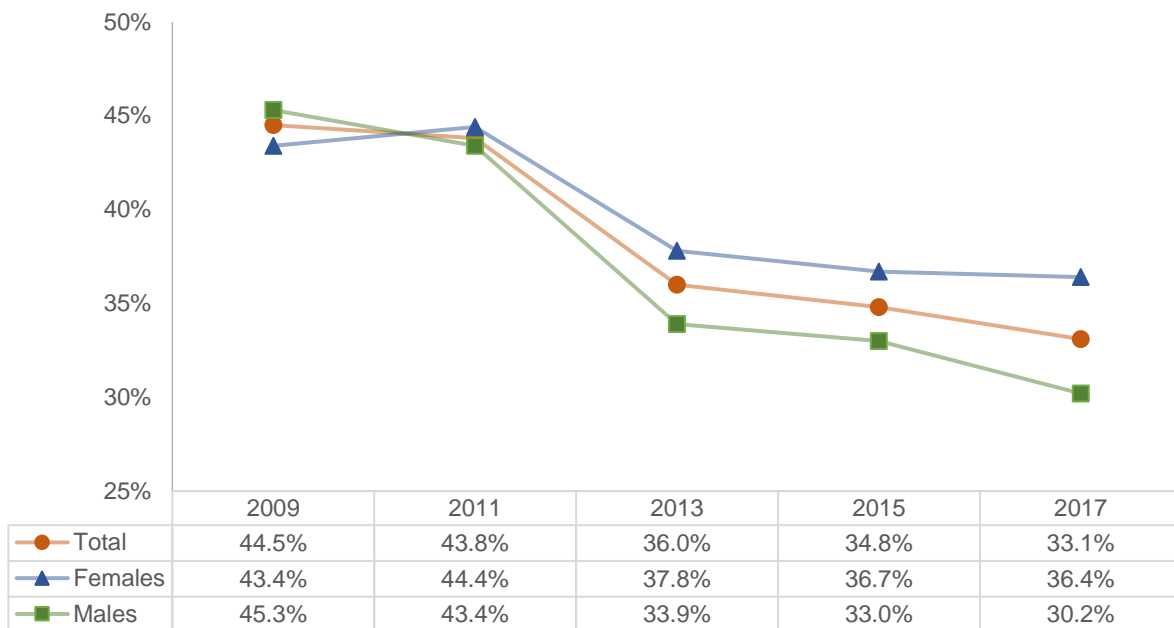


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016



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



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.

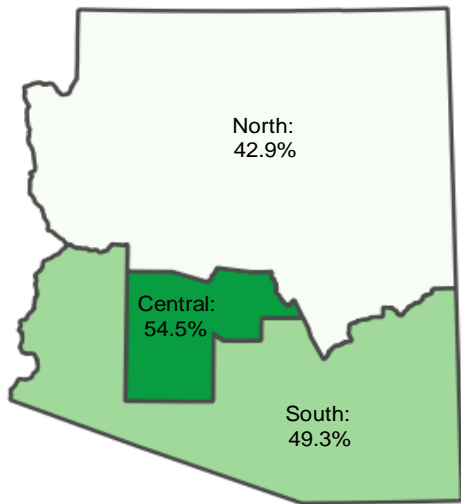
Prevalence by RBHA

Exhibit 16. Prevalence of Any Alcohol Use in the Past Month Among those 12 and Older by Arizona's RBHA, 2014 - 2016

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 Arizona Statewide Substance Use Prevention Needs Assessment 2018



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.

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

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015-2016

the past year by Arizona RBHAs. These findings drank any alcohol in likely to engage in

could suggest that those who the North Region were more

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.

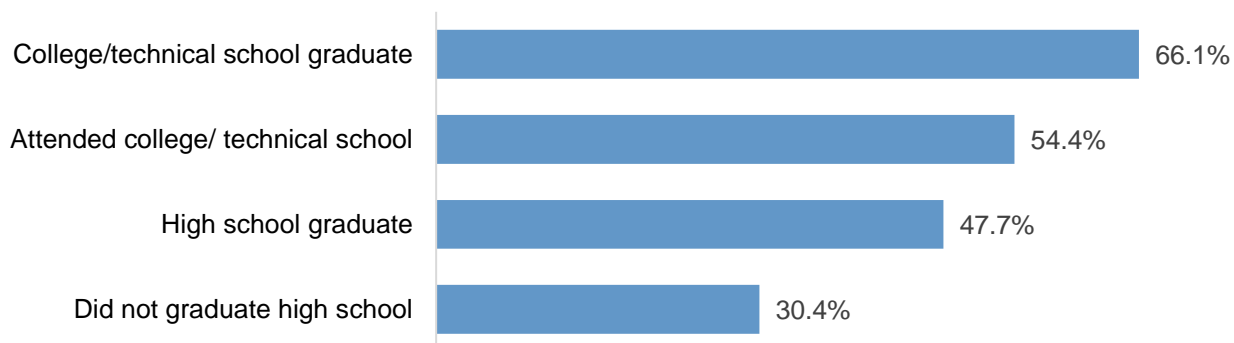
Adult Disparities

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

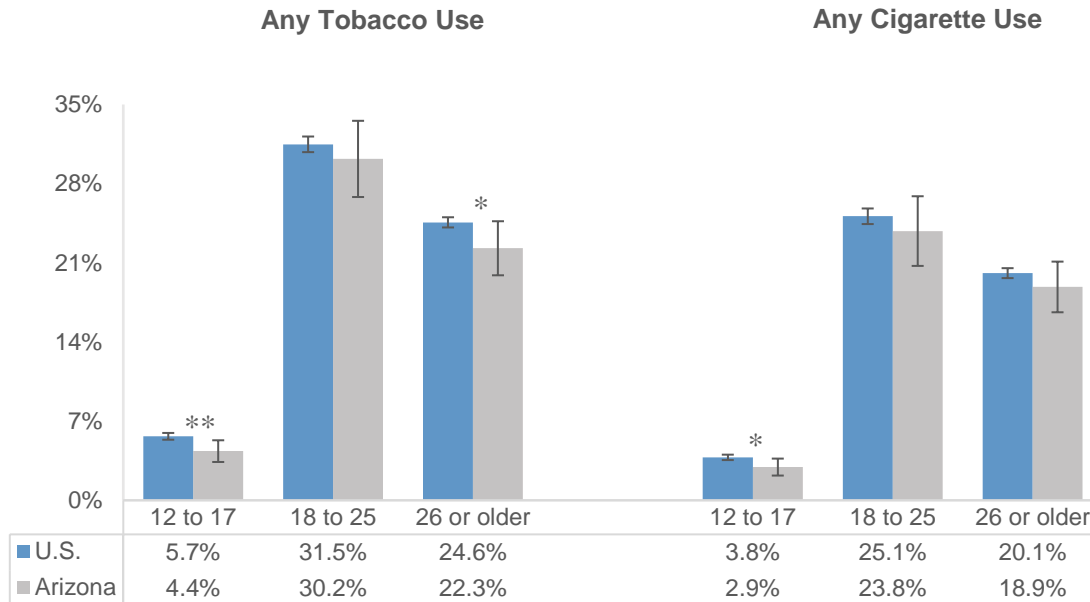
Data from the 2015-2016 NSDUH estimated that 24,000 Arizona youth aged 12 to 17 actively used tobacco products, and 16,000 used cigarettes. Youth had the lowest prevalence of tobacco use of all age groups in Arizona (See Exhibit 18). Arizona youth reported significantly less tobacco use than youth nationally (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



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

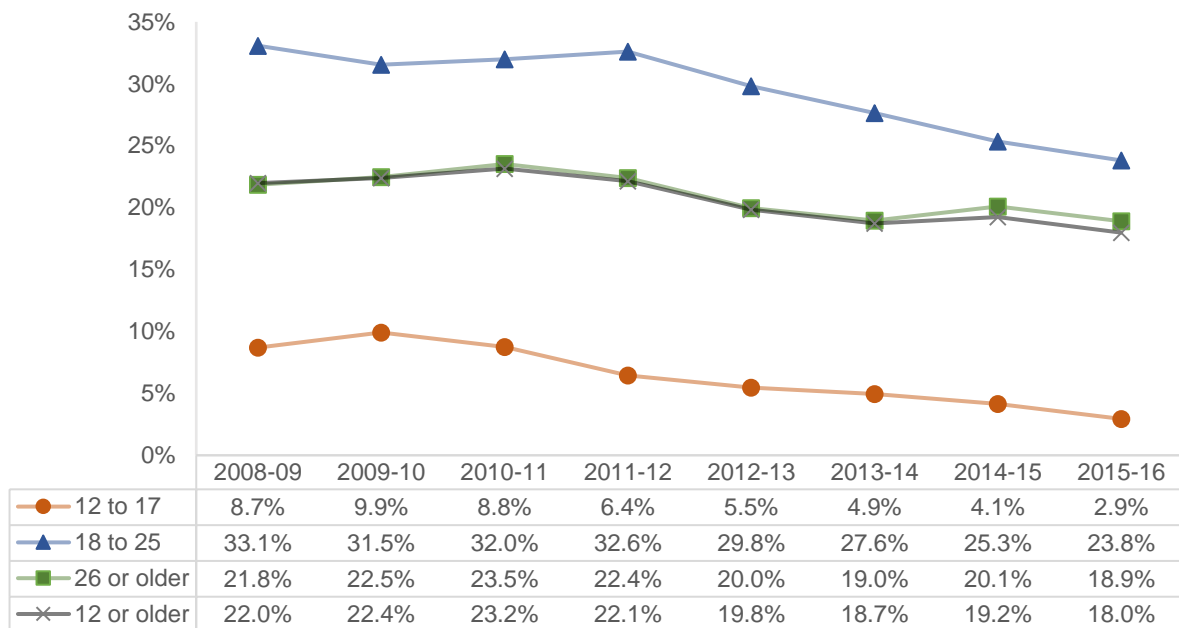


1.1% of those 65 or older ($p < .001$).

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



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

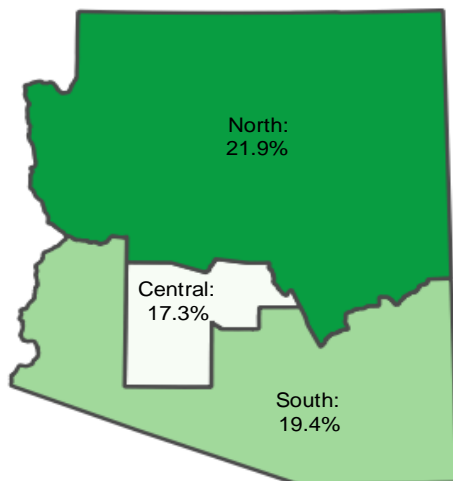


significant declines in overall active e-cigarette use between 2015 and 2017 (27.5% versus 16.1%, $p < .001$). Trends in e-cigarette use should be assessed as more data are made available.

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%, $p=0.05$).

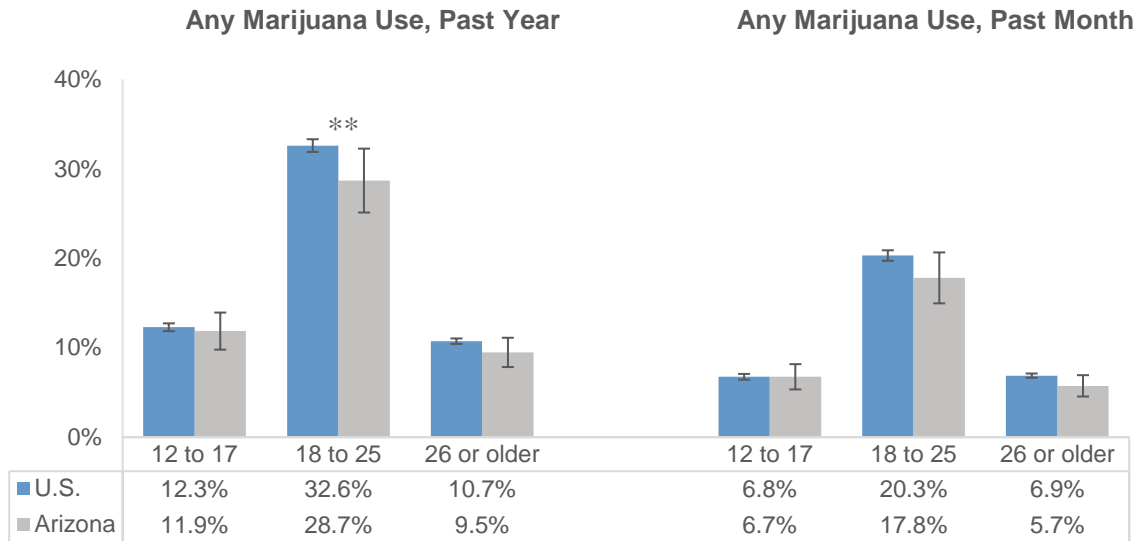
Marijuana Use

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



** 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.

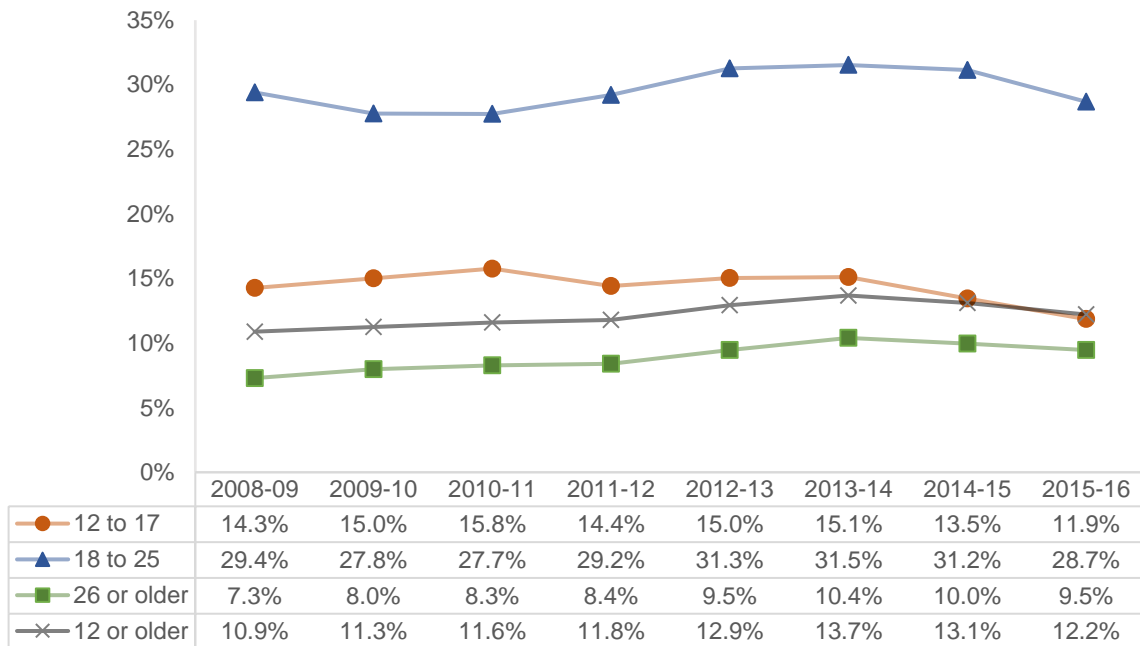
Youth Trends

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



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 identity. 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

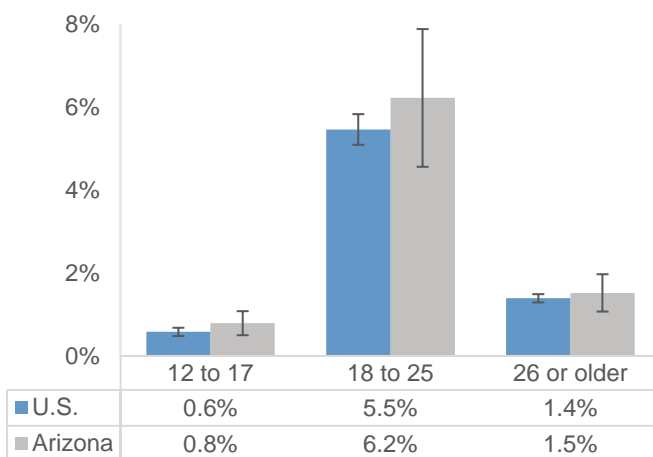
Data from 2015-2016 NSDUH estimated 118,000 (2.1%) of Arizonans 12 or older used cocaine, including crack cocaine, in the past year (See Exhibit 23). Although the estimate for past year cocaine use among those 12 or older was higher in Arizona than nationally, the difference was not statistically significant (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



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

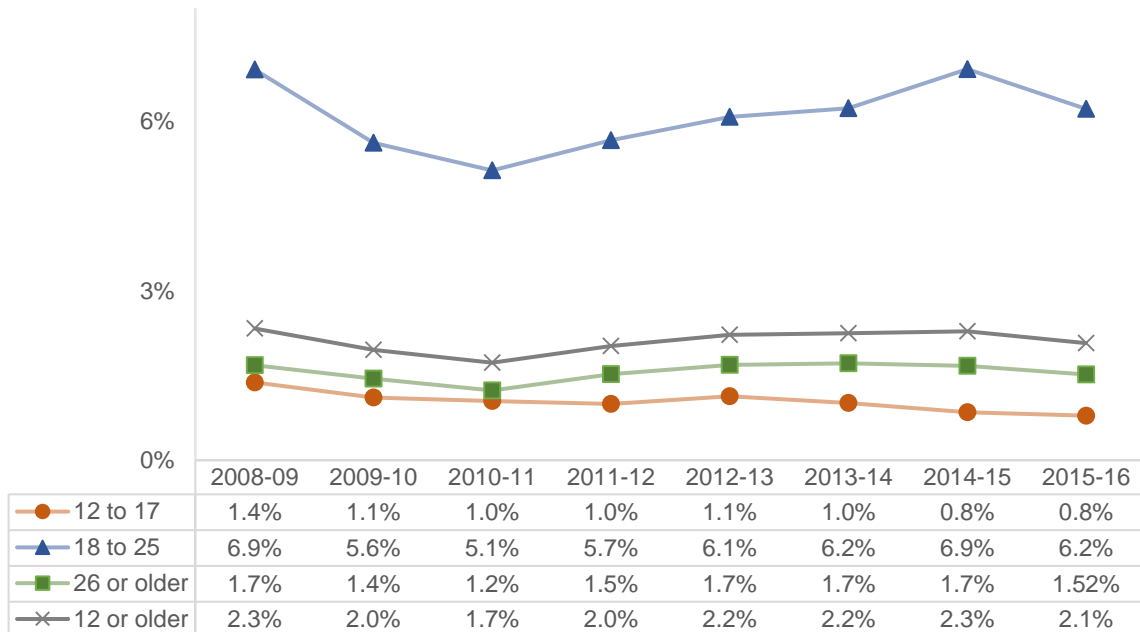


0.8%, $p=0.037$). Data from the YRBS also indicated significant declines in “ever using cocaine” among Arizona high school students from 2009 to 2017 (11.5% versus 5.6%, $p<0.001$).

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



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.



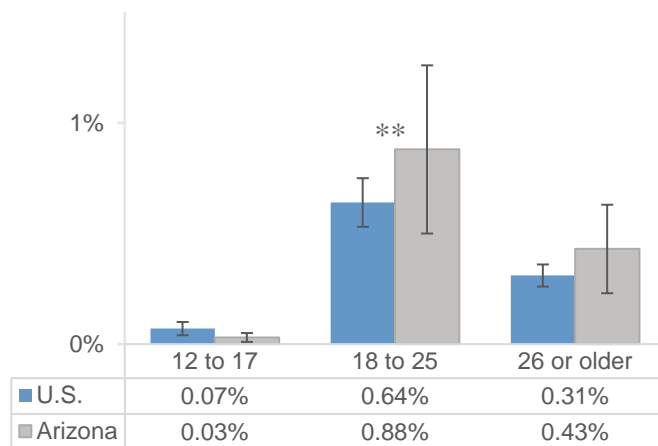
Adult Disparities

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



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.

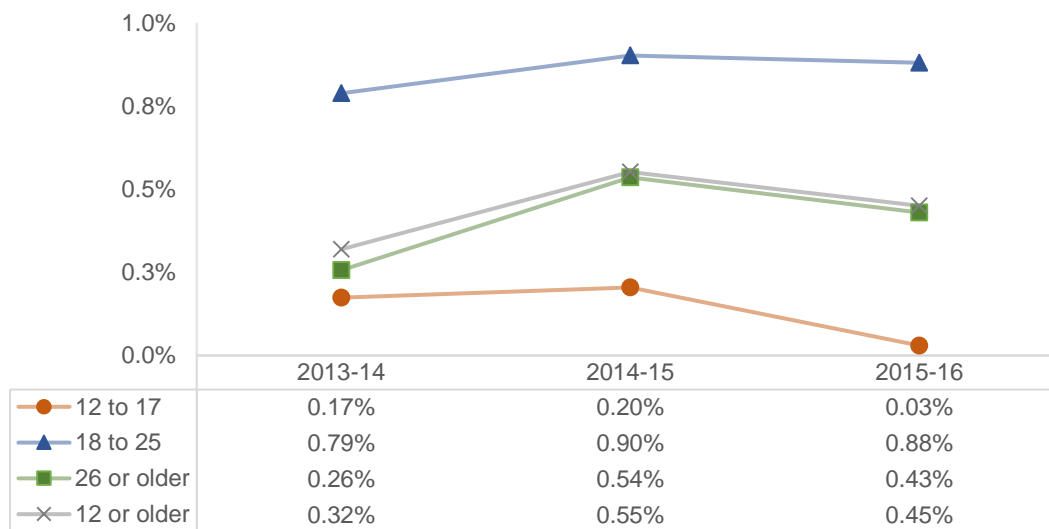
Youth Trends

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



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

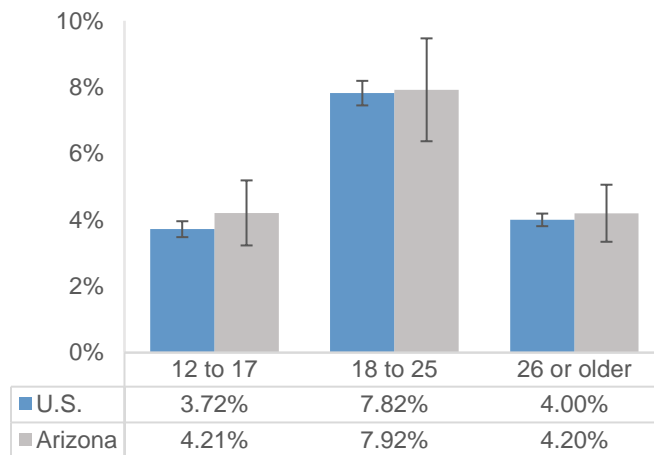
The 2015-2016 NSDUH estimated that 23,000 (4.2%) youth aged 12 to 17 misused prescription pain relievers in the past year (See Exhibit 27). The 2017 YRBS also asked about prescription pain reliever misuse among high school students, however, the measure was slightly different from NSDUH’s metric. YRBS 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

Exhibit 27. Prevalence of Past Year Pain Reliever Misuse by Age Group for the U.S. and Arizona, 2015-2016



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

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.

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.

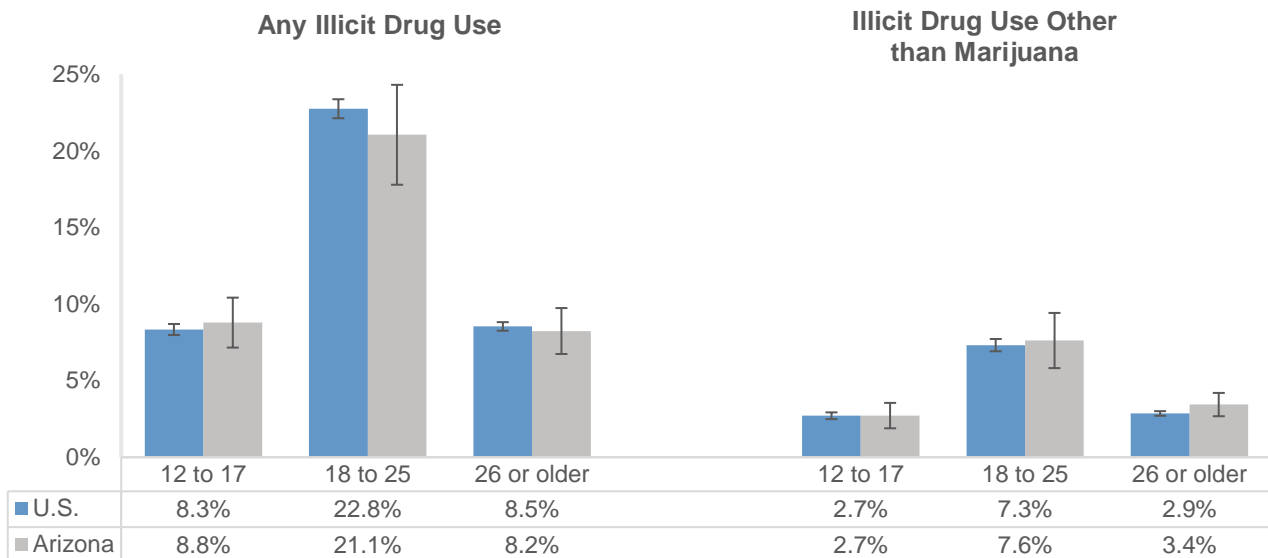
Youth Prevalence

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



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

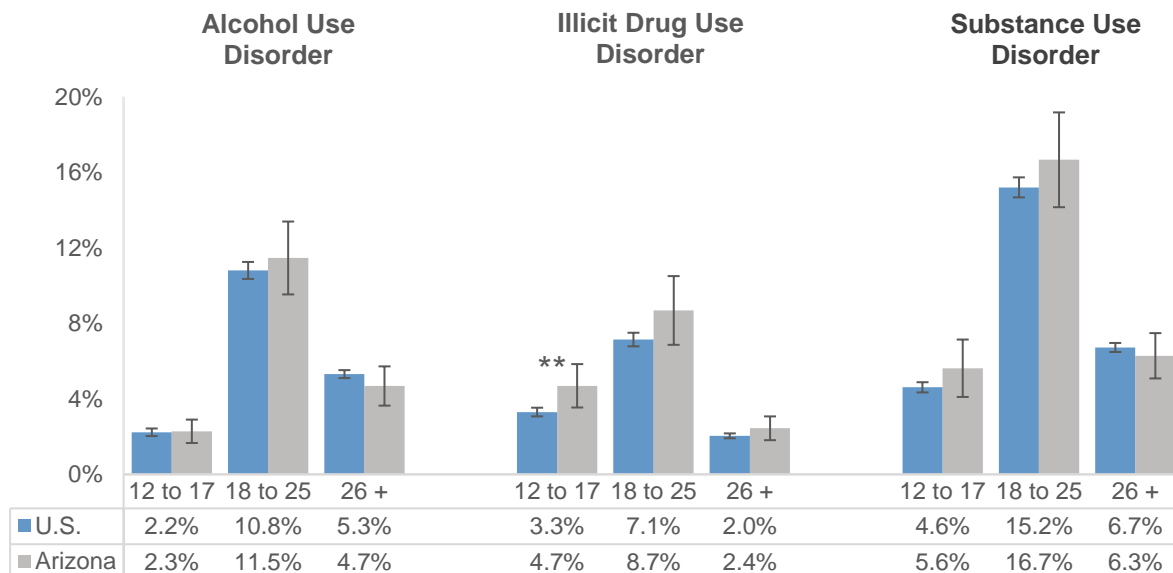
Data were not available to estimate disparities in past month illicit drug use for youth or adults.

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



** 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

Indicator	Past Month Prevalence							Past Year Prevalence				Lifetime Prevalence			
	Binge Alcohol	Tobacco Alcohol	Ciga-rette	Electronic Vapor	Mari-juana	Any Illicit Drug	Mari-juana	Cocaine	Heroin	Pain Reliever Misuse	Cocaine	Heroin	Metham-phetamine	Pain Reliever 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

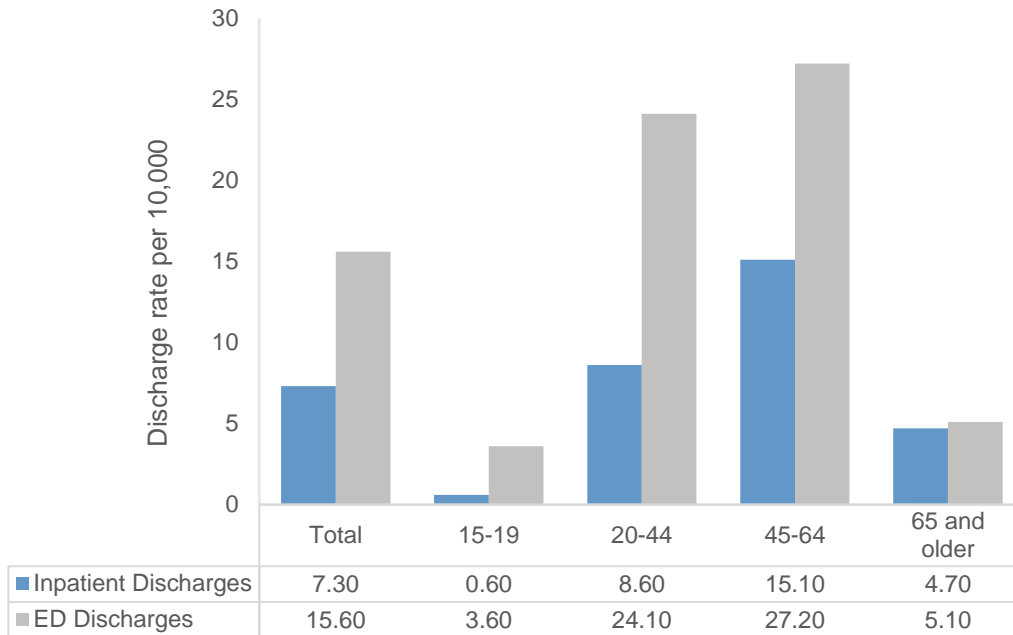
The Arizona Department of Health Services publishes discharge data on alcohol and drug related hospitalizations and Emergency Department (ED) visits. For both inpatient and ED discharges, the unit of analysis is the discharge event (i.e., individuals with multiple discharges are enumerated more than 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 to 64, 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



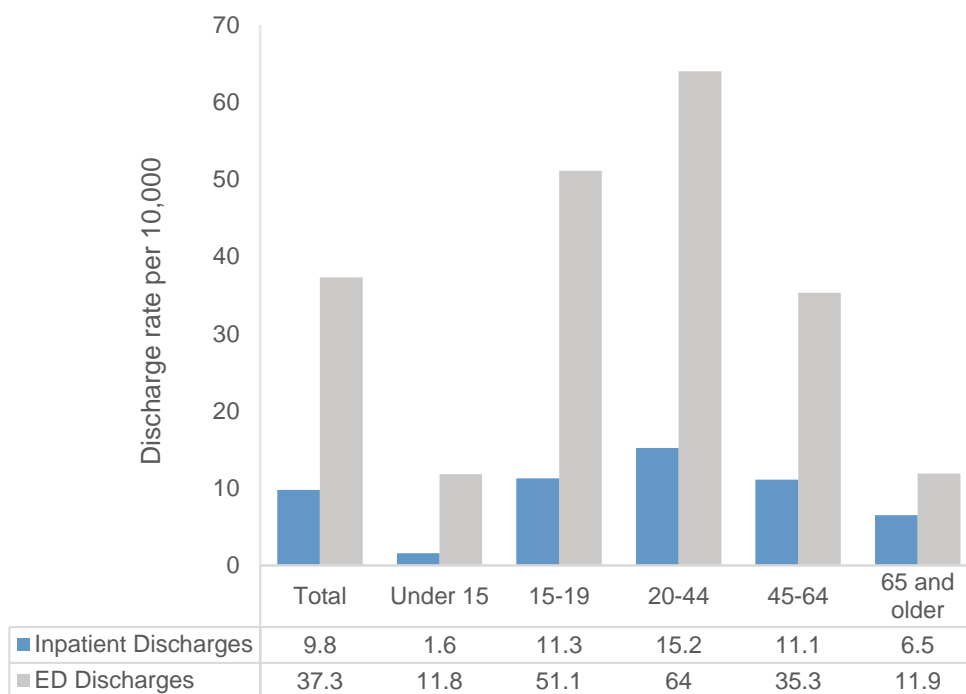
Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

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



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.



Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics*.

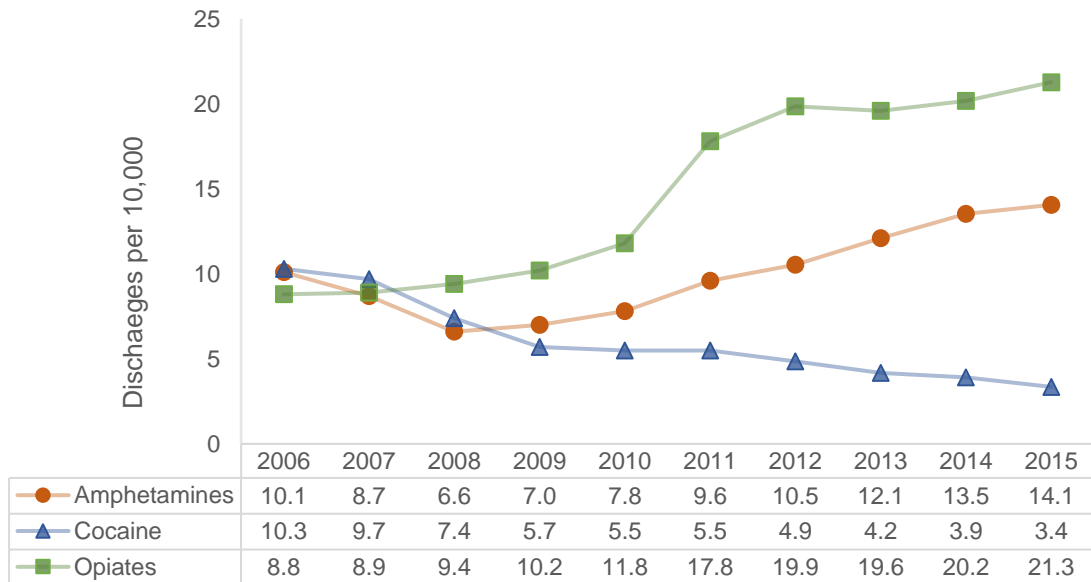
Trends in Discharge Rates for Drug Dependence, Abuse or Misuse

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.



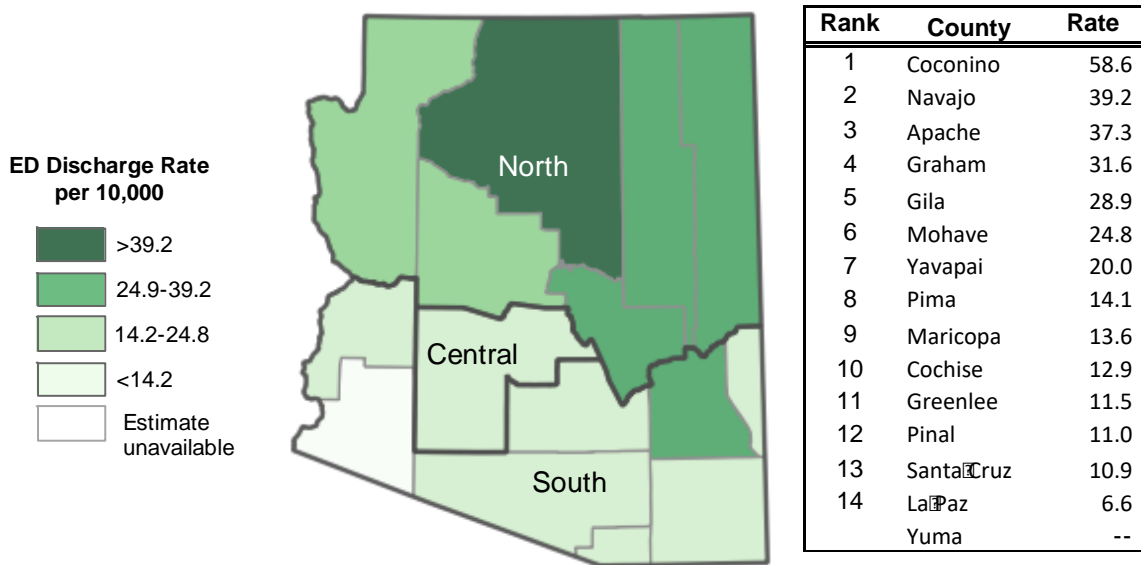
Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) Hospital inpatient discharges and emergency room visits statistics.

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.

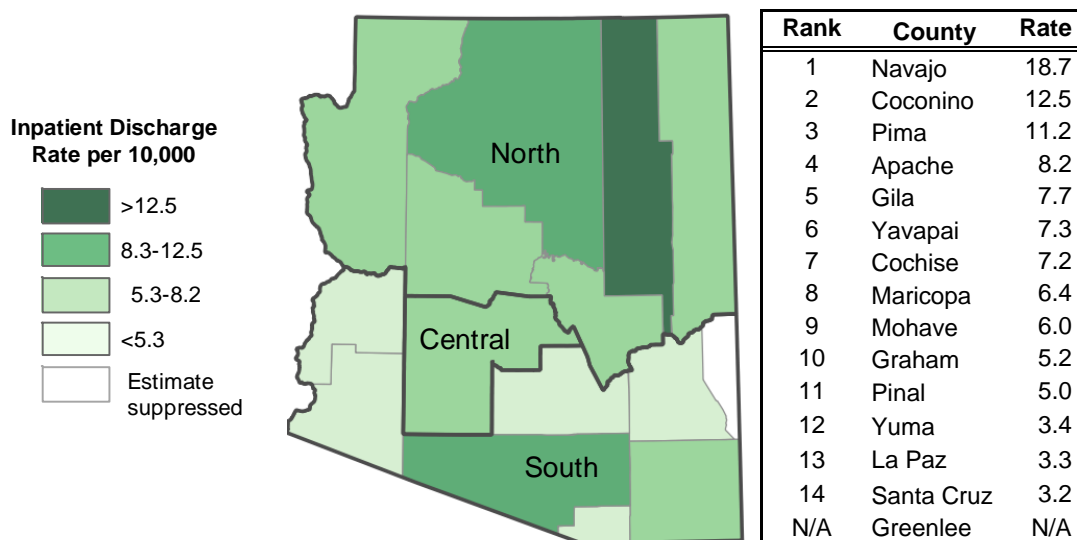


Exhibit 35. Emergency Department Discharge Rates per 10,000 for Alcohol Abuse as First-Listed Diagnosis, by Arizona County, 2016



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



Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2016) *Hospital inpatient discharges and emergency room visits statistics.*

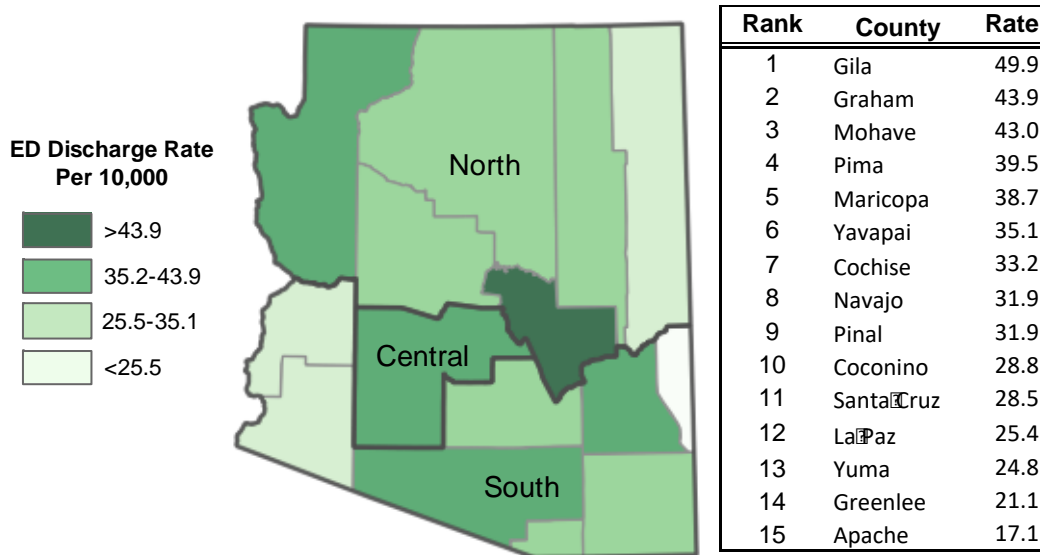
Discharge Rates for Drug Dependence, Abuse or Misuse by Arizona County

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



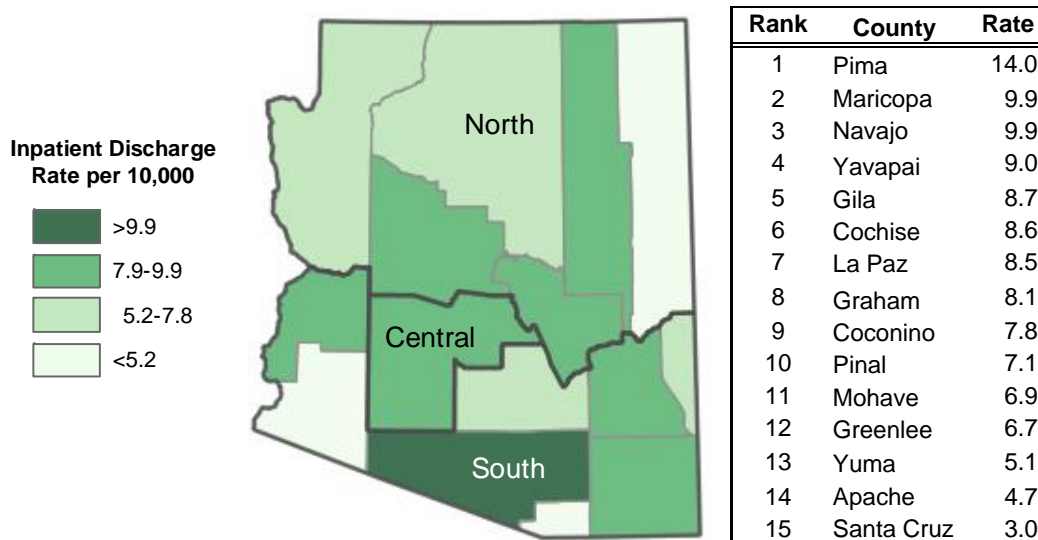
the lowest rate (17.1 per 10,000, 123 discharges) (See Exhibit 37). For hospitalizations, Pima County had the highest rate of discharges (14.0 per 10,000, 1,414 discharges) and Santa Cruz County had the lowest rate (3.0 per 10,000, 15 discharges) (See Exhibit 38).

Exhibit 37. Emergency Department Discharge Rate per 10,000 for Drug Dependence, Abuse or Misuse as First-Listed Diagnosis, by Arizona County, 2016



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



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 Diagnosis 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

Race/Ethnicity	Inpatient Discharge		ED Discharge	
	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

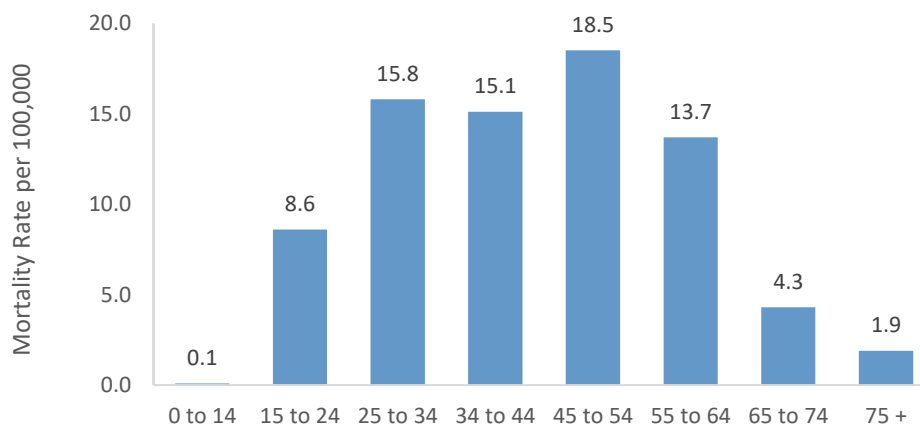
The age-adjusted alcohol-induced mortality rate in Arizona in 2016 was 17.6 per 100,000. According to the CDC data from 2015, Arizona ranked 4th in the country for alcohol poisoning deaths with an age-adjusted rate of 1.87 per 100,000 people (CDC, 2015). Arizona also ranked 4th in death rates from chronic 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 11.1⁴. 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

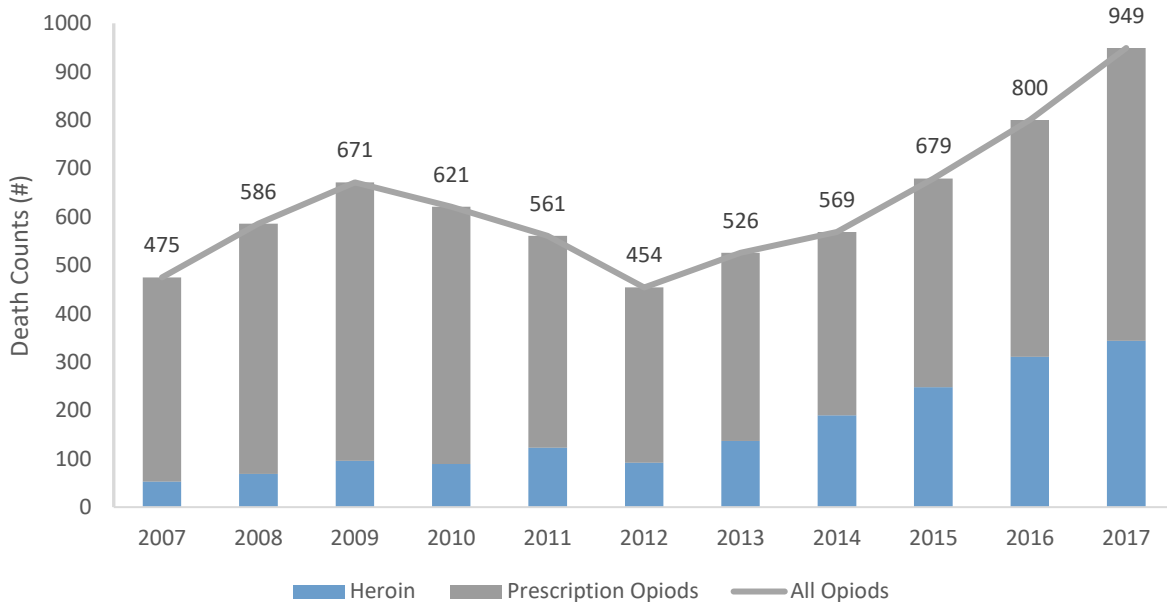
Trend data were available for mortality counts (not rates) for drug-induced deaths. In Arizona, the overall death count increased overtime from 910 in 2006 to 1,470 in 2016. Mohave County saw the greatest increase in deaths in this time from 20 to 70 (250%), based on 2-year averages (2006-2007 and 2015-2016, 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

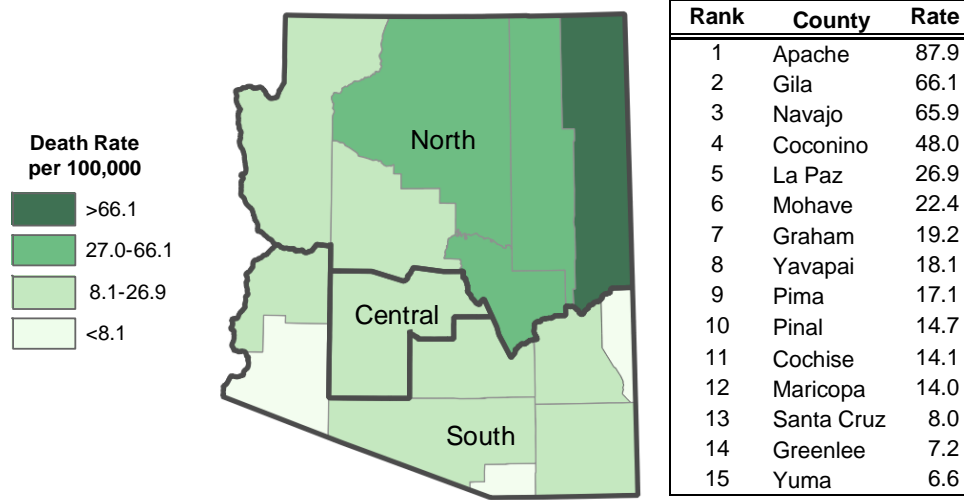
In 2016, Apache County had the highest alcohol-induced death rate (87.9 per 100,000), and Yuma County had the lowest death rate (6.6 per 100,000) (See Exhibit 44). Chronic liver disease and cirrhosis death rates were highest in La Paz County (56.8 per 100,000) and Gila County (55.9 per 100,000), with 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).

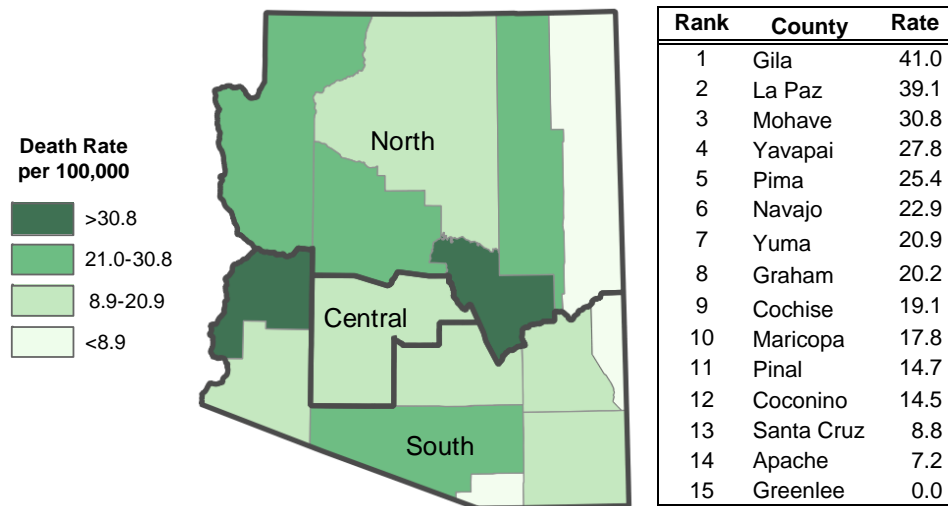


Exhibit 44. Alcohol-Induced Death Rates per 100,000 by Arizona County, 2016



Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

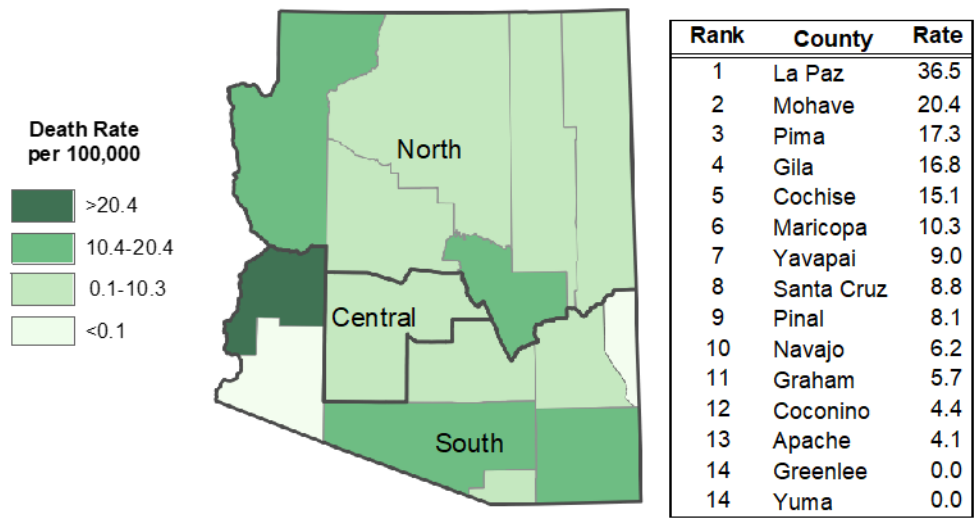
Exhibit 45. Drug-Induced Death Rates per 100,000 by Arizona County, 2016



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



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.

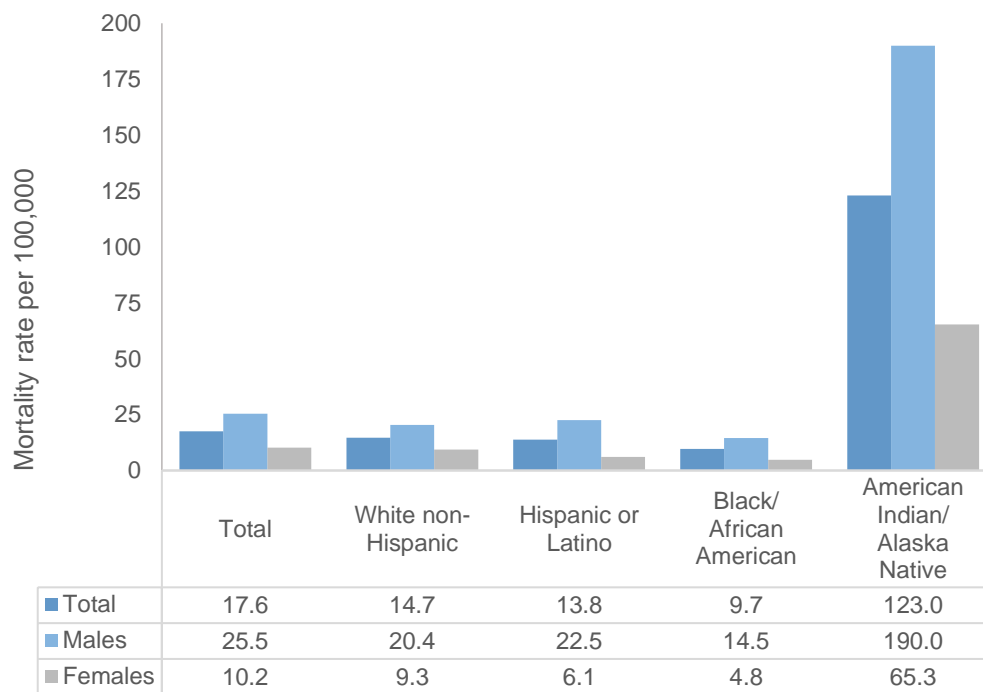
On January 26, 2018, Governor Ducey signed the Arizona Opioid Epidemic Act. The public health emergency ended May 29, 2018. The emergency response and next steps are summarized in the [Arizona Opioid Emergency Response Report- June 2017 to June 2018](#).



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



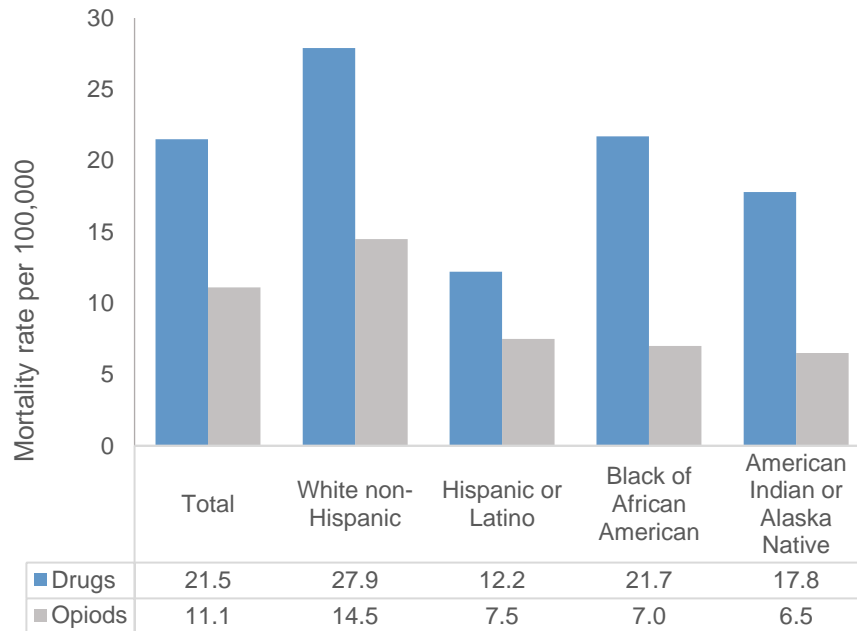
Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

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



Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics

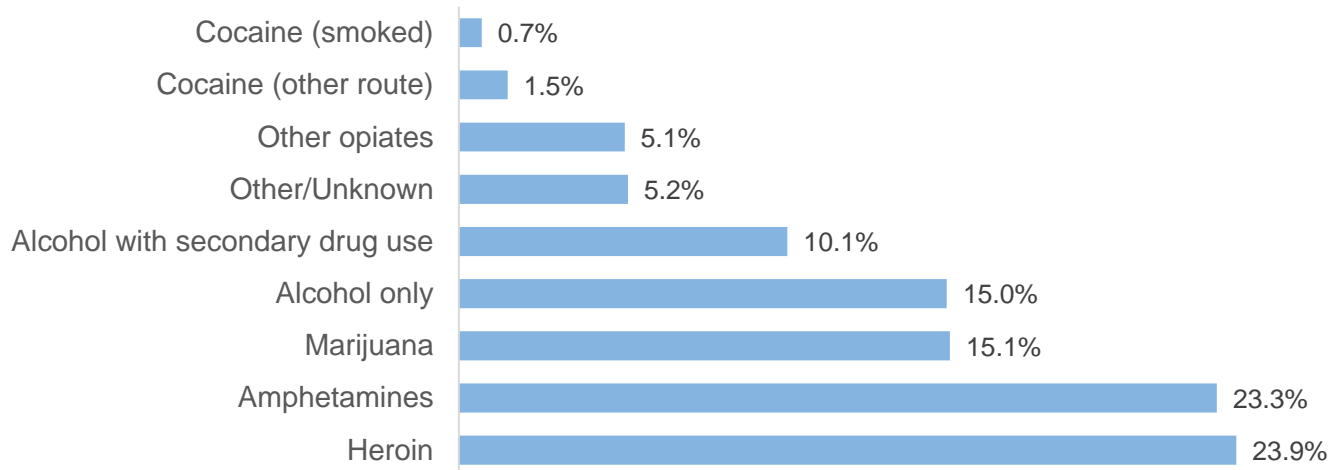
Substance Use Treatment Admissions

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.

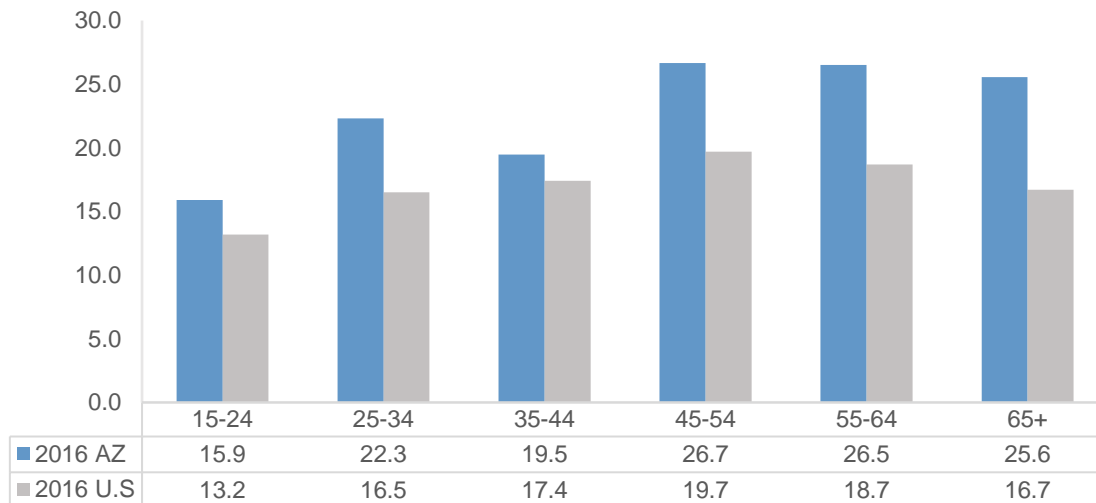
Suicide Death Rates

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



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 ($p = < 0.00001$) (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

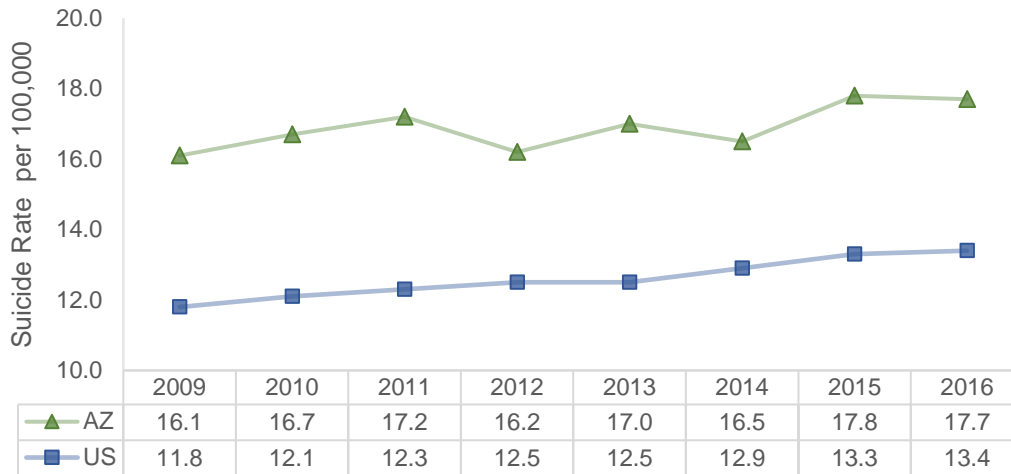
Source: Department of Veterans Affairs, Veterans Health Administration, Office of Mental Health and Suicide Prevention. Veteran Suicide Data Report, 2005–2016. September 2018.

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

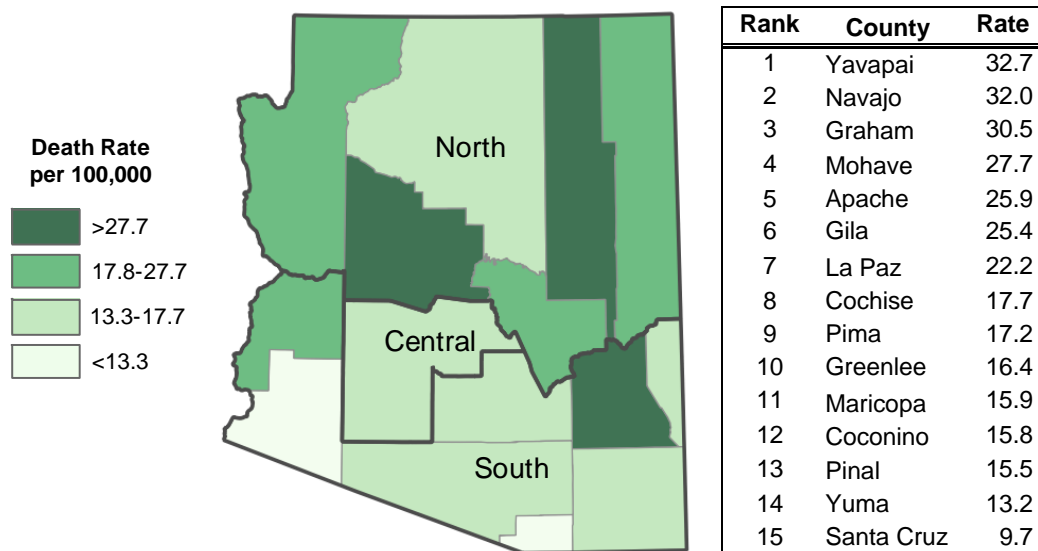


Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016) *Intentional self-harm (suicide), Arizona, 2006-2016.*

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



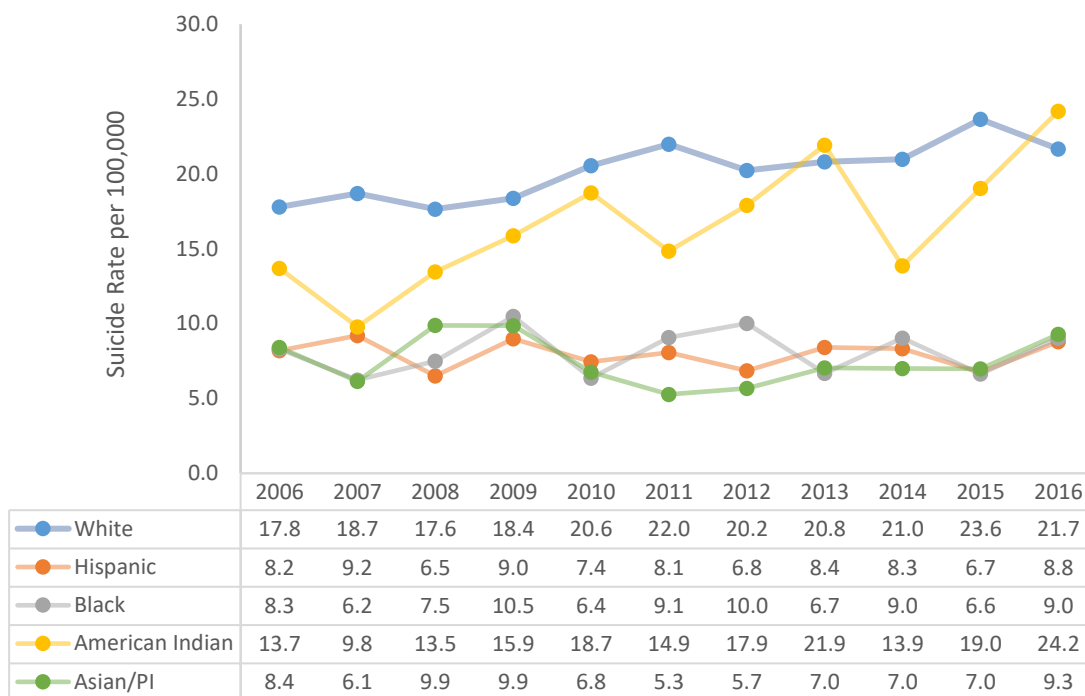
Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. Age Adjusted Mortality Rates for Selected Leading Causes of Death, 2016



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 21.7 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



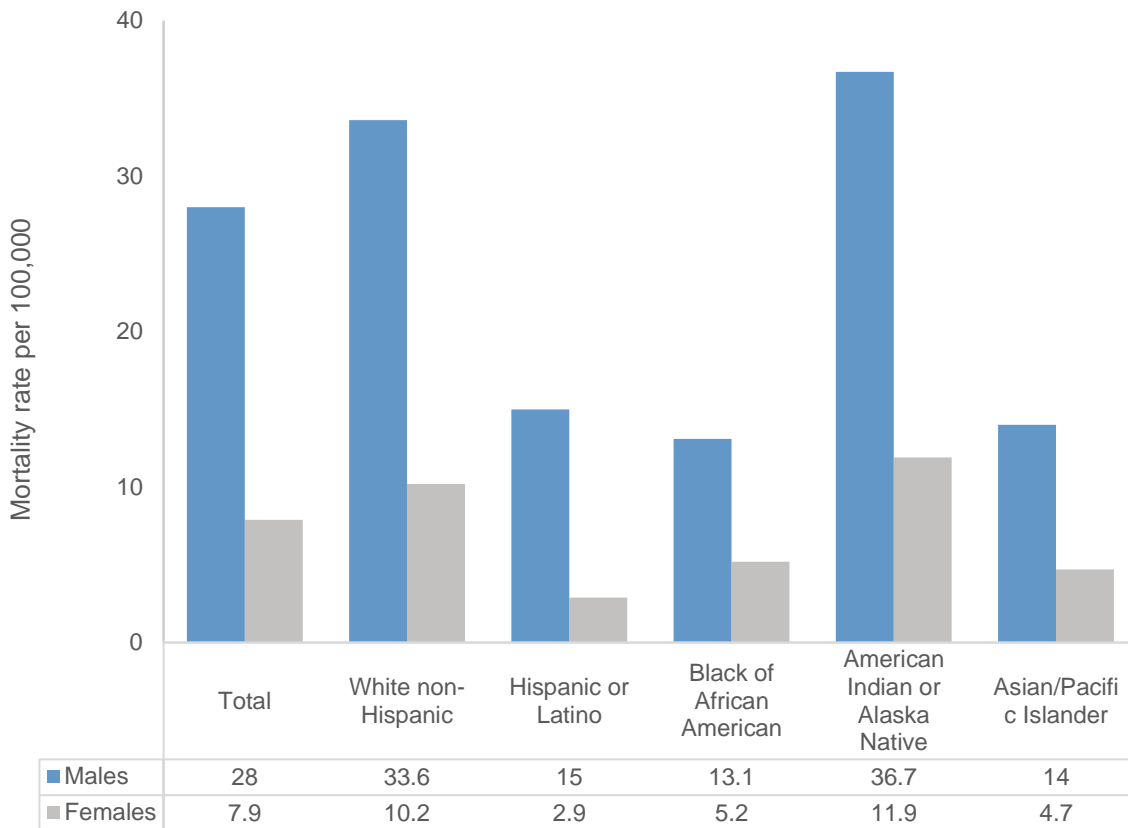
Source: Arizona Department of Health, Bureau of Public Health Statistics, Population Health and Vital Statistics. (2006-2016) *Intentional self-harm (suicide), Arizona, 2006-2016*.

- **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



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.

Youth Prevalence of Alcohol Impaired Driving

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.

Adult Prevalence of Alcohol Impaired Driving

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 difficulty 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

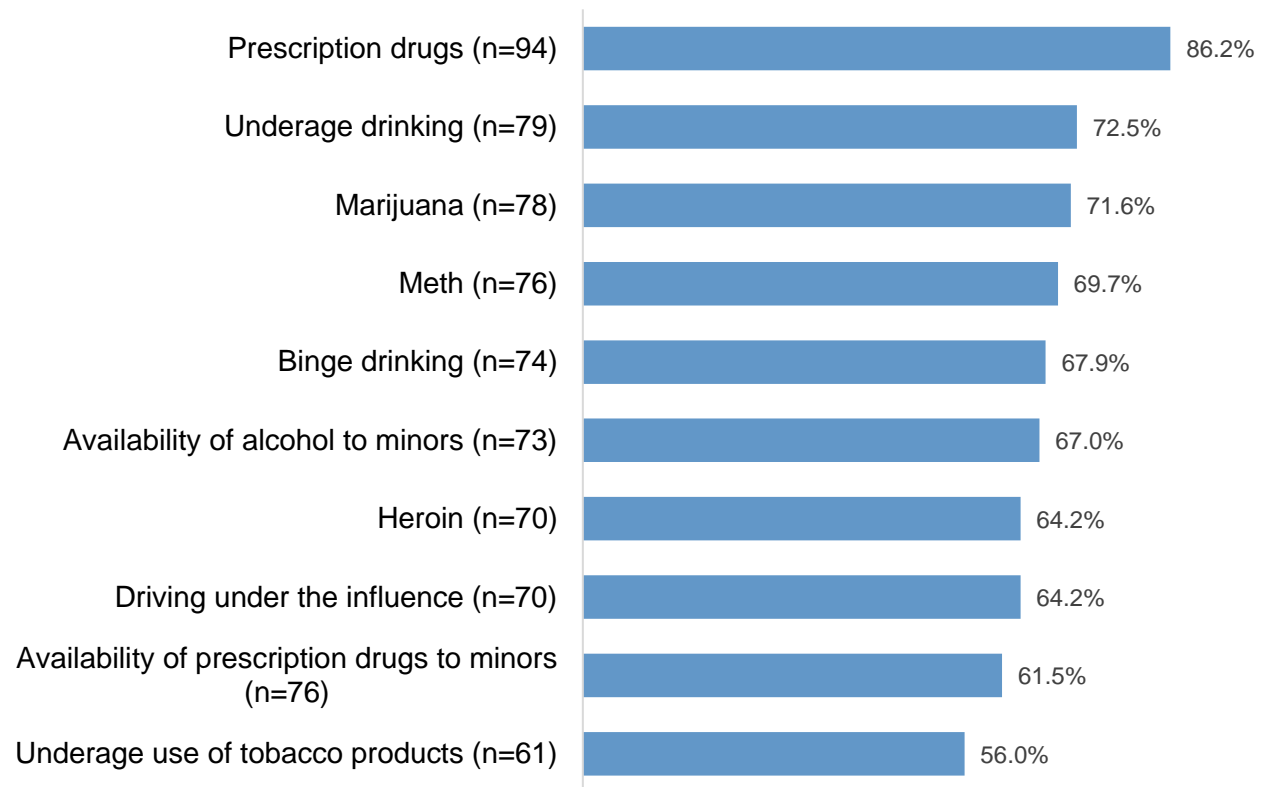


thinner, benzodiazepines, spice (synthetic marijuana) and prescription drugs. Respondents talked about the unintentional overdose of prescription medication often seen in older adults in their communities. For youth, they acquire substances from friends at school, and are sometimes offered them for free. 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 Child 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 programming 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).

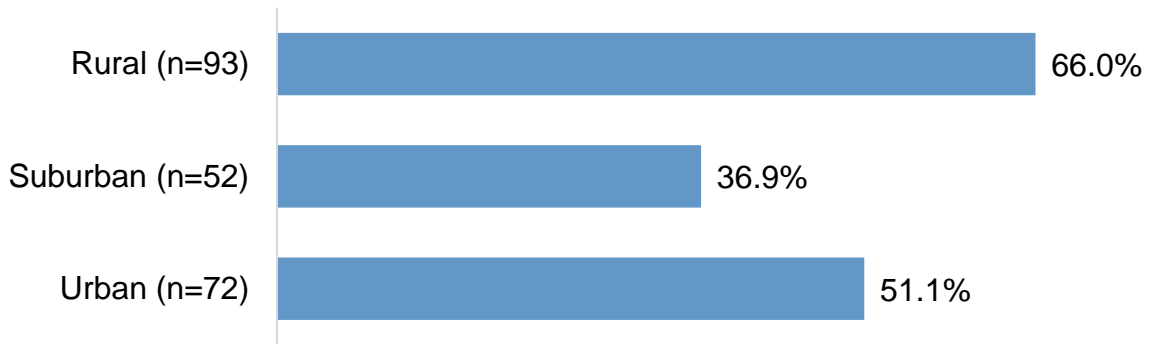
Exhibit 63. Counties where Respondents Engage in Substance Use Prevention (N=141)

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 Reconciliation 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 Rx’s 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:

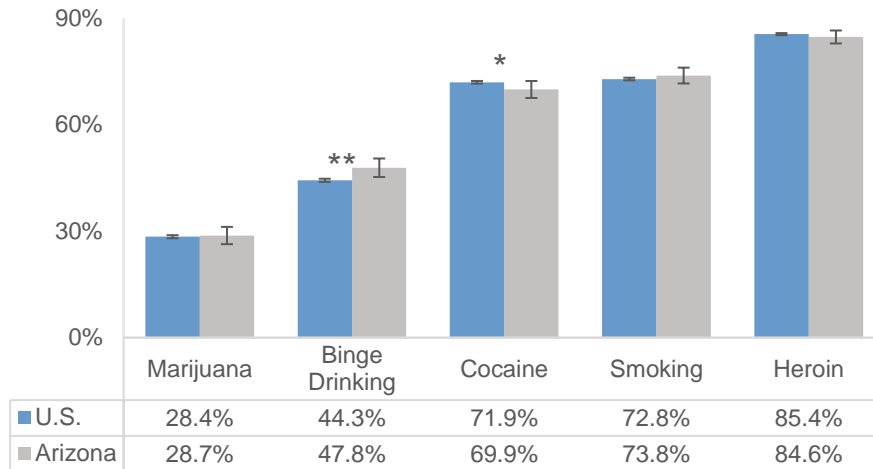
- smoking marijuana once a month
- drinking five or more alcoholic beverages once or twice a week
- using cocaine once a month
- smoking one or more packs of cigarettes a day
- trying heroin once or twice

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



Difference between the prevalence estimate for the total U.S. and Arizona is marginally significant at $p<0.10^$, or significant at $p<0.05^{**}$

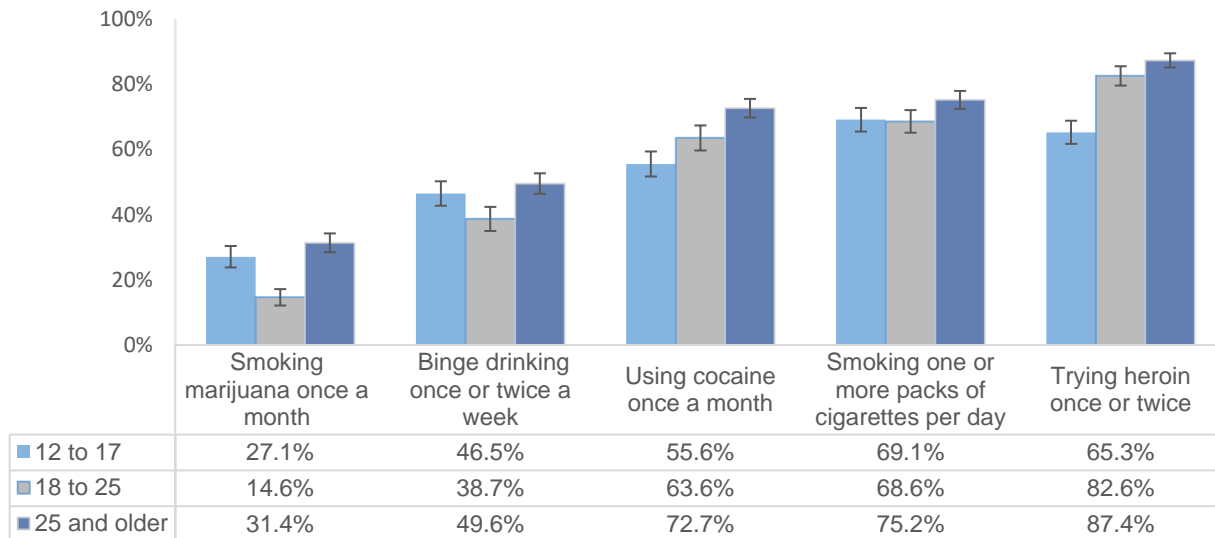
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015- 2016

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



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

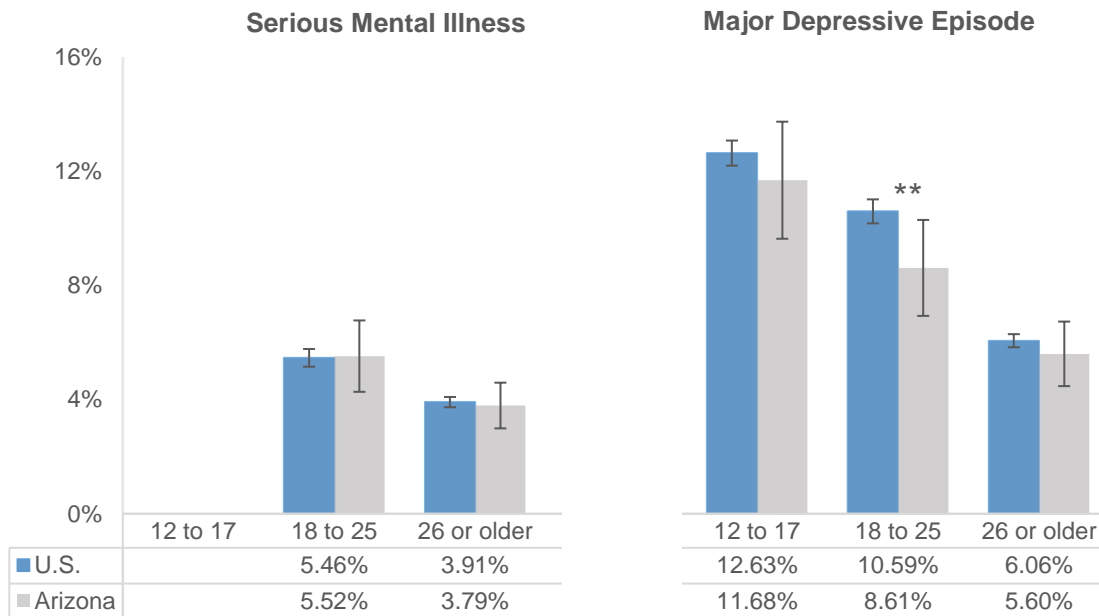
According to data from the NSDUH, the prevalence of MDE peaked for those aged 12 to 17, with an estimated 11.7% of youth reporting past year MDE. This did not statistically differ from national estimates (12.6%) (See Exhibit 76). Caution should be used when comparing NSDUH estimates with MDE between 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



**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

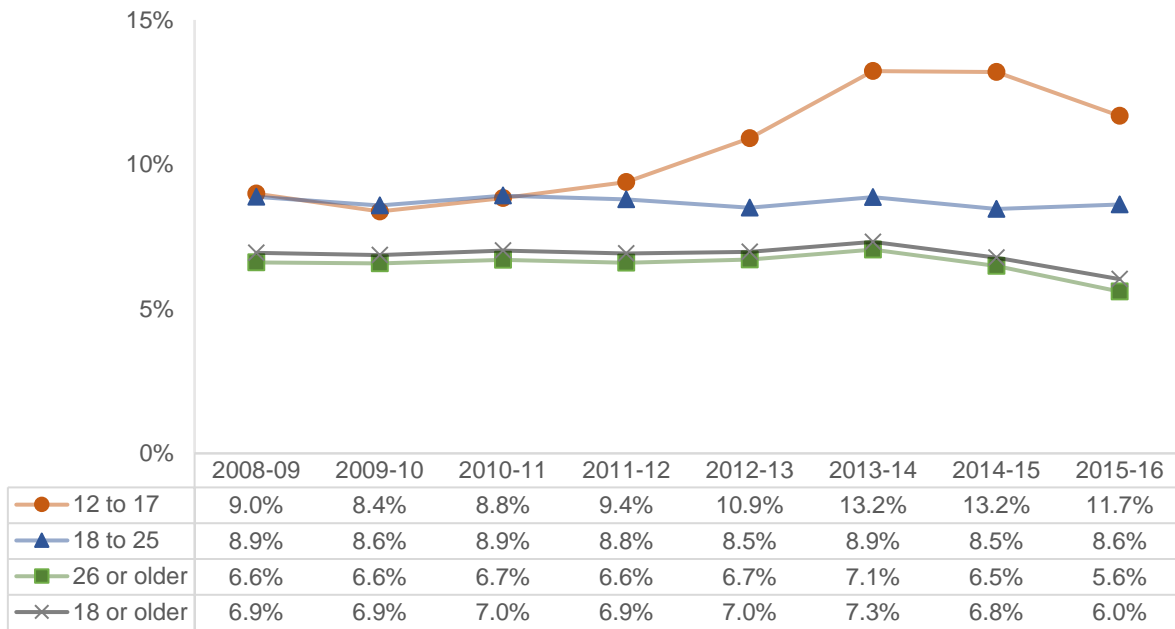
Data from the 2015-2016 NSDUH indicated the prevalence of SMI was highest for those aged 18 to 25 (5.5%) and then decreased slightly for those aged 26 or older (3.8%)(See Exhibit 76). SMI estimates in Arizona did not statistically differ from national estimates. MDE also decreased with increasing age (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.



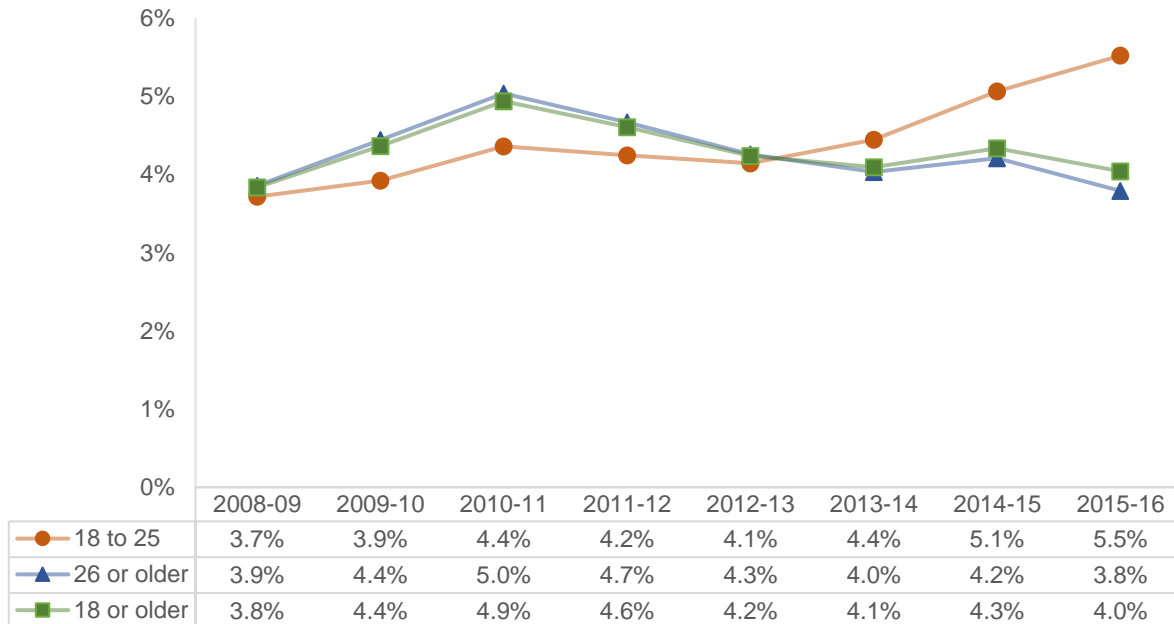
Exhibit 78. Trends in Prevalence of Past Year Major Depressive Episode in Arizona by Age Group, 2008-2016



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



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

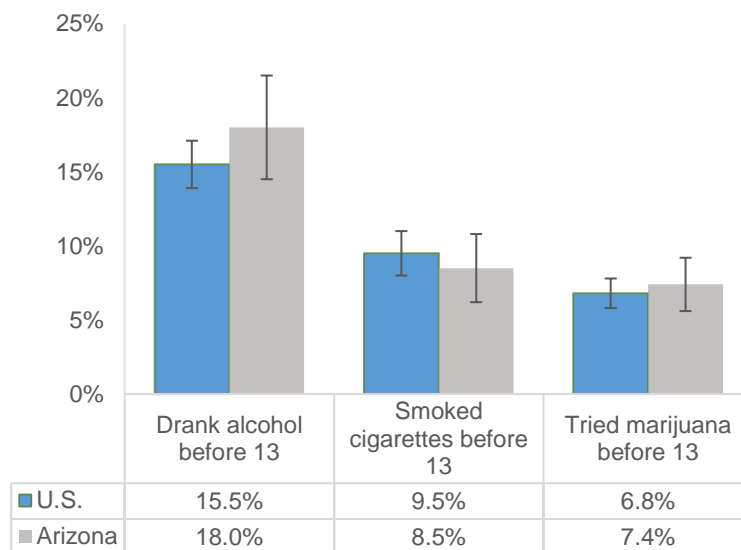
An estimated 18.0% of Arizona high school students reported that they had their first drink of alcohol, other than a few sips, before the age of 13 (See Exhibit 80). Arizona's estimate of early alcohol use did not differ significantly from the national estimate. Trend analyses reveal there were significant 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



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	8 th Grade	10 th Grade	12 th 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...	8 th Grade	10 th Grade	12 th 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

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)

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.

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).

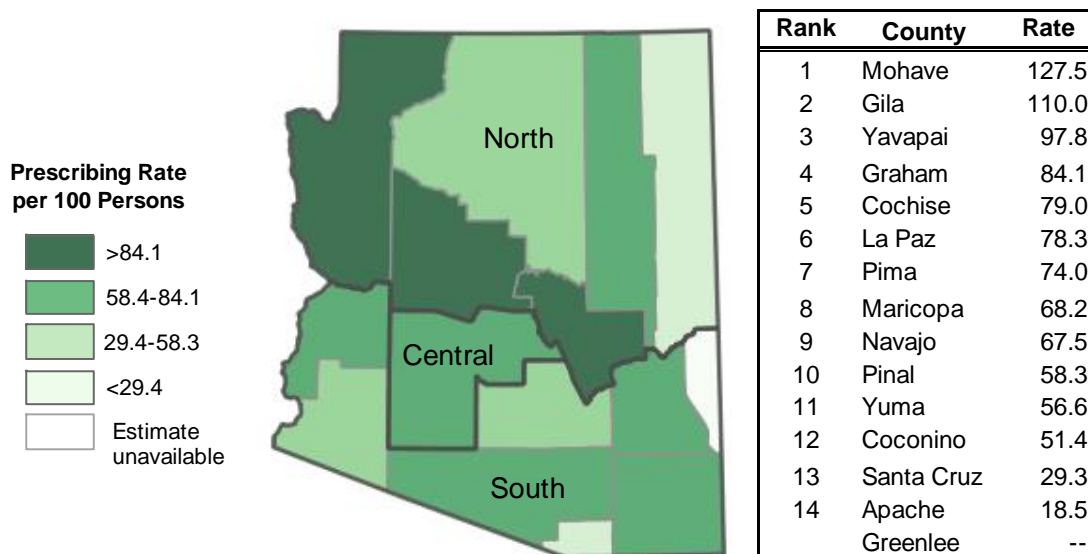
The CDC provides data on opioid prescription rates at the county, state and national levels. These data come from the QuintilesIMS Transactional Data Warehouse, which provides “estimates of the number of opioid prescriptions dispensed in the United States based on a sample of approximately 59,000 pharmacies, 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



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 unsustainable 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 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 than 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 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 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 been 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).

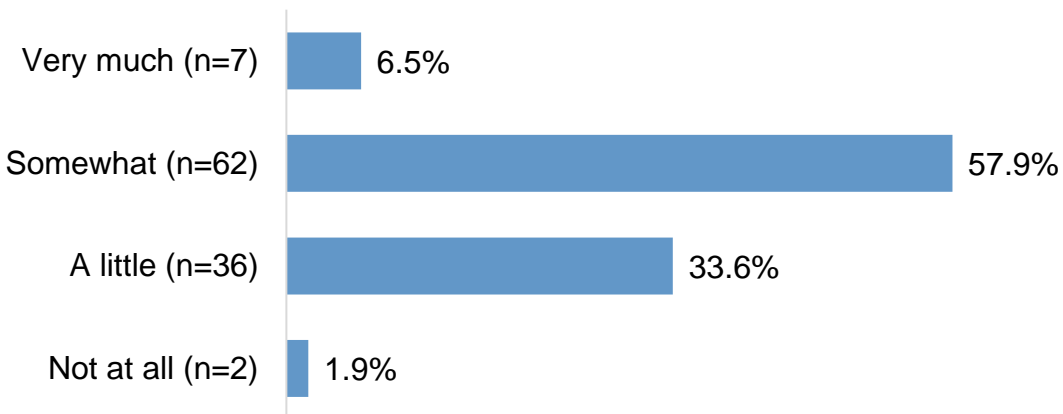


Exhibit 86. Types of Resources Needed to Help their Community be More Effective in Substance Use Prevention Efforts (N=108)

	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 devalued. 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 Clinic	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
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 – Parents Commission grant
Safe Out LGBTQ Youth Coalition	Maricopa County RBHA: Mercy Care	LGBTQ young adults aged 13-26	Alcohol, marijuana, prescription drugs	Education, collaboration, outreach & connection and community involvement	Terros Health	SABG



Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas and suicide	Strategy	Key Partners	Funding Sources
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, veterans, Native Americans, working-aged men; the focus is on these high-risk groups that	The coalition addresses substance use as part of suicide prevention.	The Coalition supports evidence-based programs, such as ASIST, safeTALK, QPR, Signs of Suicide, and another 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	The key partners are organizations who are invested in the mission of suicide prevention -i.e. behavioral health and crisis centers, hospitals, schools, state entities.	The Coalition doesn't receive specific funding, although is partnered with other suicide prevention agencies who receive funding from Mercy Care. The coalition



Appendix D: Arizona Statewide Community Substance Use Prevention Inventory

Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
		are specifically affected by 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 Jeremiah Memorial 5K Walk/Run to Support Survivors of Suicide.		receives funding through a state-wide conference that is sponsored/supported 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 Mountain High School, Maryvale Community Center, Substance Abuse Coalition Leaders of Arizona	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
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 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.	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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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 Needles, CA)	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 religious groups. Each month the members brainstorm ways to reach all ages within the community.	Bullhead City Police & Fire, many members of the medical community.	Donations and a small amount of grant funding
South Mountain Working to build Opportunities, Resources, Knowledge, and Skills (WORKS)	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



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Coalition						
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-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	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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				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 Assessment and Referral to Treatment. Outreach activities include health fairs, law enforcement events, Students Against Destructive Decisions (SADD)	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, Douglas/Bisbee Police Departments	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) Prevention for States grant.



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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)
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	Gila County RBHA: Steward Health Choice Arizona	Youth (under 21 years old)	Underage drinking			SAMHSA (STOP Act grant)



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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
(DIG YA)						
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 - Church of the Ascension, Presbyterian Church, Shepherd of the Desert, Fort McDowell Yavapai Nation	Drug Free Communities Grant - SAMHSA
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,	Cenpatico Native American Advancement Foundation



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					Gu Vo District and Community Councils	
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.
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	Parents, Sierra Vista Schools, Youth, Cochise County Sheriff's Department, Cochise County Health Department, Lori's Place, Cochise County Youth Probation, Cochise County	Substance Abuse Block Grant



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				and Empowerment Conference, Red Ribbon Week Brain Power Presentations for Elementary Schools, National Drugs and Alcohol facts week, International Overdose Awareness day.	Superintendent.	
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/comm unity	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, National Prevention Week, Junior Leadership Academy, Shoe Drive Project, Town Lighting, Appeal Letter Mailoffs etc.	We have 12 Sector Representatives. Youth, Parents, Business Community, Media, Schools, Youth-serving organizations, Law enforcement, Religious, Civic & volunteer, Healthcare professionals, Local govt. & others such as Recovery Program	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 2018.



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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
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
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)



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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	
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	Power Parents, Marijuana 360, RX 360, youth coalitions, multiple strategies across multiple sectors	Rural community members (Amado area) and organizations	



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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
			issues, local medical marijuana grow sites			
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						
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



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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
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		
Pinal Gila Council for Senior Citizens - Arizona City Triad						
MSTEPP - STR Opioid Prescription Abuse	Mohave County RBHA: Steward Health Choice Arizona			Community Lunch and Learn Events		



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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
Prevention						
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 and Control	Statewide	Youth	Underage drinking	Arizona strategies "Tool Kit"		GOYFF – SABG Prevention Funding

Universities

Arizona State University



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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
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
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



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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
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



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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)
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)



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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
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
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



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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	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

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		Program generated funds



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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				situations.		
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
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		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
				<p>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 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</p>		



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Name	County/ Target Area	Target Population	Priority Areas	Strategy	Key Partners	Funding Sources
				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	<p>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:</p> <ul style="list-style-type: none"> • 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, Rx360, Marijuana, and Underage Drinking • SafeTalk trainings • ASIST trainings 	<p>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</p>	<p>Mercy Care; GOYFF – Parents Commission grant</p>





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 Lives 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
Casualty 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



Theme	n
Follow up data collection (e.g. reentry success)	1
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

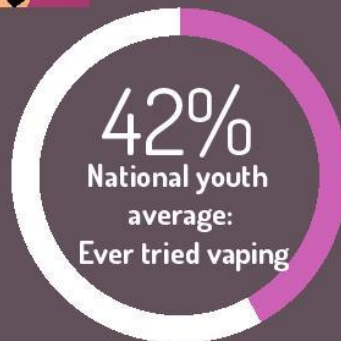


Appendix G: Short Reports (Youth, Veterans, Older Adults, LGBTQ)



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

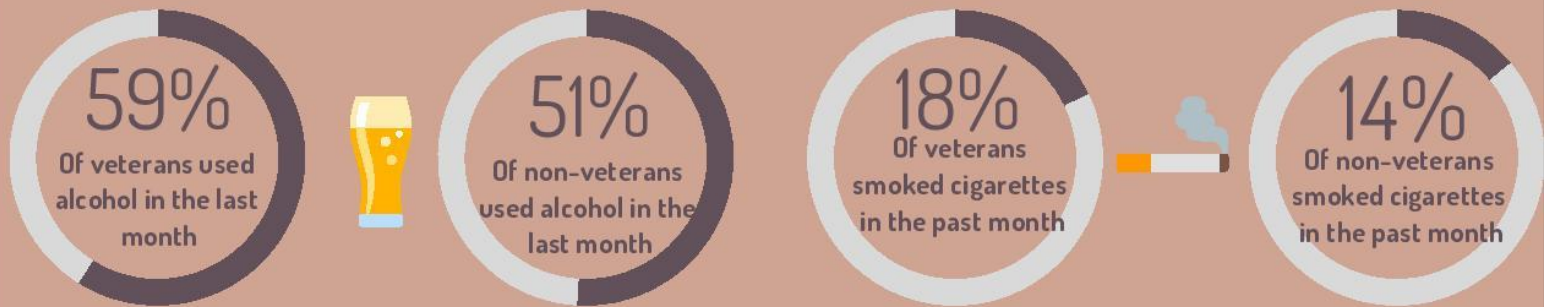
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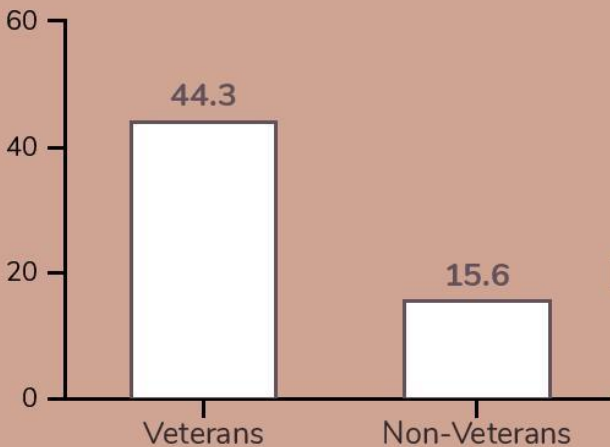
Substance Use & Suicide: Veterans in Arizona



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.

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

More education and peer support before discharge and right after to let vets know the resources available for them

Educate VA Doctors about opioid issues and how to approach patients individually

Improve access and reduce stigma of mental health services for vets

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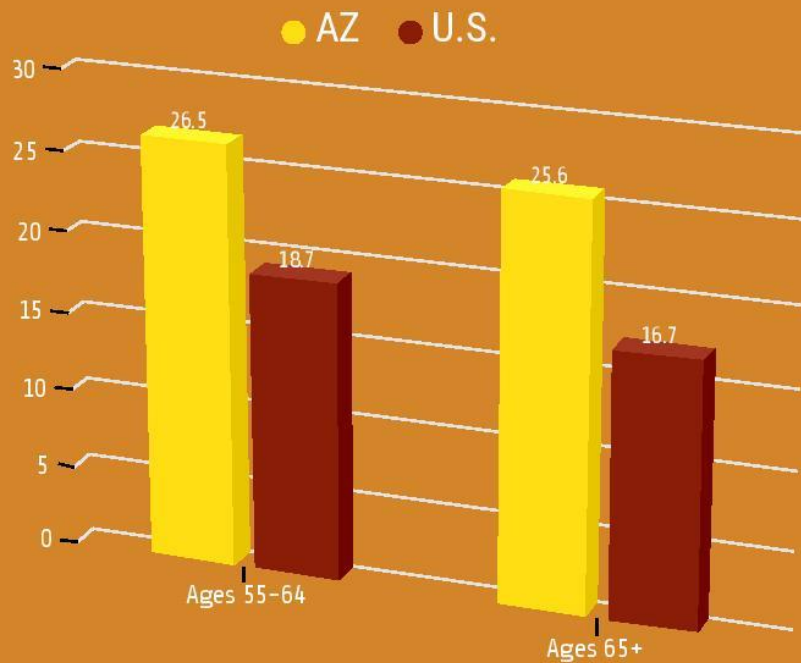
Substance Use & Suicide: Older Adults in Arizona



★ **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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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.

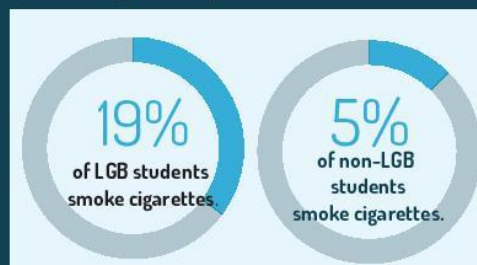
32%
of LGB students currently binge drink

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

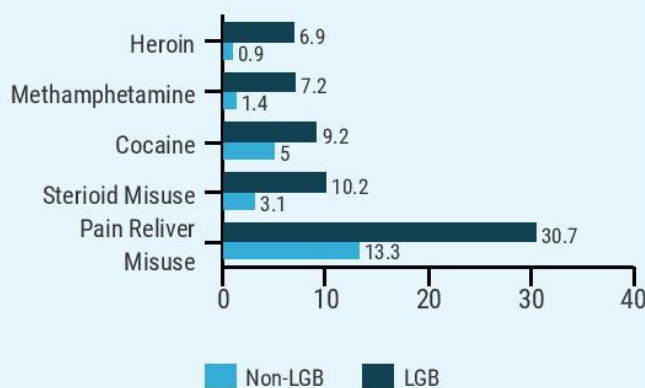
Nearly 1 in 5 LGB high school students report that they currently smoke cigarettes, which is 4 times higher than the prevalence of cigarette smoking among non-LGB students



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%).

Lifetime Drug Use by Sexual Identity (%)



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 $p < 0.10$, except for differences in lifetime cocaine use which had a p -value of 0.13.

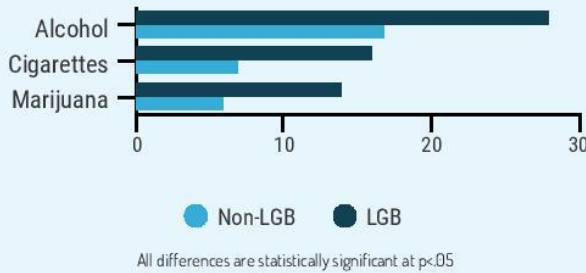
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Substance Use: Risk Factors and Consequences

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 (%)



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% vs 18%), and
- ever been forced to have sexual intercourse (23% vs 6%).

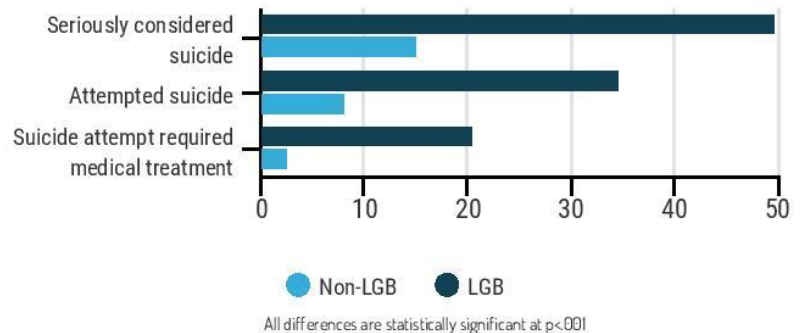


70% of LGB students reported **persistent feelings of sadness or hopelessness in the past year** compared to 32% of their non-LGB peers

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 (%)



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.pdf>

III: Expenditure Reports

Table 2 - State Agency Expenditure Report

This table provides a report of SABG and State expenditures by the State Substance Abuse Authority during the State fiscal year immediately preceding the federal fiscal year for which the state is applying for funds for authorized activities to prevent and treat substance abuse. For detailed instructions, refer to those in the Block Grant Application System (BGAS). **Include ONLY funds expended by the executive branch agency administering the SABG.**

Expenditure Period Start Date: 7/1/2018 Expenditure Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A. SA Block Grant	B. MH 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
1. Substance Abuse Prevention* and Treatment	\$30,866,408		\$0	\$11,744,807	\$0	\$0	\$0
a. Pregnant Women and Women with Dependent Children*	\$3,500,779						
b. All Other	\$27,365,629			\$11,744,807			
2. Substance Abuse Primary Prevention	\$7,542,444						
3. Tuberculosis Services							
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV)**							
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for First Episode Psychosis (10% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$1,580,164			\$433,534			
11. Total	\$39,989,016	\$0	\$0	\$12,178,341	\$0	\$0	\$0

*Prevention other than primary prevention

**Only designated states as defined in 42 U.S.C. § 300x-24(b)(2) and 45 CFR § 96.128(b) for the applicable federal fiscal year should enter information in this row. This may include a state or states that were previously considered ?designated states? during any of the three prior federal fiscal years for which a state was applying for a grant. See EIS/HIV policy change in SABG Annual Report instructions.

Please indicate the expenditures are actual or estimated.

Actual Estimated

Please identify which of the information in is estimated rather than actual:

Column A & D are actual expenditures for SFY2019. The State will provide actual expenditures for Column C & E by February 28, 2020.

Identify the date by when all estimates can be replaced with actual expenditures: 02/28/2020

0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

III: Expenditure Reports

Table 3A SABG – Syringe Services Program

Expenditure Start Date: 07/01/2018 Expenditure End Date: 06/30/2019

Syringe Services Program SSP Agency Name	Main Address of SSP	Dollar Amount of SABG funds used for SSP	SUD Treatment Provider	Number Of Locations (include mobile if any)	Narcan Provided
No Data Available					

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Footnotes:

III: Expenditure Reports

Table 3B SABG – Syringe Services Program

Expenditure Start Date: 07/01/2018 Expenditure End Date: 06/30/2019

[Please enter total number of individuals served]

Syringe Service Program Name	# of Unique Individuals Served		HIV Testing	Treatment for Substance Use Conditions	Treatment for Physical Health	STD Testing	Hep C
	0	ONSITE Testing	0	0	0	0	0
		Referral to testing	0	0	0	0	0

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Footnotes:

III: Expenditure Reports

Table 4 - State Agency SABG Expenditure Compliance Report

This table provides a description of SABG expenditures for authorized activities to prevent and treat SUDs. For detailed instructions, refer to those in BGAS. Only one column is to be filled in each year.

Expenditure Period Start Date: 10/1/2016 Expenditure Period End Date: 9/30/2018

Expenditure Category	FY 2017 SA Block Grant Award
1. Substance Abuse Prevention* and Treatment	\$30,216,065
2. Primary Prevention	\$8,148,614
3. Tuberculosis Services	\$0
4. Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV)**	\$0
5. Administration (excluding program/provider level)	\$1,823,524
Total	\$40,188,203

*Prevention other than Primary Prevention

**Only designated states as defined in 42 U.S.C. § 300x-24(b)(2) and 45 CFR § 96.128(b) for the applicable federal fiscal year should enter information in this row. This may include a state or states that were previously considered "designated states" during any of the three prior federal fiscal years for which a state was applying for a grant. See EIS/HIV policy change in SABG Annual Report instructions

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Footnotes:

Line 1 of the table was adjusted to accommodate rounding. The actuals for the table are as follows:

Row 1. SA Prevention & Treatment \$30,216,064.30

Row 2. Primary Prevention \$8,148,614.34

Row 5. Administration \$ 1,823,524.36

Total \$40,188,203

Please note Arizona was not a designated state for FFY2017.

III: Expenditure Reports

Table 5a - Primary Prevention Expenditures Checklist

Expenditure Period Start Date: Expenditure Period End Date:

Strategy	IOM Target	SAPT Block Grant	Other Federal	State	Local	Other
Information Dissemination	Selective	\$ 295,075	\$	\$	\$	\$
Information Dissemination	Indicated	\$ 48,431	\$	\$	\$	\$
Information Dissemination	Universal	\$ 1,487,836	\$	\$	\$	\$
Information Dissemination	Unspecified	\$ 11,452	\$	\$	\$	\$
Information Dissemination	Total	\$1,842,794	\$	\$	\$	\$
Education	Selective	\$ 389,618	\$	\$	\$	\$
Education	Indicated	\$ 51,631	\$	\$	\$	\$
Education	Universal	\$ 1,507,403	\$	\$	\$	\$
Education	Unspecified	\$ 0	\$	\$	\$	\$
Education	Total	\$1,948,652	\$	\$	\$	\$
Alternatives	Selective	\$ 269,837	\$	\$	\$	\$
Alternatives	Indicated	\$ 3,789	\$	\$	\$	\$
Alternatives	Universal	\$ 690,874	\$	\$	\$	\$
Alternatives	Unspecified	\$ 22,905	\$	\$	\$	\$
Alternatives	Total	\$987,405	\$	\$	\$	\$
Problem Identification and Referral	Selective	\$ 51,757	\$	\$	\$	\$
Problem Identification and Referral	Indicated	\$ 28,771	\$	\$	\$	\$
Problem Identification and Referral	Universal	\$ 173,770	\$	\$	\$	\$
Problem Identification and Referral	Unspecified	\$ 17,386	\$	\$	\$	\$
Problem Identification and Referral	Total	\$271,683	\$	\$	\$	\$
Community-Based Process	Selective	\$ 384,584	\$	\$	\$	\$

Community-Based Process	Indicated	\$ 14,888	\$	\$	\$	\$
Community-Based Process	Universal	\$ 1,417,062	\$	\$	\$	\$
Community-Based Process	Unspecified	\$ 83,985	\$	\$	\$	\$
Community-Based Process	Total	\$ 1,900,518	\$	\$	\$	\$
Environmental	Selective	\$ 94,627	\$	\$	\$	\$
Environmental	Indicated	\$ 0	\$	\$	\$	\$
Environmental	Universal	\$ 633,729	\$	\$	\$	\$
Environmental	Unspecified	\$ 26,340	\$	\$	\$	\$
Environmental	Total	\$ 754,696	\$	\$	\$	\$
Section 1926 Tobacco	Selective	\$ 0	\$	\$	\$	\$
Section 1926 Tobacco	Indicated	\$ 0	\$	\$	\$	\$
Section 1926 Tobacco	Universal	\$ 0	\$	\$	\$	\$
Section 1926 Tobacco	Unspecified	\$ 7,123	\$	\$	\$	\$
Section 1926 Tobacco	Total	\$ 7,123	\$	\$	\$	\$
Other	Selective	\$	\$	\$	\$	\$
Other	Indicated	\$ 19,469	\$	\$	\$	\$
Other	Universal	\$ 11,454	\$	\$	\$	\$
Other	Unspecified	\$ 1,338,385	\$	\$	\$	\$
Other	Total	\$ 1,369,308	\$	\$	\$	\$
	Grand Total	\$ 9,082,179	\$	\$	\$	\$

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Footnotes:

III: Expenditure Reports

Table 5b - SABG Primary Prevention Expenditures by Institute of Medicine (IOM) Categories

The state or jurisdiction must complete SABG Table 5b if it chooses to report SUD primary prevention activities utilizing the IOM Model of Universal, Selective and Indicated. Indicate how much funding supported each of the IOM classifications of Universal, Selective, or Indicated. Include all funding sources (e.g., Centers for Disease Control and Prevention Block Grant, foundations).

Expenditure Period Start Date: 10/1/2016 Expenditure Period End Date: 9/30/2018

Activity	SA Block Grant Award	Other Federal Funds	State Funds	Local Funds	Other
Universal Direct					
Universal Indirect					
Selective					
Indicated					
Column Total	\$0	\$0	\$0	\$0	\$0

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Footnotes:

III: Expenditure Reports

Table 5c - SABG Primary Prevention Priorities and Special Population Categories

The purpose of the first table is for the state or jurisdiction to identify the substance and/or categories of substances it identified through its needs assessment and then addressed with primary prevention set-aside dollars from the FY 2017 SABG NoA. The purpose of the second table is to identify each special population the state or jurisdiction selected as a priority for primary prevention set-aside expenditures.

Expenditure Period Start Date: 10/1/2016 Expenditure Period End Date: 9/30/2018

Targeted Substances	
Alcohol	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>
Marijuana	<input checked="" type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>
Cocaine	<input checked="" type="checkbox"/>
Heroin	<input checked="" type="checkbox"/>
Inhalants	<input checked="" type="checkbox"/>
Methamphetamine	<input checked="" type="checkbox"/>
Synthetic Drugs (i.e. Bath salts, Spice, K2)	<input checked="" type="checkbox"/>
Targeted Populations	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input checked="" type="checkbox"/>
LGBTQ	<input checked="" type="checkbox"/>
American Indians/Alaska Natives	<input checked="" type="checkbox"/>
African American	<input checked="" type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>
Homeless	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input checked="" type="checkbox"/>
Asian	<input checked="" type="checkbox"/>
Rural	<input checked="" type="checkbox"/>
Underserved Racial and Ethnic Minorities	<input checked="" type="checkbox"/>

Footnotes:

III: Expenditure Reports

Table 6 - Resource Development Expenditure Checklist

Expenditure Period Start Date: 10/1/2016 Expenditure Period End Date: 9/30/2018

Resource Development Expenditures Checklist						
Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment		\$84,937.41		\$528,279.51		\$613,216.92
2. Quality Assurance		\$67,886.33		\$386,710.91		\$454,597.24
3. Training (Post-Employment)		\$120,493.13		\$198,700.26	\$19,791.98	\$338,985.37
4. Education (Pre-Employment)				\$96,502.33		\$96,502.33
5. Program Development		\$24,276.70		\$679,506.14		\$703,782.84
6. Research and Evaluation		\$35,002.87		\$345,334.76		\$380,337.63
7. Information Systems		\$33,252.94		\$382,466.24		\$415,719.18
8. Total	\$0.00	\$365,849.38	\$0.00	\$2,617,500.15	\$19,791.98	\$3,003,141.51

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Footnotes:

III: Expenditure Reports

Table 7 - Statewide Entity Inventory

This table provides a report of the sub-recipients of SABG funds including community- and faith-based organizations which provided SUD prevention activities and treatment services, as well as intermediaries/administrative service organizations. Table 7 excludes resource development expenditures.

Expenditure Period Start Date: 10/1/2016 Expenditure Period End Date: 9/30/2018

										Source of Funds SAPT Block Grant					
Entity Number	I-BHS ID (formerly I-SATS)		Area Served (Statewide or SubState Planning Area)	Provider / Program Name	Street Address	City	State	Zip	A. All SA Block Grant Funds	B. Prevention (other than primary prevention) and Treatment Services	C. Pregnant Women and Women with Dependent Children	D. Primary Prevention	E. Early Intervention Services for HIV	F. Syringe Services Program	
* 845604	AZ100878		Maricopa County	Ebony House, Inc	8646 S. 14th Street	Phoenix	AZ	85042	\$483,561	\$16,977	\$466,584	\$0	\$0	\$0	
* 617183	AZ102825		Maricopa	LIFEWELL BEHAVIORAL WELLNESS - LWC Beryl	2505 W. Beryl Avenue	Phoenix	AZ	85021	\$28,412	\$6,242	\$22,171	\$0	\$0	\$0	
* 617175	AZ101866		Maricopa	LIFEWELL BEHAVIORAL WELLNESS - LWC Mitchell	40 E. Mitchell Drive	Phoenix	AZ	85012	\$241,646	\$53,084	\$188,561	\$0	\$0	\$0	
* 762746	AZ100232		Maricopa	LIFEWELL BEHAVIORAL WELLNESS - LWC Power	6915 E. Main Street	Phoenix	AZ	85201	\$213,252	\$46,847	\$166,405	\$0	\$0	\$0	
* 617167	AZ100239		Maricopa	LIFEWELL BEHAVIORAL WELLNESS - LWC University	262 E. University Drive	Phoenix	AZ	85201	\$108,324	\$23,796	\$84,528	\$0	\$0	\$0	
* 056962	AZ102764		Maricopa	LIFEWELL BEHAVIORAL WELLNESS - Site 1	3301 E. Pinchot Avenue	Phoenix	AZ	85018	\$628,136	\$137,988	\$490,148	\$0	\$0	\$0	
* 590001	AZ750535		Maricopa County	National Council on Alcoholism and Drug Dependence	4201 N. 16th street suite 140	Phoenix	AZ	85016	\$391,815	\$0	\$391,815	\$0	\$0	\$0	
* 331673	AZ103152		Pima	CODAC Health, Recovery & Wellness, Inc.	380 E Fort Lowell Road	Tucson	AZ	85705	\$1,061,987	\$662,098	\$399,889	\$0	\$0	\$0	
* 206501	AZ101834		Yuma	Community Bridges, Inc.	3250 East 40th Street, Suite B	Yuma	AZ	85365	\$435,076	\$428,833	\$6,243	\$0	\$0	\$0	
* 488183	AZ103193		Yuma	Community Bridges, Inc.	3250 B. East 40th Street	Yuma	AZ	85365	\$580,886	\$574,643	\$6,243	\$0	\$0	\$0	
* 168072	AZ102753		Coconino County	Encompass Healthcare	463 S. Lake Powell Boulevard	Page	AZ	86040	\$11,731	\$11,618	\$113	\$0	\$0	\$0	
* 433954	x		Coconino County	Encompass Healthcare	170 N Main	Fredonia	AZ	86022	\$2,843	\$2,816	\$27	\$0	\$0	\$0	
* 737330	AZ102754		Coconino County	Encompass Healthcare	32 N. 10th Avenue Ste 5	Page	AZ	86040	\$56,385	\$55,843	\$542	\$0	\$0	\$0	
* 675748	x		Mohave County	Encompass Healthcare	4103 E Fleet	Littlefield	AZ	86432	\$518	\$513	\$5	\$0	\$0	\$0	
* 346214	AZ101722		Pinal County	Gila River Health Care BHS	483 W Seed Farm Road	Sacaton	AZ	85147	\$133,724	\$19,657	\$673	\$113,394	\$0	\$0	
* x	x		x	Gila River TRBHA Administration	PO Box 37	Sacaton	AZ	85147	\$67,661	\$37,075	\$780	\$29,807	\$0	\$0	
* x	x		Statewide	Governer's Office of Youth Faith and Families (GOYFF)	1700 W Washington Street #230	Phoenix	AZ	85007	\$0	\$0	\$0	\$624,211	\$0	\$0	
* 006579	AZ101080		Coconino, Mohave, Yavapai, Apache, Navajo	Health Choice Integrated Care	1300 South Yale Street	Flagstaff	AZ	86001	\$656,379	\$555,466	\$14,708	\$86,205	\$0	\$0	
* x	x		All Counties	Mercy Care RBHA Administration	4755 S. 44th Place	Phoenix	AZ	85040	\$1,221,926	\$925,795	\$220,195	\$75,935	\$0	\$0	
* x	x		All Counties	Mercy Care RBHA Profit	4756 S. 44th Place	Phoenix	AZ	85040	\$562,086	\$425,866	\$101,290	\$34,930	\$0	\$0	
* x	AZ102963		Marana	Mountain View High School	3901 W. Linda Vista Boulevard	Tucson	AZ	85742	\$0	\$0	\$0	\$64,213	\$0	\$0	
* x	AZ101375		Navajo County	Navajo	100 E Code Talkers Drive	Holbrook	AZ	86025	\$0	\$0	\$0	\$35,104	\$0	\$0	
* x	AZ102960		Eager	Round Valley High School	550 North Butler Street	Eagar	AZ	85925	\$0	\$0	\$0	\$46,968	\$0	\$0	

*	x	AZ102966	✓	Eloy	Santa Cruz Valley High School	900 North Main Street	Eloy	AZ	85131	\$0	\$0	\$0	\$31,605	\$0	\$0
*	x	AZ101375	✗	Navajo County	Snowflake Junior High School	100 E Code Talkers Drive	Holbrook	AZ	86025	\$0	\$0	\$0	\$17,304	\$0	\$0
*	AZ100992	AZ100992	✓	Pima	Southern Arizona Aids Foundation	375 Euclid Avenue	Tucson	AZ	85719	\$540,556	\$323,890	\$0	\$216,667	\$0	\$0
*	950683	x	✗	Mohave County	Southwest Behavioral Health Clinic	401 Emery Street	Bullhead City	AZ	86442	\$248,336	\$243,260	\$5,076	\$0	\$0	\$0
*	172632	AZ100678	✗	Mohave County	Southwest Behavioral Health Clinic	809 Hancock Rd Ste 1	Bullhead City	AZ	86442	\$35,674	\$34,944	\$729	\$0	\$0	\$0
*	216898	AZ100993	✗	Mohave County	Southwest Behavioral Health Clinic	1515 E. Cedar Avenue Ste B2	Flagstaff	AZ	86004	\$20,571	\$20,150	\$420	\$0	\$0	\$0
*	237443	AZ100668	✗	Mohave County	Southwest Behavioral Health Clinic	2215 Hualapai Mountain Road Ste. H&I	Kingman	AZ	86401	\$8,970	\$8,786	\$183	\$0	\$0	\$0
*	253753	AZ100679	✗	Mohave County	Southwest Behavioral Health Clinic	1845 McColloch Boulevard Ste B1	Lake Havasu City	AZ	86403	\$9,004	\$8,820	\$184	\$0	\$0	\$0
*	435457	AZ100994	✗	Mohave County	Southwest Behavioral Health Clinic	2580 HWY 95 Ste 119-125	Bullhead City	AZ	86442	\$53,091	\$52,006	\$1,085	\$0	\$0	\$0
*	515124	AZ101974	✗	Gila County	Southwest Behavioral Health Clinic	404 W Aero Drive	Payson	AZ	85541	\$21,906	\$21,458	\$448	\$0	\$0	\$0
*	348874	AZ102777	✗	Yavapai County	Southwest Behavioral Health Clinic	7600 E. Florentine Avenue Ste. 101	Prescott Valley	AZ	86314	\$72,660	\$71,175	\$1,485	\$0	\$0	\$0
*	83489	AZ102777	✗	Yavapai County	Southwest Behavioral Health Clinic	7600 E Florentine Road	Prescott Valley	AZ	86314	\$1,742	\$1,706	\$36	\$0	\$0	\$0
*	116807	AZ101006	✗	Coconino County	The Guidance Center	220 W. Grant Street	Williams	AZ	86046	\$269	\$257	\$12	\$0	\$0	\$0
*	158133	AZ101007	✗	Coconino County	The Guidance Center	2695 E. Industrial Drive	Flagstaff	AZ	86004	\$281,388	\$269,248	\$12,139	\$0	\$0	\$0
*	969884	AZ101008	✗	Coconino County	The Guidance Center	2697 E. Industrial Drive	Flagstaff	AZ	86004	\$86,207	\$82,488	\$3,719	\$0	\$0	\$0
*	x	AZ101359	✗	Apache County	Window Rock-Tsehootsooi Middle School	75 North 1st West	St. Johns	AZ	85936	\$0	\$0	\$0	\$16,667	\$0	\$0
*	x	AZ101336	✗	Yavapai County	Yavapai	2970 Centerpointe East	Prescott	AZ	86303	\$0	\$0	\$0	\$40,000	\$0	\$0
x		AZ102967	✗	Ajo	Ajo High School	111 N Well Road	Ajo	AZ	85321	\$42,401	\$0	\$0	\$42,401	\$0	\$0
x		AZ102956	✗	Phoenix	Alhambra High School	4502 N Central Avenue	Phoenix	AZ	85326	\$52,463	\$0	\$0	\$52,463	\$0	\$0
x		AZ101359	✗	Apache County	Apache	75 North 1st West	St. Johns	AZ	85936	\$8,391	\$0	\$0	\$8,391	\$0	\$0
x		AZ102983	✗	Phoenix	Arcadia High School	4703 E. Indian School Road	Phoenix	AZ	85018	\$89,671	\$0	\$0	\$89,671	\$0	\$0
x		AZ101018	✗	Maricopa County	Area Agency on Aging, Region One, Inc.	1366 East Thomas Road, Suite 108	Phoenix	AZ	85014	\$179,940	\$0	\$0	\$179,940	\$0	\$0
x	x		✗	Statewide	Arizona Department of Health Services	150 N 18th Avenue	Phoenix	AZ	85007	\$210,772	\$203,649	\$0	\$7,123	\$0	\$0
x		AZ101348	✗	Statewide	Arizona Department of Liquor Licenses and Control	800 W. Washington	Phoenix	AZ	85007	\$200,000	\$0	\$0	\$200,000	\$0	\$0
	AZ101020	AZ101020	✗	Pima	Arizona Youth Partnership	13644 N. Sandario Road Suite101	Marana	AZ	85653	\$102,993	\$0	\$0	\$102,993	\$0	\$0
	7689949	464084325	✗	Navajo	Ascend Behavioral Health and Wellness	2432 W Eagle Feather Road	Phoenix	AZ	85085	\$17,588	\$17,588	\$0	\$0	\$0	\$0
	6006	AZ101020	✗	Mohave County	AZ Youth Partnership	4239 W. Ina Road, Ste 101	Tucson	AZ	85741	\$114,507	\$0	\$0	\$114,507	\$0	\$0

319460	AZ104213	✗	Maricopa	BAART Behavioral Health Services	908 A West Chandler Boulevard	Chandler	AZ	85225	\$760	\$760	\$0	\$0	\$0	\$0
x	AZ102970	✓	Maricopa County	Cactus Shadow High School	5802 East Dove Valley Road	Cave Creek	AZ	85331	\$87,542	\$0	\$0	\$87,542	\$0	\$0
x	AZ102955	✓	Phoenix	Camelback High School	4612 North 28th Street	Phoenix	AZ	85016	\$57,343	\$0	\$0	\$57,343	\$0	\$0
067893	AZ103012	✗	All Counties	Cenpatico Integrated Care	333 East Wetmore Road, Suite 500	Tucson	AZ	85705	\$1,256,387	\$1,072,570	\$72,151	\$183,817	\$0	\$0
x	AZ104136	✗	Cochise County	Center for Academic Success Douglass	1415 F Avenue	Douglas	AZ	85607	\$1,199	\$0	\$0	\$1,199	\$0	\$0
366918	AZ901153	✗	Maricopa	Center for Behavioral Health Phoenix, Inc.	1501 East Washington Stree	Phoenix	AZ	85034	\$14,846	\$14,846	\$0	\$0	\$0	\$0
339855	AZ100871	✗	Maricopa	Center for Behavioral Health, Inc.	2123 East Southern Avenue	Tempe	AZ	85282	\$14,846	\$14,846	\$0	\$0	\$0	\$0
925422	AZ102144	✗	Maricopa	Centered Spirit	9405 S. Avenida Del Yaqui	Guadalupe	AZ	85283	\$192,500	\$0	\$0	\$192,500	\$0	\$0
x	AZ102954	✓	Phoenix	Cesar Chavez High School	3921 West Baseline Road	Laveen	AZ	85339	\$59,825	\$0	\$0	\$59,825	\$0	\$0
x	AZ102969	✓	Chandler	Chandler High School	1525 West Frye Road	Chandler	AZ	85224	\$129,490	\$0	\$0	\$129,490	\$0	\$0
3450	AZ102014	✗	Navajo County	ChangePoint Integrated Health	105 North 5th Avenue	Holbrook	AZ	86025-2817	\$137,487	\$59,009	\$2,150	\$78,478	\$0	\$0
318067	AZ101317	✗	Navajo County	ChangePoint Integrated Health	2500 East Show Low Lake Road, Buildings A and B	Show Low	AZ	85901	\$33,871	\$33,871	\$1,234	\$0	\$0	\$0
393718	AZ300158	✗	Navajo County	ChangePoint Integrated Health	103 North 1st Avenue	Holbrook	AZ	86025	\$30,359	\$30,359	\$1,106	\$0	\$0	\$0
426191	AZ902227	✓	Navajo County	ChangePoint Integrated Health	1015 East 2nd Street	Winslow	AZ	86047	\$9,085	\$9,085	\$331	\$0	\$0	\$0
740227	AZ102799	✓	Navajo County	Changepoint Integrated Health	423 South Main Street	Snowflake	AZ	85937	\$13,575	\$13,575	\$495	\$0	\$0	\$0
x	AZ102985	✓	Scottsdale	Chaparral High School	6935 East Gold Dust Avenue	Scottsdale	AZ	85253	\$108,294	\$0	\$0	\$108,294	\$0	\$0
x	AZ104138	✗	Apache County	Chinle Junior High School	P.O. Box 587	Chinle	AZ	86305	\$18,338	\$0	\$0	\$18,338	\$0	\$0
x	AZ102977	✓	Downtown Tucson	City High School	47 East Pennington Street	Tucson	AZ	85701	\$61,667	\$0	\$0	\$61,667	\$0	\$0
x	AZ101360	✓	Cochise County	Cochise County Superintendents Office	100 Clawson Avenue	Bisbee	AZ	85603	\$8,731	\$0	\$0	\$8,731	\$0	\$0
x	AZ103653	✗	Coconino County	Coconino Coalition for Children and Youth	2625 N King Road	Flagstaff	AZ	86004	\$130,702	\$0	\$0	\$130,702	\$0	\$0
x	AZ101361	✓	Northern Arizona	Coconino County Superintendent Office	2384 North Steves Boulevard	Flagstaff	AZ	86004	\$36,303	\$0	\$0	\$36,303	\$0	\$0
806687	AZ100092	✗	Pima	CODAC Health Recovery and Wellness Inc	502 North Silverbell Street	Tucson	AZ	85745	\$97,869	\$97,869	\$89	\$0	\$0	\$0
345961	AZ100837	✗	Pima	CODAC Health Recovery and Wellness Inc	630 North Alvernon Way, Suite 161	Tucson	AZ	85711	\$126,121	\$126,121	\$7,177	\$0	\$0	\$0
159024	AZ100094	✗	Pima	CODAC Health Recovery and Wellness Inc	3130 East Broadway	Tucson	AZ	85716	\$131,573	\$131,573	\$4,218	\$0	\$0	\$0
035468	AZ100096	✗	Pima	CODAC Health Recovery and Wellness Inc	1600 North Country Club Road	Tucson	AZ	85716	\$71,495	\$71,495	\$11,970	\$0	\$0	\$0
235872	AZ103200	✗	Pima	Community Bridges Inc	250 South Toole Avenue	Tucson	AZ	85701	\$682,602	\$682,602	\$6,975	\$0	\$0	\$0
238225	AZ103200	✗	Pima	Community Bridges Inc	250 South Toole Avenue	Tucson	AZ	85701	\$954,575	\$954,575	\$48,365	\$0	\$0	\$0
23659	AZ100518	✗	Navajo County	Community Bridges Inc	993 Hermosa Drive	Holbrook	AZ	86025	\$216,400	\$216,400	\$0	\$0	\$0	\$0
599812	AZ101832	✗	Navajo County	Community Bridges, Inc.	110 East 2nd Street	Winslow	AZ	86047	\$6,911	\$6,911	\$0	\$0	\$0	\$0

488183	AZ101834	X	Yuma County	Community Bridges, Inc.	3250 B EaStreet 40th Street.	Yuma	AZ	85365	\$7,549	\$7,549	\$0	\$0	\$0	\$0
422788	AZ101833	X	Navajo County	Community Bridges, Inc.	105 N Cottonwood Avenue	Winslow	AZ	86047	\$71	\$71	\$0	\$0	\$0	\$0
333246	AZ101832	X	Navajo County	Community Bridges, Inc.	110 E. 2nd Street	Winslow	AZ	86047	\$1,169	\$1,169	\$0	\$0	\$0	\$0
252714	AZ101829	X	Gila County	Community Bridges, Inc.	803C W. Main Street	Payson	AZ	85541	\$57,581	\$57,581	\$0	\$0	\$0	\$0
388723	AZ101828	X	Gila County	Community Bridges, Inc.	5734 E. Hope Lane	Globe	AZ	85501	\$1,743	\$1,743	\$0	\$0	\$0	\$0
388770	AZ101827	X	Gila County	Community Bridges, Inc.	5737 E. Hope Lane	Globe	AZ	85501	\$71	\$71	\$0	\$0	\$0	\$0
357379	AZ101830	X	Gila County	Community Bridges, Inc.	803 W. Main Street	Payson	AZ	85541	\$46,996	\$46,996	\$0	\$0	\$0	\$0
378626	AZ101827	X	Gila County	Community Bridges, Inc.	5737 E. Hope Lane	Globe	AZ	85501	\$16,537	\$16,537	\$0	\$0	\$0	\$0
213286	AZ100796	X	Maricopa County	Community Bridges, Inc.	2770 E. Van Buren	Phoenix	AZ	85008	\$39	\$39	\$0	\$0	\$0	\$0
385867	AZ105417	X	Maricopa County	Community Bridges, Inc.	560 South Bellview, Rm B and C	Mesa	AZ	85204	\$933	\$933	\$0	\$0	\$0	\$0
242445	AZ103202	X	Pima	Community Bridges, Inc.	250 S. Toole Avenue	Tucson	AZ	85701	\$123,800	\$123,800	\$0	\$0	\$0	\$0
164588	AZ102120	X	Pima	Community Bridges, Inc.	2950 N Dodge Boulevard	Tucson	AZ	85716	\$166,547	\$166,547	\$0	\$0	\$0	\$0
333267	AZ101823	X	Cochise	Community Bridges, Inc.	646 W. Union Street	Benson	AZ	85602	\$38,982	\$38,982	\$0	\$0	\$0	\$0
576173	AZ100512	X	Cochise	Community Bridges, Inc.	470 S Ocotillo Avenue	Benson	AZ	85602	\$23,333	\$23,333	\$0	\$0	\$0	\$0
388723	AZ101828	X	Gila	Community Bridges, Inc.	5734 E. Hope Lane	Globe	AZ	85501	\$47,372	\$47,372	\$0	\$0	\$0	\$0
591991	AZ100513	X	Maricopa	Community Bridges, Inc.	1012 S. Stapley Drive Bldg. 5	Mesa	AZ	85204	\$41,614	\$41,614	\$0	\$0	\$0	\$0
908014	AZ100973	X	Maricopa	Community Bridges, Inc.	554-1 S. Bellview, Area B	Mesa	AZ	85204	\$204,474	\$204,474	\$0	\$0	\$0	\$0
677658	AZ100694	X	Maricopa	Community Bridges, Inc.	358 E. JAVenuelina Avenue, Suite 101	Mesa	AZ	85210	\$1,597,861	\$1,597,861	\$0	\$0	\$0	\$0
385867	AZ100973	X	Maricopa	Community Bridges, Inc.	560 S. Bellview	Mesa	AZ	85204	\$1,057,938	\$1,057,938	\$0	\$0	\$0	\$0
630855	AZ101831	X	Maricopa	Community Bridges, Inc.	824 N. 99th Avenue, Suite 108	Avondale	AZ	85323	\$584,187	\$584,187	\$0	\$0	\$0	\$0
630824	AZ101831	X	Maricopa	Community Bridges, Inc.	824 N. 99th Avenue, Suite 109	Avondale	AZ	85323	\$693,381	\$693,381	\$0	\$0	\$0	\$0
385867	AZ105409	X	Maricopa	Community Bridges, Inc.	560 S. Bellview	Mesa	AZ	85204	\$38,090	\$38,090	\$0	\$0	\$0	\$0
382935	AZ100796	X	Maricopa	Community Bridges, Inc.	2770 E. Van Buren	Phoenix	AZ	85008	\$5,600	\$5,600	\$0	\$0	\$0	\$0
419683	AZ101821	X	Maricopa	Community Bridges, Inc.	554 S. Bellview Street	Mesa	AZ	85204	\$15,749	\$15,749	\$0	\$0	\$0	\$0
838391	AZ100594	X	Yuma	Community Health Associates	2851 South Avenue B, Building 4	Yuma	AZ	85364	\$286,847	\$286,847	\$31,496	\$0	\$0	\$0
849596	AZ102879	X	Yuma	Community Intervention Associates	1938 E Juan Sanchez Boulevard Suite 4	San Luis	AZ	85349	\$17,944	\$17,944	\$0	\$0	\$0	\$0
211348	AZ103074	X	Pima	Community Intervention Associates	1779 West St Marys Road	Tucson	AZ	85745	\$21,698	\$21,698	\$0	\$0	\$0	\$0
014619	AZ101096	X	Pinal	Community Intervention Associates	1923 N. Trekell Road	Casa Grande	AZ	85122	\$30,074	\$30,074	\$0	\$0	\$0	\$0
325528	AZ101096	X	Pinal	Community Intervention Associates	1923 N. Trekell Road	Casa Grande	AZ	85122	\$131,048	\$131,048	\$0	\$0	\$0	\$0
849541	AZ102878	X	La Paz	Community Intervention Associates	1516 Ocotillo Avenue	Parker	AZ	85344	\$11,299	\$11,299	\$0	\$0	\$0	\$0

153671	AZ102244	X	Pima	Community Intervention Associates	32 Blvd Del Ray David	Nogales	AZ	85621	\$28,517	\$28,517	\$0	\$0	\$0	\$0
160138	AZ101097	X	Pima	Community Intervention Associates	1773 West St Mary Road Suite 105	Tucson	AZ	85745	\$142,556	\$142,556	\$0	\$0	\$0	\$0
339881	AZ102244	X	Pima	Community Intervention Associates	32 Blvd Del Ray David	Nogales	AZ	85621	\$107,417	\$107,417	\$0	\$0	\$0	\$0
156147	AZ103071	X	Pima	Community Intervention Associates	1773 West St Mary Road Suite 102	Tucson	AZ	85745	\$41,358	\$41,358	\$0	\$0	\$0	\$0
481818	AZ105649	X	Pima	Community Medical Services	6626 E. Carondelet Drive	Tucson	AZ	85710	\$185,647	\$185,647	\$0	\$0	\$0	\$0
296965	AZ103426	X	Pima	Community Medical Services	2001 W Orange Grove Road Suite 202	Tucson	AZ	85704	\$1,254	\$1,254	\$0	\$0	\$0	\$0
590019	AZ101028	X	Maricopa County	Community Medical Services	2103 West Northern Avenue	Phoenix	AZ	85021	\$19,505	\$19,505	\$8,276	\$0	\$0	\$0
231924	AZ102728	X	Cochise	Community Partners Integrated Healthcare	2039 E. Wilcox Drive Suites A & B	Sierra Vista	AZ	85635	\$15,578	\$15,578	\$0	\$0	\$0	\$0
232022	AZ102733	X	Cochise	Community Partners Integrated Healthcare	500 S. Highway 80 Suite A	Benson	AZ	85602	\$8,882	\$8,882	\$0	\$0	\$0	\$0
232459	AZ102730	X	Graham	Community Partners Integrated Healthcare	301 E. 4th Street Suites A & B	Safford	AZ	85546	\$11,317	\$11,317	\$0	\$0	\$0	\$0
232626	AZ102868	X	Maricopa	Community Partners Integrated Healthcare	1515 E. Osborn Road	Phoenix	AZ	85014	\$9,688	\$9,688	\$0	\$0	\$0	\$0
231825	AZ102870	X	Pima	Community Partners Integrated Healthcare	3939 S. Park Avenue Suite 150	Tucson	AZ	85714	\$41,412	\$41,412	\$0	\$0	\$0	\$0
271381	AZ104282	X	Pima	Community Partners Integrated Healthcare	2502 N. Dodge Boulevard Suite 130	Tucson	AZ	85716	\$10,976	\$10,976	\$0	\$0	\$0	\$0
231843	AZ101843	X	Yuma	Community Partners Integrated Healthcare	2545 S. Arizona Avenue Bldg A-D	Yuma	AZ	85364	\$33,287	\$33,287	\$0	\$0	\$0	\$0
178248	AZ102871	X	Pima	Community Partners Integrated Healthcare (CPIH)	2502 North Dodge Boulevard, Suite 190	Tucson	AZ	85716	\$47,840	\$47,840	\$480	\$0	\$0	\$0
108742	AZ101837	X	Pima	Cope Community Services	1660 W. Commerce Court Place	Green Valley	AZ	85614	\$3,312	\$3,312	\$0	\$0	\$0	\$0
927130	AZ100912	X	Pima	Cope Community Services	620 N. Craycroft Road	Tucson	AZ	85711	\$122,784	\$88,512	\$0	\$34,272	\$0	\$0
314150	AZ101836	X	Pima	Cope Community Services	1501 W. Commerce Court	Tucson	AZ	85746	\$39,324	\$39,324	\$0	\$0	\$0	\$0
921819	AZ103239	X	Pima	Cope Community Services	2435 N. Castro Avenue	Tucson	AZ	85705	\$37,262	\$37,262	\$0	\$0	\$0	\$0
112684	AZ103243	X	Pima	Cope Community Services	5840 N. La Cholla	Tucson	AZ	85741	\$17,761	\$17,761	\$0	\$0	\$0	\$0
048768	AZ103241	X	Pima	Cope Community Services	924 N. Alvernon	Tucson	AZ	85712	\$90,493	\$90,493	\$0	\$0	\$0	\$0
918854	AZ100740	X	Pima	Cope Community Services	8050 E. Lakeside Parkway	Tucson	AZ	85730	\$43,633	\$43,633	\$0	\$0	\$0	\$0
031601	AZ105524	X	Pima	Cope Community Services	5401 E. 5th Street	Tucson	AZ	85711	\$504,371	\$504,371	\$0	\$0	\$0	\$0
314150	AZ101836	X	Pima	COPE Community Services, Inc	1501 W. Commerce Court	Tucson	AZ	85746	\$36,611	\$36,611	\$0	\$0	\$0	\$0
716251	AZ102108	X	Pinal	Corazon	900 E Florence Boulevard Suite G	Casa Grande	AZ	85122	\$64,005	\$64,005	\$0	\$0	\$0	\$0
x	AZ102979	✓	Tempe	Corona del Sol High School	1001 East Knox Road	Tempe	AZ	85284	\$159,950	\$0	\$0	\$159,950	\$0	\$0

112219	AZ301719	✘	Maricopa	CPLC: CENTRO DE LA FAMILIA	6850 W. Indian School Road	Phoenix	AZ	85033	\$1,692	\$1,692	\$0	\$0	\$0	\$0
704719	AZ103164	✘	Yuma	Crossroads Mission	944 S Arizona Avenue Blvd. 200	Yuma	AZ	85364	\$255,788	\$255,788	\$0	\$0	\$0	\$0
021883	AZ103906	✘	Maricopa	Crossroads, Inc.	1700 E. Thomas Road	Phoenix	AZ	85016	\$253,680	\$253,680	\$0	\$0	\$0	\$0
x	AZ102982	✔	Scottsdale	Desert Mountain High School	12575 East Via Linda	Scottsdale	AZ	85259	\$105,228	\$0	\$0	\$105,228	\$0	\$0
x	AZ102980	✘	Tempe / Phoenix	Desert Vista/McClintock/Compadre High Schools	500 West Guadalupe Road	Tempe	AZ	85283	\$157,801	\$0	\$0	\$157,801	\$0	\$0
439095	AZ100600	✘	Maricopa	Destiny Sober Living	5306 N 17th Avenue	Phoenix	AZ	85015	\$10,049	\$10,049	\$0	\$0	\$0	\$0
439095	AZ100171	✘	Maricopa	Destiny Sober Living	5306 N 17th Avenue	Phoenix	AZ	85015	\$2,210	\$2,210	\$0	\$0	\$0	\$0
319790	AZ750154	✘	Maricopa County	Ebony House, Inc	6222 S. 13th Street	Phoenix	AZ	85042	\$16,977	\$16,977	\$0	\$0	\$0	\$0
274629	AZ103994	✘	Maricopa County	Ebony House, Inc	6218 S. 13th Street	Phoenix	AZ	85042	\$27,699	\$27,699	\$0	\$0	\$0	\$0
186858	AZ102875	✘	Maricopa	EMPACT - Suicide Prevention Center	914 S 52nd St, Suite 100	Tempe	AZ	85281	\$3,141	\$3,141	\$0	\$0	\$0	\$0
296638	AZ100540	✘	Maricopa	EMPACT - Suicide Prevention Center	618 S Madison Drive	Tempe	AZ	85281	\$11,729	\$11,729	\$0	\$0	\$0	\$0
622987	AZ101844	✘	Maricopa	EMPACT - Suicide Prevention Center	4425 W Olive Avenue, Suite 194	Glendale	AZ	85302	\$10,689	\$10,689	\$0	\$0	\$0	\$0
084711	AZ102873	✘	Pinal	EMPACT - Suicide Prevention Center	2474 E Hunt Highway, Suite A100	San Tan Valley	AZ	85143	\$9,892	\$9,892	\$0	\$0	\$0	\$0
183711	AZ102874	✘	Pinal	EMPACT - Suicide Prevention Center	11518 E Apache Trail, Suite 129	Apache Junction	AZ	85120	\$5,297	\$5,297	\$0	\$0	\$0	\$0
100587	AZ101032	✘	Maricopa County	Empact Suicide Prevention	1232 E Broadway, Suite 320	Tempe	AZ	85282	\$14,038	\$0	\$0	\$14,038	\$0	\$0
128821	AZ102753	✘	Coconino County	Encompass Health Services	463 South Lake Powell Boulevard	Page	AZ	86040	\$460,382	\$460,382	\$4,468	\$0	\$0	\$0
747058	AZ102106	✘	Maricopa County	Florence Crittenton Services of AZ	715 W. Mariposa Street	Phoenix	AZ	85013	\$1,917	\$1,917	\$0	\$0	\$0	\$0
x	AZ102957	✔	Tucson	Flowing Wells High School	3725 North Flowing Wells Road	Tucson	AZ	85705	\$78,319	\$0	\$0	\$78,319	\$0	\$0
x	AZ101368	✔	Gila County	Gila County Superintendent	1400 East Ash Street	Globe	AZ	85501	\$18,016	\$0	\$0	\$18,016	\$0	\$0
334582	AZ100964	✘	Pinal County	Gila River Health Care Family Planning	PO BOX 2175	Sacaton	AZ	85147	\$15,296	\$15,296	\$0	\$0	\$0	\$0
589093	AZ101809	✘	Maricopa County	Gila River Health Care Thwajik Ki RTC	3850 N. 16th Street	Laveen	AZ	85339	\$11,636	\$11,636	\$0	\$0	\$0	\$0
683287	AZ101722	✘	Pinal County	Gila River Healthcare BHS/OASIS	291 West Casa Blanca Road	Sacaton	AZ	85147	\$120,546	\$120,546	\$3,224	\$0	\$0	\$0
x	AZ102972	✘	Gilbert	Gilbert High School	1101 East Elliot Road	Gilbert	AZ	85234	\$89,696	\$0	\$0	\$89,696	\$0	\$0
049454	AZ101861	✘	Pinal	Helping assoc	1901 N. Trekell Road, Suite A	Casa Grande	AZ	85122	\$93,829	\$93,829	\$0	\$0	\$0	\$0
x	AZ104151	✘	Yavapai County	Heritage Middle School	1076 North Road 1 West	Chino Valley	AZ	86323	\$17,009	\$0	\$0	\$17,009	\$0	\$0
x	AZ104152	✘	Gila County	High Desert Middle School	5000 High Desert Drive	Globe	AZ	85501	\$14,247	\$0	\$0	\$14,247	\$0	\$0
x	AZ101340	✘	Navajo County	Holbrook Junior High School	100 E Code Talker Drive	Holbrook	AZ	86025	\$15,607	\$0	\$0	\$15,607	\$0	\$0
756638	AZ100839	✘	Pima	HOPE, Inc.	1200 N Country Club Road	Tucson	AZ	85716	\$33,759	\$33,759	\$0	\$0	\$0	\$0
122261	AZ101224	✘	Pima	HOPE, Inc.	4067 E Grant Road	Tucson	AZ	85712	\$17,565	\$17,565	\$0	\$0	\$0	\$0
006758	AZ103086	✘	Yuma	HOPE, Inc.	201 S First Avenue	Yuma	AZ	85364	\$23,384	\$23,384	\$0	\$0	\$0	\$0

872095	AZ100208	✘	Maricopa County	Intensive Treatment Systems	651 West Coolidge Street	Phoenix	AZ	85013	\$63,432	\$63,432	\$17,747	\$0	\$0	\$0
946791	AZ101030	✘	Maricopa County	Intensive Treatment Systems	4136 N 75th Avenue Suite 116	Phoenix	AZ	85033	\$126,864	\$126,864	\$35,494	\$0	\$0	\$0
540865	AZ101490	✘	Maricopa County	Intensive Treatment Systems LLC	19401 North Cave Creek Road, Suite 18	Phoenix	AZ	85024	\$126,864	\$126,864	\$35,494	\$0	\$0	\$0
198509	421585856	✘	Navajo	Intermountain Health Center	5055 East Broadway C104	Tucson	AZ	85711	\$9,654	\$9,654	\$0	\$0	\$0	\$0
810459	AZ101534	✘	Maricopa County	Jewish Family & Children's Service	3001 N. 33rd Avenue	Phoenix	AZ	85017	\$21,745	\$21,745	\$0	\$0	\$0	\$0
584965	AZ100507	✘	Maricopa County	Jewish Family & Children's Service	1840 N. 99th Avenue Suite 146	Phoenix	AZ	85037	\$12,133	\$12,133	\$0	\$0	\$0	\$0
007486	AZ100726	✘	Maricopa County	Jewish Family & Children's Service	5701 W. Talavi Boulevard Suite 180	Glendale	AZ	85306	\$25,855	\$25,855	\$0	\$0	\$0	\$0
810095	AZ100374	✘	Maricopa County	Jewish Family & Children's Service	1255 W. Baseline Road. Suite B258	Mesa	AZ	85202	\$17,016	\$17,016	\$0	\$0	\$0	\$0
x	AZ104155	✘	Cochise County	Joyce Clark Middle School	1945 South Lezner Avenue	Sierra Vista	AZ	85635	\$16,292	\$0	\$0	\$16,292	\$0	\$0
x	AZ101037	✘	Maricopa County	Kathleen Stanton, Consultant	5342 N 3rd Avenue	Phoenix	AZ	85013	\$21,600	\$0	\$0	\$21,600	\$0	\$0
069139	AZ100223	✘	Pima	La Frontera Arizona	504 West 29th Street	Tucson	AZ	85713	\$489,470	\$372,517	\$10,031	\$116,953	\$0	\$0
593849	AZ100227	✘	Pima	La Frontera Center	260 South Scott Avenue	Tucson	AZ	85701	\$414,201	\$414,201	\$18,650	\$0	\$0	\$0
x	AZ101347	✔	Statewide	Lavidge	2777 East Camelback Road	Phoenix	AZ	85016	\$547,326	\$0	\$0	\$547,326	\$0	\$0
7519	AZ101913	✘	Apache County	Little Colorado Behavioral Health Center	50 North Hopi Street	Springerville	AZ	85938	\$26,916	\$26,916	\$2,973	\$0	\$0	\$0
3442	AZ300133	✘	Apache County	Little Colorado Behavioral Health Centers	470 West Cleveland Street	Saint Johns	AZ	85936	\$8,088	\$8,088	\$893	\$0	\$0	\$0
x	AZ102964	✘	Marana	Marana High School	12000 West Emigh Road	Marana	AZ	85743	\$100,725	\$0	\$0	\$100,725	\$0	\$0
x	AZ102981	✘	Tempe / Phoenix	Marcos de Niza/Tempe/Mountain Pointe High Schools	500 West Guadalupe Road	Tempe	AZ	85283	\$155,805	\$0	\$0	\$155,805	\$0	\$0
AZ103371	AZ103371	✘	Pinal	Maricopa Ak-Chin CCA	18150 N. Alterra Parkway	Maricopa	AZ	85139	\$117,500	\$0	\$0	\$117,500	\$0	\$0
x	AZ102962	✔	Maricopa/Ak-Chin	Maricopa High School	45012 West Honeycutt Avenue	Maricopa	AZ	85139	\$75,803	\$0	\$0	\$75,803	\$0	\$0
x	AZ102953	✔	Phoenix	Maryvale High School	3415 North 59th Avenue	Phoenix	AZ	85033	\$65,480	\$0	\$0	\$65,480	\$0	\$0
x	AZ101040	✘	Yavapai County	MATForce	8056 E. Vallet Road, Ste B.	Prescott	AZ	86314	\$114,507	\$0	\$0	\$114,507	\$0	\$0
x	AZ104158	✘	Yavapai County	Mayer Elementary School K-8	12568 East Main Street	Mayer	AZ	86333	\$15,364	\$0	\$0	\$15,364	\$0	\$0
x	AZ102975	✔	Gilbert	Mesquite High School	500 South McQueen Road	Gilbert	AZ	85233	\$99,705	\$0	\$0	\$99,705	\$0	\$0
x	AZ102958	✔	Miami, Globe, Claypool and surrounding areas	Miami High School	4739 East Ragus Road	Miami	AZ	85539	\$63,143	\$0	\$0	\$63,143	\$0	\$0
x	AZ104160	✘	Miami, Globe, Claypool and surrounding areas	Miami Junior High School	4739 East Ragus Road	Miami	AZ	85339	\$16,742	\$0	\$0	\$16,742	\$0	\$0
x	AZ104161	✘	Yavapai County	Mile High Middle School	300 South Granite Street	Prescott	AZ	86303	\$18,555	\$0	\$0	\$18,555	\$0	\$0
114743	AZ100279	✘	Mohave County	Mohave Mental Health Clinic Inc	1080 Sheldon Avenue	Kingman	AZ	86409	\$8,362	\$8,362	\$240	\$0	\$0	\$0
116667	AZ104246	✔	Mohave County	Mohave Mental Health Clinic Inc	1145 Marina Boulevard	Bullhead City	AZ	86442	\$183,565	\$183,565	\$5,258	\$0	\$0	\$0

117136	AZ300174	✓	Mohave County	Mohave Mental Health Clinic Inc	3505 Western Avenue	Kingman	AZ	86409	\$376,837	\$376,837	\$10,794	\$0	\$0	\$0
147125	AZ104725	✓	Mohave County	Mohave Mental Health Clinic Inc	2187 Swanson Avenue	Lake Havasu City	AZ	86403	\$144,008	\$144,008	\$4,125	\$0	\$0	\$0
213385	AZ101296	✗	Mohave County	Mohave Mental Health Clinic Inc	151 Riviera Drive, Suite B	Lake Havasu City	AZ	86403	\$9,285	\$9,285	\$266	\$0	\$0	\$0
515719	AZ100619	✗	Mohave County	Mohave Mental Health Clinic Inc	2580 Highway 95, Suite 209	Bullhead City	AZ	86442	\$20,729	\$20,729	\$594	\$0	\$0	\$0
589848	AZ100944	✓	Mohave County	Mohave Mental Health Clinic Inc	1741 Sycamore Avenue	Kingman	AZ	86401	\$79,203	\$79,203	\$2,269	\$0	\$0	\$0
690405	AZ102327	✗	Mohave County	Mohave Mental Health Clinic Inc	2002 Stockton Hill Road, Suite 104	Kingman	AZ	86401	\$32,740	\$32,740	\$938	\$0	\$0	\$0
151346	AZ750162	✗	Maricopa County	Native American Connections	4520 N. Central Avenue, Suite 600	Phoenix	AZ	85012	\$15,097	\$15,097	\$0	\$0	\$0	\$0
151346	AZ750162	✗	Maricopa	Native American Connections	4520 N. Central Avenue - Suite 100	Phoenix	AZ	85012	\$238,531	\$238,531	\$0	\$0	\$0	\$0
424472	AZ750162	✗	Maricopa	Native American Connections	4520 N. Central Avenue, Suite 120	Phoenix	AZ	85012	\$36,779	\$36,779	\$0	\$0	\$0	\$0
098534	AZ750600	✗	Maricopa	New Casa de Amigas	1648 W Colter Street	Phoenix	AZ	85015	\$39,844	\$39,844	\$0	\$0	\$0	\$0
893554	AZ101283	✗	Maricopa.Pinal.Gila	New Hope Behavioral Health Centers Inc	215 South Power Road, Suite 114	Mesa	AZ	85206	\$74,215	\$74,215	\$71,303	\$0	\$0	\$0
467641	AZ100989	✗	Maricopa County	New Horizon Youth Homes	PO Box 2754	Chandler	AZ	85244	\$206	\$206	\$0	\$0	\$0	\$0
x	AZ102961	✓	Phoenix	North Canyon High School	1700 East Union Hills Drive	Phoenix	AZ	85024	\$88,481	\$0	\$0	\$88,481	\$0	\$0
539184	AZ101041	✗	Mohave, Yavapai, and Coconino Counties	North Country Healthcare	2920 N. 4th Street	Flagstaff	AZ	86004	\$70,151	\$70,151	\$0	\$0	\$0	\$0
x	AZ102952	✓	Phoenix	North High School	1101 East Thomas Road	Phoenix	AZ	85014	\$58,654	\$0	\$0	\$58,654	\$0	\$0
349127	AZ101835	✗	Maricopa County	Open Hearts	4414 N. 19th Avenue	Phoenix	AZ	85015	\$48,780	\$48,780	\$0	\$0	\$0	\$0
218075	AZ101774	✗	Pima	Pascua Yaqui Tribe TRBHA	7490 S. Camino de Oeste	Tucson	AZ	85757	\$98,958	\$98,958	\$0	\$0	\$0	\$0
143643	AZ105698	✗	Maricopa	Patina Wellness Treatment	337 E Virginia Avenue	Phoenix	AZ	85004	\$34,842	\$34,842	\$0	\$0	\$0	\$0
x	AZ104166	✗	Cochise County	Pearce Elementary School	1487 East School Road	Pearce	AZ	85625	\$15,992	\$0	\$0	\$15,992	\$0	\$0
x	AZ102973	✓	Peoria	Peoria Accelerated High School	8885 West Peoria Avenue	Peoria	AZ	85345	\$40,040	\$0	\$0	\$40,040	\$0	\$0
x	AZ104237	✗	Maricopa County	Phoenix Indian Center, Inc	4520 N. Central Avenue, Suite 250	Phoenix	AZ	85012	\$167,838	\$0	\$0	\$167,838	\$0	\$0
620528	AZ103169	✗	Pima	Pima Council on Aging	8467 E. Broadway Boulevard	Tucson	AZ	85710	\$187,900	\$0	\$0	\$187,900	\$0	\$0
274453	AZ102093	✗	Pima	Pima Prevention Partnership	924 N. Alvernon Way Suite 150	Tucson	AZ	85711	\$52,800	\$52,800	\$0	\$0	\$0	\$0
665391	AZ101049	✗	Pinal, Gila	Pinal-Gila Council for Senior Citizens	8969 W McCartney Road	Casa Grande	AZ	85194	\$112,083	\$0	\$0	\$112,083	\$0	\$0
x	AZ102974	✓	Phoenix	Pinnacle High School	3535 East Mayo Boulevard	Phoenix	AZ	85050	\$104,646	\$0	\$0	\$104,646	\$0	\$0
x	AZ102965	✓	Queen Creek and Mesa	Queen Creek High School	22149 East Ocotillo Road	Queen Creek	AZ	85142	\$88,759	\$0	\$0	\$88,759	\$0	\$0

752701	AZ101418	✘	Maricopa County	Red Mountain Behavioral Health, LLC	2915 E. Baseline Road., Suite 115	Gilbert	AZ	85234	\$1,018	\$1,018	\$0	\$0	\$0	\$0
007667	AZ103627	✘	Maricopa County	Residents at the Heights, LLC	215 S Power Road Suite 1251	Mesa	AZ	85206	\$170,719	\$170,719	\$0	\$0	\$0	\$0
258528	OTC8147	✘	Maricopa County	Residents at the Heights, LLC	5801 E Main Street	Mesa	AZ	85205	\$6,323	\$6,323	\$0	\$0	\$0	\$0
x	AZ104167	✘	Gila County	Rim Country Middle School	304 South Meadow Road	Payson	AZ	85541	\$17,006	\$0	\$0	\$17,006	\$0	\$0
x	AZ104168	✘	Apache County	Round Valley Middle School	P.O. Box 610	Springerville	AZ	85938	\$17,591	\$0	\$0	\$17,591	\$0	\$0
x	AZ104180	✘	Apache County	Saint Johns Middle School	P.O. Box 3030	Saint Johns	AZ	85936	\$16,908	\$0	\$0	\$16,908	\$0	\$0
625239	x	✘	Navajo	Saliba's Extended Care Pharmacy	928 E Covey Lane	Phoenix	AZ	85024	\$9	\$9	\$0	\$0	\$0	\$0
624230	AZ101155	✘	Gila	San Carlos Apache Wellness Center	5 San Carlos Avenue	San Carlos	AZ	85550	\$83,337	\$0	\$0	\$83,337	\$0	\$0
x	AZ104174	✘	Navajo County	Show Low Junior High School	500 West Old Linden Road	Show Low	AZ	85901	\$14,922	\$0	\$0	\$14,922	\$0	\$0
x	AZ102971	✔	East Mesa	Skyline High School	845 South Crismon Road	Mesa	AZ	85208	\$144,372	\$0	\$0	\$144,372	\$0	\$0
407398	AZ103544	✘	Statewide	Sonoran Prevention Works	3201 N 16th Street, Suite 9	Phoenix	AZ	85016	\$588,601	\$588,601	\$0	\$0	\$0	\$0
783673	AZ102746	✘	Gila County	Southeastern Arizona Behavioral Health Services	996 North Broad St Ste 9&10	Globe	AZ	85501	\$120,879	\$14,050	\$0	\$106,829	\$0	\$0
154878	AZ100848	✘	Cochise	Southeastern Arizona Behavioral Health Services	590 S Ocotillo	Benson	AZ	85602	\$124,138	\$0	\$0	\$124,138	\$0	\$0
895659	AZ901070	✘	Graham	Southeastern Arizona Behavioral Health Services	1615 S 1st Avenue	Safford	AZ	85546	\$48,750	\$48,750	\$0	\$0	\$0	\$0
389892	AZ104584	✘	Maricopa County	Southwest Behavioral Health Services, Inc	1424 S. 7th Avenue	Phoenix	AZ	85007	\$157,325	\$157,325	\$0	\$0	\$0	\$0
633167	AZ102777	✘	Yavapai County	Southwest Behavioral Health Servs	7600 East Florentine Road, Suite 101	Prescott Valley	AZ	86314	\$28,019	\$28,019	\$585	\$0	\$0	\$0
654156	AZ102820	✘	Yavapai County	Southwest Behavioral Health Servs	7763 East Florentine Road	Prescott Valley	AZ	86314	\$3,718	\$3,718	\$78	\$0	\$0	\$0
57952	AZ100384	✔	Yavapai County	Spectrum Healthcare	8 East Cottonwood Street	Cottonwood	AZ	86326	\$359,798	\$359,798	\$14,000	\$0	\$0	\$0
144577	AZ102024	✘	Yavapai County	Spectrum Healthcare	2880 Hopi Drive	Sedona	AZ	86336	\$1,787	\$1,787	\$70	\$0	\$0	\$0
153499	AZ101228	✘	Yavapai County	Spectrum Healthcare	651 Mingus Street	Cottonwood	AZ	86326	\$850	\$850	\$33	\$0	\$0	\$0
184460	AZ100384	✔	Yavapai County	Spectrum Healthcare	8 East Cottonwood Street	Cottonwood	AZ	86326	\$103,713	\$103,713	\$4,035	\$0	\$0	\$0
438745	AZ100384	✔	Yavapai County	Spectrum Healthcare	8 East Cottonwood Street	Cottonwood	AZ	86326	\$1,422	\$1,422	\$55	\$0	\$0	\$0
755689	AZ102023	✘	Yavapai County	Spectrum Healthcare	452 West Finnie Flat Road	Camp Verde	AZ	86322	\$29,199	\$29,199	\$1,136	\$0	\$0	\$0
x	AZ101056	✘	Maricopa County	Tanner Community Development	700 East Jefferson Street, Suite 200	Phoenix	AZ	85034	\$176,049	\$0	\$0	\$176,049	\$0	\$0
x	AZ103619	✘	Maricopa County	Teen Lifeline	4612 North 12th Street	Phoenix	AZ	85014	\$148,235	\$0	\$0	\$148,235	\$0	\$0
881343	AZ100682	✘	Maricopa County	Terros, Inc	10220 N. 31st Avenue, #120	Phoenix	AZ	85051-9581	\$63,525	\$63,525	\$0	\$0	\$0	\$0
980961	AZ100003	✘	Maricopa County	Terros, Inc	1111 S. Stapley Drive	Mesa	AZ	85204	\$316,424	\$316,424	\$0	\$0	\$0	\$0
810053	AZ104113	✘	Maricopa County	Terros, Inc	3864 N. 27th Avenue	Phoenix	AZ	85017-4703	\$249,948	\$249,948	\$0	\$0	\$0	\$0
907972	AZ100766	✘	Maricopa County	Terros, Inc	4425 W. Olive Avenue #200 & #140	Glendale	AZ	85302-3843	\$182,272	\$182,272	\$0	\$0	\$0	\$0

056996	AZ301404	✘	Maricopa County	Terros, Inc	4909 E. McDowell Road	Phoenix	AZ	85008-7735	\$332,097	\$332,097	\$0	\$0	\$0	\$0
906404	AZ103582	✘	Maricopa County	Terros, Inc	5801 N. 51st Avenue	Glendale	AZ	85301	\$72,567	\$72,567	\$0	\$0	\$0	\$0
011432	AZ100001	✘	Maricopa County	Terros, Inc	6153 W. Olive Avenue	Glendale	AZ	85302-4564	\$175,693	\$175,693	\$0	\$0	\$0	\$0
950925	AZ101378	✘	Maricopa County	Terros, Inc	2400 W Dunlap Avenue Suite 300	Phoenix	AZ	85021	\$11,538	\$11,538	\$0	\$0	\$0	\$0
016658	AZ101379	✘	Maricopa County	Terros, Inc	1232 E. Broadway Road Suite 120	Tempe	AZ	85282	\$27,591	\$27,591	\$0	\$0	\$0	\$0
x	AZ104308	✘	Maricopa County	Terros, Inc	3302 N. 35th Avenue, Suite 8	Phoenix	AZ	85017	\$166,265	\$0	\$0	\$166,265	\$0	\$0
037862	AZ100968	✘	Maricopa County	Terros, Inc - 23rd Ave	8836 N 23rd Avenue Suite B-1	Phoenix	AZ	85021	\$19,388	\$19,388	\$0	\$0	\$0	\$0
232932	AZ101383	✘	Maricopa County	Terros, Inc - 51st Ave	4616 N 51st Avenue	Phoenix	AZ	85031	\$14,023	\$14,023	\$0	\$0	\$0	\$0
223657	AZ101384	✘	Maricopa County	Terros, Inc - Priest Drive	1642 S. Priest Drive	Phoenix	AZ	85281	\$14,504	\$14,504	\$0	\$0	\$0	\$0
78528	AZ102063	✘	Coconino County	The Guidance Center	2697 East Industrial Drive	Flagstaff	AZ	86004	\$1,186	\$1,186	\$53	\$0	\$0	\$0
106944	AZ100434	✘	Coconino County	The Guidance Center	2188 North Vickey Street	Flagstaff	AZ	86004	\$13,167	\$13,167	\$594	\$0	\$0	\$0
154902	AZ100434	✘	Coconino County	The Guidance Center	2187 North Vickey Street	Flagstaff	AZ	86004	\$62,375	\$62,375	\$2,812	\$0	\$0	\$0
592867	AZ100453	✘	Pima	The Haven	1107 East Adelaide Drive	Tucson	AZ	85719	\$333,529	\$333,529	\$0	\$0	\$0	\$0
711969	208126559	✘	Navajo	The Oasis Home, LLC	845 West Calle Barbitas	Sahuarita	AZ	85269	\$5,848	\$5,848	\$0	\$0	\$0	\$0
x	AZ102959	✘	Tucson	Toltecalli/Envision High Schools	251 West Irvington Road	Tucson	AZ	85714	\$44,337	\$0	\$0	\$44,337	\$0	\$0
151359	AZ100463	✘	Pima	Touchstone Behavioral Health	1430 E Fort Lowell Road Suite 100	Tucson	AZ	85719	\$90,900	\$90,900	\$0	\$0	\$0	\$0
357279	AZ101943	✘	Maricopa County	Touchstone Behavioral Health, Inc	15648 North 35th Avenue	Phoenix	AZ	85053	\$622	\$622	\$0	\$0	\$0	\$0
378853	AZ100737	✘	Maricopa County	Touchstone Behavioral Health, Inc	3602 East Greenway, Suite 102	Phoenix	AZ	85032	\$1,264	\$1,264	\$0	\$0	\$0	\$0
425931	AZ100684	✘	Pinal	Transitional Living Center Recovery	117 E. 2nd Street	Casa Grande	AZ	85122	\$51,897	\$51,897	\$0	\$0	\$0	\$0
384591	AZ102793	✘	Yuma	Transitional Living Center Recovery	1340 S. 4th Avenue	Yuma	AZ	85364	\$25,793	\$25,793	\$0	\$0	\$0	\$0
AZ101060	AZ101060	✘	Pima	University of Arizona ERAD	1717 E Speedway Street	Tucson	AZ	85719	\$131,250	\$0	\$0	\$131,250	\$0	\$0
493467	AZ102229	✘	Maricopa County	Valle del Sol	10320 W McDowell Road Suite. G	Avondale	AZ	85392	\$2,579	\$2,579	\$0	\$0	\$0	\$0
053059	AZ100095	✔	Maricopa County	Valle del Sol	1209 South 1st Avenue	Phoenix	AZ	85003	\$147,028	\$147,028	\$20,550	\$0	\$0	\$0
388606	AZ100504	✔	Maricopa County	Valle del Sol	3807 North 7th Street	Phoenix	AZ	85014	\$13,611	\$13,611	\$200	\$0	\$0	\$0
580100	AZ101704	✘	Maricopa County	Valle del Sol	4135 South Power Road, Suite 108	Mesa	AZ	85212	\$3,692	\$3,692	\$125	\$0	\$0	\$0
347204	AZ102758	✘	Maricopa County	Valle del Sol	509 South Rockford Drive	Tempe	AZ	85281	\$72,251	\$72,251	\$15,497	\$0	\$0	\$0
801237	AZ103667	✘	Maricopa County	Valle del Sol	8410 West Thomas Road	Phoenix	AZ	85037	\$11,987	\$11,987	\$18	\$0	\$0	\$0
x	x	✘	Navajo	Veterans for Veterans	1626 W. Denton Lane	Phoenix	AZ	85015	\$1,500	\$1,500	\$0	\$0	\$0	\$0
540303	AZ100688	✘	Yavapai County	West Yavapai Guidance Center	625 Hillside Avenue	Prescott	AZ	86301	\$2,678	\$2,678	\$81	\$0	\$0	\$0

591562	AZ100689	✘	Yavapai County	West Yavapai Guidance Center	642 Dameron Drive	Prescott	AZ	86301	\$503,451	\$396,622	\$12,011	\$106,829	\$0	\$0
904511	AZ101278	✘	Yavapai County	West Yavapai Guidance Center	555 W Road 3 North	Chino Valley	AZ	86323	\$4,238	\$4,238	\$128	\$0	\$0	\$0
3434	AZ300117	✘	Yavapai County	West Yavapai Guidance Clinic	505 South Cortez Street	Prescott	AZ	86301	\$60,895	\$60,895	\$1,844	\$0	\$0	\$0
116790	AZ100484	✘	Yavapai County	West Yavapai Guidance Clinic	642 Dameron Drive	Prescott	AZ	86301	\$221,853	\$221,853	\$6,719	\$0	\$0	\$0
159727	AZ102029	✘	Yavapai County	West Yavapai Guidance Clinic	3345 North Windsong Drive	Prescott Valley	AZ	86314	\$28,870	\$28,870	\$874	\$0	\$0	\$0
290802	AZ103177	✘	Yavapai County	West Yavapai Guidance Clinic	8655 East Eastridge Road, Suites A and B	Prescott Valley	AZ	86314	\$691	\$691	\$21	\$0	\$0	\$0
347207	x	✘	Yavapai County	West Yavapai Guidance Clinic	8655 East Eastridge Road	Prescott Valley	AZ	86314	\$4,049	\$4,049	\$123	\$0	\$0	\$0
366233	AZ000221	✔	Yavapai County	West Yavapai Guidance Clinic	3345 North Windsong Drive	Prescott Valley	AZ	86314	\$53,805	\$53,805	\$1,629	\$0	\$0	\$0
x	AZ102978	✔	Willcox	Willcox High School	480 North Bisbee Avenue	Willcox	AZ	85643	\$43,178	\$0	\$0	\$43,178	\$0	\$0
x	AZ104187	✘	Cochise County	Willcox Middle School	360 North Bisbee Avenue	Bisbee	AZ	85643	\$17,040	\$0	\$0	\$17,040	\$0	\$0
AZ101061	AZ101061	✘	Yuma	Yuma Family YMCA	1917 W 32nd Street	Yuma	AZ	85364	\$162,867	\$0	\$0	\$162,867	\$0	\$0
Total									\$34,297,593	\$24,567,269	\$3,090,981	\$8,019,957	\$0	\$0

* Indicates the imported record has an error.

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Footnotes:

III: Expenditure Reports

Table 8b - Expenditures for Services to Pregnant Women and Women with Dependent Children

This table provides a report of all statewide, non-federal funds expended on specialized treatment and related services which meet the SABG requirements for pregnant women and women with dependent children during the state fiscal year immediately preceding the federal fiscal year for which the state is applying for funds.

Expenditure Period Start Date: 10/1/2016 Expenditure Period End Date: 09/30/2018

Base

Period	Total Women's Base (A)
SFY 1994	\$ 2,796,016.00

Maintenance

Period	Total Women's Base (A)	Total Expenditures (B)	Expense Type
SFY 2017		\$ 3,500,777.00	
SFY 2018		\$ 3,500,777.00	
SFY 2019		\$ 3,500,777.00	<input checked="" type="radio"/> Actual <input type="radio"/> Estimated

Please provide a description of the amounts and methods used to calculate the base and, for 1994 and subsequent fiscal years, report the Federal and State expenditures for such services for services to pregnant women and women with dependent children as required by 42 U.S.C. §300x-22(b)(1). Please see attachment for the SABG Description of Calculations for Table 8b, Expenditures for Services to Pregnant Women and Women with Dependent Children.

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Please see uploaded attachment for the SABG Description of Calculations for Table 8b, Expenditures for Services to Pregnant Women and Women with Dependent Children.

SABG Description of Calculations for SFY2019, Reporting Due 12/1/2019

Table 8a: Maintenance of Effort for State Expenditures for SABG as required by 42 U.S.C. §300x-30(a);

The calculations reflect the aggregate state expenditures spent on authorized activities at the State Mental Health Agency (SMHA), which directly administers the SABG. The methodology is based on the requirements of 42 U.S.C. §300x-30(a). The methodology utilizes generally accepted accounting principles and is applied consistently each year. The calculation includes expenditures from the State General Fund (GF) and the Substance Abuse Services Fund (SASF). The calculation excludes federal, city, and county funds.

Table 8b: Women’s base for services to pregnant women and women with dependent children as required by 42 U.S.C §300x-22(b)(1); and for 1994 and subsequent fiscal years;

Calculations for the Women’s Base are grounded in a survey done in FY92 attempting to capture all specialty women’s treatment programs operating during that year. The total value of services to pregnant women, and women with dependent children who received primarily residential treatment services in FY92 at state supported treatment programs equaled \$1,225,977, which consisted of \$1,164,678 of Federal funds and \$61,299 of State Appropriations. This became the FY92 Women’s Base (**Table II**).

For FY93, States must spend not less than 5% of grant to increase, relative to FY92, the availability of treatment services designed for pregnant women and women with dependent children. In FY93, 5% of the block grant award equated to \$768,307. For FY94, States must spend not less than 5%, relative to FY93, for these services. In FY94, 5% of the block grant award equated to \$801,732 (**Table III**). The state will expend for such services for women not less than an amount equal to the amount expended for FY94 with equates to \$2,796,016.

Table II: Expenditures for Services to Pregnant Women & Women with Dependent Children (Base)

Period	(1992) Amount from ADMS Block Grant Spent for Pregnant Women and Women with Dependent Children	(1992) State Expenditures for Pregnant Women and Women with Dependent Children	(1992) Women’s Base
1992	\$1,164,678	\$61,299	\$1,225,977

Table III: Expenditures for Services to Pregnant Women & Women with Dependent Children (MOE)

Period	Total Women’s Base From Previous Year (A)	Total SAPT Block Grant Award (B)	5 % of SAPT Block Grant Award (C)	State Expenditures (D)	Total Women’s Base (A+B+C+D)
1993	\$1,225,977	\$15,366,146	\$768,307	\$0	\$1,994,284
1994	\$1,994,284	\$16,034,641	\$801,732	\$0	\$2,796,016
1995					\$2,796,016
1996					\$2,796,016

The State’s Chart of Accounts has a Major Program Structure set up in the AFIS Accounting System that tracks all disbursements for Pregnant Women and Women with Dependent Children from the SABG Block Grant. The amount reported in the 2019 reporting period reflects the total amount of federal block grant expenditures from the FFY2017 SABG Block Grant to ensure consistency in reporting with prior years.

Table 8b: Expenditures for Services to Pregnant Women & Women with Dependent Children

Period (State Fiscal Year)	Total Women’s Base (A)	Total Expenditures (B)	Reflects Grant Award
1994	\$2,796,016		
2008		\$3,500,777	FFY2006
2009		\$3,500,777	FFY2007
2010		\$3,500,777	FFY2008
2011		\$3,500,777	FFY2009
2012		\$3,515,680	FFY2010
2013		\$3,860,921	FFY2011
2014		\$3,500,777	FFY2012
2015		\$3,496,101	FFY2013
2016		\$4,274,549	FFY2014
2017		\$3,500,777	FFY2015
2018		\$3,500,777	FFY2016
2019		\$3,500,777	FFY2017

Footnote: Expenses reported in Column B reflect the Federal Fiscal Year Grant Award to maintain consistency in reporting.

IV: Population and Services Reports

Table 9 - Prevention Strategy Report

This table requires additional information (pursuant to Section 1929 of Title XIX, Part B, Subpart II of the PHS Act(42 U.S.C.? 300x29) about the primary prevention activities conducted by the entities listed on SABG Table 7.

Expenditure Period Start Date: 10/1/2016 Expenditure Period End Date: 9/30/2018

Column A (Risks)	Column B (Strategies)	Column C (Providers)
No Risk Assigned	1. Information Dissemination	
	1. Clearinghouse/information resources centers	19
	2. Resources directories	20
	3. Media campaigns	73
	4. Brochures	63
	5. Radio and TV public service announcements	28
	6. Speaking engagements	74
	7. Health fairs and other health promotion, e.g., conferences, meetings, seminars	81
	8. Information lines/Hot lines	14
	9. Distribution of Rx Safe Storage Materials, Rx Take Back Events	9
	2. Education	
	1. Parenting and family management	31
	2. Ongoing classroom and/or small group sessions	69
	3. Peer leader/helper programs	36
	4. Education programs for youth groups	81
	5. Mentors	14
	6. Preschool ATOD prevention programs	2
	7. Education/training for adults and/or community members	5
	3. Alternatives	
	1. Drug free dances and parties	32
	2. Youth/adult leadership activities	58
	3. Community drop-in centers	13
	4. Community service activities	39
	5. Outward Bound	3
	6. Recreation activities	56
	7. Drug-free zone at community events	2

4. Problem Identification and Referral	
1. Employee Assistance Programs	1
2. Student Assistance Programs	34
3. Driving while under the influence/driving while intoxicated education programs	11
4. Referral activities for behavioral health needs as indicated	10
5. Community-Based Process	
1. Community and volunteer training, e.g., neighborhood action training, impactor-training, staff/officials training	47
2. Systematic planning	64
3. Multi-agency coordination and collaboration/coalition	76
4. Community team-building	30
5. Accessing services and funding	21
6. Environmental	
1. Promoting the establishment or review of alcohol, tobacco, and drug use policies in schools	35
2. Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drugs	12
3. Modifying alcohol and tobacco advertising practices	6
4. Product pricing strategies	4
5. Law/Ordinances Passed	2

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Footnotes:

IV: Population and Services Reports

Table 10 - Treatment Utilization Matrix

This table is intended to capture the count of persons with initial admissions and subsequent admission(s) to an episode of care.

Expenditure Period Start Date: 7/1/2018 Expenditure Period End Date: 6/30/2019

Level of Care	Number of Admissions \geq Number of Persons Served		Costs per Person		
	Number of Admissions (A)	Number of Persons Served (B)	Mean Cost of Services (C)	Median Cost of Services (D)	Standard Deviation of Cost (E)
DETOXIFICATION (24-HOUR CARE)					
1. Hospital Inpatient	0	0	\$0	\$0	\$0
2. Free-Standing Residential	0	0	\$0	\$0	\$0
REHABILITATION/RESIDENTIAL					
3. Hospital Inpatient	0	0	\$0	\$0	\$0
4. Short-term (up to 30 days)	0	0	\$0	\$0	\$0
5. Long-term (over 30 days)	0	0	\$0	\$0	\$0
AMBULATORY (OUTPATIENT)					
6. Outpatient	0	0	\$0	\$0	\$0
7. Intensive Outpatient	0	0	\$0	\$0	\$0
8. Detoxification	0	0	\$0	\$0	\$0
MEDICATION-ASSISTED TREATMENT					
9. Medication-Assisted Treatment	0	0	\$0	\$0	\$0

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Table 11 - Unduplicated Count of Persons Served for Alcohol and Other Drug Use

This table provides an aggregate profile of the unduplicated number of admissions and persons for services funded through the SABG.

Expenditure Period Start Date: 7/1/2018 Expenditure Period End Date: 6/30/2019

Age	A. Total	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKA NATIVE		G. MORE THAN ONE RACE REPORTED		H. Unknown		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO		
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
1. 17 and Under	0																			
2. 18 - 24	0																			
3. 25 - 44	0																			
4. 45 - 64	0																			
5. 65 and Over	0																			
6. Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7. Pregnant Women	0																			
Number of persons served who were admitted in a period prior to the 12 month reporting period																				
Number of persons served outside of the levels of care described on Table 10																				

Are the values reported in this table generated from a client based system with unique client identifiers? Yes No

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Table 12 - SABG Early Intervention Services Regarding the Human Immunodeficiency Virus (EIS/HIV) in Designated States

Expenditure Period Start Date: 7/1/2018 Expenditure Period End Date: 6/30/2019

Early Intervention Services for Human Immunodeficiency Virus (HIV)		
1. Number of SAPT HIV EIS programs funded in the State	Statewide: _____	Rural: _____
2. Total number of individuals tested through SAPT HIV EIS funded programs		
3. Total number of HIV tests conducted with SAPT HIV EIS funds		
4. Total number of tests that were positive for HIV		
5. Total number of individuals who prior to the 12-month reporting period were unaware of their HIV infection		
6. Total number of HIV-infected individuals who were diagnosed and referred into treatment and care during the 12-month reporting period		
Identify barriers, including State laws and regulations, that exist in carrying out HIV testing services:		

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Table 13 - Charitable Choice

Under Charitable Choice Provisions; Final Rule (42 CFR Part 54), states, local governments, and religious organizations, such as 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.

Expenditure Period Start Date: 7/1/2018 Expenditure Period End Date: 6/30/2019

Notice to Program Beneficiaries - Check all that apply:

- Used model notice provided in final regulation.
- Used notice developed by State (please attach a copy to the Report).
- State has disseminated notice to religious organizations that are providers.
- State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- State has developed specific referral system for this requirement.
- State has incorporated this requirement into existing referral system(s).
- SAMHSA's Behavioral Health Treatment Locator is used to help identify providers.
- Other networks and information systems are used to help identify providers.
- State maintains record of referrals made by religious organizations that are providers.

0 Enter the total number of referrals to other substance abuse providers ("alternative providers") necessitated by religious objection, as defined above, made during the State fiscal year immediately preceding the federal fiscal year for which the state is applying for funds. Provide the total only. No information on specific referrals is required. If no alternative referrals were made, enter zero.

Provide a brief description (one paragraph) of any training for local governments and/or faith-based and/or community organizations that are providers on these requirements.

Trainings that local governments and/or faith-based and/or community organizations have are the Annual Substance Abuse and Mental Health Block Grant Relias Trainings, provider manual, contract requirement. One Regional Behavioral Health Authority (RBHA) reported that during the expenditure period provided, Over 548 staff affiliated with 32 network providers were trained on provisions affiliated with Charitable Choice through the Substance Abuse Block Grant (SABG) Relias training module. This content reinforced the expectation that Individuals receiving Substance Use treatment services under the SABG have the right to receive services from a provider to whose religious character they do not object. The training module also offers a definition for AMPM Exhibit 320-9, Notice to Individuals Receiving Substance Use Services.

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Footnotes:

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Table 14 - Treatment Performance Measure Employment/Education Status (From Admission to Discharge)

Short-term Residential(SR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	47	41
Total number of clients with non-missing values on employment/student status [denominator]	493	493
Percent of clients employed or student (full-time and part-time)	9.5 %	8.3 %
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		621
Number of CY 2018 discharges submitted:		526
Number of CY 2018 discharges linked to an admission:		522
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		493
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):		493

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

Long-term Residential(LR)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	4	9
Total number of clients with non-missing values on employment/student status [denominator]	34	34
Percent of clients employed or student (full-time and part-time)	11.8 %	26.5 %
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		37
Number of CY 2018 discharges submitted:		40
Number of CY 2018 discharges linked to an admission:		37
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		34

Number of CY 2018 linked discharges eligible for this calculation (non-missing values):	34
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Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

Outpatient (OP)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	4,349	4,674
Total number of clients with non-missing values on employment/student status [denominator]	13,658	13,658
Percent of clients employed or student (full-time and part-time)	31.8 %	34.2 %
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		23,221
Number of CY 2018 discharges submitted:		16,225
Number of CY 2018 discharges linked to an admission:		15,455
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		13,704
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):		13,658

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

Intensive Outpatient (IO)

Employment/Education Status – Clients employed or student (full-time and part-time) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of clients employed or student (full-time and part-time) [numerator]	1	2
Total number of clients with non-missing values on employment/student status [denominator]	22	22
Percent of clients employed or student (full-time and part-time)	4.5 %	9.1 %
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		27
Number of CY 2018 discharges submitted:		24
Number of CY 2018 discharges linked to an admission:		24
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		22

Number of CY 2018 linked discharges eligible for this calculation (non-missing values):

22

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

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Table 15 - Treatment Performance Measure Stability of Housing (From Admission to Discharge)

Short-term Residential(SR)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	235	231
Total number of clients with non-missing values on living arrangements [denominator]	459	459
Percent of clients in stable living situation	51.2 %	50.3 %
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		621
Number of CY 2018 discharges submitted:		526
Number of CY 2018 discharges linked to an admission:		522
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		493
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):		459

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

Long-term Residential(LR)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	25	28
Total number of clients with non-missing values on living arrangements [denominator]	33	33
Percent of clients in stable living situation	75.8 %	84.8 %
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		37
Number of CY 2018 discharges submitted:		40
Number of CY 2018 discharges linked to an admission:		37
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		34
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):		33

Outpatient (OP)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	11,648	11,698
Total number of clients with non-missing values on living arrangements [denominator]	13,154	13,154
Percent of clients in stable living situation	88.6 %	88.9 %
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		23,221
Number of CY 2018 discharges submitted:		16,225
Number of CY 2018 discharges linked to an admission:		15,455
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		13,704
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):		13,154

Intensive Outpatient (IO)

Clients living in a stable living situation (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients living in a stable situation [numerator]	18	18
Total number of clients with non-missing values on living arrangements [denominator]	21	21
Percent of clients in stable living situation	85.7 %	85.7 %
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		27
Number of CY 2018 discharges submitted:		24
Number of CY 2018 discharges linked to an admission:		24
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		22
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):		21

Footnotes:

IV: Population and Services Reports

Table 16 - Treatment Performance Measure Criminal Justice Involvement (From Admission to Discharge)

Short-term Residential(SR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	458	462
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	500	500
Percent of clients without arrests	91.6 %	92.4 %
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		621
Number of CY 2018 discharges submitted:		526
Number of CY 2018 discharges linked to an admission:		522
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		500
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):		500

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

Long-term Residential(LR)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	34	36
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	37	37
Percent of clients without arrests	91.9 %	97.3 %
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		37
Number of CY 2018 discharges submitted:		40
Number of CY 2018 discharges linked to an admission:		37
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		37

Number of CY 2018 linked discharges eligible for this calculation (non-missing values):	37
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Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
 [Records received through 5/1/2019]

Outpatient (OP)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	12,341	12,466
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	14,269	14,269
Percent of clients without arrests	86.5 %	87.4 %
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		23,221
Number of CY 2018 discharges submitted:		16,225
Number of CY 2018 discharges linked to an admission:		15,455
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		14,269
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):		14,269

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
 [Records received through 5/1/2019]

Intensive Outpatient (IO)

Clients without arrests (any charge) (prior 30 days) at admission vs. discharge

	At Admission(T1)	At Discharge(T2)
Number of Clients without arrests [numerator]	19	17
Total number of Admission and Discharge clients with non-missing values on arrests [denominator]	23	23
Percent of clients without arrests	82.6 %	73.9 %
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		27
Number of CY 2018 discharges submitted:		24
Number of CY 2018 discharges linked to an admission:		24
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		23

Number of CY 2018 linked discharges eligible for this calculation (non-missing values):

23

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

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Footnotes:

IV: Population and Services Reports

Table 17 - Treatment Performance Measure Change in Abstinence - Alcohol Use (From Admission to Discharge)

Short-term Residential(SR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	364	416
All clients with non-missing values on at least one substance/frequency of use [denominator]	500	500
Percent of clients abstinent from alcohol	72.8 %	83.2 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		67
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	136	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		49.3 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		349
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	364	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		95.9 %

Notes (for this level of care):

Number of CY 2018 admissions submitted:	621
Number of CY 2018 discharges submitted:	526
Number of CY 2018 discharges linked to an admission:	522
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	500
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):	500

Long-term Residential(LR)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	25	22
All clients with non-missing values on at least one substance/frequency of use [denominator]	37	37
Percent of clients abstinent from alcohol	67.6 %	59.5 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		1
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	12	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		8.3 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		21
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	25	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		84.0 %

Notes (for this level of care):

Number of CY 2018 admissions submitted:	37
Number of CY 2018 discharges submitted:	40
Number of CY 2018 discharges linked to an admission:	37
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	37
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):	37

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	10,904	10,755
All clients with non-missing values on at least one substance/frequency of use [denominator]	14,269	14,269
Percent of clients abstinent from alcohol	76.4 %	75.4 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		620
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	3,365	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		18.4 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		10,135
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	10,904	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		92.9 %

Notes (for this level of care):

Number of CY 2018 admissions submitted:	23,221
Number of CY 2018 discharges submitted:	16,225
Number of CY 2018 discharges linked to an admission:	15,455
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	14,269
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):	14,269

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

Intensive Outpatient (IO)

A. ALCOHOL ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Alcohol Abstinence – Clients with no alcohol use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol [numerator]	18	16
All clients with non-missing values on at least one substance/frequency of use [denominator]	23	23
Percent of clients abstinent from alcohol	78.3 %	69.6 %

B. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL USERS AT ADMISSION

Clients abstinent from alcohol at discharge among clients using alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients using alcohol at admission [numerator]		1
Number of clients using alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	5	
Percent of clients abstinent from alcohol at discharge among clients using alcohol at admission [#T2 / #T1 x 100]		20.0 %

C. ALCOHOL ABSTINENCE AT DISCHARGE, AMONG ALCOHOL ABSTINENT AT ADMISSION

Clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [numerator]		15
Number of clients abstinent from alcohol at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	18	
Percent of clients abstinent from alcohol at discharge among clients abstinent from alcohol at admission [#T2 / #T1 x 100]		83.3 %

Notes (for this level of care):

Number of CY 2018 admissions submitted:	27
Number of CY 2018 discharges submitted:	24
Number of CY 2018 discharges linked to an admission:	24
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	23
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):	23

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

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Footnotes:

IV: Population and Services Reports

Table 18 - Treatment Performance Measure Change in Abstinence - Other Drug Use (From Admission to Discharge)

Short-term Residential(SR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	165	302
All clients with non-missing values on at least one substance/frequency of use [denominator]	500	500
Percent of clients abstinent from drugs	33.0 %	60.4 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		156
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	335	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		46.6 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		146
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	165	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		88.5 %

Notes (for this level of care):

Number of CY 2018 admissions submitted:	621
Number of CY 2018 discharges submitted:	526
Number of CY 2018 discharges linked to an admission:	522
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	500
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):	500

Long-term Residential(LR)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	22	25
All clients with non-missing values on at least one substance/frequency of use [denominator]	37	37
Percent of clients abstinent from drugs	59.5 %	67.6 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		6
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	15	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		40.0 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		19
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	22	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		86.4 %

Notes (for this level of care):

Number of CY 2018 admissions submitted:	37
Number of CY 2018 discharges submitted:	40
Number of CY 2018 discharges linked to an admission:	37
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	37
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):	37

Outpatient (OP)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	7,709	7,349
All clients with non-missing values on at least one substance/frequency of use [denominator]	14,269	14,269
Percent of clients abstinent from drugs	54.0 %	51.5 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		1,113
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	6,560	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		17.0 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		6,236
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	7,709	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		80.9 %

Notes (for this level of care):

Number of CY 2018 admissions submitted:	23,221
Number of CY 2018 discharges submitted:	16,225
Number of CY 2018 discharges linked to an admission:	15,455
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	14,269
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):	14,269

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

Intensive Outpatient (IO)

A. DRUG ABSTINENCE AMONG ALL CLIENTS – CHANGE IN ABSTINENCE (From Admission to Discharge)

Drug Abstinence – Clients with no Drug use at admission vs. discharge, as a percent of all clients (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs [numerator]	13	10
All clients with non-missing values on at least one substance/frequency of use [denominator]	23	23
Percent of clients abstinent from drugs	56.5 %	43.5 %

B. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG USERS AT ADMISSION

Clients abstinent from Drug at discharge among clients using Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients using drugs at admission [numerator]		5
Number of clients using drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	10	
Percent of clients abstinent from drugs at discharge among clients using Drug at admission [#T2 / #T1 x 100]		50.0 %

C. DRUG ABSTINENCE AT DISCHARGE, AMONG DRUG ABSTINENT AT ADMISSION

Clients abstinent from Drug at discharge among clients abstinent from Drug at admission (regardless of primary problem)

	At Admission(T1)	At Discharge(T2)
Number of clients abstinent from drugs at discharge among clients abstinent from drugs at admission [numerator]		5
Number of clients abstinent from drugs at admission (records with at least one substance/frequency of use at admission and discharge [denominator]	13	
Percent of clients abstinent from drugs at discharge among clients abstinent from Drug at admission [#T2 / #T1 x 100]		38.5 %

Notes (for this level of care):

Number of CY 2018 admissions submitted:	27
Number of CY 2018 discharges submitted:	24
Number of CY 2018 discharges linked to an admission:	24
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	23
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):	23

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
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Footnotes:

IV: Population and Services Reports

Table 19 - Treatment Performance Measure Change in Social Support Of Recovery (From Admission to Discharge)

Short-term Residential(SR)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	104	278
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	500	500
Percent of clients participating in self-help groups	20.8 %	55.6 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	34.8 %	
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		621
Number of CY 2018 discharges submitted:		526
Number of CY 2018 discharges linked to an admission:		522
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):		500
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):		500

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

Long-term Residential(LR)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	8	13
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	37	37
Percent of clients participating in self-help groups	21.6 %	35.1 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	13.5 %	
Notes (for this level of care):		
Number of CY 2018 admissions submitted:		37
Number of CY 2018 discharges submitted:		40

Number of CY 2018 discharges linked to an admission:	37
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	37
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):	37

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

Outpatient (OP)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	2,469	2,726
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	14,269	14,269
Percent of clients participating in self-help groups	17.3 %	19.1 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	1.8 %	

Notes (for this level of care):

Number of CY 2018 admissions submitted:	23,221
Number of CY 2018 discharges submitted:	16,225
Number of CY 2018 discharges linked to an admission:	15,455
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	14,269
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):	14,269

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

Intensive Outpatient (IO)

Social Support of Recovery - Clients participating in self-help groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge

	At Admission (T1)	At Discharge (T2)
Number of clients participating in self-help groups (AA NA meetings attended, etc.) [numerator]	6	7
Total number of Admission and Discharge clients with non-missing values on participation in self-help groups [denominator]	23	23
Percent of clients participating in self-help groups	26.1 %	30.4 %
Percent of clients with participation in self-help groups at discharge minus percent of clients with self-help attendance at admission Absolute Change [%T2-%T1]	4.3 %	

Notes (for this level of care):

Number of CY 2018 admissions submitted:	27
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Number of CY 2018 discharges submitted:	24
Number of CY 2018 discharges linked to an admission:	24
Number of linked discharges after exclusions (excludes: detox, hospital inpatient, opioid replacement clients; deaths; incarcerated):	23
Number of CY 2018 linked discharges eligible for this calculation (non-missing values):	23

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file
[Records received through 5/1/2019]

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Footnotes:

IV: Population and Services Reports

Table 20 - Retention - Length of Stay (in Days) of Clients Completing Treatment

Level of Care	Average (Mean)	25 th Percentile	50 th Percentile (Median)	75 th Percentile
DETOXIFICATION (24-HOUR CARE)				
1. Hospital Inpatient	153	33	68	170
2. Free-Standing Residential	180	21	126	237
REHABILITATION/RESIDENTIAL				
3. Hospital Inpatient	191	22	101	232
4. Short-term (up to 30 days)	112	46	60	117
5. Long-term (over 30 days)	367	169	328	524
AMBULATORY (OUTPATIENT)				
6. Outpatient	274	91	197	378
7. Intensive Outpatient	209	45	99	209
8. Detoxification	0	0	0	0
MEDICATION-ASSISTED TREATMENT				
9. Medication-Assisted Treatment	894	894	894	894

Level of Care	2018 TEDS discharge record count	
	Discharges submitted	Discharges linked to an admission
DETOXIFICATION (24-HOUR CARE)		
1. Hospital Inpatient	16	15
2. Free-Standing Residential	23	22
REHABILITATION/RESIDENTIAL		
3. Hospital Inpatient	78	77
4. Short-term (up to 30 days)	526	522
5. Long-term (over 30 days)	40	37

AMBULATORY (OUTPATIENT)		
6. Outpatient	16225	14393
7. Intensive Outpatient	24	24
8. Detoxification	0	0
MEDICATION-ASSISTED TREATMENT		
9. Medication-Assisted Treatment		1

Source: SAMHSA/CBHSQ TEDS CY 2018 admissions file and CY 2018 linked discharge file

[Records received through 5/1/2019]

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Footnotes:

V: Performance Indicators and Accomplishments

TABLE 21 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: REDUCED MORBIDITY - ABSTINENCE FROM DRUG USE/ALCOHOL USE MEASURE: 30-DAY USE

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. 30-day Alcohol Use	<p>Source Survey Item: NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from [DATEFILL] through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?[Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having used alcohol during the past 30 days.</p>		
	Age 12 - 20 - CY 2016 - 2017	16.4	
	Age 21+ - CY 2016 - 2017	56.7	
2. 30-day Cigarette Use	<p>Source Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you smoke part or all of a cigarette?[Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having smoked a cigarette during the past 30 days.</p>		
	Age 12 - 17 - CY 2016 - 2017	1.5	
	Age 18+ - CY 2016 - 2017	17.7	
3. 30-day Use of Other Tobacco Products	<p>Survey Item: NSDUH Questionnaire: "During the past 30 days, that is, since [DATEFILL], on how many days did you use [other tobacco products]^[1]?[Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having used a tobacco product other than cigarettes during the past 30 days, calculated by combining responses to questions about individual tobacco products (cigars, smokeless tobacco, pipe tobacco).</p>		
	Age 12 - 17 - CY 2016 - 2017	1.3	
	Age 18+ - CY 2016 - 2017	7.1	
4. 30-day Use of Marijuana	<p>Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?[Response option: Write in a number between 0 and 30.]</p> <p>Outcome Reported: Percent who reported having used marijuana or hashish during the past 30 days.</p>		
	Age 12 - 17 - CY 2016 - 2017	5.7	
	Age 18+ - CY 2016 - 2017	9.1	
5. 30-day Use of Illegal Drugs Other Than Marijuana	<p>Source Survey Item: NSDUH Questionnaire: "Think specifically about the past 30 days, from [DATEFILL] up to and including today. During the past 30 days, on how many days did you use [any other illegal drug]^[2]</p> <p>Outcome Reported: Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, hallucinogens, inhalants, methamphetamine, and misuse of prescription drugs).</p>		
	Age 12 - 17 - CY 2016 - 2017	1.5	

	Age 18+ - CY 2016 - 2017	4.2	
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[1]NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.

[2]NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

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V: Performance Indicators and Accomplishments

Table 22 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: REDUCED MORBIDITY-ABSTINENCE FROM DRUG USE/ALCOHOL USE; MEASURE: PERCEPTION OF RISK/HARM OF USE

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
1. Perception of Risk From Alcohol	<p>Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.</p>		
	Age 12 - 20 - CY 2016 - 2017	79.2	
	Age 21+ - CY 2016 - 2017	79.3	
2. Perception of Risk From Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day? [Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.</p>		
	Age 12 - 17 - CY 2016 - 2017	92.0	
	Age 18+ - CY 2016 - 2017	92.7	
3. Perception of Risk From Marijuana	<p>Source Survey Item: NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?[Response options: No risk, slight risk, moderate risk, great risk] Outcome Reported: Percent reporting moderate or great risk.</p>		
	Age 12 - 17 - CY 2016 - 2017	65.0	
	Age 18+ - CY 2016 - 2017	53.9	

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Table 23 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: REDUCED MORBIDITY-ABSTINENCE FROM DRUG USE/ALCOHOL USE; MEASURE: AGE OF FIRST USE

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
1. Age at First Use of Alcohol	<p>Source Survey Item: NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink. [Response option: Write in age at first use.]</p> <p>Outcome Reported: Average age at first use of alcohol.</p>		
	Age 12 - 20 - CY 2016 - 2017	14.9	
	Age 21+ - CY 2016 - 2017		
2. Age at First Use of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?[Response option: Write in age at first use.]</p> <p>Outcome Reported: Average age at first use of cigarettes.</p>		
	Age 12 - 17 - CY 2016 - 2017	12.9	
	Age 18+ - CY 2016 - 2017	16.3	
3. Age at First Use of Tobacco Products Other Than Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product]^[1]?[Response option: Write in age at first use.]</p> <p>Outcome Reported: Average age at first use of tobacco products other than cigarettes.</p>		
	Age 12 - 17 - CY 2016 - 2017	14.0	
	Age 18+ - CY 2016 - 2017	20.8	
4. Age at First Use of Marijuana or Hashish	<p>Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?[Response option: Write in age at first use.]</p> <p>Outcome Reported: Average age at first use of marijuana or hashish.</p>		
	Age 12 - 17 - CY 2016 - 2017	13.6	
	Age 18+ - CY 2016 - 2017	18.3	
5. Age at First Use Heroin	<p>Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used heroin? [Response option: Write in age at first use.]</p> <p>Outcome Reported: Average age at first use of heroin.</p>		
	Age 12 - 17 - CY 2016 - 2017		
	Age 18+ - CY 2016 - 2017		
6. Age at First Misuse of Prescription Pain Relievers Among Past Year Initiates	<p>Source Survey Item: NSDUH Questionnaire: "How old were you the first time you used [specific pain reliever]^[2] in a way a doctor did not direct you to use it?"[Response option: Write in age at first use.]</p> <p>Outcome Reported: Average age at first misuse of prescription pain relievers among those who first misused prescription pain relievers in the last 12 months.</p>		

	Age 12 - 17 - CY 2016 - 2017		
	Age 18+ - CY 2016 - 2017		

[1]The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.

[2]The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

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Table 24 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: REDUCED MORBIDITY-ABSTINENCE FROM DRUG USE/ALCOHOL USE; MEASURE: PERCEPTION OF DISAPPROVAL/ATTITUDES

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
1. Disapproval of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>		
	Age 12 - 17 - CY 2016 - 2017	94.7	
2. Perception of Peer Disapproval of Cigarettes	<p>Source Survey Item: NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent reporting that their friends would somewhat or strongly disapprove.</p>		
	Age 12 - 17 - CY 2016 - 2017	88.7	
3. Disapproval of Using Marijuana Experimentally	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>		
	Age 12 - 17 - CY 2016 - 2017	77.3	
4. Disapproval of Using Marijuana Regularly	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>		
	Age 12 - 17 - CY 2016 - 2017	79.1	
5. Disapproval of Alcohol	<p>Source Survey Item: NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?[Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove]"</p> <p>Outcome Reported: Percent somewhat or strongly disapproving.</p>		
	Age 12 - 20 - CY 2016 - 2017		

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Table 25 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: EMPLOYMENT/EDUCATION; MEASURE: PERCEPTION OF WORKPLACE POLICY

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
Perception of Workplace Policy	<p>Source Survey Item: NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?[Response options: More likely, less likely, would make no difference]"</p> <p>Outcome Reported: Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.</p>		
	Age 15 - 17 - CY 2016 - 2017		
	Age 18+ - CY 2016 - 2017	35.2	

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Table 26 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN - EMPLOYMENT/EDUCATION; MEASURE: AVERAGE DAILY SCHOOL ATTENDANCE RATE

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
Average Daily School Attendance Rate	<p>Source: National Center for Education Statistics, Common Core of Data: <i>The National Public Education Finance Survey</i> available for download at http://nces.ed.gov/ccd/stfis.asp.</p> <p>Measure calculation: Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.</p>		
	School Year 2016		

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Table 27 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: CRIME AND CRIMINAL JUSTICE MEASURE: ALCOHOL-RELATED TRAFFIC FATALITIES

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
Alcohol-Related Traffic Fatalities	<p>Source: National Highway Traffic Safety Administration Fatality Analysis Reporting System</p> <p>Measure calculation: The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.</p>		
	CY 2017		

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Table 28 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: CRIME AND CRIMINAL JUSTICE MEASURE: ALCOHOL- AND DRUG-RELATED ARRESTS

A. Measure	B. Question/Response	C. Pre-populated Data	D. Supplemental Data, if any
Alcohol- and Drug-Related Arrests	<p>Source: Federal Bureau of Investigation Uniform Crime Reports</p> <p>Measure calculation: The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.</p>		
	CY 2017		

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Table 29 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN: SOCIAL CONNECTEDNESS; MEASURE: FAMILY COMMUNICATIONS AROUND DRUG AND ALCOHOL USE

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
1. Family Communications Around Drug and Alcohol Use (Youth)	<p>Source Survey Item: NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you.?[Response options: Yes, No]"</p> <p>Outcome Reported: Percent reporting having talked with a parent.</p>		
	Age 12 - 17 - CY 2016 - 2017	62.4	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12-17)	<p>Source Survey Item: NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?^[1][Response options: 0 times, 1 to 2 times, a few times, many times]"</p> <p>Outcome Reported: Percent of parents reporting that they have talked to their child.</p>		
	Age 18+ - CY 2016 - 2017		

[1]NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

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Table 30 - SUBSTANCE ABUSE PREVENTION NOMS DOMAIN - RETENTION MEASURE: PERCENTAGE OF YOUTH SEEING, READING, WATCHING, OR LISTENING TO A PREVENTION MESSAGE

A. Measure	B. Question/Response	C. Pre- populated Data	D. Supplemental Data, if any
Exposure to Prevention Messages	Source Survey Item: NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] ^[1] ? Outcome Reported: Percent reporting having been exposed to prevention message.		
	Age 12 - 17 - CY 2016 - 2017	81.6	

[1]This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context
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Table 31-35 - Reporting Period - Start and End Dates for Information Reported on Tables 31, 32, 33, 34, and 35

Reporting Period Start and End Dates for Information Reported on Tables 33, 34, 35, 36 and 37

Please indicate the reporting period for each of the following NOMS.

Tables	A. Reporting Period Start Date	B. Reporting Period End Date
1. Table 31 - SUBSTANCE ABUSE PREVENTION - Individual-Based Programs and Strategies: Number of Persons Served by Age, Gender, Race, and Ethnicity	7/1/2018	6/30/2019
2. Table 32 - SUBSTANCE ABUSE PREVENTION - Population-Based Programs and Strategies? Number of Persons Served by Age, Gender, Race, and Ethnicity	7/1/2018	6/30/2019
3. Table 33 (Optional) - SUBSTANCE ABUSE PREVENTION - Number of Persons Served by Type of Intervention	7/1/2018	6/30/2019
4. Table 34 - Substance Abuse Prevention - Evidence-Based Programs and Strategies by Type of Intervention	7/1/2018	6/30/2019
5. Table 35 - Total SUBSTANCE ABUSE PREVENTION Number of Evidence Based Programs/Strategies and Total SABG Dollars Spent on SUBSTANCE ABUSE PREVENTION Evidence-Based Programs/Strategies	7/1/2018	6/30/2019

General Questions Regarding Prevention NOMS Reporting

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

Manual process.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race.

Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

Participants that identify more than one race are counted only in the More Than One Race Subcategory.

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Table 31 - SUBSTANCE ABUSE PREVENTION - Individual-Based Programs and Strategies: Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Total
A. Age	250557
0-4	772
5-11	9859
12-14	30817
15-17	64151
18-20	5267
21-24	1412
25-44	8319
45-64	5384
65 and over	3299
Age Not Known	121277
B. Gender	250557
Male	65074
Female	71500
Gender Not Known	113983
C. Race	250557
White	70996
Black or African American	6219
Native Hawaiian/Other Pacific Islander	580
Asian	2965
American Indian/Alaska Native	18335
More Than One Race (not OMB required)	7416

Race Not Known or Other (not OMB required)	144046
D. Ethnicity	250557
Hispanic or Latino	37058
Not Hispanic or Latino	75088
Ethnicity Unknown	138411

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Table 32 - SUBSTANCE ABUSE PREVENTION - Population-Based Programs and Strategies?Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Total
A. Age	2740944
0-4	3503
5-11	17590
12-14	204574
15-17	298225
18-20	193208
21-24	147614
25-44	380155
45-64	402276
65 and over	160046
Age Not Known	933753
B. Gender	2740944
Male	917146
Female	958019
Gender Not Known	865779
C. Race	2740944
White	657209
Black or African American	269188
Native Hawaiian/Other Pacific Islander	34107
Asian	145752
American Indian/Alaska Native	238585
More Than One Race (not OMB required)	150107

Race Not Known or Other (not OMB required)	1245996
D. Ethnicity	2740944
Hispanic or Latino	619130
Not Hispanic or Latino	1257412
Ethnicity Unknown	864402

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Table 33 (Optional) - SUBSTANCE ABUSE PREVENTION - Number of Persons Served by Type of Intervention

Number of Persons Served by Individual- or Population-Based Program or Strategy

Intervention Type	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct		N/A
2. Universal Indirect	N/A	
3. Selective		N/A
4. Indicated		N/A
5. Total	0	0

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Table 34 - Substance Abuse Prevention - Evidence-Based Programs and Strategies by Type of Intervention

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, **Identifying and Selecting Evidence-based Interventions**, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
 - Guideline 1:
The intervention is based on a theory of change that is documented in a clear logic or conceptual model; and
 - Guideline 2:
The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; and
 - Guideline 3:
The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to Identifying and Selecting Evidence-Based Interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
 - Guideline 4:
The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.

Arizona has delegated the process to implement Evidence-Based Programs (EBP) and Strategies to the contractors. Arizona has completed a Needs Assessment that addresses the use and development of Evidence Based Programs. A Strategic Plan will be developed based on the information obtained through the Needs Assessment and will guide the process to provide for a consistent statewide effort and ease of access for local programs to demonstrate they meet the four guidelines listed above to be deemed an EBP for their respective demographic and culture. Starting October 1, 2019, Arizona has implemented a protocol to gather a baseline of EBPs, Promising Practices (PPs), and Innovative Practices (IPs) currently being implemented within the state. This protocol will also serve as an additional monitoring and compliance tool that Arizona will use to monitor the contractors. This protocol requires contractors to adhere to a ratio of EBPs/PPs to IPs (1:1), as well as to report the use of any/all IPs to the state before they can be implemented. The reports are reviewed by state staff and require the contractor to include information regarding the innovative program's available evidence for implementation over the use of available EBPs/PPs, description of the interventions practical and conceptual fit, and protocol to mitigate/remove risks of innovative intervention implementation on the priority population, including a process for referral to appropriate services as needed. State staff will provide an approval or denial for all proposed innovative programs.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?

The contractors employ several different sources of data for collecting information regarding the programs and strategies including, contracts, database for all prevention providers under the contractor, interviews, questionnaires and surveys, annual submissions of logic models and strategic plans, and review of program curricula. Starting October 1, 2019, Arizona has implemented a protocol to further monitoring and provide state staff with a mechanism to hold contractors accountable to the reports being submitted for these items. This protocol includes the submission of all contractor logic models to state staff for review, and the submission of copies of all contractor and subcontractor contracts for review by state staff. Using these protocols allows a checks and balances to ensure all programs being implemented are within AZ guidelines are requirements.

Table 34 - SUBSTANCE ABUSE PREVENTION Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selective	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	61	7	68	16	23	107
2. Total number of Programs and Strategies Funded	308	132	440	65	112	617
3. Percent of Evidence-Based Programs and Strategies	19.81 %	5.30 %	15.45 %	24.62 %	20.54 %	17.34 %

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Table 35 - Total SUBSTANCE ABUSE PREVENTION Number of Evidence Based Programs/Strategies and Total SABG Dollars Spent on SUBSTANCE ABUSE PREVENTION Evidence-Based Programs/Strategies

	Total Number of Evidence-Based Programs/Strategies for IOM Category Below	Total SAPT Block Grant Dollars Spent on evidence-based Programs/Strategies
Universal Direct	Total # 38	\$ 1141049.00
Universal Indirect	Total # 7	\$ 204256.00
Selective	Total # 13	\$ 227184.00
Indicated	Total # 13	\$ 239558.00
Unspecified	Total # 0	\$ 0.00
	Total EBPs: 71	Total Dollars Spent: \$1812047.00

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Prevention Attachments

Submission Uploads

FFY 2020 Prevention Attachment Category A:		
File	Version	Date Added

FFY 2020 Prevention Attachment Category B:		
File	Version	Date Added

FFY 2020 Prevention Attachment Category C:		
File	Version	Date Added

FFY 2020 Prevention Attachment Category D:		
File	Version	Date Added

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