

# **Arizona**

Substance Abuse Prevention and Treatment Block Grant  
(SAPT)

Community Mental Health Services Block Grant  
(CMHS)

## **Combined Planning Application FY 2014 – 2015**

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services  
Center for Substance Abuse Treatment  
Center for Substance Abuse Prevention

## I: State Information

### State Information

#### Plan Year

Start Year:

2014

End Year:

2015

#### State SAPT DUNS Number

Number

804745420

Expiration Date

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

Agency Name

Arizona Department of Health Services

Organizational Unit

Division of Behavioral Health Services

Mailing Address

150 N. 18th Avenue, Suite 240

City

Phoenix

Zip Code

85007

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

First Name

Will

Last Name

Humble

Agency Name

Arizona Department of Health Services

Mailing Address

150 N. 18th Avenue, Suite 500

City

Phoenix

Zip Code

85007

Telephone

602-542-1025

Fax

602-542-1062

Email Address

will.humble@azdhs.gov

#### State CMHS DUNS Number

Number

Expiration Date

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

Agency Name

Arizona Department of Health Services

**Organizational Unit**

Division of Behavioral Health Services

**Mailing Address**

150 N. 18th Avenue, Suite 240

**City**

Phoenix

**Zip Code**

85007

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

**First Name**

Will

**Last Name**

Humble

**Agency Name**

Arizona Department of Health Services

**Mailing Address**

150 N. 18th Avenue, Suite 500

**City**

Phoenix

**Zip Code**

85007

**Telephone**

602-542-1025

**Fax**

602-542-1062

**Email Address**

will.humble@azdhs.gov

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

**From**

**To**

**IV. Date Submitted**

NOTE: this field will be automatically populated when the application is submitted.

**Submission Date**

**Revision Date**

**V. Contact Person Responsible for Application Submission**

**First Name**

Kelly

**Last Name**

Charbonneau

**Telephone**

602-364-1356

**Fax**

602-364-4736

**Email Address**

kelly.charbonneau@azdhs.gov

**Footnotes:**



# I: State Information

## Assurance - Non-Construction Programs

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Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

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Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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Name	<input type="text" value="Will Humble"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="Arizona Department of Health Services"/>

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Footnotes:**

Please see Application Attachments for Arizona's Chief Executive Delegation Letter.

# I: State Information

## Assurance - Non-Construction Programs

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**Note:** Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

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

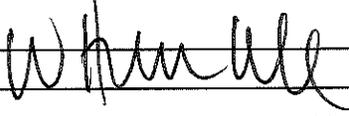
1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
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15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
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17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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Name:   
Title:   
Organization:

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Signature:  Date: 2/11/13

**Footnotes:**

Please see Application Attachments for Arizona's Chief Executive Delegation Letter.

# I: State Information

## Certifications

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

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

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management  
Office of Grants Management  
Office of the Assistant Secretary for Management and Budget

### 3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

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

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

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

### 4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

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

### 5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

---

Name	<input type="text" value="Will Humble"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="Arizona Department of Health Services"/>

---

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Footnotes:

Please see Application Attachments for Arizona's Chief Executive



# I: State Information

## Certifications

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

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

For purposes of paragraph (f) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

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Office of Grants Management  
Office of the Assistant Secretary for Management and Budget

### 3. Certifications Regarding Lobbying

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

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

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

### 4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

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

### 5. Certification Regarding Environmental Tobacco Smoke

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

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

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

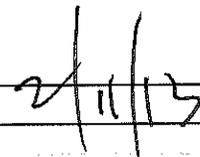
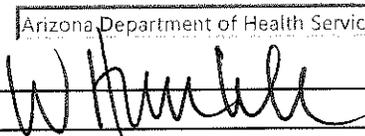
The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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

Name:   
Title:   
Organization:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



#### Footnotes:

Please see Application Attachments for Arizona's Chief Executive

Delegation Letter.

### CHECKLIST

**Public Burden Statement:** Public reporting burden of this collection of information is estimated to average 4 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC.

Clearance Officer, 1600 Clifton Road, MS D-24 Atlanta, GA 30333, Attn: PRA (0920-0428). Do not send the completed form to this address.

**NOTE TO APPLICANT:** This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last page of the signed original of the application. This page is reserved for PHS staff use only.

Type of Application:  New  Noncompeting Continuation  Competing Continuation  Supplemental

**PART A: the following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.**

	Included	NOT Applicable
1. Proper Signature and Date for Item 18 on SF 424 (FACE PAGE)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Proper Signature and Date on PHS-5161-1 "Certifications" page	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Proper Signature and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. If your organization currently has on file with DHHS the following Assurances, please identify which have been filed by indicating the Date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690)		
<input checked="" type="checkbox"/> Civil Rights Assurance (45 CFR 80)	03/24/1997	
<input checked="" type="checkbox"/> Assurance Concerning the Handicapped (45CFR 84)	03/24/1997	
<input checked="" type="checkbox"/> Assurance Concerning Sex Discrimination (45CFR 86)	03/24/1997	
<input checked="" type="checkbox"/> Assurance Concerning Age Discrimination (45CFR 90 & 45 CFR 91)	03/24/1997	
5. Human Subjects Certification, when applicable (45CFR 46)	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**PART B: this part is provided to assure that pertinent information has been addressed and included in the application.**

	YES	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Has the appropriate box been checked for item #16 on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	<input checked="" type="checkbox"/>	
3. Has the entire proposed project period been identified in item # 13 of the FACE PAGE	<input checked="" type="checkbox"/>	
4. Have biographical sketch(es) with job description(s) been attached, when required?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	<input checked="" type="checkbox"/>	
6. Has the 12 month detailed budget been provided?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Has the budget for the entire proposed project period with sufficient detail been provided?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. For a Supplemental application, does the detailed budget address only the additional funds requested?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. For Competing continuation and Supplemental applications, has a progress report been included?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**PART C: In the spaces provided below, please provide the requested information.**

Business Official to be notified if an award is to be made.

<b>Name</b>	Will Humble
<b>Title</b>	Director
<b>Organization</b>	Arizona Department of Health Services
<b>Address</b>	150 N. 18 <sup>th</sup> Ave., Phoenix, AZ 85007
<b>E-mail Address</b>	humblew@azdhs.gov
<b>Telephone Number</b>	(602) 542-1025
<b>Fax Number</b>	(602) 542-1062

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

<b>Name</b>	Kelly Charbonneau
<b>Title</b>	Substance Abuse Grants Coordinator
<b>Organization</b>	Arizona Department of Health Services
<b>Address</b>	150 North 18th Avenue, Phoenix, AZ 85007
<b>E-mail Address</b>	kelly.charbonneau@azdhs.gov
<b>Telephone Number</b>	(602) 364-1354
<b>Fax Number</b>	(602) 364-4737

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (if already assigned)

SOCIAL SECURITY NUMBER

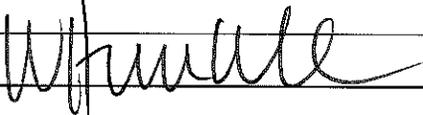
HIGHEST DEGREE EARNED

8 6 - 6 0 0 4 7 9 1

- -

**DISCLOSURE OF LOBBYING ACTIVITIES**

Complete this form to disclose activities pursuant to 31 U.S.C. 1352  
(See reverse for public burden disclosure.)

<p>1. <b>Type of Federal Action:</b>  <input checked="" type="checkbox"/> a. contract                  b. grant                  c. cooperative agreement                  d. loan                  e. loan guarantee                  f. loan insurance</p>	<p>2. <b>Status of Federal Action</b>  <input checked="" type="checkbox"/> a. bid/offer/application                  b. initial award                  c. post-award</p>	<p>3. <b>Report Type:</b>  <input checked="" type="checkbox"/> a. initial filing                  b. material change  <b>For Material Change Only:</b>                  Year ____ Quarter ____                  date of last report ____</p>
<p>4. <b>Name and Address of Reporting Entity:</b>  <input checked="" type="checkbox"/> Prime                      <input type="checkbox"/> Subawardee                  Tier _____, if known:                  Arizona Department of Health Services                  1740 West Adams                  Phoenix, AZ 85007                   Congressional District, if known:</p>		<p>5. <b>If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</b>                      Congressional District, if known:</p>
<p>6. <b>Federal Department/Agency:</b>                  Substance Abuse and Mental Health Services Administration</p>	<p>7. <b>Federal Program Name/Description:</b>                  Substance Abuse Prevention &amp; Treatment Block Grant                  CFDA Number, if applicable: <u>93.959</u></p>	
<p>8. <b>Federal Action Number, if unknown:</b></p>	<p>9. <b>Award Amount, if known:</b>                  \$</p>	
<p>10. a. <b>Name and Address of Lobbying Entity</b>                  Not Applicable</p>	<p>b. <b>Individuals Performing Services</b> (including address if different from No. 10a.)                  (last name, first name, MI):                  Not Applicable</p>	
<p>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</p>	<p>Signature:                   Print Name: <u>Will Humble</u>                  Title: <u>Director, Arizona Department of Health Services</u>                  Telephone No.: <u>(602) 542-1025</u>                      Date: _____</p>	
<p><b>Federal Use Only:</b></p>		<p>Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)</p>

# I: State Information

## Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

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

### Title XIX, Part B, Subpart II of the Public Health Service Act

Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32

### Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

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

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

Name of Chief Executive Officer (CEO) or Designee

Title

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_ Date: \_\_\_\_\_

<sup>1</sup> If the agreement is signed by an authorized designee, a copy of the designation must be attached.

**Footnotes:**

Please see Application Attachments for Arizona's Chief Executive Delegation Letter.

# I: State Information

## Chief Executive Officer's Funding Agreements/Certification (Form 3) [SA]

### FY 2014 Substance Abuse Prevention and Treatment Block Grant Funding Agreements/Certifications as required by Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act

Title XIX, Part B, Subpart II and Subpart III of the PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

SAMHSA will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

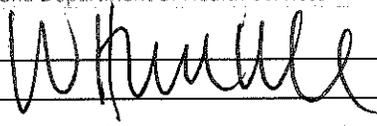
- I. FORMULA GRANTS TO STATES, SECTION 1921
- II. Certain Allocations (Prevention Programs utilizing IOM populations ; Pregnant women and women with dependent children) Section 1922
- III. INTRAVENOUS DRUG ABUSE, SECTION 1923
- IV. REQUIREMENTS REGARDING TUBERCULOSIS AND HUMAN IMMUNODEFICIENCY VIRUS, SECTION 1924
- V. Group Homes for Recovering Substance Abusers, Section 1925
- VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926
- VII. TREATMENT SERVICES FOR PREGNANT WOMEN, SECTION 1927
- VIII. ADDITIONAL AGREEMENTS(IMPROVED REFERRAL PROCESS, CONTINUING EDUCATION, COORDINATION OF ACTIVITIES AND SERVICES), SECTION 1928
- IX. IX SUBMISSION TO SECRETARY OF STATEWIDE ASSESSMENT OF NEEDS, SECTION 1929
- X. MAINTENANCE OF EFFORT REGARDING STATE EXPENDITURES, SECTION 1930
- XI. Restrictions on Expenditure of Grant, Section 1931
- XII. APPLICATION FOR GRANT; APPROVAL OF STATE PLAN, SECTION 1932
- XIII. Opportunity for Public Comment on State Plans, Section 1941
- XIV. Requirement of Reports and Audits by States, Section 1942
- XV. ADDITIONAL REQUIREMENTS, SECTION 1943
- XVI. Prohibitions Regarding Receipt of Funds, Section 1946
- XVII. Nondiscrimination, Section 1947
- XVIII. Continuation of Certain Programs, Section 1953

XIX. Services Provided By Nongovernmental Organizations, Section 1955

XX. Services for Individuals with Co-Occurring Disorders, Section 1956

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

Name: Will Humble  
Title: Director  
Organization: Arizona Department of Health Services

Signature:  Date: 2/11/13

**Footnotes:**

Please see Application Attachments for Arizona's Chief Executive Delegation Letter.

## REQUEST TO PROCEED FOR OUTSIDE FUNDING

Today's Date	<u>2.5.2013</u>	Grant/IGA/ISA/Fund Request Due Date	<u>4.01.2013</u>
<b>APPLICANT INFORMATION</b>			
Program/Division Applying: <u>Program Operations, Division of Behavioral Health Services</u>			
Program Contact Name:	<u>Kelly Charbonneau, SAPT/CMHS BG Coordinator</u>	Phone:	<u>602.364-1356</u>
<b>FUNDING INFORMATION</b>			
Application/Proposal Title: <u>Substance Abuse Prevention &amp; Treatment Block Grant</u>			
CFDA Catalog #:	<u>93.959</u>	<u>ADHS Index</u> <u>99X56</u>	Project Period: Starts <u>10.01.2013</u> Ends <u>9.30.2015</u>
Type of Funding:	Federal Grant <input checked="" type="checkbox"/>	Private Source <input type="checkbox"/>	IGA <input type="checkbox"/> ISA <input type="checkbox"/> Contract <input type="checkbox"/>
Type of Request:	New <input type="checkbox"/>	Supplemental <input type="checkbox"/>	Noncompeting Continuation <input type="checkbox"/> <input checked="" type="checkbox"/> Competing Continuation <input type="checkbox"/>
Will this Grant be submitted On Line?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	
Funding Agency Guidance Attached (Required):	Yes <input checked="" type="checkbox"/>	Admin Cap: No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>	Rate <u>5</u> %
Outside Funding Control Document Attached (Required):	Yes <input checked="" type="checkbox"/>	Indirect Rate <u>14.4</u> %	ITS Direct Charge Rate <u>1.31706</u> %
<b>FINANCIAL INFORMATION</b>			
Budget Period:	From (Date) <u>10.01.2013</u>	To (Date) <u>9.30.2015</u>	
Amount Requested:	\$ <u>37,009,944</u>	Soft Money: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Distribution of Funds:	In-House <u>5</u> %	Subvented <u>0</u> %	Contracted <u>95</u> %
Cost Sharing/Matching:	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>		
Maintenance of Effort Required:	No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>	<b>Please fill out next page with Match/MOE Breakdown</b>	
<b>RELATED INFORMATION</b>			
Number of Employees:	FTEs New <input type="checkbox"/> Continued <u>24.55</u>	<i>Note: All new positions must be established as Limited.</i>	
Additional Space Requirements:	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>	If yes, attach <i>Support Resource Requirements Need Impact Statement</i>	
Computer/Software Requirements:	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>	If yes, attach <i>ITS Resource Requirements Need Impact Statement</i>	
Conference(s)/Meeting(s):	Sponsor No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>	Attend No <input type="checkbox"/> Yes <input type="checkbox"/>	Unknown <input type="checkbox"/>
<b>SUBMISSION</b>			
Submit all required forms electronically to the Central Budget Office (See instructions.)			
<b>AUTHORIZATIONS-OBTAINED BY CENTRAL BUDGET OFFICE</b>			
Assistant Director or Designee (Initials):	<u>Ph...</u> <u>2-8-13</u>	Recommend <input type="checkbox"/>	Do Not Recommend <input type="checkbox"/> Date <u>2-8-13</u>
Chief Financial Officer (CFO) (Initials):	<u>[Signature]</u>	Reviewed <input checked="" type="checkbox"/>	Date <u>2/8/13</u>
Approve <input checked="" type="checkbox"/>	Do Not Approve <input type="checkbox"/>	<u>[Signature]</u> <u>Will Humble, Director</u>	Date <u>2/11/13</u>

Revised 10/1/12

**Arizona Department of Health Services  
Federal Grants Match/MOE Information Form**

Match = \$

**Personnel**

Name	Position Number	Index/PCA/OBJ	Match Amount

**Appropriated and Non Appropriated Dollars**

Name/SLI	Appropriation Year	Index/PCA/OBJ	Match Amount

**In-Kind \***

Name/Entity	Contact Information	Description of Service	Match Amount

Maintenance of Effort/MOE = \$

**Inside ADHS**

Fund Source	Appropriation Year	Index/PCA/OBJ	MOE Amount
General Fund (GF), Substance Abuse Services Fund (SASF), Liquor Fees	All AYs paid on an allowable fund source and allowable activity during the corresponding State Fiscal Year Period.	Various <sup>(2)</sup>	\$41,140,141

<sup>(1)</sup> The amount reflects the FY2013 MOE requirement. FY2014 & FY2015 are not available.  
<sup>(2)</sup> The attachment reflects the FY2012 MOE data query and shows the various separate index/PCA combinations that may be used in the calculation of MOE.

**Outside ADHS \***

Name/Entity	Contact Information	Description of Service	MOE Amount

**\* For In-Kind Match and Outside ADHS MOE please request documentation in writing from the entity to provide a breakdown of costs that they are providing.**

## OUTSIDE FUNDING CONTROL DOCUMENT

Program Contact: Kelly Charbonneau Phone: 602.364-1356 Business Manager: Debbie Gann Phone: 602.364-4719

Requesting Division/Bureau/Office: Program Operations, Division of Behavioral Health Services

Application/Proposal Name: Substance Abuse Prevention and Treatment Block Grant

Funding Agency: SAMHSA Funding Agency Revenue Grant/Contract ID #: \_\_\_\_\_

Strategic Plan Completed: Yes  (Attach copy of plan for review) No  Date to be completed: \_\_\_\_\_

**Purpose** (Briefly explain what program or activities will be funded and what the expected benefits to the state and agency will be. Detail the expected outcomes and how the results will be objectively measured. Explain how the grant or contract activities will support the Governor's priorities, an ADHS priority or goal, an ADHS program or subprogram goal or a Healthy Arizona 2010 goal.):

This grant heavily underwrites drug and alcohol treatment & prevention service capacity in Arizona and has played that role for over 10 years. One of the Governor's priorities is behavioral health services. The Governor's Drug and Gang Policy Council emphasizes effective drug and alcohol prevention services. The opportunity to fund significantly more treatment and prevention services than underwritten exclusively by State appropriated funds is the main goal to be accomplished by acquiring this grant. Each regional contractor is able to considerably augment treatment and prevention capacity with funds derived from this award.

The 2005-2007 Arizona Master List of State Government Programs, DHS, Behavioral Health Services, Subprogram Summary, "Substance Abuse", lists four goals relevant to the purpose of this grant. They are, 1.) To reduce/eliminate use of alcohol and other drugs among clients who complete substance abuse treatment, 2.) To increase paid employment among clients who complete substance abuse treatment, 3.) To reduce criminal activity among clients who complete substance abuse treatment, 4.) To provide substance abuse services to Title XIX and Title XXI eligible adults and targeted adults who are not eligible for Title XIX or Title XXI funded services.

In addition, the Subprogram Summary, "Prevention" mission statement is "To provide preventative behavioral health services that will increase the health and productivity of Arizonans." Each is associated with single or multiple methods of evaluation.

Program/Service is **Mandated** by ARS Citation: \_\_\_\_\_

Program/Service is  
**Authorized by Federal  
Citation:** \_\_\_\_\_

Subparts II & III, B, Title XIX, PHS Act 45,  
CFR part 96, as amended by P.L. 106-310, &  
Health & Human Services B.G. Regulations.

**Collaboration** (List the internal and external agencies/groups that will be collaborating in the development and implementation of the proposal if funding is awarded.):

The preponderance of funds from this grant will be distributed to four behavioral health care corporations and three tribal governments who in turn distribute them to 65 or more other agencies. These partnerships with DHS make service delivery statewide feasible. A small portion is distributed to the State Laboratory and the Office of HIV/AIDS for testing costs and test materials thereby providing a pre-arranged method for substance abuse programs to serve their clients.

**Interested Parties** (List the *known* outside agencies, individuals, groups and any legislators that have a vested interest in whether the grant is funded and give a brief description of their interest.):

The preponderance of funds from this grant are distributed to four behavioral health care corporations including Northern Arizona Regional Behavioral Health Authority, Cenpatico, Magellan, Community Partnership of Southern Arizona, Gila River Indian Community, White Mountain, and Pascua Yaqui who in turn distributes them to 65 or more other agencies. These partnerships with DHS make service delivery statewide feasible.

**Consequences of not Proceeding** (Probable consequences if grant, ISA, IGA or funding is not pursued or obtained.):

DHS-sponsored drug and alcohol abuse treatment capacity would be severely impacted. Treatment and prevention program closures would occur. Other State agencies that also provide some funding for drug and alcohol abuse treatment would experience similar shrinkage in treatment capacity since they use many of the same providers funded primarily via DHS contracts.

**Justification** (Briefly explain why outside funding is needed and provide data, if available, to support the request.):

To deliver drug and alcohol treatment and prevention services throughout Arizona.

**Flexibility of Funds** (Explain ADHS' ability to determine the direction of the program/services to be provided.):

The funds are exclusively for the creation of drug and alcohol treatment and prevention services as stipulated in federal statute/ rule and as described in each year's uniform application. In addition, various set-asides, maintenance of effort stipulations, and other requirements establish expenditure parameters.

DHS has flexibility in distributing the funds statewide.

**Compliance Procedures and Reporting** (Describe all relevant requirements, restrictions and compliance measures stipulated by the funding

agency.):

#### Compliance Procedures

Fiscal controls must assure no more than 5% of the gross is for internal administration and no less than 20% is for prevention. Maintenance of effort (the average of state expenditures for the previous two years) must be maintained and, when a CDC indicator is triggered for rate of AIDS, 5% of the gross must be made available for AIDS early intervention services. Prohibitive and proscriptive language from the law must be passed in contract.

The State shall not expend the Block Grant on the following activities:

1. To provide inpatient hospital services, except as provided in paragraph (c) of Title 45, Part 96;
2. To make cash payments to intended recipients of health services;
3. To purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
4. To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;
5. To provide financial assistance to any entity other than a public or nonprofit private entity; or
6. To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for AIDS.

The State shall limit expenditures on the following:

1. The State involved will not expend more than 5% of the grant to pay the costs of administering the grant; and
2. The State will not, in expending the grant for the purpose of providing treatment services in penal or correctional institutions of the State, expend more than an amount prescribed by section 1931(a)(3) of the PHS Act.

Exception regarding inpatient hospital services.

1. With respect to compliance with the agreement made under paragraph (a) of this section, a State (acting through the Director of the principal agency) may expend a grant for inpatient hospital-based substance abuse programs subject to the limitations of paragraph (c)(2) of this section only when it has been determined by a physician that:
  - (1.) The primary diagnosis of the individual is substance abuse, and the physician certifies this fact
  - (2.) The individual cannot be safely treated in a community-based, non-hospital, residential treatment program
  - (3.) The Service can reasonably be expected to improve an individual's condition or level of functioning
  - (4.) The hospital-based substance abuse program follows national standards of substance abuse professional practice
2. In the case of an individual for whom a grant is expended to provide inpatient hospital services described above, the allowable expenditure shall conform to the following:
  - (1.) The daily rate of payment provided to the hospital for providing services to the individual will not exceed the comparable daily rate provided for community-based, non-hospital, residential programs of treatment for substance abuse
  - (2.) The grant may be expended for such services only to the extent that it is medically necessary, i.e., only for those days that the patient cannot be safely treated in a residential, community-based program.

#### Synar Amendment

The State must have in effect a law providing that it is unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18.

The State will enforce the law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18. The State will annually conduct random, unannounced inspections to ensure compliance with the law, and will annually submit to the Secretary a report describing the activities carried out by the State to enforce the law during the fiscal year preceding the fiscal year for which the State is seeking the grant. The State will report the extent of success (requires  $\leq$  20% illegal buy rate) the State has achieved in reducing the availability of tobacco products to individuals under the age of 18. The State will report the strategies to be used by the State for enforcing the law during the fiscal year for which the grant is sought. If the State is not in compliance, the Secretary of the Department of Health and Human Services shall withhold 40% of the award.

#### Reporting

The Block Grant application incorporates compliance information and progress reporting. Information provided to the Client Information System by Regional Behavioral Health Authorities and providers is summarized each year in the application. Fiscal information is also summarized in the application. In addition, single state audits conducted by the Auditor General's Office are required. Periodically, federal contractors visit Arizona and perform their own reviews of compliance

**Related Underlying Contracts** (Identify key provider/vendor contracts funded by the grant and any mismatch of requirements, term of grant, term of contract, or issues that need to be addressed.):

RBHA contracts funded by the grant include Magellan, Cenpatico, NARBHA, CPSA Gila River Indian Community, White Mountain, and Pascua Yaqui.

# I: State Information

## Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

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

### Title XIX, Part B, Subpart I of the Public Health Service Act

Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6

### Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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

Name of Chief Executive Officer (CEO) or Designee

Will Humble

Title

Director

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_ Date: \_\_\_\_\_

<sup>1</sup> If the agreement is signed by an authorized designee, a copy of the designation must be attached.

**Footnotes:**

Please see Application Attachments for Arizona's Chief Executive Delegation Letter.

# I: State Information

## Chief Executive Officer's Funding Agreements/Certification (Form 3) [MH]

### Community Mental Health Services Block Grant Funding Agreements FISCAL YEAR 2014

I hereby certify that Arizona agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

#### I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

#### II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

#### III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

- (A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services.
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

#### IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:

(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and  
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;

(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;

(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and

(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

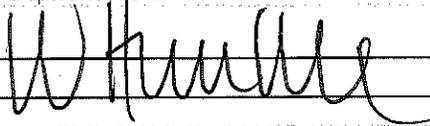
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

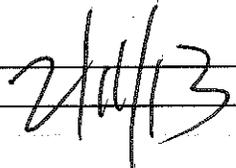
(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name: Will Humble  
Title: Director  
Organization: Arizona Department of Health Services

Signature: 

Date: 

**Footnotes:**

Please see Application Attachments for Arizona's Chief Executive Delegation Letter.

### CHECKLIST

**Public Burden Statement:** Public reporting burden of this collection of information is estimated to average 4 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC.

Clearance Officer, 1600 Clifton Road, MS D-24 Atlanta, GA 30333, Attn: PRA (0920-0428). Do not send the completed form to this address.

**NOTE TO APPLICANT:** This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last page of the signed original of the application. This page is reserved for PHS staff use only.

Type of Application:  New  Noncompeting Continuation  Competing Continuation  Supplemental

**PART A: the following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.**

	Included	NOT Applicable
1. Proper Signature and Date for Item 18 on SF 424 (FACE PAGE)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Proper Signature and Date on PHS-5161-1 "Certifications" page	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Proper Signature and Date on appropriate "Assurances" page, i.e., SF-424B (Non-Construction Programs) or SF-424D (Construction Programs)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. If your organization currently has on file with DHHS the following Assurances, please identify which have been filed by indicating the Date of such filing on the line provided. (All four have been consolidated into a single form, HHS Form 690)		
<input checked="" type="checkbox"/> Civil Rights Assurance (45 CFR 80)	03/24/1997	
<input checked="" type="checkbox"/> Assurance Concerning the Handicapped (45CFR 84)	03/24/1997	
<input checked="" type="checkbox"/> Assurance Concerning Sex Discrimination (45CFR 86)	03/24/1997	
<input checked="" type="checkbox"/> Assurance Concerning Age Discrimination (45CFR 90 & 45 CFR 91)	03/24/1997	
5. Human Subjects Certification, when applicable (45CFR 46)	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**PART B: this part is provided to assure that pertinent information has been addressed and included in the application.**

	YES	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. Has the appropriate box been checked for item #16 on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	<input checked="" type="checkbox"/>	
3. Has the entire proposed project period been identified in item # 13 of the FACE PAGE	<input checked="" type="checkbox"/>	
4. Have biographical sketch(es) with job description(s) been attached, when required?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) or SF-424C (Construction Programs), been completed and included?	<input checked="" type="checkbox"/>	
6. Has the 12 month detailed budget been provided?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Has the budget for the entire proposed project period with sufficient detail been provided?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. For a Supplemental application, does the detailed budget address only the additional funds requested?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. For Competing continuation and Supplemental applications, has a progress report been included?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

**PART C: In the spaces provided below, please provide the requested information.**

Business Official to be notified if an award is to be made.

**Name** Will Humble  
**Title** Director  
**Organization** Arizona Department of Health Services  
**Address** 150 N. 18<sup>th</sup> Ave., Phoenix, AZ 85007  
**E-mail Address** humblew@azdhs.gov  
**Telephone Number** (602) 542-1140  
**Fax Number** (602) 364-

Program Director/Project Director/Principal Investigator designated to direct the proposed project or program.

**Name** Kelly Charbonneau  
**Title** Substance Abuse Grants Coordinator  
**Organization** Arizona Department of Health Services  
**Address** 150 North 18th Avenue, Phoenix, AZ 85007  
**E-mail Address** kelly.charbonneau@azdhs.gov  
**Telephone Number** (602) 364-1354  
**Fax Number** (602) 364-4760

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (If already assigned)

SOCIAL SECURITY NUMBER

HIGHEST DEGREE EARNED

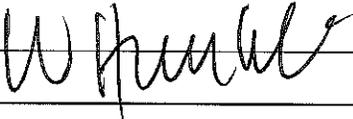
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**DISCLOSURE OF LOBBYING ACTIVITIES**

Complete this form to disclose activities pursuant to 31 U.S.C. 1352  
(See reverse for public burden disclosure.)

<b>1. Type of Federal Action:</b> <input checked="" type="checkbox"/> a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	<b>2. Status of Federal Action</b> <input checked="" type="checkbox"/> a. bid/offer/application b. initial award c. post-award	<b>3. Report Type:</b> <input checked="" type="checkbox"/> a. initial filing b. material change <b>For Material Change Only:</b> Year ____ Quarter ____ date of last report ____
<b>4. Name and Address of Reporting Entity:</b> <input checked="" type="checkbox"/> Prime <input type="checkbox"/> Subawardee Tier _____, if known:  Arizona Department of Health Services 1740 West Adams Phoenix, AZ 85007  Congressional District, if known:	<b>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</b>     Congressional District, if known:	
<b>6. Federal Department/Agency:</b> Substance Abuse and Mental Health Services Administration	<b>7. Federal Program Name/Description:</b> Community Mental Health Services Block Grant Application CFDA Number, if applicable: <u>93.958</u>	
<b>8. Federal Action Number, if unknown:</b>	<b>9. Award Amount, if known:</b> \$	
<b>10. a. Name and Address of Lobbying Entity</b> Not Applicable	<b>b. Individuals Performing Services</b> (including address if different from No. 10a.) (last name, first name, MI): Not Applicable	
<b>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</b>	Signature:  Print Name: <u>Will Humble</u> Title: <u>Director</u> Telephone No.: <u>(602) 542-1025</u> Date: <u>2/11/13</u>	
<b>Federal Use Only:</b>	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)	

## REQUEST TO PROCEED FOR OUTSIDE FUNDING

Today's Date	<u>2.5.2013</u>	Grant/IGA/ISA/Fund Request Due Date	<u>4.01.2013</u>
<b>APPLICANT INFORMATION</b>			
Program/Division Applying:	<u>ADHS/DBHS</u>		
Program Contact Name:	<u>Kelly Charbonneau, SAPT/CMHS BG Coordinator</u>	Phone:	<u>602.364.1356</u>
<b>FUNDING INFORMATION</b>			
Application/Proposal Title:	<u>Community Mental Health Services Block Grant</u>		
CFDA Catalog #:	<u>93.958</u>	<u>ADHS Index</u> <u>99X43</u>	Project Period: Starts <u>10.01.2013</u> Ends <u>9.30.2015</u>
Type of Funding:	Federal Grant <input checked="" type="checkbox"/>	Private Source <input type="checkbox"/>	IGA <input type="checkbox"/> ISA <input type="checkbox"/> Contract <input type="checkbox"/>
Type of Request:	New <input type="checkbox"/>	Supplemental <input type="checkbox"/>	Noncompeting Continuation <input type="checkbox"/> <input checked="" type="checkbox"/> Competing Continuation <input type="checkbox"/>
Will this Grant be submitted On Line?	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>	
Funding Agency Guidance Attached (Required):	Yes <input checked="" type="checkbox"/>	Admin Cap: No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>	Rate <u>5</u> %
Outside Funding Control Document Attached (Required):	Yes <input checked="" type="checkbox"/>	Indirect Rate <u>14.4</u> %	ITS Direct Charge Rate <u>1.31706</u> %
<b>FINANCIAL INFORMATION</b>			
Budget Period:	From (Date) <u>10.01.2013</u>	To (Date) <u>9.30.2015</u>	
Amount Requested:	<input checked="" type="checkbox"/> \$ <u>9,783,232</u>	Soft Money: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Distribution of Funds:	In-House <u>5</u> %	Sub vented <u>0</u> %	Contracted <u>95</u> %
Cost Sharing/Matching:	No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>		
Maintenance of Effort Required:	No <input type="checkbox"/> Yes <input checked="" type="checkbox"/>	<b>Please fill out next page with Match/MOE Breakdown</b>	
<b>RELATED INFORMATION</b>			
Number of Employees:	FTEs New <input type="checkbox"/> Continued <u>5.62</u>	<i>Note: All new positions must be established as Limited.</i>	
Additional Space Requirements:	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, attach <i>Support Resource Requirements Need Impact Statement</i>	
Computer/Software Requirements:	No <input type="checkbox"/> Yes <input type="checkbox"/>	If yes, attach <i>ITS Resource Requirements Need Impact Statement</i>	
Conference(s)/Meeting(s):	Sponsor No <input checked="" type="checkbox"/> Yes <input type="checkbox"/>	Attend No <input type="checkbox"/> Yes <input type="checkbox"/>	Unknown <input type="checkbox"/>
<b>SUBMISSION</b>			
Submit all required forms electronically to the Central Budget Office (See instructions.)			
<b>AUTHORIZATIONS-OBTAINED BY CENTRAL BUDGET OFFICE</b>			
Assistant Director or Designee (Initials):	<u>M...</u>	Recommend <input checked="" type="checkbox"/>	Do Not Recommend <input type="checkbox"/> Date <u>2-8-13</u>
Chief Financial Officer (CFO) (Initials):	<u>W...</u>	Reviewed <u>TH</u>	Date <u>2/8/13</u>
Approve <input checked="" type="checkbox"/>	Do Not Approve <input type="checkbox"/>	<u>Will Humble, Director</u> Date <u>2/11/13</u>	

Revised 10/1/12

**Arizona Department of Health Services  
Federal Grants Match/MOE Information Form**

Match = \$

**Personnel**

Name	Position Number	Index/PCA/OBJ	Match Amount

**Appropriated and Non Appropriated Dollars**

Name/SLI	Appropriation Year	Index/PCA/OBJ	Match Amount

**In-Kind \***

Name/Entity	Contact Information	Description of Service	Match Amount

Maintenance of Effort/MOE = \$

**Inside ADHS**

Fund Source	Appropriation Year	Index/PCA/OBJ	MOE Amount
General Fund, and Bridge Subsidy	All AYs paid on an allowable fund source and allowable activity during the corresponding State Fiscal Year Period.	Various <sup>(2)</sup>	\$391,219,585

<sup>(1)</sup> The amount reflects the FY2013 MOE requirement. FY2014 & FY2015 are not available.

<sup>(2)</sup> The attachment reflects the FY2012 MOE data query and shows the various separate index/PCA combinations that may be used in the calculation of MOE.

**Outside ADHS \***

Name/Entity	Contact Information	Description of Service	MOE Amount

**\* For In-Kind Match and Outside ADHS MOE please request documentation in writing from the entity to provide a breakdown of costs that they are providing.**

## OUTSIDE FUNDING CONTROL DOCUMENT

Program Contact: Kelly Charbonneau Phone: 602.364-1356 Business Manager: Debbie Gann Phone: 602.364-4719

Requesting Division/Bureau/Office: Division of Behavioral Health Services

Application/Proposal Name: Community Mental Health Services Block Grant

Funding Agency: DHHS-SAMHSA-CMHS Funding Agency Revenue Grant/Contract ID #: \_\_\_\_\_

Strategic Plan Completed: Yes  (Attach copy of plan for review) No  Date to be completed: \_\_\_\_\_

**Purpose** (Briefly explain what program or activities will be funded and what the expected benefits to the state and agency will be. Detail the expected outcomes and how the results will be objectively measured. Explain how the grant or contract activities will support the Governor's priorities, an ADHS priority or goal, an ADHS program or subprogram goal or a Healthy Arizona 2010 goal.):

Grant will provide funding for Arizona's organized community-based system of care for non-Title XIX/XXI adults with SMI and children with SED. The grant addresses Goal 1 of the ADHS/DBHS FY 2007 Strategic Plan, "To ensure a comprehensive, unified high quality behavioral health system for Arizonans." In addition, 50% of the Block Grant funds are allocated to children's services, and children are a priority population for Arizona's Governor.

Program/Service is **Mandated** by ARS Citation: \_\_\_\_\_ Program/Service is **Authorized** by Federal Citation: \_\_\_\_\_

**Collaboration** (List the internal and external agencies/groups that will be collaborating in the development and implementation of the proposal if funding is awarded.):

Grant requires the collaboration of several internal ADHS and DBHS Bureaus and Offices. These are: DBHS/Clinical, QM, and Financial Operations, DBHS Deputy Director's Office, ADHS Division of Business & Financial Services, ADHS Grants Management, and the Director's Office. External groups include the Tribal and Regional Behavioral Health Authorities (T/RBHAs), AZ Behavioral Health Planning Council and its standing committees, as well as participation by other state government agencies, advocacy groups and others as required.

**Interested Parties** (List the *known* outside agencies, individuals, groups and any legislators that have a vested interest in whether the grant is funded and give a brief description of their interest.):

Not Applicable.

**Consequences of not Proceeding** (Probable consequences if grant, ISA, IGA or funding is not pursued or obtained.):

Each State is required by federal law (P.L. 102-321) to submit annually a Block Grant Application, including a comprehensive State Plan identifying how the federal block grant dollars will be used. If Arizona chooses not to submit the application, over \$9.7 million will be lost.

**Justification** (Briefly explain why outside funding is needed and provide data, if available, to support the request.):

The Block Grant provides much needed funds for the provision of services to children with SED and adults with SMI. 50% of the funding will be allocated to the non-Title XIX/XXI SED child population, and 50% will be allocated to non-Title XIX/XXI adults with SMI. Arizona's publicly funded behavioral health system will benefit from the additional funds.

**Flexibility of Funds** (Explain ADHS' ability to determine the direction of the program/services to be provided.):

Block Grant funding is provided to the States to establish or expand an organized, community-based system of care for children with SED and adults with SMI.

**Compliance Procedures and Reporting** (Describe all relevant requirements, restrictions and compliance measures stipulated by the funding agency.):

The Block Grant requires data, as identified in P.L. 102-321. Section II of the law stipulates that States will provide any data required by the Center for Mental Health Services (CMHS) in developing uniform criteria for the collection of data. Section III requires that applications contain all assurances and agreements as CMHS deems necessary.

**Related Underlying Contracts** (Identify key provider/vendor contracts funded by the grant, and any mismatch of requirements, term of grant, term of contract, or issues that need to be addressed.):

Not Applicable.

## I: State Information

### Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

---

Name	<input type="text"/>
Title	<input type="text"/>
Organization	<input type="text"/>

---

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Footnotes:

## II: Planning Steps

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

Narrative Question:

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Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities.

Footnotes:

### **Background and Structure of the Service Delivery System**

Established in 1986 by Arizona Revised Statute (A.R.S.) §36-3402, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) is authorized and responsible for providing coordination, planning, administration, regulation and monitoring of all facets of the State's public behavioral health system. ADHS/DBHS serves as both the Single State Authority (SSA) for the Substance Abuse Prevention and Treatment Block Grant (SAPT), as well as the State Mental Health Authority (SMHA) for the Community Mental Health Services Block Grant (CMHS). In this capacity ADHS/DBHS has numerous responsibilities, including:

- Administering a comprehensive, regionalized, behavioral health system of community-based prevention, intervention, treatment and rehabilitative services for individuals and families;
- The application, execution and oversight of numerous federal grants providing funding for mental health, substance abuse and prevention services, as well as workforce development training initiatives;
- Partnering with other state agencies to improve service delivery for shared clients, including children and adults in the correctional, criminal justice, primary and public health care, education, child welfare, and developmental disability systems;
- Contracting with the Arizona Health Care Cost Containment System (AHCCCS) to plan, administer, and monitor behavioral health services funded through Medicaid;
- Partnering with county and city municipalities to provide necessary services within those communities;
- Providing care to individuals enrolled within other state programs, including the Arizona Long Term Care System for those with Developmental Disabilities (DD-ALTCS), and Child Protective Services, and;
- Operating the Arizona State Hospital (ASH), accredited by the Joint Commission, to provide long-term psychiatric care to the most seriously mentally ill Arizonans.

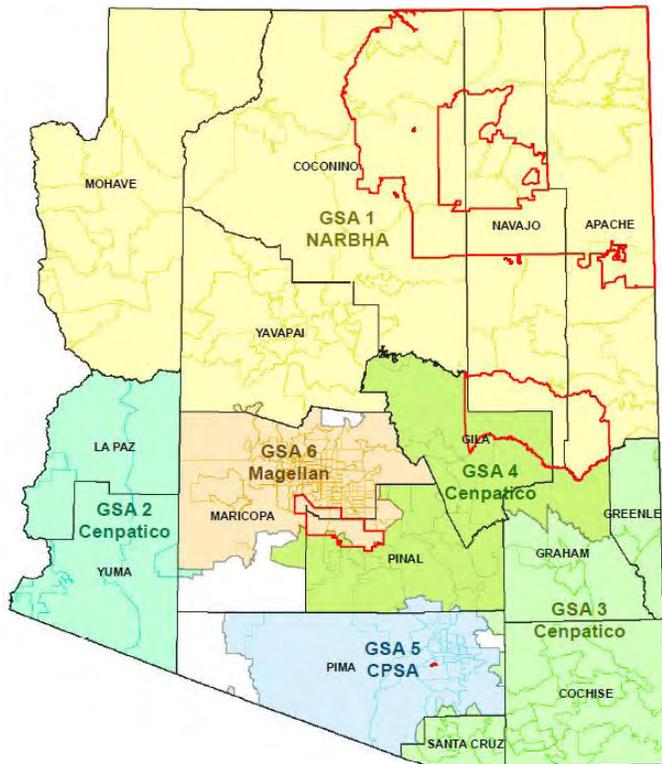
ADHS/DBHS contracts with Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) to administer integrated managed care delivery services in six distinct geographic service areas (GSAs) throughout the State (please see map, next page). The T/RBHAs, in return, subcontract with various prevention and treatment providers within their respective regions to ensure a full spectrum of services are available to behavioral health consumers. This regionalized system allows local communities to provide services in a manner appropriate to meet the unique needs of individuals and families in those areas. Furthermore, the Division has established partnerships with various state agencies to coordinate care for specific population subsets, including individuals involved with Child Protective Services (CPS) and those in foster care.<sup>1</sup>

The Division of Behavioral Health Services has direct oversight authority of the programmatic and fiscal activities of the T/RBHAs and, in turn, the T/RBHAs are required by contract to monitor their treatment providers. Monitoring for contract compliance, adherence to Medicaid regulations, fiscal accounting, program design, delivery, and effectiveness, occurs in a structured manner at least annually – with some oversight procedures conducted each fiscal quarter, or on a monthly basis, by DBHS staff. Additionally, DBHS regularly contracts with outside consultants for independent system-wide, or population-specific, evaluations, as required by Federal regulations.

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<sup>1</sup> Please see Section V of this application for more details.

The T/RBHAs are required to maintain and operate a comprehensive network of behavioral health providers that deliver prevention, intervention, treatment and rehabilitative services to a variety of populations, including: Adults with a Serious Mental Illness (SMI); Adults with General Mental Health Disorders (GMH); Adults with Substance Use Disorders (SUD/SA), and; Children and Adolescents – including those with a diagnosed Serious Emotional Disturbance (SED).



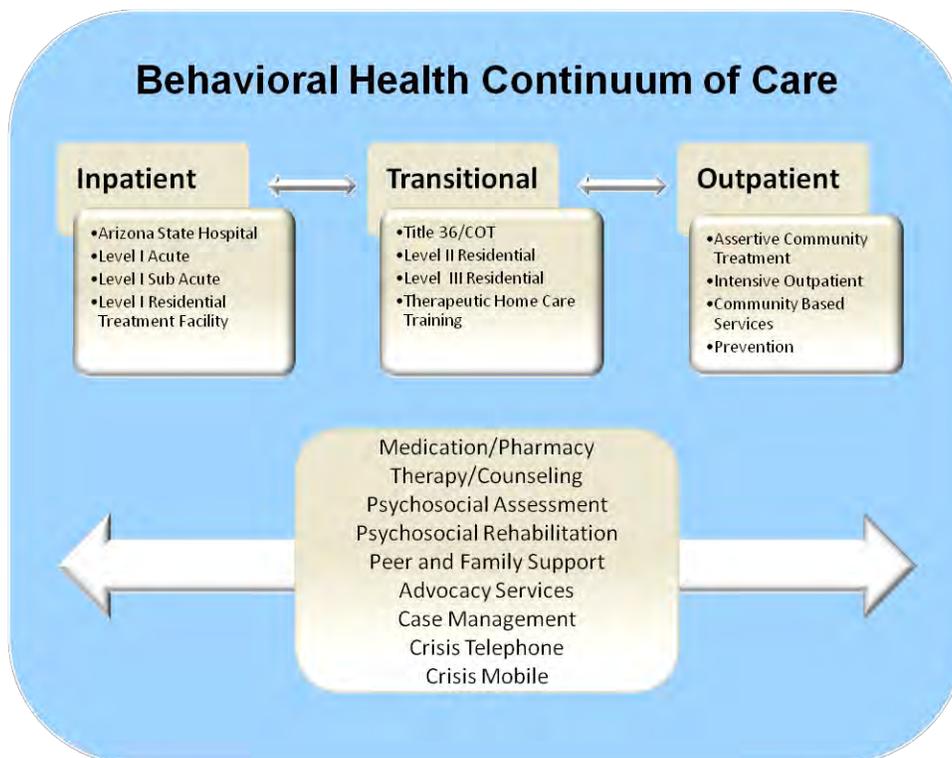
### **Continuum of Care**

Arizona has been recognized as a leader in the public sector behavioral health field in its managed care approach to service delivery. ADHS/DBHS focuses its efforts and energies toward providing leadership in activities designed to integrate and adapt the behavioral health system to more effectively meet the needs of those we serve.

ADHS/DBHS endorses a comprehensive, person/family supportive, and recovery oriented system of care for people in need of publicly funded behavioral health treatment. To ensure this vision of recovery is achieved in a manner that promotes a *good and modern* mental health and addiction system, DBHS maintains a firm commitment to increasing access to care and reducing barriers to treatment; collaborating with the greater community; cultural competency; effective innovation and program evaluation, and; emphasizing consumer and family involvement in an individual’s treatment program.

The Division offers a wide range of behavioral health services and the continuum of care spans from services that are more restrictive to those that are less restrictive. Generally speaking, services can be grouped into seven categories: Crisis, Inpatient, Residential, Outpatient, Medical/Pharmacy, Support, and Rehabilitation services (please see Continuum of Care diagram, next page). Furthermore, DBHS works collaboratively with RBHAs, TRBHAs and Tribal Nations to ensure that this full continuum is available in all urban and rural areas of Arizona, and is capable of sufficiently addressing the disparate

needs of various groups, including racial and ethnic minorities, the LGBTQ community, and other historically underserved populations.<sup>2</sup>



*Crisis services* are available to anyone and include access to 24/7 telephone hotlines, crisis mobile response teams, screening, assessment, evaluation and short-term inpatient stabilization services. These critical services offer both a front door into the behavioral health system and a safety-net for persons at grave risk of harm. Without a crisis system, police, fire and emergency responders would be left to deal with situations that, in the vast majority of cases, do not involve criminal behavior or public safety issues.

*Inpatient Treatment Services* are designed to provide continuous treatment to persons experiencing acute and severe behavioral health or substance abuse symptoms. Level I Acute, Level I Sub-Acute, and Level I Residential Treatment Center settings refer to the behavioral health license and are based on the level of supervision provided on site.

*Residential Services* are those provided in a structured treatment setting with 24-hour supervision from an on-site or on-call behavioral health professional for persons who do not require on-site medical services or who need protective oversight. Level II, Level III, and Therapeutic Home Care Training refer to the behavioral health license and are based on the level of supervision provided on site.

<sup>2</sup> DBHS has a robust framework around providing culturally competent care and outreach for historically underserved persons; a thorough review of the DBHS' Cultural Competency programs and initiatives is included in Section L of this application.

*Outpatient Treatment Services* are typically provided at a clinic or in the community and include assessment, evaluation, screening, group and individual counseling and other services that help reduce symptoms and improve or maintain functioning. The vast majority of behavioral health recipients are served in their local communities in an outpatient setting, which is significantly less-costly than inpatient care, or placement within a residential facility.

*Medical/Pharmacy Services* such as prescription medications to prevent, stabilize or reduce symptoms of a behavioral health condition. This also includes medical tests ordered for diagnosis, screening or monitoring of a behavioral health condition, i.e. blood and urine tests. Ongoing medical assessment and management services to review the effects of medications and to adjust the type and dosage of prescribed medications are also included here.

*Support Services* include a wide variety of activities to help persons with mental illness live independently and remain productive members of the community. This includes case management, peer support, family support and respite care, housing support, transportation, and personal care services.

Peer and family support is an especially critical service because it accomplishes two very important objectives. First, because peers have been recipients of behavioral health services, they are able to relate to persons with mental illness in a way that professionals cannot. Second, peers and family members are trained and employed by provider agencies including agencies that are themselves run by peers or family members. Peers or family members who provide services offer unique support to recipients because they share personal experience with substance abuse and or mental illness themselves or in their families. This type of relationship often takes more of a self-help/recovery approach since the peer or family worker can serve as an example of a person who has progressed in managing the behavioral health or substance abuse challenges in their lives. Accordingly, the Behavioral Health System employs over 440 Peer and Family Support Professionals.

*Rehabilitation Services* include teaching of independent living, social and communication skills, health and wellness promotion, and ongoing support to maintain employment—most often provided in an outpatient setting.

### **Service Capacity and Network Sufficiency**

ADHS/DBHS utilizes a Logic Model for Network Sufficiency to review multiple data sources in an effort to identify patterns, gaps, trends, and service demands. The analysis of this data assists in determining the network capacity, configuration of needs and service gaps, and assessment of essential minimum network requirements. The Logic Model provides a framework for analysis and is one factor in determining essential minimum network requirements. Below is an overview of the complete Network Analysis process:

- Ongoing review and monitoring of T/RBHAs' utilization data and single case agreements to identify barriers and the need for network expansion of contracted providers
- Ongoing review and monitoring of T/RBHAs' and state level Complaint/Issue Resolution Data to identify any potential network gaps in behavioral health services or providers
- Ongoing statewide on-site T/RBHA/Provider validation activities to assess network availability of services, quality of programs, and facility tours.
- Ongoing statewide review and monitoring of T/RBHAs contract reporting requirements to network sufficiency enhancements and or reductions, including:
  - Assessment and tracking of provider enhancements and reductions.

- Monitoring the continuity of care for consumers
- Identification of potential network sufficiency needs.
- Quarterly review of T/RBHA utilization data by Covered Service category and Sub-Category.
- Annual T/RBHA Geo-Mapping analysis and monitoring to assess statewide networks for access to certain provider types using geo-mapping technology.
- Annual review and monitoring of the Adult Consumer Satisfaction Survey to assess statewide independent feedback from Medicaid-eligible adults receiving services through the RBHAs. This monitoring activity measures member perception of behavioral health services in relation to the following domains:
  - General Satisfaction
  - Access to Services
  - Service Quality/Appropriateness
  - Participation in treatment
  - Outcomes
  - Cultural Sensitivity
  - Improved functions
  - Social Connectedness
- Annual and ongoing review and monitoring of the T/RBHAs' network capacity for Behavioral Health Professionals (Prescribers). This monitoring activity involves review of Complaint/Issue Resolution data, Network Provider Notification Changes in relation to established Network Inventory data and Minimum Network Standards.
- Quarterly review and monitoring of the T/RBHAs' Adult & Child System of Care Plan to assess identified network development and/or enhancement needs. The plan is evaluated by DBHS Adult System of Care staff and monthly meetings are held with each T/RBHA to discuss progress, barriers, and priorities for the following quarter. DBHS provides technical assistance to the T/RBHAs, as needed, related to regional network development activities.

The review of the above-mentioned data also includes an analysis of any trends observed in enrollment, eligibility, and penetration rates specific to each RBHA.<sup>3</sup> The outcome of this analysis determines whether the current network is sufficient for each RBHA. Following this review process, meetings occur with each RBHA, during which this information is discussed, and possible network needs are identified. In response to ADHS/DBHS' findings, each RBHA develops a network report and plan, which is extensively reviewed by DBHS staff. These plans are revised as necessary to address all concerns identified during the review process, prior to implementation of any action.

#### *Annual Network Inventory*

Once the aforementioned review has been completed, ADHS/DBHS synthesizes the results and compiles an annual inventory of the available facility capacity by level of care across the service delivery network. Doing so allows ADHS/DBHS to identify weaknesses within the continuum of care and may prompt further gap analyses. The most recent network inventory, completed in April, 2012, is summarized in the table on the next page.

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<sup>3</sup> Enrollment trends and numbers served are discussed in the next section of this application

Facility Type	RBHA GSA*	Number Serving Each Population*	
		Child	Adult
Outpatient Clinic	NARBHA	43	47
	Centpatico 2	17	23
	Centpatico 3	21	20
	Centpatico 4	30	35
	CPSA 5	124	68
	Magellan	4	0
	<b>Arizona</b>	<b>239</b>	<b>193</b>
Opiate/Methadone Clinic	NARBHA	0	3
	Centpatico 2	0	2
	Centpatico 3	0	6
	Centpatico 4	0	7
	CPSA 5	0	7
	Magellan	0	13
	<b>Arizona</b>	<b>0</b>	<b>38</b>
Level I Residential	NARBHA	1	0
	Centpatico 2	0	0
	Centpatico 3	0	0
	Centpatico 4	0	0
	CPSA 5	0	0
	Magellan	5	0
	<b>Arizona</b>	<b>6</b>	<b>0</b>
Level II Residential	NARBHA	6	8
	Centpatico 2	1	2
	Centpatico 3	0	2
	Centpatico 4	0	8
	CPSA 5	10	23
	Magellan	11	107
	<b>Arizona</b>	<b>28</b>	<b>150</b>
Level III Residential	NARBHA	0	3
	Centpatico 2	0	0
	Centpatico 3	1	1
	Centpatico 4	1	0
	CPSA 5	5	0
	Magellan	2	8
	<b>Arizona</b>	<b>9</b>	<b>12</b>
Rural Substance Abuse Transitional Center	NARBHA	0	3
	Centpatico 2	0	1
	Centpatico 3	0	1
	Centpatico 4	0	3
	CPSA 5	0	0
	Magellan	0	0
	<b>Arizona</b>	<b>0</b>	<b>8</b>
Level I Sub-acute Facility	NARBHA	0	1
	Centpatico 2	0	1
	Centpatico 3	0	1
	Centpatico 4	0	1
	CPSA 5	0	3
	Magellan	0	4
	<b>Arizona</b>	<b>0</b>	<b>11</b>

Discussed in more detail later in this application, DBHS and its contracted RBHAs maintain a firm commitment to partnering with peer and family-run organizations and increasing the utilization of the crucial support services provided by these organizations. As of February, 2013, there were eleven peer-run, and five family-run organizations operating within the public behavioral health system. The below table illustrates their geographical distribution.

RBHA – GSA	Peer Run Organizations	Family Run Organizations
NARBHA	1	1
Cenpatico 2	1	1
Cenpatico 3	1	0
Cenpatico 4	1	0
CPSA	2	1
Magellan	5	2

### **Eligibility for Behavioral Health Services**

The continuum of care broadly describes services and treatment modalities available to all Medicaid-eligible behavioral health recipients, including those with a GMH, an SMI, an SED, and/or an SUD. With the exception of limitations placed on residential care, hospitalizations, and psychotropic medications, non-Medicaid eligible recipients with a diagnosed SUD have access to the full service array as needed to treat their dependence and contingent upon available funding.<sup>4</sup>

### **Health Integration**

In order to improve the delivery of integrated health services, ADHS/DBHS is implementing a Demonstration project for Medicaid-eligible adults with an SMI in Maricopa County beginning in October, 2013.<sup>5</sup> This new model will provide physical and behavioral health care services through a prepaid, capitated managed care delivery system. The goal of the Demonstration is to test health care delivery to provide organized and coordinated health care for both acute and long term care that include pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and management of health services. The Demonstration will also test the extent to which health outcomes in the overall population are improved by expanding coverage to additional needy groups with a particular focus on care and disease management for select conditions, including diabetes, chronic obstructive pulmonary disease (COPD) and cardiac disease.

<sup>4</sup> SAPT Funded Room and Board / Residential services are limited to Children/Adolescents with a Substance Use Disorder (SUD), and adult priority population members (pregnant females, females with dependent child(ren), and intravenous drug users with a SUD).

<sup>5</sup> For more information on the Demonstration project, please see Section K of this application and <http://www.azdhs.gov/diro/integrated>.

## II: Planning Steps

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

### Narrative Question:

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This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact [planningdata@samhsa.hhs.gov](mailto:planningdata@samhsa.hhs.gov).

### Footnotes:

ADHS/DBHS utilizes a number of data feeds, surveys, systemic evaluations, as well as stakeholder forums, to determine statewide need for services and works in tandem with the T/RBHAs to ensure that efficient resource allocation permits system capacity to correlate with service demand. Although effective, because of the multiple data sources utilized, this process is difficult to manage and ADHS/DBHS is working to implement a new methodology for assessing prevention, subvention, and treatment needs for both mental health and substance use disorders. ADHS/DBHS recently procured the assistance of an independent consultant to examine available data, as well as review allocation methodologies of other states in order to determine an appropriate approach to fund distribution based on need.

The State has received the recommendations of the consultant, which are described in more detail later in this section, and we anticipate implementing these findings beginning in Federal Fiscal Year (FFY) 2015. The following section details the current instruments and methodology used for assessing service needs; the identified strengths, needs and programmatic initiatives within Arizona's service delivery system, and; the Systems of Care plans.

#### ***Substance Abuse – Assessing the Need for Prevention and Treatment Services***

The National Survey on Drug Use and Health (NSDUH), prepared by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Office of Applied Studies (OAS), provides the underlying methodology used by ADHS/DBHS to quantify substance abuse treatment need in Arizona.<sup>1</sup> On an annual basis, prevalence information from the NSDUH is compared to census data, both actual and estimated, for the State of Arizona. Formerly, this was done to comply with Forms 4 and 5 of the SAPT Block Grant, the results outlined treatment need based on race/ethnicity, gender, and age group for the state as a whole, and then for each county and/or sub-state planning area.

The most recent review of this information, as seen on the following page, notes that 667,801 individuals (approximately 10.3 percent of the population) were in need of treatment for an illicit drug or alcohol use problem. Additionally, of the number needing treatment, 10.8 percent would actively seek treatment. These percentages were applied to the population for each sub-state planning area to determine the total number in need of treatment services – over 72,000 individuals seeking treatment for a substance use disorder, or dependence, statewide. Unfortunately, the NSDUH does have a significant shortcoming in that it does not identify substance use prevalence for individuals under the age of 12 – making it exceedingly difficult to determine true need for services within this age group without the use of a more specific, state-tailored, assessment method.

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<sup>1</sup> Substance Abuse and Mental Health Services Administration. (2012). *Results from the 2011 National Survey on Drug Use and Health: Summary of National Findings* (Office of Applied Studies, NSDUH Series H-38A, HHS Publication No. SMA 12-4713 Findings). Rockville, MD.

Calendar Year: 2011<sup>2</sup>

Planning Area	Population	Total Population in Need		Number of IVDUs in Need		Number of Women in Need		Prevalence of Substance-related Criminal Activity		Incidence of Communicable Diseases (per 100,000)		
		Needing Treatment Services	That Would Seek Treatment	Needing Treatment Services	That Would Seek Treatment	Needing Treatment Services	That Would Seek Treatment	Number of DUI Arrests	Number of Drug-related Arrests	Hepatitis B	AIDS	Tuberculosis
Apache	72,401	7,457	805	123	22	2,367	256	398	355	7	0.11	13
Coconino	134,511	13,855	1,496	229	41	4,398	475	740	659	9	0.20	3
Mohave	202,351	20,842	2,251	344	61	6,616	715	1,113	992	11	0.30	2
Navajo	107,398	11,062	1,195	183	32	3,511	379	591	526	7	0.16	3
Yavapai	211,888	21,824	2,357	360	64	6,928	748	1,165	1,038	6	0.31	2
La Paz	20,419	2,103	227	35	6	668	72	112	100	10	0.03	0
Yuma	200,870	20,690	2,234	341	61	6,567	709	1,105	984	7	0.30	15
Cochise	133,289	13,729	1,483	227	40	4,358	471	733	653	8	0.20	1
Gila	53,144	5,474	591	90	16	1,738	188	292	260	8	0.08	0
Graham	37,147	3,826	413	63	11	1,215	131	204	182	0	0.05	0
Greenlee	8,606	886	96	15	3	281	30	47	42	0	0.01	0
Santa Cruz	47,676	4,911	530	81	14	1,559	168	262	234	0	0.07	4
Pinal	383,992	39,551	4,272	653	116	12,555	1,356	2,112	1,882	13	0.56	14
Pima	989,569	101,926	11,008	1,682	299	32,354	3,494	5,443	4,849	13	1.46	3
Maricopa	3,880,244	399,665	43,164	6,596	1,174	126,865	13,701	21,341	19,013	20	5.71	3
Arizona	6,483,505	667,801	72,123	11,022	1,962	211,978	22,894	35,659	31,769	16	9.53	4

<sup>2</sup> **County and State Populations:** US Census, 2011 Estimates; Accessed from <http://www.census.gov>

**IVDU:** Accessed from <http://www.samhsa.gov/data/2k7/idu/idu.htm>; Updated source for IVDUs only: *NSDUH Report: Injection Drug Use and Related Risk Behaviors, 2009* (IVDUs (0.17%)). Accessed from <http://www.samhsa.gov/data/2k9/139/139IDU.htm>

**Women:** NSDUH Calculations [Women in population (50.3%); SA prevalence among women (6.5%); Percent of women who receive treatment (10.8%)]

**DUI Arrests:** Arizona Dept. of Public Safety, *Crime in Arizona Report, 2011* (0.55%); Accessed from [http://www.azdps.gov/About/Reports/docs/Crime\\_In\\_Arizona\\_Report\\_2011.pdf](http://www.azdps.gov/About/Reports/docs/Crime_In_Arizona_Report_2011.pdf)

**Drug-Related Arrests:** Arizona Dept. of Public Safety, *Crime in Arizona Report, 2011* (0.49%); Accessed from [http://www.azdps.gov/About/Reports/docs/Crime\\_In\\_Arizona\\_Report\\_2011.pdf](http://www.azdps.gov/About/Reports/docs/Crime_In_Arizona_Report_2011.pdf)

**Hepatitis B:** ADHS, *Communicable Disease Summary by County, 2011*; Accessed from <http://www.azdhs.gov/phs/oids/pdf/weekly2011.pdf>

**AIDS:** ADHS, *HIV/AIDS Annual Report-Executive Summary, 2012*. Number of persons living with HIV/AIDS in AZ (14,705)/100,000= aggregated state rate\*county pop per 100,000=county incidence rate per 100,000.

<http://www.azdhs.gov/phs/hiv/documents/reporting/2012/2012-executive-summary.pdf>

**Tuberculosis:** ADHS, *2011 Cases and Rates by County*; Accessed from <http://www.azdhs.gov/phs/oids/tuberculosis/pdf/2011-az-tb-cases-rates-by-county.pdf>

Calendar Year: 2011

Age Band	Population	White		African American		Native Hawaiian/ Other Pacific Islander		Asian		American Indian / Alaskan Native		Multiracial		Not Hispanic or Latino		Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
0-9 Years	920,658	22,380	25,016	1,257	1,405	61	69	858	960	1,410	1,576	1,042	1,165	21,583	24,125	9,074	10,144
10 - 14 Years	453,845	11,032	12,332	620	693	30	34	423	473	695	777	514	574	10,639	11,893	4,473	5,000
15 - 19 Years	447,362	19,315	10,020	1,085	563	53	27	741	384	1,217	631	900	467	18,627	9,663	7,832	4,063
20 - 24 Years	447,362	19,315	10,020	1,085	563	53	27	741	384	1,217	631	900	467	18,627	9,663	7,832	4,063
25 - 29 Years	447,362	19,315	10,020	1,085	563	53	27	741	384	1,217	631	900	467	18,627	9,663	7,832	4,063
30 - 34 Years	421,428	18,195	9,439	1,022	530	50	26	698	362	1,147	595	847	440	17,547	9,103	7,378	3,827
35 - 39 Years	421,428	18,195	9,439	1,022	530	50	26	698	362	1,147	595	847	440	17,547	9,103	7,378	3,827
40 - 44 Years	414,944	17,915	9,294	1,006	522	49	25	687	356	1,129	586	834	433	17,277	8,963	7,264	3,769
45 - 49 Years	434,395	18,755	9,730	1,053	546	51	27	719	373	1,182	613	874	453	18,087	9,383	7,605	3,945
50 - 54 Years	421,428	18,195	9,439	1,022	530	50	26	698	362	1,147	595	847	440	17,547	9,103	7,378	3,827
55 - 59 Years	382,527	16,515	8,568	928	481	45	23	633	329	1,041	540	769	399	15,927	8,263	6,697	3,474
60 - 64 Years	356,593	15,396	7,987	865	449	42	22	591	306	970	503	717	372	14,847	7,703	6,243	3,239
65 - 69 Years	285,274	12,317	6,390	692	359	34	18	472	245	776	403	574	298	11,878	6,162	4,994	2,591
70 -74 Years	220,439	9,517	4,938	535	277	26	14	365	189	600	311	443	230	9,178	4,762	3,859	2,002
75 - 79 Years	162,088	6,998	3,631	393	204	19	10	268	139	441	229	326	169	6,749	3,501	2,838	1,472
80 - 84 Years	123,187	5,319	2,759	299	155	15	8	204	106	335	174	248	129	5,129	2,661	2,157	1,119
85 Years +	103,736	4,479	2,324	252	131	12	6	172	89	282	146	209	108	4,319	2,241	1,816	942
<b>Total</b>	<b>6,483,505</b>	<b>253,150</b>	<b>151,347</b>	<b>14,218</b>	<b>8,500</b>	<b>694</b>	<b>415</b>	<b>9,710</b>	<b>5,805</b>	<b>15,952</b>	<b>9,537</b>	<b>11,791</b>	<b>7,049</b>	<b>244,134</b>	<b>145,956</b>	<b>102,647</b>	<b>61,368</b>

The Substance Abuse Epidemiology Work Group (SEOW), originally created in 2004 as requirement of the Strategic Prevention Framework State Incentive Grant (SPF SIG), and later formalized as a subcommittee of the Arizona Substance Abuse Partnership (ASAP), has a membership roster including statisticians, data analysts, academics, holders of key datasets, and other key stakeholders from various state and federal agencies, tribal entities, private and non-profit substance abuse-related organizations, and universities.<sup>3</sup> This group is tasked with providing communities, policymakers and local, state and tribal officials with data on the use of alcohol and illicit, over-the-counter, and prescription drugs to inform their substance abuse prevention and intervention strategies. The primary responsibilities of the Epidemiology Workgroup include:

- Compiling and synthesizing information and data on substance abuse and its associated consequences and correlates, including mental illness and emerging trends, through a collaborative and cooperative data-sharing process;
- Assessing substance abuse treatment service capacity in Arizona and detail gaps in service availability;
- Serving as a resource to the Arizona Substance Abuse Partnership and member agencies to support data-driven decision-making that makes the best use of the resources available to address substance abuse and related issues in Arizona; and
- Identifying data gaps and address them in order to provide Arizona with a comprehensive picture of substance abuse in the state.

To this extent, the Epidemiology Workgroup develops a bi-annual Substance Abuse Profile for the state. In return, ADHS/DBHS uses this profile to help assess need for substance abuse prevention and treatment.<sup>4</sup>

The NSDUH analysis and the Epidemiologic Profile reinforce the findings of Arizona's qualitative data feeds. When reviewed in concert, and used in conjunction with other special reports to assist in understanding the statewide distribution of need, demand, and capacity for substance abuse treatment, these studies generally support the resource allocation formulary used by DBHS for non-Medicaid populations. Specifically, they disclose that:

- There is little geographic variation in the prevalence of need for substance abuse treatment;
- Demand for treatment varies most by population size, with denser areas of the state experiencing the highest demand for treatment;
- Certain high-risk groups do exist, including young adults and women in the Northern Arizona region;
- Statewide, treatment capacity is insufficient to meet the needs of the general population;
- Alcohol is Arizona's most prevalently used substance and carries the greatest economic burden, and;
- Prescription drug abuse and related consequences have been increasing for the past five years.

ADHS/DBHS also relies on the results of numerous qualitative surveys to determine need and directs resources accordingly. These surveys are critical to identifying potential service gaps as they are able to capture the human component, most notably, the effect that a lack of services can have on a community that a quantitative analysis cannot adequately determine. These surveys, as well as other tools for assessing need, are detailed in the tables on the following pages.

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<sup>3</sup> Please see Section V of this application for more information on the Arizona Substance Abuse Partnership.

<sup>4</sup> The most recent state epidemiological profile is available at <http://sirc.asu.edu/evaluations-contracts/pdfs-for-reports/arizona-behavioral-health-epidemiology-profile>

Tool	Administration Method	Frequency of Administration	Theme	Important Findings
Arizona Department of Health Services Title V needs assessment Affordable Health Care Act Maternal, Infant, and Early Childhood Home Visiting Program Arizona Needs Assessment 2010	Includes a review of epidemiological data combined with community input.	Once	Behavioral and physical needs of women	Nearly one-in-five women age 18-44 years had problems dealing with depression, stress, and/or emotions during the past month. Intentional injury-related mortality, (suicide and homicide) declined during the past decade for women of reproductive age.
Arizona Health Status and Vital Statistics 2010 <a href="http://www.azdhs.gov/plan/report/ahs/ahs2010/toc10.htm">http://www.azdhs.gov/plan/report/ahs/ahs2010/toc10.htm</a>	Collection of data	Statistics are updated annually	Morbidity and mortality of Arizonans	Arizonans experienced an increase in the number of accidental drug poisonings and overdose deaths (from 414 in 2001 to 798 in 2010). The age adjusted suicide rate increased from 14.8 suicides per 100,000 residents of the state in 2008 to 16.1/100,000 in 2009 and 16.7/100,000 in 2010; the highest suicide rate since 1998. From 2007 to 2010, there was a 33.6% increase in suicide-related emergency room visits where the principal diagnosis was an injury.
Arizona Behavioral Health Epidemiology Profile 2011 <a href="http://sirc.asu.edu/evaluations-contracts/pdfs-for-reports/arizona-behavioral-health-epidemiology-profile">http://sirc.asu.edu/evaluations-contracts/pdfs-for-reports/arizona-behavioral-health-epidemiology-profile</a>	Compilation of state and community level statistics	One time	Substance Abuse	Use of emergency departments for mental illness and substance abuse-related disorders is on the rise with rates of emergency department use catching up with and sometimes surpassing hospital discharges. For example, the rates of emergency department visits for schizophrenia, manic depressive psychoses and anxiety disorders all increased by more than four-fold between 2003 and 2010; the rate for depression-related neuroses also increased by more than four times; and the rate for drug dependence-related neuroses looks poised to surpass hospital discharges in the future.  Middle-aged adults were the most likely to visit a hospital and an emergency department in connection with alcohol dependence syndrome (more than twice the rate of any other age group), while those aged 65 and older were discharged from hospitals for drug psychosis-related mental health issues at a rate nearly twice that of middle-aged adults.
Arizona Youth Survey <a href="http://www.azcic.gov/ACIC.Web/sac/AYSReports/2012/AYS%202012%20Report%20Final%2012%2031%202012.pdf">http://www.azcic.gov/ACIC.Web/sac/AYSReports/2012/AYS%202012%20Report%20Final%2012%2031%202012.pdf</a>	8 <sup>th</sup> , 10 <sup>th</sup> , and 12 <sup>th</sup> grade students	Every 2 years	Substance use, risk and protective factors	Alcohol is the most prevalently used substance for youths in AZ. In 2010 there was a dramatic statewide rise in 30 day use of Marijuana among Arizona 8th, 10th, and 12th grade students.
St Luke's Health Initiative 2010 Arizona Health Survey <a href="http://www.arizonahealthsurvey.org/wp-content/uploads/2011/05/ahs-2010-veterans-May11.pdf">http://www.arizonahealthsurvey.org/wp-content/uploads/2011/05/ahs-2010-veterans-May11.pdf</a>	Adults	One time only	Substance Abuse & Mental Health needs of Arizonans	Veterans have higher rates of alcohol use than general public

Tool	Administration Method	Frequency of Administration	Theme	Important Findings
AZHEIN (2011) Survey of Students, <i>Unpublished data/report</i>	Students enrolled in Arizona Universities	Annually	Substance use behaviors, consequences, & contributing factors	Alcohol is the most commonly used substance among Arizona college students. LGBTQ students use alcohol and other substances at a greater rate than other students.
Community Health Centers of Arizona Integration Survey, <i>Unpublished report, January 2011</i>	Survey of behavioral health and community health clinics	One time	Integration between behavioral and physical health services & the use of SBIRT	None of the community health centers in Northern Arizona currently use SBIRT. Nor do they use any of the standardized substance abuse assessment tools. Low use of these tools may be due to Arizona's waiver to reimburse medical providers for screening and brief intervention.
Emergency Department (ED) Initiative Assessment Finding Report, <i>Unpublished report September, 2010</i>	Survey data from 38 emergency departments statewide.	One time	ED suicide and substance abuse prevalence rates, as well as recommendations for interventions to serve patients.	Behavioral health consultation and referral to local community resources are the most common interventions for suicide and substance abuse-related emergency department cases. Medical staff recommended that community resource options for low-income and uninsured patients increase and that referral guides for resources are made readily available. Screening for substance abuse and suicide was identified as a resource need, and was recommended for integration in emergency department nursing assessments.
Living well with disabilities community needs assessment, <i>Non published report submitted to ADHS/DBHS, Fall, 2010</i>	Comprehensive assessment of needs for people with disabilities in Maricopa County collected through 1 focus group, 6 key informant interviews.	Every 3 years	Substance abuse and other behavioral health issues	Within both the civilian and the veteran populations there are signs of growing abuse of prescription medications, particularly medications for pain relief and behavioral health issues such as depression and acute anxiety. There is a greater need for integration of medical and behavioral health services.
Youth Risk Behavior Survey (YRBS)	Survey for Arizona students in grades 9 through 12	Every 2 years	Physical health, substance use, suicide ideation and suicide attempts.	17.3% of students in Arizona said that they had seriously considered suicide, 12.1% said they had made a plan to commit suicide, and 9.5% said they had actually attempted to commit suicide within the last 12 months. Females are at higher risk of suicidal ideation and attempted suicide. Youth residing in Arizona are significantly more likely to engage in binge drinking, although the proportion of students in Arizona reporting this behavior declined from 34.8 percent in 2003 to 27.4 percent in 2009.
Arizona Community Data Project <a href="http://www.bach-harrison.com/arizonadataproject/Indicators.aspx">http://www.bach-harrison.com/arizonadataproject/Indicators.aspx</a>	Compilation of statistics	Updated continuously	Substance Abuse Trends and Consequences	Alcohol is the number one most prevalent and costly substance in Arizona.

**Mental Health- Prevalency among Adults and Children**

The need for mental health treatment for both the adult and child/adolescent populations is established primarily through the application of prevalency rates provided by the National Association of State Mental Health Directors Research Institute, Inc. (NRI). This data has been provided to the states in previous years and used exclusively to estimate the number of adults with a Serious Mental Illness (SMI)<sup>5</sup>, and children with a Serious Emotional Disturbance (SED)<sup>6</sup> when developing the annual Community Mental Health Services (CMHS) Block Grant.

NRI updates the estimates of adults with SMI, and children with SED, using the federal estimation methodologies developed by the Center for Mental Health Services. For 2011, the adult with serious mental illness rate was defined as 5.4 percent of the adult civilian population for each state.<sup>7</sup>

**Adult SMI Prevalence**

Civilian Population Age 18+ Population 2011 <sup>8</sup>	Civilian Population with SMI (5.4%)	Lower Limit of estimate (3.7%)	Upper Limit of estimate (7.1%)
4,835,917	261,140	178,929	343,350

Adult SMI Calculation Method:

Column 1: Civilian Population Aged 18 and Over in 2011

Column 2: Civilian Population with SMI (5.4% of adults age 18+)

Column 3: Lower Limit of Estimate (5.4% - 1.96(.8673)): 95% confidence bound

Column 4: Upper Limit of Estimate (5.4% + 1.96(.8673)): 95% confidence bound

**Child SED Prevalence<sup>9</sup>**

2009 Population of Youth Aged 9 to 17	Level of Functioning Score = 50		Level of Functioning Score = 60	
	Lower Limit	Upper Limit	Lower Limit	Upper Limit
811,233	56,786	73,011	89,236	105,460

Child SED Calculation Method:

Column 1: 2011 Estimated Civilian Population Aged 9-17

Column 2: Lower Limit of Estimate

Column 3: Upper Limit of Estimate

Column 4: Lower Limit of Estimate

Column 5: Upper Limit of Estimate

It is important to note that these estimates are an attempt to quantify the overall statewide prevalency for adults with an SMI and children with an SED, regardless of the individuals' true need for services or the likelihood they would seek treatment with the *public* behavioral health system. Many individuals in need of mental health care receive treatment outside of the public system and are covered by private insurance or some other third-party payment source; therefore, it should not be expected that the number of individuals estimated to have an SMI or SED would equal the number enrolled and served by the public behavioral health system. Accordingly, in fiscal year (FY) 2012, DBHS enrolled and served

<sup>5</sup> SMI is defined by SAMHSA as: persons 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 DSM-IV that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities. Accessed from [http://www.samhsa.gov/healthReform/healthHomes/Definitions\\_SIM\\_SUD\\_508.pdf](http://www.samhsa.gov/healthReform/healthHomes/Definitions_SIM_SUD_508.pdf)

<sup>6</sup> SED is defined by SAMHSA as: children from birth to age 18 who currently have, or any time during the last year, had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria with DSM-III-R. Accessed from [http://www.samhsa.gov/healthReform/healthHomes/Definitions\\_SIM\\_SUD\\_508.pdf](http://www.samhsa.gov/healthReform/healthHomes/Definitions_SIM_SUD_508.pdf)

<sup>7</sup> 2011 prevalency data for the Adult SMI and Child SED populations was the most recently available information at the time of application's drafting; Accessed from *Results from the 2011 National Survey on Drug Use and Health: Mental Health Findings* at [http://www.samhsa.gov/data/NSDUH/2k11MH\\_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.pdf](http://www.samhsa.gov/data/NSDUH/2k11MH_FindingsandDetTables/2K11MHFR/NSDUHmhfr2011.pdf)

<sup>8</sup> U.S. Census Bureau, 2011 URS Table.

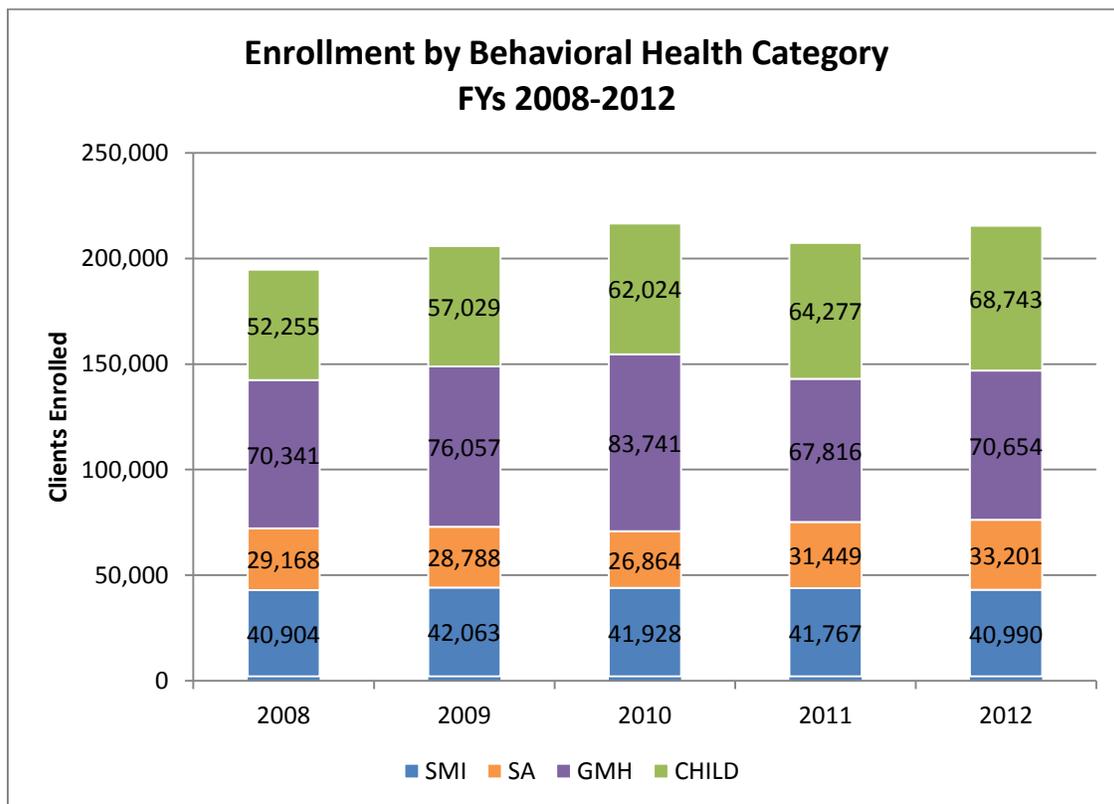
<sup>9</sup> U.S. Census Bureau, 2011 URS Table; estimates are tied to the child poverty rate.

40,990 adults with an SMI (29.0 percent of all enrolled adults) and 22,580 children with an SED (31.0 percent of all enrolled children).

**Assessing the Overall Enrollment Population**

Collecting and reviewing past years’ behavioral health enrollment data in comparison to available needs assessment information allows DBHS to identify areas of concern, including underserved populations and other potential service disparities. In this respect, enrollment data is extracted from the ADHS/DBHS’ Client Information System (CIS) upon the close of each state fiscal year and evaluated on the statewide aggregate and sub-state planning levels, with a specific focus on the distribution of client demographics such as age, race, ethnicity, and gender across the service delivery network.<sup>10</sup>

In FY 2012 ADHS/DBHS provided behavioral health services to over 213,588 individuals. This represented an enrollment increase of 5.0 percent, compared to FY 2011. Most of the increase was found in adults with a GMH disorder. The graph below details enrollment changes from state fiscal years 2008 through 2012 by behavioral health category; additionally, the following two tables show the regions where these persons were enrolled in FY 2012 and provide basic demographic information for these individuals.



<sup>10</sup> Consumer Enrollment and Demographic data is available in October for the preceding state fiscal year.

**FY 2012 Enrollment**

Counties	T/RBHA	Number Enrolled	Percent of Clients Enrolled Statewide
Apache Coconino Mohave Navajo Yavapai	<b>Northern Arizona Regional Behavioral Health Authority (NARBHA)</b>	30,745	14.4%
La Paz Yuma Cochise Gila Graham Greenlee Santa Cruz Pinal	<b>Cenpatico Behavioral Health System (CBHS)</b>	25,166	8.5%
Pima	<b>Community Partnership of Southern Arizona (CPSA)</b>	49,932	23.4%
Maricopa	<b>Magellan of Arizona</b>	104,665	49.0%
Tribal Authority	<b>Navajo Nation</b>	310	0.1%
Tribal Authority	<b>Gila River Indian Community</b>	1,847	0.9%
Tribal Authority	<b>Pascua Yaqui</b>	822	0.4%
Tribal Authority	<b>White Mountain Apache</b>	101	0.04%

**FY 2012 Demographics (Statewide Aggregate; n=213,588)**

Client Financial Eligibility		Age Distribution		Race and Ethnicity	
<b>Medicaid Title XIX:</b>	84.1%	Birth –5:	4.6%	African American:	7.4%
<b>Medicaid Title XXI:</b>	0.6%	6-12:	15.5%	American Indian:	4.8%
<b>Non-Title XIX/XXI:</b>	15.4%	13-17:	12.1%	Asian:	0.7%
		18-21:	7.0%	Native Hawaiian:	0.3%
		22-30:	15.5%	White:	85.2%
<b>Male:</b>	48.8%	31-40:	22.0%	Multiracial:	1.7%
<b>Female:</b>	51.2%	41-50:	12.6%		
		51+:	10.8%		
		Median Age:	28.4 Years	Hispanic/Latino:	31.8%

When compared to information from the United States’ Census, ADHS/DBHS is able to determine whether or not its outreach programs are effective and if the treatment population adequately reflects the characteristics of the general population in Arizona. With respect to Gender, Race, and Ethnicity, those individuals in treatment are largely representative of Arizona’s population, with select instances of specific groups being over-represented. For example, whereas African Americans and Hispanic/Latino account for 4.5 percent and 30.1 percent of the general population, these groups make up 7.4 percent and 31.8 percent of the treatment population.<sup>11</sup> However, while 3.0 percent of Arizonans indicate being Asian, this group accounts for 0.7 percent of those enrolled in the treatment population.

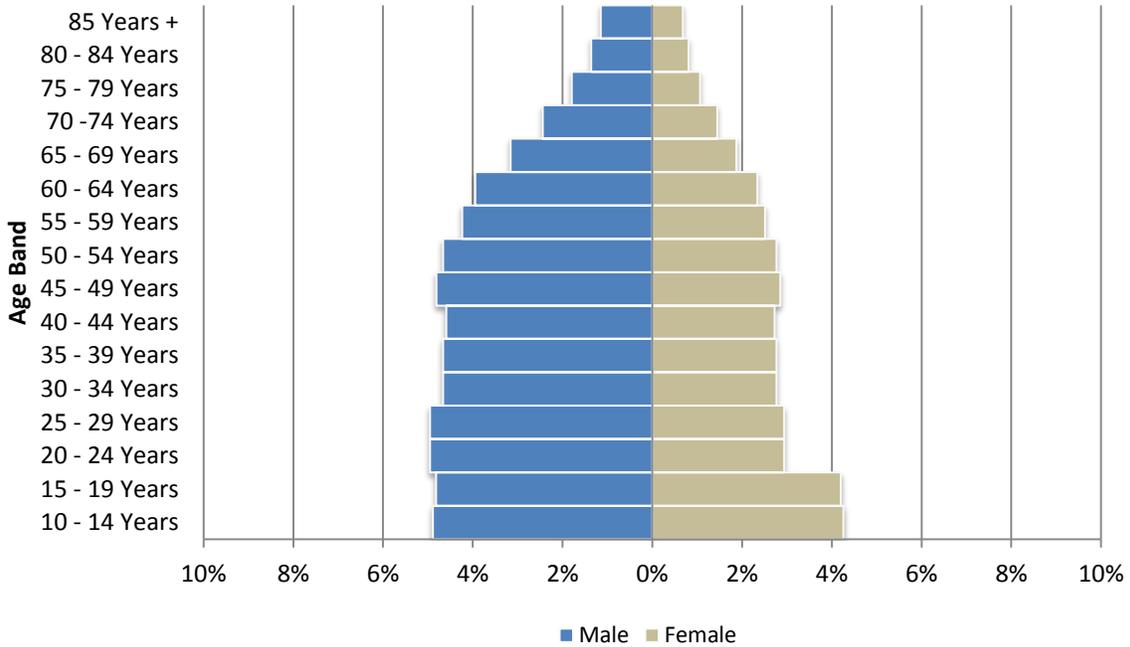
Furthermore, by using the prevalence data from the NSDUH, in comparison to enrollment rosters, ADHS/DBHS is able to establish expected substance abuse treatment penetration rates by gender and age band, and determine if any age groups may be underserved. For example, according to the most

<sup>11</sup> U.S. Census Bureau, State and County QuickFacts, 2011 Arizona Estimates

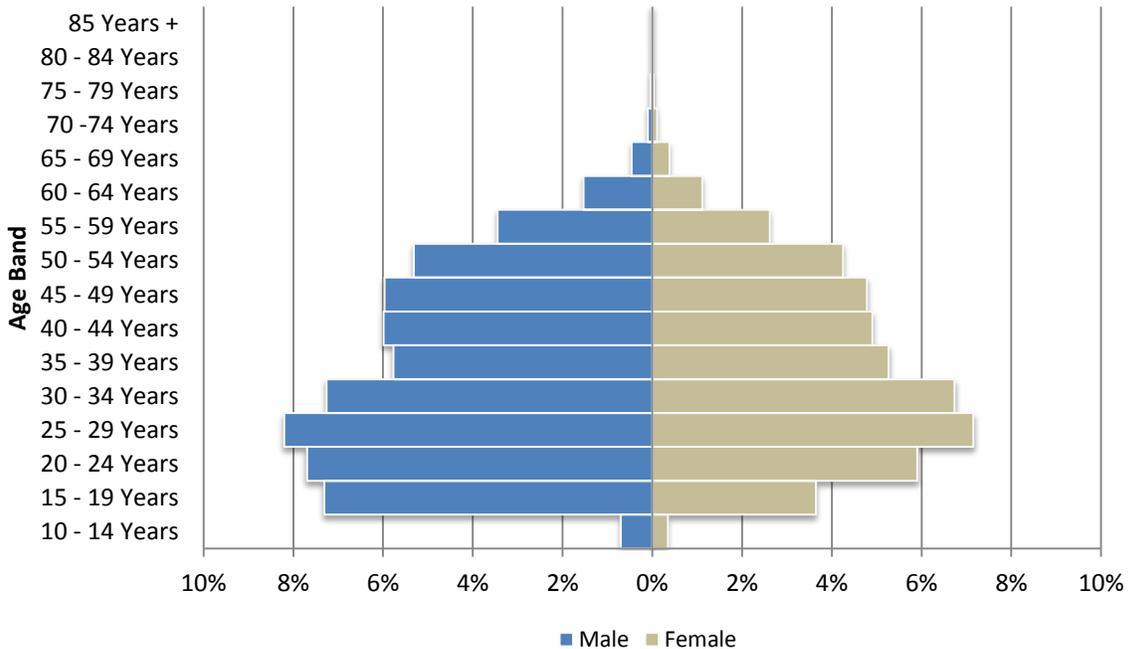
recent NSDUH information available, 4.3 percent of the treatment population should be females between the ages of 10-14, with 4.9 percent of the treatment population comprised of males ages 10-14; however, actual enrollment rates for these groups fell below the expected volume (females 0.35 percent; males 0.70 percent). The same was generally true for adults over the age of 55, regardless of gender, as this group was underrepresented in the treatment population (please see following figures). This level of micro-analysis is directly responsible for justifying two state priorities (see Application Table 3) for increasing enrollment for older adults, and children/adolescents, in need of substance abuse treatment.

It is also important to note that this same analysis showed evidence that past State initiatives around increasing enrollment for women who may be pregnant or have dependent children, a SAPT priority population, have been successful – as the rates of women of childbearing age (20-34 years) in treatment is greater than expected. Despite this performance, ADHS/DBHS will continue to focus on outreach and engagement efforts for this priority group and ensure gender-specific services are available and readily accessible.

### Distribution of Substance Abuse Treatment Need by Age and Gender (FY12)



### Distribution of Substance Abuse Treatment Provision by Age and Gender (FY12)



### **Arizona's Strengths, Needs, and Priority Initiatives for Addressing Grant-Identified Populations and Other Targeted Services**

Despite the service limitations noted in the preceding section, and reflective of the State's economic situation, ADHS/DBHS works diligently with the RBHAs, and TRBHAs to ensure the service delivery network presents individuals with a choice of multiple, highly-qualified providers, each offering varying levels of care spanning multiple treatment modalities. This section describes unique strengths, needs, critical gaps and priority initiatives around specific groups or services, including:<sup>12</sup>

- Children with an SED and Adults with an SMI
- Pregnant women and women with dependent children
- Persons who use drugs by injection
- Adolescents with substance abuse and/or mental health problems
- Military personnel and their families
- Individuals with mental and/or substance use disorders who live in rural areas
- Historically underserved populations
- Individuals with tuberculosis and other communicable diseases
- Individuals with substance abuse and/or mental health problems who are homeless

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<sup>12</sup> Further programmatic details are also included in preceding sections.

**Children with a Serious Emotional Disturbance and Adults with a Serious Mental Illness**

In FY 2012, of the 213,588 members enrolled in the behavioral health system nearly 41,000 were adults with an SMI, and 22,580 were children with an SED. As indicated in the following table, enrollment shows the male and female behavioral health populations are approximately equal. However, for adults with an SMI, there are considerably more females than males; whereas, for children with an SED there are more males than females, 64.1 percent and 35.9 percent, respectively.

Adults with SMI and Children with SED (Enrolled FY 2012)		Child with SED	Adult with SMI	All Members Enrolled FY 2012
<b>Total in Population</b>		22,580	40,999	<b>213,588</b>
<b>Median Age (Years)</b>		12.46	47.23	<b>28.35</b>
<b>Gender</b>	Male	64.1%	44.5%	<b>48.8%</b>
	Female	35.9%	55.5%	<b>51.2%</b>
<b>Race</b>	White	85.1%	87.7%	<b>85.2%</b>
	Black	8.0%	7.6%	<b>7.4%</b>
	Native American	3.2%	2.2%	<b>4.8%</b>
	Asian	0.4%	1.2%	<b>0.7%</b>
	Hawaiian	0.3%	0.2%	<b>0.3%</b>
	Multiracial	3.0%	1.1%	<b>1.7%</b>
<b>Ethnicity</b>	Hispanic	39.5%	17.5%	<b>31.8%</b>
	Not-Hispanic	60.5%	82.5%	<b>68.2%</b>
<b>Percent Attending School</b>		92.1%	11.0%	<b>36.3%</b>
<b>Percent with HS Diploma / GED or Greater</b>		0.7%	69.4%	<b>45.0%</b>
<b>Employment Status</b>	Employed	0.2%	12.8%	<b>13.0%</b>
	Unemployed	2.2%	31.0%	<b>31.0%</b>
	Not in Labor Force <sup>13</sup>	97.6%	56.2%	<b>56.0%</b>
<b>Percent with a Recent Arrest</b>		4.5%	6.9%	<b>6.3%</b>
<b>Housing Status</b>	Homeless	0.3%	2.9%	<b>2.4%</b>
	Not Homeless	99.7%	97.1%	<b>97.6%</b>
<b>Primary Substance Type</b>	Heroin	0.1%	1.5%	<b>3.2%</b>
	Methamphetamine	0.2%	4.8%	<b>4.8%</b>
	Alcohol	1.9%	16.8%	<b>13.3%</b>
	Crack/Cocaine	0.1%	3.0%	<b>1.6%</b>
	Marijuana	6.3%	8.3%	<b>8.8%</b>
	Other Opiates	0.1%	1.3%	<b>1.8%</b>
	Other Substances	0.1%	2.1%	<b>1.1%</b>

Arizona's comprehensive recovery-oriented system of care for adults and children is fully integrated to address both the mental health, and substance use prevention and treatment, needs. The service delivery system is designed to operate, and provide services, in the least restrictive community-based environment available. For example, ADHS has utilized the evidenced-based practice, Community-Based Participatory Research (CBPR), in initiatives such as Raise Your Voice Project.<sup>14</sup>

Additionally, in an effort of improving service delivery for SMI adults, ADHS has adopted four evidence-based practice models supported by SAMHSA: Assertive Community Treatment (ACT), Supported Employment, Permanent Supportive Housing, and Consumer-Operated Services. In accordance with

<sup>13</sup> Employment status category "Not in Labor Force" includes persons that were not employed and were not seeking employment in the last 30 days (e.g. volunteer, retired, disabled, etc.).

<sup>14</sup> Please see Section M for more details on this initiative.

SAMHSA's definition, ADHS defines consumer-operated services, also known as peer-run programs, as services/programs incorporating the following concepts:

- Independence: the agency is administratively controlled and operated by behavioral health consumers;
- Autonomy: Decisions about governance, fiscal, personnel, policy, and operational issues are made by the program;
- Accountability: Responsibility for decisions rests with the program;
- Consumer-Controlled: The governance board is at least 51% behavioral health consumers; and
- Peer Workers: Staff and management are individuals who have received behavioral health services.<sup>15</sup>

In April, 2011, the Arizona State Legislature passed ground breaking legislation creating, for the first time in Arizona's history, a State Housing Trust Fund, operated by the Arizona Department of Health Services, specifically for adults with serious mental illness. The Governor signed the bill into law and it became effective July 1, 2011. This new law required ADHS to develop a permanent housing program and submit their first report to the legislature and Governor by September 2011. Over \$2 million annually is appropriated to the ADHS State Housing Trust Fund until FY 2044. These monies will continue to be used to purchase homes and apartment complexes through contracts with local Arizona non-profit organizations to increase the capacity of permanent housing for RBHA enrolled members who are Medicaid-eligible. All properties purchased with these funds will be deed restricted for the sole use of housing adults with serious mental illnesses for a twenty five year period. This program has been specifically designed to integrate individuals in recovery with their community.

An additional \$38.7 million was appropriated for community-based, recovery-oriented behavioral health services for individuals with an SMI in the FY 2013 state budget.<sup>16</sup> Using the additional funding, ADHS/DBHS plans to provide the following services to non-Medicaid-eligible adults with an SMI:

- Supported employment
- Peer and family support
- Permanent supportive housing
- Living skills training
- Health promotion
- Personal assistance
- Case management
- Respite care
- Medication/medication monitoring
- Crisis services

The Arizona Vision and Principles, the array of covered services, the collaboration with RBHAs and sister-agencies, the strong partnerships with family-run organizations and the commitment to the Child and Family Team Practice Model all provide a solid framework for continued system development. During the past three years the state has worked to improve care for the most complex needs children in the system and to reduce the use of out of home treatment through a number of initiatives, such as the High Needs Case Management Initiative and the development of the Generalist Direct Support program.

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<sup>15</sup> Adoption of SAMHSA Practice Models Letter from ADHS/DBHS Deputy Director. Accessed from <http://www.azdhs.gov/bhs/documents/news/dbhs-adotion-of-samsha-practice-models.pdf>

<sup>16</sup> FY13 Budget Stakeholder Letter from the ADHS/DBHS Deputy Director. Accessed from [http://www.azdhs.gov/bhs/documents/title19/StakeholderLetterFY13Budget\\_05-11-12.pdf](http://www.azdhs.gov/bhs/documents/title19/StakeholderLetterFY13Budget_05-11-12.pdf)

The Child and Adolescent Service Intensity Instrument (CASII) was introduced across the system as one way to help identify children and families with complex needs. During the coming year there is a plan to establish a standardized measure to help identify complex needs of children ages birth to five. Additional goals include promoting the use of the CASII to increased fidelity and to examine ways to use the tool as a measure of functional improvement.

**Priority Populations**

In FY 2012 there were 75,115 individuals enrolled in Arizona’s public behavioral health system for substance abuse treatment. Of the number enrolled, there were 10,979 females enrolled in treatment who met the criteria for priority placement, as they were abusing substances and were either pregnant and/or had dependent children. During the same fiscal year, 6,684 individuals indicated using drugs by injection.<sup>17</sup>

The following table details the demographic makeup of these groups in comparison to the overall Substance Abuse population served during that same time period.

Substance Abuse (Enrolled FY 2012)		Pregnant/ Parenting Women	Injection Drug Users	All Substance Abusers
<b>Total in Population</b>		10,979	6,684	<b>75,115</b>
<b>Median Age (Years)</b>		31.98	35.27	<b>34.44</b>
<b>Gender</b>	Male		61.4%	<b>55.9%</b>
	Female	100.0%	38.6%	<b>44.1%</b>
<b>Race</b>	White	81.0%	93.6%	<b>83.1%</b>
	Black	7.3%	2.3%	<b>7.1%</b>
	Native American	9.8%	2.7%	<b>7.8%</b>
	Asian	0.3%	0.2%	<b>0.4%</b>
	Hawaiian	0.3%	0.5%	<b>0.3%</b>
	Multiracial	1.3%	0.7%	<b>1.3%</b>
<b>Ethnicity</b>	Hispanic	25.0%	24.7%	<b>26.5%</b>
	Not-Hispanic	75.0%	75.3%	<b>73.5%</b>
<b>Percent Attending School</b>		10.5%	5.1%	<b>15.4%</b>
<b>Percent with HS Diploma / GED or Greater</b>		64.4%	69.7%	<b>59.6%</b>
<b>Employment Status</b>	Employed	20.9%	17.7%	<b>18.3%</b>
	Unemployed	57.7%	60.3%	<b>50.4%</b>
	Not in Labor Force	21.4%	22.0%	<b>31.3%</b>
<b>Percent with a Recent Arrest</b>		10.6%	14.2%	<b>14.1%</b>
<b>Housing Status</b>	Homeless	3.5%	9.0%	<b>5.1%</b>
	Not Homeless	96.5%	91.0%	<b>94.9%</b>
<b>Primary Substance Type<sup>18</sup></b>	Heroin	7.3%	75.7%	<b>9.7%</b>
	Methamphetamine	25.2%	18.0%	<b>14.2%</b>
	Alcohol	29.6%	0.1%	<b>35.2%</b>
	Crack/Cocaine	4.4%	1.4%	<b>4.8%</b>
	Marijuana	20.3%	0.1%	<b>26.1%</b>
	Other Opiates	8.6%	4.0%	<b>5.3%</b>
	Other Substances	2.9%	0.7%	<b>3.1%</b>

<sup>17</sup> Includes those who indicate ‘injection’ as the route of use for their primary, secondary, or tertiary substance type preferences.

<sup>18</sup> Primary Substance Types includes both illicit and licit substances.

***Pregnant women and women with dependent children who have a substance use disorder***

As indicated in the above table, nearly one out of three of these individuals (29.6 percent) cited alcohol as their primary substance, with methamphetamine and marijuana being the next most commonly abused substances.

The service delivery network has a rich array of providers available to treat these individuals, including more than twenty residential programs offering evidenced based, gender specific, programming to pregnant women, and women with dependent children, in accordance with nationally-recognized standards. For example:

- **The Haven** is a level II residential treatment program that serves both pregnant/post-partum women and women with dependent children. Program places emphasis on the multi-dimensional holistic approach to substance-use disorders. Services include peer support, on-site child care and “Native Way”. Native Way services include use of Smudging, Medicine Wheel, Talking Circles, Sweat Lodge, Pipe ceremonies, Native music as art, and Storytelling.
- **Weldon House**, a facility operated by the National Council on Alcoholism and Drug Dependence (NCADD), is a unique supported independent living environment that offers specialized, gender-specific living to women and their children. Weldon House is innovative in that the women with their child/children have their own fully furnished apartment that provides them with the setting in which to learn hands on how to manage a home, parent their child/children and develop a family.
- **Community Bridges/Center for Hope** is a level II residential facility that is a nationally recognized best practice program targeting pregnant/ post-partum women and women with dependent children. Services include on-site child care, relapse prevention, recovery support groups, GED preparation, employment training, and grief and loss counseling.
- **Pinchot Gardens** is a facility serving low-income women with co-occurring general mental health and substance abuse diagnosed, and is operated by LifeWell Behavioral Wellness. Some of the services provided include: on-site childcare, group and individual counseling, substance abuse recovery, parenting classes, interpersonal development, and relapse prevention.
- **Las Amigas** is a residential facility, operated by CODAC Behavioral Health Services, serving women in need of substance abuse treatment. Priority is given to women who are pregnant and/or parenting, are homeless, have sexual or physical abuse histories, or are in the criminal justice system. Services incorporated in the individualized treatment plan may include: individual, group, and/or family counseling; classes on parenting and smoking cessation; relapse prevention; and coordination of medical and educational services, as well as after-discharge community support and resources.

Another significant strength of Arizona’s system, especially as it relates to capacity management for this priority population has been the recent (April, 2011) implementation of a new waitlist tracking system for priority population members whom are not eligible for Medicaid. Prior to this development, there was a significant delay between the time a non-Medicaid priority population member (pregnant or parenting female, and Injection Drug User) was placed on a waitlist and ADHS/DBHS being notified. The new system is web-based, and sends an alert to the RBHA and ADHS/DBHS immediately upon an individual seeking residential treatment being waitlisted when a provider is unable to meet the

placement timeframes established in 42 U.S.C. 300x-23(a)(2)(A)(B). As of FY 2012, twenty-one non-Medicaid priority population members were placed on the waitlist, with an average wait time of 9.9 days. There were four individuals on the waitlist who were males using drugs by injection, and the remaining seventeen members were women who were pregnant and/or had dependent children. Nine of those individuals were placed on the waitlist because the facility was full, and the remaining twelve elected to postpone treatment at the time of assessment.

Despite the comprehensive service package available to substance abusing women who are pregnant or have dependent children, there are still areas of need in Arizona; specifically, the state aims to improve the quality and quantity of gender-responsive practices available in our standard and intensive outpatient programs. Furthermore, ADHS/DBHS has been working to address the lack of available childcare options for these individuals; in many cases, child care has been noted as the primary barrier preventing females from entering, or continuing, a treatment program. Because child care is not an encounterable service, many providers are hesitant to offer this service due to lack of funding. Arizona would greatly appreciate any guidance from SAMHSA on addressing child care for this population.

Additionally, ADHS/DBHS is required by both the terms of the Block Grant, and by Arizona Revised Statute (A.R.S.) §36-141(B) to give treatment priority to pregnant females who abuse drugs or alcohol; in this respect, DBHS has set a goal of increasing enrollment & penetration rates by 5 percent annually for pregnant females and females with dependent children, with a substance use disorder or dependence.<sup>19</sup>

#### ***Persons who use drugs by injection***

Overall, the behavioral health population is divided nearly evenly between males and females; however, as noted in the previous table, the substance abuse population is comprised of slightly more men than women – 55.9 percent versus 44.1 percent respectively. This disparity increases when comparing injection drug using males (61.4 percent) and females (38.6 percent).

Additionally, nearly 80 percent of intravenous drug users (IVDU) cite heroin or other opiates as their primary substance of choice; in comparison, only 15 percent of non-injection drug users indicated opiates were their primary substance. ADHS/DBHS and the RBHAs have established a statewide network of clinics offering methadone maintenance administration and treatment services to those with an opiate addiction – including those using drugs by injection. The geographical distribution of these clinics was detailed on the network inventory table included in the previous section of this application.

ADHS/DBHS ensures adequate capacity management for the IVDU population through contractual mechanisms. Providers are required by contract to notify their RBHA when they have reached the 90 percent capacity threshold, as required by 42 U.S.C. 300x-23(a)(1). The system allows for these programs to request and receive additional funding when the population being served approaches a predetermined number identified in their contracts. As the majority of IVDU treatment is done in an outpatient setting (both standard and intensive care), this additional funding allows the provider to expand services as necessary to accommodate more clients.

Despite these strengths, ADHS/DBHS has identified two areas of need for the injection drug using population. To begin, ADHS/DBHS has been placing an emphasis on the need to expand network capacity in relation to the number of certified physicians who are licensed to provide non-methadone Medically Assisted Therapy (MAT) services for those with an opiate addiction – specifically for

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<sup>19</sup> Please see Table 3

buprenorphine and Suboxone. The lack of access to these physicians in the rural areas of the state restricts consumers with an opiate addiction to only methadone maintenance, and adds to the increased utilization of transportation services. As a result, all RBHAs are working to add buprenorphine prescribers to their network in the most cost effective way possible.

Furthermore, in early FY 2012, ADHS/DBHS instituted a statewide pilot program in an effort to expand the use of non-methadone Medically Assisted Therapies to those with an opiate addiction. Specifically, RBHAs were permitted to expend a portion of their annual SAPT general services allocation to provide buprenorphine or Suboxone to non-Medicaid eligible behavioral health recipients.<sup>20</sup> Prior to this pilot, SAPT funding for opiate medications had been limited to methadone due to the high costs of the alternatives. This pilot ran through FY2012 and as a result of its success, DBHS revised policies as appropriate to permit SAPT funding to be used for all non-methadone MAT drugs as clinically and medically necessary to promote treatment and successful recovery.<sup>21</sup> Currently, RBHAs have expanded their MAT programs and are working on promoting the availability of these services; however, MAT options vary by RBHA.

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<sup>20</sup> "General Services Allocation" refers to monies not already set aside for the SAPT-designated priority populations

<sup>21</sup> For more information on this pilot program please see Table 3, Priority 10, of this application.

### ***Adolescents with substance abuse and/or mental health problems***

In FY 2012 there were 72,336 children and adolescents enrolled in Arizona's public behavioral health system. For the past 12 years, the development of the state-wide Children's System of Care (CSOC) has been guided by the Arizona Vision and Principles which were developed to model SAMHSA's System of Care to serve children with an SED. As a state-wide model, there are a number of unique advantages for system of care development. Arizona's Covered Behavioral Health Services Guide provides a wide array of services including respite, support and rehabilitation, and other community based services vital to supporting the goal of keeping children with their families and close to their school and community whenever possible. There is a strong collaboration with family-run organizations across the state to engage families, provide support, guidance, and self-advocacy. There is significant family and youth participation as meaningful members on policy making committees at the state and local level and there are family members employed at the provider level in roles such as Family Support Partners (FSP).

An area of need, and one of Arizona's priority initiatives identified for the next three years, is to build upon family member and youth involvement in the system of care. Currently, the role of the FSP is not clearly defined in the CSOC, and as a result the manner in which they are trained, supervised and incorporated into the Child and Family Team process is inconsistent. Similarly, the collaboration between the state's two primary family-run organizations, (The Family Involvement Center and MIKID), and the local provider organizations also lack consistency, resulting in a diminished potential benefit for children and families. As a state, Arizona has experienced the benefits of working together with family members, youth, and family-run organizations as a means to identify priorities, define policy, and to engage youth and families in their own process of recovery. Arizona's CSOC Plan outlines steps toward developing increased consistency for family and youth roles and to continue to strengthen family and youth voice and involvement in system development. It will be essential to define consistent roles with job descriptions as well as training and coaching structures. Specific targets for the number of employed family members within the system will also need to be developed. Collaborative arrangements with the family-run organizations to recruit and support youth and family members in their roles as providers of service and participants on state and local boards and committees will also need to be more clearly defined.

Another area of focus for Arizona has been to promote the development of Evidence-Based Practice (EBP) in the areas of screening, and providing services, for substance use disorders among adolescents. Each of the state's RBHAs are charged with ensuring there are sufficient providers of substance abuse treatment within their geographic service areas, including Outpatient, Intensive Outpatient, and Inpatient / Residential Treatment services, available to meet the needs of their enrolled population. This is measured with an annual Network Inventory which identifies the number of providers as well as the EBP model that is employed. EBP's include those such as The Matrix Model, Adolescent Community Reinforcement Approach (A-CRA), Seven Challenges, Motivational Interviewing, and Cognitive-Behavioral Therapy (CBT). Each of the RBHAs conducts annual monitoring activities for intensive outpatient (IOP) and residential programs through medical record audits and interviews with key staff.

Arizona is currently focused on pulling together efforts from the treatment sector with those from the prevention arena, as evidenced by the FY 2012 Annual Work Plan. Statistics show that marijuana use specifically is on the rise in Arizona among adolescents. As a state, Arizona is attempting to find creative ways to engage and encourage adolescents to avoid substance use through prevention efforts while at the same time in, the treatment arena plans are focused on the need to more effectively screen for substance use disorders for those adolescents entering the behavioral health system. There is concern that substance use disorders among adolescents in the behavioral health system are under-identified

and that more effective screening procedures could help identify and engage more youth in need of treatment into services. As a result the FY 2012 Work Plan identified the goal of establishing a standardized screening process for all providers by the end of the fiscal year.<sup>22</sup> Moving forward ADHS/DBHS is encouraging children's providers to use the American Society of Addiction Medicine Patient Placement Criteria 2R (ASAM PPC-2R) as a screening tool. Use of this tool will be incorporated into the Children's System of Care plan to track the number of clinicians trained in use of the ASAM PPC-2R.

***Children and youth at risk for mental, emotional and behavioral disorders, including, but not limited to addiction, conduct disorder and depression***

The Children's System of Care incorporates multiple strategies to identify and direct prevention activities towards children and youth in need, and utilizes the resources of numerous system partners to accomplish this.

Arizona's *First Things First* program has led to an increased capacity to provide preventive health services for children ages birth to five through funding from the Early Education and Health Development Board. Additionally, the Arizona Department of Education (ADE) administers the Federal *Safe and Supportive Schools* grant; DBHS is a collaborating partner in this project. In 2011, ADHS, in concert with the Department of Education and other system partners focusing on children and youths, developed *Understanding Arizona's Education System Manual*, a training guide specifically designed to assist behavioral health providers to better interact with the educational system.<sup>23</sup>

In an effort to reunite children with their parents in recovery, *Arizona Families F.I.R.S.T.* (Families in Recovery Succeeding Together), a program under Arizona Department of Economic Security, assists parents in addressing substance abuse issues that are affecting their ability to parent their children. ADHS/DBHS collaborates with Families F.I.R.S.T. to ensure that the full array of substance abuse services are being provided, regardless of eligibility, in order to keep families together. In the most recent AFF Annual Report, there was no subsequent maltreatment report filed for almost 90 percent of all AFF participants in FY 2012.<sup>24</sup> December 2012, ADHS/DBHS was able to allocate additional funds specifically to parents who were at risk of becoming involved with CPS due to substance use.

Despite these accomplishments, there are still areas of increased need and attention; specifically, family-run organizations report a need for increased natural and peer supports for families. There is also a need for increased opportunities for youth leadership strategies for youths in recovery from behavioral health disorders. Furthermore, the system must work to increase the familiarity, understanding, and knowledge of early identification of warning signs indicative of suicidal risk among gatekeepers, i.e. educators, medical providers, and other adults who have access to youths.

Accordingly, ADHS/DBHS and its partner agencies have identified several priority initiatives to address these needs. The full list of initiatives and objectives are detailed in CSOC Plan, including: increasing the use of evidence based best practices, increasing the availability and use of peer and family supports, and improving collaborative efforts with other child serving agencies.<sup>25</sup>

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<sup>22</sup> For more information on this initiative, please see Table 3, Priority 1, of this application.

<sup>23</sup> *Understanding Arizona's Education System Manual*. Accessed from [http://www.azdhs.gov/bhs/pdf/Education\\_System\\_Manual.pdf](http://www.azdhs.gov/bhs/pdf/Education_System_Manual.pdf)

<sup>24</sup> *Arizona Families F.I.R.S.T. Program, Annual Evaluation Report, State Fiscal Year 2012*. Accessed from [https://www.azdes.gov/InternetFiles/Reports/pdf/aff\\_sfy2012\\_evaluation\\_report.pdf](https://www.azdes.gov/InternetFiles/Reports/pdf/aff_sfy2012_evaluation_report.pdf)

<sup>25</sup> The Children's System of Care Plan has been added as an attachment to this application.

### ***Decreasing Youth Access to Tobacco***

The 2013 SYNAR Report details the Arizona's youth tobacco access laws and the results of the most recent tobacco enforcement inspections. The SYNAR inspection results indicated that 35 of 585 (6.0 percent) attempted tobacco purchases made by minors were successful –yet still well below both the federally established Retailer Violation Rate (RVR) of 20 percent, and the national rate of 8.5 percent.<sup>26</sup>

The State has identified several challenges pertaining to enforcing Youth Tobacco Laws; namely, while the Office of the Attorney General conducts the majority of tobacco enforcement inspections, actual citations may only be issued by local law enforcement entities. Due to the economic downturn, many law enforcement agencies in Arizona experienced workforce reductions. Recently, Arizona received an FDA enforcement grant, which will increase the number of officers participating in tobacco enforcement activities.

Furthermore, youth tobacco access laws do not provide for fines for the actual vendors, only the clerk making the sale. However, in the City of Tucson, a tobacco license may be revoked as a penalty for selling to minors; otherwise, penalties for sales are minimal. To resolve this issue, DBHS has submitted recommended wording to the State Legislature in an effort to amend the laws.

Finally, between 2008 and 2012, there was a 37 percent decline in the number of businesses selling tobacco products – which, if not accounted for, could skew the findings of future inspection results. To compensate for this, ADHS has been placing phone calls to as many businesses as possible, prior to SYNAR inspections, to verify the existence of the vendor, their location, and if the vendor continues to sell tobacco products.

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<sup>26</sup> FY 2011 Annual Synar Reports – Tobacco Sales to Youth. Accessed from <http://www.samhsa.gov/prevention/2011-Annual-Synar-Report.pdf>

**Military personnel (active, guard, reserve, and veteran) and their families**

Addressing the mental health and substance dependence needs of service members and veterans is quickly becoming a major priority for DBHS and its partner agencies. According to a recent survey, in comparison to other Arizonans and veterans of other wars, veterans of the Iraq and Afghanistan wars were more than twice as likely to report a diagnosed mental health problem. Further, Iraq/Afghanistan veterans were more likely to binge drink and engage in illicit substance use (specifically marijuana and prescription drug abuse) at greater rates than other veterans and other Arizonans.<sup>27</sup>

Veterans (Enrolled FY 2012)		Enrolled Veterans <sup>28</sup>	All Members Enrolled FY 2012
<b>Total in Population</b>		1,768	213,588
<b>Median Age (Years)</b>		49.69	28.35
<b>Gender</b>	Male	78.6%	48.8%
	Female	21.4%	51.2%
<b>Race</b>	White	86.1%	85.2%
	Black	7.5%	7.4%
	Native American	4.5%	4.8%
	Asian	0.5%	0.7%
	Hawaiian	0.1%	0.3%
	Multiracial	1.2%	1.7%
<b>Ethnicity</b>	Hispanic	16.6%	31.8%
	Not-Hispanic	83.4%	68.2%
<b>Percent Attending School</b>		10.6%	36.3%
<b>Employment Status</b>	Employed	16.1%	13.0%
	Unemployed	36.8%	31.0%
	Not in Labor Force	47.1%	56.0%
<b>Percent with a Recent Arrest</b>		13.3%	6.3%
<b>Housing Status</b>	Homeless	0%	2.4%
	Not Homeless	100%	97.6%
<b>Primary Substance Type</b>	Heroin	4.9%	3.2%
	Methamphetamine	5.7%	4.8%
	Alcohol	29.4%	13.3%
	Crack/Cocaine	2.3%	1.6%
	Marijuana	10.5%	8.8%
	Other Opiates	2.6%	1.8%
	Other Substances	1.3%	1.1%
<b>Behavioral Health Category</b>	Child (<18 years)	2.1%	32.2%
	Adult – SMI	42.2%	19.2%
	Adult – GMH	33.4%	33.1%
	Adult - SA	22.2%	15.5%
<b>Financial Eligibility Status</b>	Title-19 Medicaid	77.7%	84.7%
	Non-Medicaid	22.3%	15.4%
<b>Region</b>	NARBHA	23.0%	14.4%
	Cenpatico 2	2.9%	3.1%
	Cenpatico 3	4.1%	3.3%
	Cenpatico 4	5.9%	5.4%
	CPSA	33.0%	23.4%
	Magellan	30.7%	49.0%

<sup>27</sup> 2010 Arizona Health Survey: Substance Use and Mental Health Problems among Arizona Veterans, 2011. Accessed from <http://www.arizonahealthsurvey.org/wp-content/uploads/2011/05/ahs-2010-veterans-May11.pdf>

<sup>28</sup> DBHS began tracking veteran status of its members in January 2012; therefore information on this population is limited at this time.

Data from the CIS reflects a similar trend. Since ADHS/DBHS added a demographic data field in January 2012, capturing the veteran status of all adult behavioral health recipients, data has shown veterans experience higher rates of use in every primary substance type compared to the general population (please see the table above). For example, veterans documented in the behavioral health system in FY 2012 indicated alcohol as a primary substance type at a rate more than double in comparison to all enrolled members (29.4 percent and 13.3 percent, respectively). That being the case, it is imperative that the public behavioral health system be able to engage these individuals into treatment and assist them in recognizing and addressing their addiction. Additionally, it was found in an analysis of veterans documented in Arizona’s System of Care, that the top five primary diagnoses veterans receive are as follows:

Diagnosis	Percent of Enrolled Veterans
Schizoaffective Disorder	7.9%
Alcohol Dependence	7.1%
Post-Traumatic Stress Disorder	6.6%
Mood Disorder	5.0%
Paranoid Schizophrenia	4.8%

ADHS/DBHS has specific initiatives to address the need for behavioral health services for veterans, National Guard members, the Reserve, and families of military members. For example, ADHS/DBHS is designing an e-learning tool for the assessment of traumatic brain injuries (TBI), which can greatly affect the behavioral health of veterans<sup>29</sup>. The Arizona Department of Veterans’ Services, the Governor’s Council on Spinal Cord and Brain Injury, the Arizona Brain Injury Association, and St. Joseph’s Hospital/Barrow’s Neurological Institute support this initiative. ADHS/DBHS has also sponsored, provided, or arranged trainings with mental health professionals, or other providers, on TBI for returning veterans or their family members. Additionally, Community Partnership of Southern Arizona (CPSA), in partnership with other organizations, is piloting a version of Mental Health First Aid (MHFA) specific to veterans, service members and their families. These trainings focus on educating the general public on mental illness with service members, identifying warning signs and how to connect service members and veterans to available resources. In January, 2013, the first two-day training was held.<sup>30</sup>

One of Arizona’s priorities is to increase the expertise, competency, ability, and comfort of behavioral health providers to provide quality treatment for service members, veterans, and their families – ultimately resulting in an increased number of service members, and veterans, enrolled and receiving services through the public behavioral health system, which will be tracked through the veteran status demographic data field.<sup>31</sup>

To achieve this objective in the upcoming years, ADHS/DBHS will collaborate with the Arizona Coalition for Military Families, the VA, and stakeholders to develop advanced training in cultural competency with military families for BH providers, as well as provide access to the at-risk training for families of veterans. Furthermore, ADHS/DBHS is working to provide training for service members, veterans, and their

<sup>29</sup> 2010 Arizona Health Survey: Substance Use and Mental Health Problems among Arizona Veterans, 2011. Accessed from <http://www.arizonahealthsurvey.org/wp-content/uploads/2011/05/ahs-2010-veterans-May11.pdf>

<sup>30</sup> CPSA Partners in Pilot Training for Military Specific MHFA

Accessed from <http://www.azdhs.gov/bhs/pdf/newsletters/recovery-works-jan-feb-2013.pdf>

<sup>31</sup> Please see Table 3, Priority 3, of this application for more details.

families in recognizing signs of PTSD and TBI and the referral process. ADHS/DBHS will continue to determine the success of the above initiatives through data on veterans enrolled in the public behavioral health system. Additionally, DBHS will continue to work with parent agencies, such as the Arizona Coalition for Military Families which supports the health and well-being of military families, and the Arizona Suicide Prevention Coalition that has a subcommittee devoted to the prevention of suicide among those who have served in the military.

***Individuals with mental and/or substance use disorders who live in rural areas***

The geographic diversity of Arizona requires ADHS/DBHS to maintain a service delivery network capable of providing behavioral health care not only to the fourth most populous county in the United States, Maricopa, which is also home to more than half of Arizona's residents, but also to the vast rural, frontier, and tribal reservations, within the state.

To accomplish this, ADHS/DBHS collects and reviews numerous data elements to measure the available inventories of treatment types across the states several geographic service areas (GSA), including the number of inpatient, outpatient, residential, and methadone providers operating in each region.<sup>32</sup>

In addition, ADHS/DBHS has the internal capacity to utilize geo-mapping technology to view the geographic location of various provider types within the state and regional areas in relation to enrolled adult and child members. As the result of an analysis on the geographic location of behavioral health outpatient clinics, it was found that of the 35 different provider facility types, outpatient clinics are the most utilized type of facility in both the urban and rural areas, especially due to ADHS/DBHS' ongoing commitment to treating individuals in the least restrictive community setting.

ADHS/DBHS used the results of this geo-mapping exercise to determine a statewide and GSA baseline of the percentage of enrolled consumers living within 15 miles from a Behavioral Health Outpatient Clinic. The following are observations from that analysis:

- Over 98 percent of the clients with a known street address (not homeless) reside within 15 miles of an outpatient clinic.
- Northern and Southeastern Arizona both have more than 5 percent of their clients living more than 15 miles from an outpatient clinic.
- There were 1,092 children and 2,245 adults (3,337 total) living more than 15 miles from an outpatient clinic statewide.

Although this analysis reflects sufficient placement of outpatient facilities across the state, and while nearly 50 percent of Arizona's substance abuse prevention coalitions are located in rural communities throughout Arizona, there is still a need to increase and enhance the availability of the full range of substance abuse treatment services in rural communities. Specifically, Northern Arizona counties tend to have higher rates of suicide<sup>33</sup> and drug-induced deaths<sup>34</sup>, and emergency department visit rates for substance abuse were highest in Northern Arizona<sup>35</sup>. Finally, in the rural counties there are few opportunities for advanced prevention trainings.

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<sup>32</sup> The Network Inventory was included in the first section of this application.

<sup>33</sup> *Suicide Mortality Rates by County of Residence, Arizona Residents, 1999-2009*. Accessed from <http://www.azdhs.gov/plan/report/im/im09/3/pdf/3-8.pdf>

<sup>34</sup> *Rates of Substance Abuse in 2010 by County*. Accessed from [http://www.azdhs.gov/plan/report/ahs/ahs2010/pdf/6b1\\_10.pdf](http://www.azdhs.gov/plan/report/ahs/ahs2010/pdf/6b1_10.pdf)

<sup>35</sup> *Rate of emergency room visits with alcohol abuse as first-listed diagnosis by gender, age group and county of residence, Arizona, 2009*. Accessed from <http://www.azdhs.gov/plan/hip/for/alcohol/2009/alcohol609.xls>

Starting in 2012, ADHS/DBHS, Northern Arizona Regional Behavioral Health Authority (NARBHA), and the Governor's Office was provided with the funding and the task of facilitating Screening, Brief Intervention and Referral to Treatment (SBIRT), a SAMHSA sponsored five-year project focused on the early intervention and prevention services of substance abuse. The funding allows trained professionals in eight community health centers and one emergency department in Northern Arizona counties<sup>36</sup>, using a standard screening tool, to provide early intervention for individuals with substance use disorders and those at-risk of developing a substance use disorder.

Additionally, ADHS/DBHS has multiple initiatives designed to increase the quality and availability of service provision in the more rural areas of Arizona, including the expansion of ASIST trainings in Northern Arizona (Mohave, Apache, Navajo, Yavapai, Coconino Counties); conducting a needs, resource, and gap analysis of the Arizona-Sonora border region, and increasing the availability and service utilization of Medication-Assisted Treatment (MAT) options, including buprenorphine, naltrexone, Suboxone, and Campral, among individuals with a substance use disorder. However, identifying needs for Tribal areas has been difficult due to the lack of data available for data analysis.

***American Indians/Alaska Natives, persons with disabilities, racial and ethnic minorities, the LGBTQ community, and other historically underserved populations***

Culture, language, and society each play a pivotal role in the design and delivery of behavioral health services and understanding these roles enables the behavioral health system to act in a responsive manner to the needs of racial and ethnic minorities, as well as other underserved populations. Today's America is unmistakably multicultural, and since there are a variety of ways to define a cultural group (e.g., by ethnicity, religion, geographic region, age group, sexual orientation, or profession), many people consider themselves as having multiple cultural identities. Culture affects how individuals communicate symptoms or seek help, what coping skills they have and how much stigma they attach to mental illness. Culture also affects strengths, such as resilience and adaptive ways of coping that people bring into the treatment setting. Likewise, the cultures of the clinician and the service system influence diagnosis, treatment, and service delivery.<sup>37</sup>

To this extent, ADHS/DBHS has developed a comprehensive service structure designed to address the needs of Arizona's richly multicultural population, including racial and ethnic minorities, American Indians and Alaskan Natives, persons with disabilities, and the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) population. Additionally, multiple committees have been created and tasked with providing advice and operational guidance directed towards integrating culturally sensitive care and recognition into the service delivery system; this includes:

- *The Cultural Competency Steering Committee* – this governing body of cultural competency is comprised of active participants from all functional areas of DBHS to ensure that cultural competency penetrates all levels of DBHS. The purpose of the committee is to strategize the implementation of the cultural initiatives and provide input in the revision of cultural competency policies and contract amendments with analysis of culturally and linguistically appropriate services.

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<sup>36</sup>The Northern Arizona counties of Apache, Coconino, Mohave, Navajo, and Yavapai were selected to receive SBIRT services due to the region's higher rates of injuries and deaths attributable to alcohol and other substances compared to other regions in Arizona. Accessed from <http://www.azdhs.gov/bhs/pdf/newsletters/Recovery-Works-September2012.pdf>

<sup>37</sup> *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Accessed from <http://www.surgeongeneral.gov/library/mentalhealth/cre/execsummary-1.html>

- *The Cultural Competency Operations Committee* – comprised of Cultural Competency leaders and Tribal Liaison representation from all T/RBHAs areas, the purpose of the committee is to ensure implementation, monitoring and compliance of cultural competency plans and initiatives. This body also provides a forum for discussion of culturally relevant services and policies based on identified need and geographic service area.
- *The Mental Health Roundtable for the Deaf and Hard of Hearing* – serves as an advisory committee and provides a forum for dialogue, decision making, and discussions regarding the continuum of comprehensive and integrated statewide behavioral health services that meet the needs of the Deaf and Hard of Hearing youth and adults. In addition, it conducts research about educational programs for agencies to improve treatment options and identify the means to promote education to mental health professionals on the appropriate and culturally relevant individualized client services for the Deaf and/or Hard of Hearing population.
- *The LGBTQ Advisory Committee* – meeting on a bi-monthly basis, the committee develops an annual work plan which informs and guides all of ADHS/DBHS' activities related to prevention and treatment of substance use disorders and suicide in LGBTQ populations.
- *The Native American Behavioral Health Forum* – occurring bi-annually, provides an opportunity for the various Tribal Authorities to convene with ADHS' staff and discuss current and upcoming behavioral health issues on the respective reservations, including new developments in service delivery and treatment practices.

As is to be expected, undertaking an ambitious exercise such as implementing a system-wide cultural competency plan, in a complex service delivery structure such as that of Arizona's, requires an acute oversight and monitoring process. ADHS/DBHS reviews multiple data feeds on a recurring basis, conducts extensive demographic and service utilization reviews, and publishes various reports detailing system performance. These reports, which will be later discussed in detail, are available to the general public at <http://www.azdhs.gov/bhs/reports.htm>, and include: *The Annual Diversity Report, The Semi-Annual Language Services Reports, The Cultural Competency Plans, and The Annual Effectiveness Review of the Cultural Competency Plan Reports.*

Through methods of data collection and community collaboration, ADHS/DBHS has determined that many disparities and/or gaps still exist with regard to the inclusion of tradition, cultural beliefs, diverse cultures, and race and ethnicity, as vital elements affecting the quality of care and the effectiveness of services provided. Therefore, ADHS/DBHS has determined continued efforts on data driven outcomes, new initiatives, and programs to provide a comprehensive range of inclusive and high quality services for all the underserved/underrepresented populations identified within Arizona's geographic regions is essential in providing system change.

Specifically, there is a need to adequately gather information on cultural awareness within the system, and then establish a mechanism to provide/promote education, awareness, and trainings related to special populations and underrepresented/underserved populations. A workgroup has been formed to assess DBHS' cultural competency needs and provide educational forums quarterly on cultural competency topics. ADHS/DBHS is also working to develop a cultural competency retreat for executive staff specifically to assist in the identification of management needs in terms of cultural competent services and culturally sensitive environments.

With respect to American Indians and Alaska Natives, the Department of Health Services' Division of Public Health Services, has identified several health disparities, specifically differences in mortality rates, between this group and the general population. For example, American Indians and Alaska Natives are more than 2.5 times more likely to die from complications associated with Diabetes than others in Arizona; similarly, this group is more than 4 times more likely to die from alcohol-related illnesses than the general population of Arizona.<sup>38</sup>

Accordingly, past reports have revealed a need for increased outreach and collaboration with the tribes. To address this, ADHS/DBHS will continue collaboration efforts such as tribal consultations, relationship building strategies, trainings on cultural preferences in service provision, and meetings with tribal liaisons, to provide the foundation where initiatives can be developed to identify need within these communities. DBHS has also indicated this is potential technical assistance topic.<sup>39</sup>

ADHS/DBHS has set numerous priority initiatives around enhancing the service quality and appropriateness for racial and ethnic minorities, American Indians and Alaskan Natives, persons with disabilities, the LGBTQ population, and other historically underserved groups.<sup>40</sup>

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<sup>38</sup> *Differences in the Health Status among Race/Ethnic Groups, 2009*. Accessed from <http://www.azdhs.gov/plan/report/dhsag/dhsag09/ethnic09.pdf>

<sup>39</sup> Please see Section P of this application

<sup>40</sup> Please see Section L of this application

***Individuals with tuberculosis and other communicable diseases***

In accordance with 42 U.S.C. §300x-24(a) and 45 C.F.R. §96.127, ADHS/DBHS ensures that Tuberculosis (TB) services are available and provided as needed to individuals receiving treatment for a substance abuse disorder or dependence (SUD).

The T/RBHAs are required by contract to screen all persons with a SUD for tuberculosis services for referrals. ADHS funds all counties within Arizona, as well as several Tribal governments, for an array of TB screening and treatment services. Substance abuse treatment providers are aware of county services and utilize them through the referral process. Additionally, requirements to provide access to TB screening in residential environments are included in agency licensure standards and are monitored through the ADHS/Office of Behavioral Health Licensure (OBHL). These requirements are published in the current Administrative Rules for Behavioral Health Licensure.

Statewide oversight of tuberculosis is managed by The Arizona Department of Health Services (ADHS) Office of Infectious Disease Services (OIDS). OIDS is responsible for monitoring, controlling, and preventing infection, disease, and death associated with tuberculosis in Arizona through surveillance, data analyses, health education, guidelines, consultation, epidemiological investigations, and rules.

There were 256 reported cases of TB in Arizona in 2011, representing a 9.5 percent decrease compared to that of 2010.<sup>41</sup> However, Arizona's TB infection rate of 4.0 cases per 100,000 persons was more than the U.S. rate of 3.4 cases per 100,000. Arizona will continue to target specific populations for TB prevention activities including those with a substance use disorder, regardless of substance preference or route of use. ADHS/DBHS has identified the screening and referral process of clients entering treatment as a priority area.

***Persons with or at risk for HIV/AIDS and who are in need of mental health or substance abuse early intervention, treatment or prevention services***

Although last determined to be an HIV-Designated State by the Centers for Disease Control (CDC) in FFY 2008, Arizona has continued to obligate funds and provide HIV prevention and early intervention services at a level commensurate with that of past Designated time periods as outlined in 42 U.S.C. §300x-24(b) and 45 C.F.R. §96.128.

The Office of HIV has nationally-recognized prevention and early intervention services targeting HIV-positive individuals statewide, including MSM (men who have sex with men), African Americans, and non-Hispanic women. The HIV/AIDS, Sexually Transmitted Disease, and Hepatitis C programs have been merged, which has positively impacted Arizona's HIV Prevention activities. This integration was based on evidence showing that the modes of transmission for HIV, Hepatitis and other Sexually Transmitted Diseases are virtually identical, and epidemiological data clearly demonstrates a link between HIV, Hepatitis, and STD transmission and co-morbid patterns.

HIV prevalence rates continue to rise in Arizona. Prevalence of reported HIV infection is 230.05 cases per 100,000 persons. Currently, there are 14,705 persons living with HIV/AIDS in Arizona, a rise of 30 percent in 5 years. The increase in prevalence rates appears to be due to the efficacy of multi-drug treatments for HIV infection, which have sharply reduced HIV-related death. Additionally, Arizona's

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<sup>41</sup> 2012 Tuberculosis counts were not yet available at the time of application submission. These numbers will be updated at a later date.

increased population growth may be contributing to an increase in prevalence, as 23 percent of prevalent cases were first diagnosed in a state other than Arizona.<sup>42</sup>

**Individuals with mental and/or substance use disorders who are homeless**

ADHS/DBHS works with its State partners and contractors to provide needed services to homeless individuals. To begin, on an annual basis, ADHS/DBHS staff, and other volunteers perform a point-in-time street and shelter count to determine the number of homeless individuals in Arizona, including those with a serious mental illness, or a co-occurring serious mental illness with a substance use disorder.<sup>43</sup>

2012 Estimated Totals

Sheltered Persons	Unsheltered <sup>1</sup> Persons	Total	Individuals with HIV <sup>2</sup>	Individuals with Hepatitis-C <sup>3</sup>	Individuals reporting Alcohol Abuse <sup>2</sup>	Individuals reporting Drug Abuse <sup>2</sup>	Individuals reporting Mental Health Problems <sup>2</sup>	Veterans
22702	8127	30829	220	158	1084	1422	2996	4318

<sup>1</sup> Unsheltered is defined as someone receiving Permanent Support

<sup>2</sup> Pima County data was not included due to unavailability of data

<sup>3</sup> Only Maricopa County data was included due to unavailability of data from other counties

Information obtained from this exercise, including that in the above table, is compiled into an annual report by the Arizona Department of Economic Security; the most recent report noted that there were over 28,000 homeless people in Arizona in FY 2012, including persons who lived in emergency shelters, transitional housing, or other locations such as on the streets, camped in forests, or living in cars or buildings that are unsafe and/or unsuitable for habitation. Additionally, a large percentage of persons in shelters and transitional housing experience problems with substance abuse, and discrimination against homeless persons is a substantial barrier to housing.<sup>44</sup>

Arizona has placed an increased emphasis on addressing and alleviating homelessness; specifically, in April, 2010, the Governor’s Office established the *Arizona Interagency on Homeless and Housing Committee*, this group is charged with developing strategies to end homelessness in Arizona. The Director of the Department of Health Services serves on this Committee. Additionally, ADHS has allocated funding across the system in a manner that allows homeless individuals with SMI and/or substance use disorders to be served through multiple mechanisms, including:

- Substance Abuse Prevention & Treatment (SAPT)/Community Mental Health Block Grant (CMHS) – Funds provided by the mental health block grant are utilized for services to persons with serious mental illness and children with serious emotional disturbance, including those who are homeless or at imminent risk of being homeless. Provisions are made through the SAPT block grant for services to be delivered through street outreach/drop-in centers serving homeless individuals with substance use disorders at high risk for HIV, in addition to other community settings such as probation offices, domestic violence facilities and homeless

<sup>42</sup> *Executive Summary of the HIV/AIDS Annual Report, 2012, State of Arizona.* Accessed from <http://www.azdhs.gov/phs/hiv/documents/reporting/2012/2012-executive-summary.pdf>

<sup>43</sup> “Shelter” refers to emergency shelters and homeless transitional housing.

<sup>44</sup> *Homelessness in Arizona Annual Report, 2012.* Accessed from [https://www.azdes.gov/InternetFiles/Reports/pdf/des\\_annual\\_homeless\\_report\\_2012.pdf](https://www.azdes.gov/InternetFiles/Reports/pdf/des_annual_homeless_report_2012.pdf)

shelters. In addition, Flex Funds provides resources to assist clients in finding shelter or remaining in their homes.

- State General Fund Revenue – State general funds allocated as a match for PATH federal funds are specifically targeted for persons who are homeless and have a serious mental illness and/or a co-occurring substance use disorder.

ADHS/DBHS receives a PATH grant to provide services to persons who are homeless, at risk of becoming homeless, and those determined to have a SMI, including those with a co-occurring substance abuse disorder. Providers conduct outreach in locations where homeless individuals gather such as food banks, parks, vacant buildings and the streets. The PATH grant provides community education; field assessment and evaluations; hotel vouchers in emergency situations; assistance in meeting basic needs (i.e. applications for Medicaid, SSI/SSDI, food stamps, coordination of health care, etc.) transition into a behavioral health case management system; assistance in getting prescriptions filled; moving assistance; and referrals for both transitional and permanent housing.

**2011 PATH Outreach Efforts**

Outreach		Referrals <sup>1</sup>	Enrolled in PATH
6704		504	3053
Categories of Persons Served			
Veterans	Persons released from the Justice System	Persons with an Axis I Diagnosis	Persons with an Axis I Diagnosis and a Substance Abuse disorder
148	136	1991	566

<sup>1</sup>Includes data from Maricopa, Pima, Mohave, Yavapai, Coconino, Navajo, and Apache counties only

Furthermore, provider recipients of PATH funds are required to form working relationships with the Veterans Administration Medical Center, the State Veterans’ Services, and the U.S. Vets to assist with coordination of services for homeless veterans. This includes coordinating mental health care, benefits assistance, medical care, emergency, transitional, and permanent housing to homeless vets and participation in Stand Downs and Project Challenge events, including developing collaborations with local agencies and hospitals to increase the location and services to Veterans who meet the PATH eligibility criteria.

In response to the requirement from SAMHSA, and in an effort to gather meaningful data for program analysis and evaluation, all Arizona local PATH teams are utilizing the Homeless Management Information System (HMIS). All information received regarding HMIS from the federal and local levels (e.g.: trainings, presentations, websites, webinars, teleconferences and materials) is shared with PATH funded agencies’ Executive Directors, Administrative/Program Directors, Outreach workers and Front Line staff through email transmissions and statewide teleconferences. In November, 2010, Arizona conducted a training session, in conjunction with the PATH TA Center/Center for Social Innovation. The TA provided several sessions on data collection to strengthen HMIS strategies, educate outreach workers on supported housing programs, promote effective Veterans outreach, and develop employment opportunities for PATH enrolled adults.

Despite the progress made by ADHS/DBHS and its numerous partners, including PATH-funded providers, in helping those who are homeless, there are still many areas where more can be done. Specifically, there is a need for emergency, transitional, and permanent supportive housing based on a harm-reduction model for dually diagnosed consumers who are not maintaining abstinence, as well as housing

options for convicted felons and sex-offenders. Another gap in the system is the lack of funding to provide bus passes, or other means of transportation, in order to assist individuals in accessing services and appearing for scheduled appointments.

Additionally, there is a need for specialty providers to offer services to the older homeless population. These individuals are often discharged from hospitals and the criminal justice system without sufficient follow-up for services. As aging homeless individuals experience more barriers to accessing services, especially housing, spending more time in a state of homelessness, their health issues continue to deteriorate and symptoms of mental illness, such as depression, may result.

Furthermore, the number of homeless families appears to be on the rise, with a noticeable increase in cases involving domestic violence, especially when one or more members of the family has a mental health or substance abuse problem, therefore creating an increase in the number of homeless women with children. The lack of available services for this population is best illustrated by the increased number of homeless youth on the streets whose parent(s) are often substance abusers and/or mentally impaired.

Unfortunately, due to the current economic environment, homelessness is not expected to significantly decrease in future years.<sup>45</sup> However, Arizona will continue to address the needs of our system, including those identified above. Specifically, providers are assisting homeless individuals in locating transitional housing, helping clients apply for subsidized housing programs including Section VIII, and coordinating housing services such as motel vouchers, security deposits, application fees, and one-time only “Move-In, Keep-In” assistance. Providers are also forming close relationships with faith-based and other community organizations to offer wide range of social services to families, children, and single adults. These services include permanent supportive housing programs, family homeless shelters, eviction prevention/utility assistance funding, emergency motel stays, adoption and foster care services, referrals to local service agencies, food and clothing vouchers, and counseling services.

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<sup>45</sup> *Homelessness in Arizona Annual Report, 2012*. Accessed from [https://www.azdes.gov/InternetFiles/Reports/pdf/des\\_annual\\_homeless\\_report\\_2012.pdf](https://www.azdes.gov/InternetFiles/Reports/pdf/des_annual_homeless_report_2012.pdf)

### **System of Care Plan Development**

ADHS/DBHS synthesizes the various assessments, both for needs and capacity, and uses this information, along with legislative and contractual requirements to steer the development of the multiyear System of Care plans for Adults (ASOC) and Children (CSOC) served by the behavioral health service delivery network.<sup>46</sup>

In the spring and early summer of 2011, staff from the various functional units within ADHS/DBHS, peer and family members, and representatives from family and peer-run organizations held meetings to determine the priority areas of focus for the next several state fiscal years and outlined numerous goals, objectives, and strategies necessary to improve system performance in these priority areas, which are as follows:

#### *Children's System of Care*

- Increase the percentage of children who live with their families;
- Increase the percent of youth who experience educational success;
- Increase the percent of youth who transition to a successful adulthood;
- Decrease youth substance use; and
- Decrease statewide rates of youth suicide completion.

#### *Adult System of Care*

- Enhance the physical health of all adult behavioral health recipients;
- Improve overall quality, effectiveness, and access to services, for individuals with a substance use disorder;
- Increase and retain employment of adult members served by the behavioral health system
- Reduce the overall suicide rate in Arizona;
- Integrate the Trauma Informed Care philosophy throughout all levels of the public behavioral health system;
- Increase the use of peer and family support services for all populations; and
- Promote the inclusion of community voices, and peer and family involvement, in all aspects of the public behavioral health system.

Importantly, while separated for ease of strategy development and strategic planning purposes, the above objectives are inherently related and largely interdependent of one another, as excelling in one area will likely lead to measurable improvements within others. For example, increasing the use of peer and family support services across the network is likely to contribute to a noticeable decline in suicides, as well as an increase in overall treatment effectiveness – as established by the National Outcome Measures.

Where appropriate and quantifiable, many of these priorities, or their measurable objectives, have been incorporated into this planning application and identified as State Priorities as identified in Table 3.

### **Allocation of SAPT/CMHS Grant Funds**

In fall 2012, ADHS/DBHS contracted with an outside consultant to address the need for a more sophisticated allocation formula for SAPT/CMHS grant funds. In previous years, block grant dollars were allocated based primarily on population. To better understand need throughout Arizona, the consultant

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<sup>46</sup> The complete Children and Adult System of Care Plans are included as attachments at the end of this application

met with numerous stakeholders including RBHA representatives, tribal workgroup members, the Planning Council, and Prevention leaders. In addition to gathering this input, the consultants completed a comprehensive review of allocation methods developed and used by other states. From this review the consultants formulated a tool for evaluating data sources as recommended by stakeholders.

Once it was determined which data sources were available throughout the state, collected on a regular and ongoing basis, broken down by county, were correlated in determining need for substance abuse prevention and treatment or for mental health services; a formula was created which could be used year over year. For the SAPT grant this formula uses population, unmet need as determined by: alcohol and drug related emergency department visits, alcohol and drug related hospital visits, and alcohol and drug related deaths as well as a rural differential. For the CMHS grant this formula uses population, unmet need as determined by: Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) emergency department visits, SMI and SED hospital visits, intentional self-harm deaths (suicides) and a rural differential. This data is available at the county level for ADHS/DBHS use each year. Beginning in FY2015 SAPT/CMHS grant funds will be allocated to each RBHA based on the following formula:

$$\text{Allocation Percentage} = 80\% (\text{population}) + 10\% (\text{unmet need}) + 10\% (\text{rural differential})$$

The amount for each county will be calculated based on the formula with the exception of Tribal regions which will be determined separately. To minimize the impact on the system, ADHS/DBHS will use a split allocation methodology for the first three years that combines the current logic with the new formula. Each year there will be a 25 percent shift of funding using the new allocation formula. In FY 2015 75 percent of funding will be based on the current method, and 25 percent of funding will be based on the allocation formula. In FY 2016, this will shift to a 50/50 split, with the following year using a 25/75 split. Finally, in the fourth year (FY 2017), funds will be based solely on the allocation formula. All prevention providers will receive a base amount of funding in addition to what is allocated based on the formula. Providing a base amount will ensure that there are adequate resources for program development.

## II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #:	1
Priority Area:	Youth
Priority Type:	SAT
Population (s):	Other (Entire population under 18 years old)
Goal of the priority area:	<p>Increase the number of youth in the behavioral health system identified as having a diagnosed substance use disorder.</p>
Strategies to attain the goal:	<p>Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) will monitor enrollment numbers of youth with a substance use diagnosis in the system of care.</p> <p>Regional Behavioral Health Authorities (RBHAs) will continue to collaborate and meet regularly with children/adolescent providers to share information on substance abuse screening, trends and best practices.</p> <p>ADHS/DBHS and RBHAs will provide and promote access to substance abuse training initiative available to children/adolescent providers- including those employed through other agencies, such as Child Protective Services and Juvenile Justice as well as education for medical providers and teachers.</p> <p>ADHS/DBHS and 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.</p> <p>ADHS/DBHS will ensure the availability of a standardized, parent-friendly, screening tool to identify substance use/abuse in children and adolescents.</p>
Annual Performance Indicators to measure goal success	
Indicator #:	1

Indicator: Percentage of those under the age of 18 in the behavioral health system who were diagnosed as having a substance use disorder or dependence

Baseline Measurement: FY2012 6.9%

First-year target/outcome measurement: FY2014 7.5%

Second-year target/outcome measurement: FY2015 8%

Data Source:

Client Information System (CIS)

Description of Data:

The Division tracks the enrollment of all members receiving services within the behavioral health system.

Data issues/caveats that affect outcome measures::

There is a two month lag on demographic data submitted as well as a six month lag on claims or encounters submitted. Assessment information is based on self-report.

Priority #: 2

Priority Area: Older Adults

Priority Type: SAP, SAT

Population (s): Other (Entire population over 55 years old)

Goal of the priority area:

Reduce the rates of older adult (55+) deaths from 15.9 to 15.5 and hospitalizations from 110.6 to 110.0 due to poisonings.

Strategies to attain the goal:

Expand the Prescription Drug Initiative statewide incorporating a variety of prevention and early intervention strategies. Strategies include ongoing engagement with the medical community to increase participation with the Prescription Drug Monitoring Database, use of the Screening, Brief Intervention, and Referral to Treatment, and community education on safe storage practices.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Rate of deaths and hospitalizations for individuals over the age of 55 due to poisonings.

Baseline Measurement: CY2012: Deaths- 15.9 per 100,000, Hospitalizations- 110.6 per 100,000

First-year target/outcome measurement: Deaths- 15.5 per 100,000 due to poisonings for Arizonans ages 55+, Hospitalizations- 110.0 per 100,000 due to poisonings for Arizonans ages 55+

Second-year target/outcome measurement: Deaths- 15.5 per 100,000 due to poisonings for Arizonans ages 55+, Hospitalizations- 110.0 per 100,000 due to poisonings for Arizonans ages 55+

Data Source:

-Arizona Department of Health Services Office of Vital Registration death certificates  
-Arizona Hospital Discharge Database at the Arizona Department of Health Services

Description of Data:

Mortality data were compiled from the death certificates registered with the Arizona Department of Health Services Office of Vital Registration. Any death record for an Arizona resident assigned an International Classification of Diseases, 10th Revision (ICD-10) code for poisoning as the underlying cause of death was included in the count. Poisonings due to envenomation by animals, plants, or insects (X20 – X29) were excluded from this report. Inpatient hospitalization discharge data and emergency department discharge data from 2007 through 2011 were compiled from the Arizona Hospital Discharge Database at the Arizona Department of Health Services. The discharge database contains information from private, acute-care facilities in the state of Arizona, and do not include visits to federal facilities, such as Veterans’ Affairs Hospitals or Indian Health Services facilities.

Data issues/caveats that affect outcome measures::

The discharge databases do not contain data from urgent care facilities, private physician practices, or medical clinics. Hospital discharge data include hospital transfers and readmissions. Therefore, a single injured individual may be counted more than once. These data should be interpreted as episodes of medical treatment, not individual injuries.

Priority #: 3

Priority Area: Service Members and Veterans

Priority Type: SAP, SAT, MHP, MHS

Population Other (Military Families, Military and Veterans)

(s):

Goal of the priority area:

Increase enrollment of service members and veterans enrolled in the behavioral health system.

Strategies to attain the goal:

ADHS/DBHS is engaged with Arizona Coalition for Military Families to connect service members, veterans and family members to services throughout the State. ADHS/DBHS disseminates information to all levels of services and encourages collaboration for the provision of culturally competent care.

ADHS/DBHS will assist RBHAs in establishing a relationship with local Veterans Affairs (VAs) in order to coordinate care and participate in trainings.

ADHS/DBHS and RBHAs to increase the ability and comfort of behavioral health providers (treatment and prevention) to offer culturally competent services for service members, veterans, and their families.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of military/veterans within the behavioral health system
Baseline Measurement:	FY2012 .6%
First-year target/outcome measurement:	Increase FY2012 data by 5%
Second-year target/outcome measurement:	Increase FY2013 data by 5%

Data Source:

Client Information System (CIS)

Description of Data:

The Division tracks the enrollment of all members receiving services within the behavioral health system.

Data issues/caveats that affect outcome measures::

There is a two month lag on demographic data submitted as well as a six month lag on claims or encounters submitted.

Assessment information is based on self-report.

Priority #: 4

Priority Area: Healthcare Integration

Priority Type: SAT, MHS

Population SMI

(s):

Goal of the priority area:

Increase coordination of care between behavioral health providers and primary care physician.

Strategies to attain the goal:

In FY2014, Maricopa County will pilot a healthcare integration program to provide behavioral and physical care within one location for Seriously Mentally Ill (SMI) clients. The outcomes of this pilot will be tracked to determine the impact on a client's overall health. Based on the outcomes of this pilot, healthcare integration for the SMI population will be rolled out statewide. ADHS/DBHS will work closely with the healthcare providers to ensure that clients are receiving both physical and behavioral health services and that there is continued collaboration between all professionals.

#### Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Coordination of Care within Maricopa County for SMI clients
Baseline Measurement:	FY2012 97.4%
First-year target/outcome measurement:	100%
Second-year target/outcome measurement:	100%
Data Source:	

Case file review

Description of Data:

ADHS/DBHS preforms a random sample case file review for coordination of care for those with a Seriously Mentally Ill (SMI)

diagnosis non a quarterly basis.

Data issues/caveats that affect outcome measures::

Documentation indicating coordination of care may vary between providers causing discrepancies in compliance rates.

Priority #: 5

Priority Area: Suicide Rate

Priority Type: MHP

Population Other (Entire population)

(s):

Goal of the priority area:

Reduce the suicide rate in Arizona

Strategies to attain the goal:

ADHS/DBHS is implementing a wide variety of strategies in an effort to reduce the suicide rate. Strategies include social media messaging, social marketing/public awareness, youth leadership programs, gatekeeper trainings, improved surveillance, and ongoing collaboration with stakeholders for system improvement.

#### Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Arizona suicide rate per calendar year

Baseline Measurement:

Calendar year 2011 16.81 per 100,000 population

First-year target/outcome

14.9 per 100,000

measurement:

Second-year target/outcome

14 per 100,000

measurement:

Data Source:

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

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 2010 data will be made available in fall 2011). This number is then aggregated across the general population to establish a suicide rate per 100,000 persons. This information is then published on the ADHS/PHS website for public dissemination (see <http://www.azdhs.gov/plan/report/ahs/index.htm>)

Data issues/caveats that affect outcome measures::

Personnel turnover at Vital Statistics has caused potential data lag and miscalculations for the suicide rate.

Priority #: 6

Priority Area: Pregnant Women and Women with Dependent Children

Priority Type: SAP, SAT

Population PWWDC

(s):

Goal of the priority area:

Ensure that all women are aware of SAPT services and monitor utilization of treatment services.

Strategies to attain the goal:

ADHS/DBHS and RBHAs to collaborate ways to expand public awareness campaigns directed towards priority populations.

RBHAs as well as ADHS/DBHS staff to regularly monitor treatment waitlist to ensure access to care.

ADHS/DBHS will review encounter codes to ensure that pregnant women and women with children are receiving the full array of services.

#### Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Number of pregnant and parenting women with dependent children receiving substance abuse treatment services/

Baseline Measurement:

FY2012 10,979

First-year target/outcome measurement: Increase FY2012 enrollment by 5%

Second-year target/outcome measurement: Increase FY2013 enrollment by 5%

Data Source:

Client Information System (CIS)

Description of Data:

The Division tracks the enrollment of all members receiving services within the behavioral health system.

Data issues/caveats that affect outcome measures::

There is a two month lag on demographic data submitted as well as a six month lag on claims or encounters submitted. Assessment information is based on self-report.

Priority #: 7

Priority Area: Intravenous Drug Users

Priority Type: SAT

Population IVDUs

(s):

Goal of the priority area:

Increase the availability and service utilization of Medication Assisted Treatment (MAT) options for individuals with a substance use disorder with a specific focus on reaching the IV drug using population.

Strategies to attain the goal:

ADHS/DBHS will further rollout the expanded MAT services available to those with a substance use diagnosis through additional advertising within the community.

ADHS/DBHS and RBHAs to provide education for healthcare practitioners on best practices and availability of MAT services.

ADHS/DBHS to compile a listing of various MATs available throughout the State to assist clients in locating appropriate services.

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Percentage of IVDU clients utilizing MAT services out of total number of IVDU clients  
Baseline Measurement: Calendar Year 2011 43%  
First-year target/outcome measurement: 46%  
Second-year target/outcome measurement: 50%

Data Source:

Client Information System (CIS)

Description of Data:

The Division tracks the enrollment of all members receiving services within the behavioral health system.

Data issues/caveats that affect outcome measures::

There is a two month lag on demographic data submitted as well as a six month lag on claims or encounters submitted. Assessment information is based on self-report.

Priority #: 8

Priority Area: Underage Drinking

Priority Type: SAP

Population Other (Youth ages 21 and younger)

(s):

Goal of the priority area:

Increase the percentage of youth who perceive 1-2 drinks of alcohol per day harmful to 64% as measured by the Arizona Youth Survey.

Strategies to attain the goal:

1. Conduct youth driven media campaigns to promote positive youth values and community pride  
a) Youth developed social media campaigns: radio; PSA's poster contests; billboards; murals; alcohol free pledges

- b) Collect samples of youth written letters to the editor with anti-alcohol messages
- c) Host a statewide youth UAD prevention media display and recognition event
- d) Verify that all prevention programs incorporate education on perception of harm into prevention programs
  - Request data on inclusion of perception of harm in RBHA annual evaluation report
  - Identify which programs need to increase incorporation of perception of harm
  - Meet with RBHA Prevention Administrators who have programs that need to include perception of harm to determine a means for inclusion
  - Monitor incorporation of perception of harm into prevention programs
- 2. Implement afterschool and leadership programs for youth
  - a) Implement alcohol prevention focused peer leadership programs such as:
    - SADD
    - YES
    - Sources of Strength
    - University leadership organizations
  - b) Host annual statewide and regional conferences/ retreats/ youth camps
  - c) Develop a statewide venue for recognition of youth UAD prevention projects and other successes
- 3. Implement an adult targeted media campaign to educate parents about the risks
  - a) Community media campaign/ Draw the Line (DTL)/ Hasta Aqui Implementation
    - Request data on inclusion of Draw the Line in SFY 2011 annual evaluation report
    - Identify which programs need to increase incorporation of DTL in their parenting programs
    - Meet with RBHA Prevention Administrators to determine a means for inclusion of DTL in programs
    - Distribution of DTL materials to RBHAs during alcohol awareness month

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Percentage of youth who perceive 1/2 drinks per day as harmful.
Baseline Measurement:	Pre-tests administered at the beginning of the year (annual measure). 2012 Arizona Youth Survey 34.2% (every even year measure).
First-year target/outcome measurement:	1.5% increase from baseline per post tests administered at the end of the year. 2014 Arizona Youth Survey 35.5%.
Second-year target/outcome measurement:	1.5% increase from baseline per post tests administered at the end of the year. 2016 Arizona Youth Survey 37.2%
Data Source:	

Pre post test (Arizona Adolescent Core Measure)  
Arizona Youth Survey

Description of Data:

ADHS Core Instrument for Adolescents is administered through prevention providers on a yearly basis. Arizona Youth Survey is administered by the Arizona Criminal Justice Commission in the schools every two years to individuals 8, 10 and 12th grades.

Data issues/caveats that affect outcome measures::

Arizona Youth Survey is administered every two years.

Priority #: 9

Priority Area: Tuberculosis Screening

Priority Type: SAT

Population TB

(s):

Goal of the priority area:

Increase the number of clients who are screened for tuberculosis services when entering substance abuse treatment.

Strategies to attain the goal:

ADHS/DBHS to provide guidance to RBHAs regarding accurate documentation on screening and referral for TB services.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of clients receiving substance abuse services with documentation of a screening or referral for TB services.
Baseline Measurement:	FY2011 14%
First-year target/outcome measurement:	Increase FY2011 data by 5%
Second-year target/outcome measurement:	Increase FY2012 data by 5%
Data Source:	

Independent Case Review (ICR)

Description of Data:

ADHS/DBHS hires an independent contractor annually to conduct a case review of clients receiving substance abuse services.

Data issues/caveats that affect outcome measures::

The sample size is not statistically significant.

Footnotes:

Table 2 State Agency Planned Expenditures [SA]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention and Treatment*	\$54,836,710		\$241,688,216	\$2,607,736	\$21,336,050	\$3,379,742	\$
a. Pregnant Women and Women with Dependent Children*	\$ 7,001,554		\$241,688,216	\$ 2,607,736	\$21,336,050	\$ 3,379,742	\$
b. All Other	\$ 47,835,156		\$	\$	\$	\$	\$
2. Substance Abuse Primary Prevention	\$ 14,623,122		\$	\$	\$	\$	\$
3. Tuberculosis Services	\$		\$	\$	\$ 5,938	\$	\$
4. HIV Early Intervention Services	\$		\$	\$	\$	\$	\$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	\$ 3,655,780		\$ 13,907,212	\$ 548,112	\$ 7,762	\$	\$
11. Total	\$73,115,612	\$	\$255,595,428	\$3,155,848	\$21,349,750	\$3,379,742	\$

\* Prevention other than primary prevention

Footnotes:

HIV Early Intervention is included in item 1 as the assumption is that Arizona will not be a designated state for FFY2014 and FFY2015. The 3% Set Aside Requirement is not separated, but included in the amount designated for substance abuse and prevention services. Award amount based on Allotments as described in the FY2014 Justification of Estimates for Appropriations Committees and May 15 Letter to State SSAs.

### III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$ 19,683,924	\$	\$ 194,142,999	\$ 6,543,676	\$
6. Other 24 Hour Care		\$ 1,582,159	\$ 141,114,141	\$	\$ 10,783,754	\$ 6,050,419	\$
7. Ambulatory/Community Non -24 Hour Care		\$ 15,997,388	\$ 1,938,067	\$	\$ 148,104,521	\$ 83,096,716	\$
8. Mental Health Primary Prevention		\$	\$	\$	\$	\$	\$
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)		\$ 976,642	\$	\$	\$	\$	\$
10. Administration (Excluding Program and Provider Level)		\$ 976,642	\$ 23,215,278	\$	\$ 1,224,173	\$	\$
11. Total	\$	\$ 19,532,831	\$ 2,122,080,979	\$	\$ 354,255,447	\$ 95,690,811	\$

\* Prevention other than primary prevention

**Footnotes:**

The 3% Set Aside Requirement is not separated, but included in the amount designated for MH services. Award amount based on Allotments as described in the FY2014 Justification of Estimates for Appropriates Committees and May 15 Letter to SSAs.

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			\$	\$
Specialized Outpatient Medical Services			\$	\$
Acute Primary Care			\$	\$
General Health Screens, Tests and Immunizations			\$	\$
Comprehensive Care Management			\$	\$
Care coordination and Health Promotion			\$	\$
Comprehensive Transitional Care			\$	\$
Individual and Family Support			\$	\$
Referral to Community Services Dissemination			\$	\$
Prevention (Including Promotion)			\$	\$
Screening, Brief Intervention and Referral to Treatment			\$	\$

Brief Motivational Interviews			\$	\$
Screening and Brief Intervention for Tobacco Cessation			\$	\$
Parent Training			\$	\$
Facilitated Referrals			\$	\$
Relapse Prevention/Wellness Recovery Support			\$	\$
Warm Line			\$	\$
Substance Abuse (Primary Prevention)			\$	\$
Classroom and/or small group sessions (Education)			\$	\$
Media campaigns (Information Dissemination)			\$	\$
Systematic Planning/Coalition and Community Team Building(Community Based Process)			\$	\$
Parenting and family management (Education)			\$	\$
Education programs for youth groups (Education)			\$	\$
Community Service Activities (Alternatives)			\$	\$
Student Assistance Programs (Problem Identification and Referral)			\$	\$
Employee Assistance programs (Problem Identification and Referral)			\$	\$
Community Team Building (Community Based Process)			\$	\$

Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			\$	\$
Engagement Services			\$	\$
Assessment			\$	\$
Specialized Evaluations (Psychological and Neurological)			\$	\$
Service Planning (including crisis planning)			\$	\$
Consumer/Family Education			\$	\$
Outreach			\$	\$
Outpatient Services			\$	\$
Evidenced-based Therapies			\$	\$
Group Therapy			\$	\$
Family Therapy			\$	\$
Multi-family Therapy			\$	\$
Consultation to Caregivers			\$	\$
Medication Services			\$	\$
Medication Management			\$	\$

Pharmacotherapy (including MAT)			\$	\$
Laboratory services			\$	\$
Community Support (Rehabilitative)			\$	\$
Parent/Caregiver Support			\$	\$
Skill Building (social, daily living, cognitive)			\$	\$
Case Management			\$	\$
Behavior Management			\$	\$
Supported Employment			\$	\$
Permanent Supported Housing			\$	\$
Recovery Housing			\$	\$
Therapeutic Mentoring			\$	\$
Traditional Healing Services			\$	\$
Recovery Supports			\$	\$
Peer Support			\$	\$
Recovery Support Coaching			\$	\$

Recovery Support Center Services			\$	\$
Supports for Self-directed Care			\$	\$
Other Supports (Habilitative)			\$	\$
Personal Care			\$	\$
Homemaker			\$	\$
Respite			\$	\$
Supported Education			\$	\$
Transportation			\$	\$
Assisted Living Services			\$	\$
Recreational Services			\$	\$
Trained Behavioral Health Interpreters			\$	\$
Interactive Communication Technology Devices			\$	\$
Intensive Support Services			\$	\$
Substance Abuse Intensive Outpatient (IOP)			\$	\$
Partial Hospital			\$	\$
Assertive Community Treatment			\$	\$

Intensive Home-based Services			\$	\$
Multi-systemic Therapy			\$	\$
Intensive Case Management			\$	\$
Out-of-Home Residential Services			\$	\$
Children's Mental Health Residential Services			\$	\$
Crisis Residential/Stabilization			\$	\$
Clinically Managed 24 Hour Care (SA)			\$	\$
Clinically Managed Medium Intensity Care (SA)			\$	\$
Adult Mental Health Residential			\$	\$
Youth Substance Abuse Residential Services			\$	\$
Therapeutic Foster Care			\$	\$
Acute Intensive Services			\$	\$
Mobile Crisis			\$	\$
Peer-based Crisis Services			\$	\$
Urgent Care			\$	\$

23-hour Observation Bed			\$	\$
Medically Monitored Intensive Inpatient (SA)			\$	\$
24/7 Crisis Hotline Services			\$	\$
Other (please list)			\$	\$

**Footnotes:**

Due to multiple limitations, including an inexact estimation of enrollment changes due to potential Medicaid expansion, participation in the Health Insurance Exchange and the implementation of the Essential Health Benefits Package, the State is not able to populate Table 3 with a suitable degree of confidence. Additionally, the State's Financial System cannot separate Grant funds from other non-medicaid dollars in determining how a service was funded at the member level. These factors prevent the State from completing Tabel 3.

### III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$ 27,418,355	\$27,757,458
2 . Substance Abuse Primary Prevention	\$ 7,311,561	\$7,401,989
3 . Tuberculosis Services	\$	
4 . HIV Early Intervention Services**	\$	
5 . Administration (SSA Level Only)	\$ 1,827,890	\$1,850,497
6. Total	\$36,557,806	\$37,009,944

\* Prevention other than primary prevention

\*\* HIV Early Intervention Services

**Footnotes:**

Award amount based on Allotments as described in the FY2014 Justification of Estimates for Appropriates Committees and May 15 Letter to SSAs.

### III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal	\$ 700,000	\$700,000
	Selective	\$ 100,000	\$100,000
	Indicated	\$ 90,000	\$90,000
	Unspecified	\$	
	Total	\$890,000	\$890,000
Education	Universal	\$ 1,000,000	\$1,000,000
	Selective	\$ 500,000	\$500,000
	Indicated	\$ 100,000	\$100,000
	Unspecified	\$	
	Total	\$1,600,000	\$1,600,000
Alternatives	Universal	\$ 1,000,000	\$1,000,000
	Selective	\$ 50,000	\$50,000
	Indicated	\$ 10,000	\$10,000
	Unspecified	\$	
	Total	\$1,060,000	\$1,060,000
Problem Identification and Referral	Universal	\$ 60,000	\$60,000
	Selective	\$ 10,000	\$10,000
	Indicated	\$ 5,000	\$5,000
	Unspecified	\$	

	Total	\$75,000	\$75,000
Community-Based Process	Universal	\$ 1,200,000	\$1,200,000
	Selective	\$ 100,000	\$100,000
	Indicated	\$ 100,000	\$100,000
	Unspecified	\$	
	Total	\$1,400,000	\$1,400,000
Environmental	Universal	\$ 1,000,989	\$1,000,989
	Selective	\$ 200,000	\$200,000
	Indicated	\$ 49,572	\$100,000
	Unspecified	\$	
	Total	\$1,250,561	\$1,300,989
Section 1926 Tobacco	Universal	\$ 20,000	\$60,000
	Selective	\$	
	Indicated	\$	
	Unspecified	\$	
	Total	\$20,000	\$60,000
Other	Universal	\$ 1,000,000	\$1,000,000
	Selective	\$ 6,000	\$6,000
	Indicated	\$ 10,000	\$10,000
	Unspecified	\$	
	Total	\$1,016,000	\$1,016,000
Total Prevention Expenditures		\$7,311,561	\$7,401,989
Total SABG Award*		\$36,557,806	\$37,009,944
Planned Primary Prevention Percentage		20.00 %	20.00 %

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

### III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	\$ 5,000,989	\$5,000,989
Universal Indirect	\$ 1,020,000	\$1,020,000
Selective	\$ 966,000	\$966,000
Indicated	\$ 324,572	\$415,000
Column Total	\$7,311,561	\$7,401,989
Total SABG Award*	\$36,557,806	\$37,009,944
Planned Primary Prevention Percentage	20.00 %	20.00 %

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Table 5c SABG Planned Primary Prevention Targeted Priorities

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

Footnotes:



### III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$ 56,000	\$	\$	\$56,000	\$56,000			\$56,000
2. Quality Assurance	\$ 10,000	\$	\$	\$10,000	\$30,000			\$30,000
3. Training (Post-Employment)	\$ 50,000	\$	\$	\$50,000	\$50,000			\$50,000
4. Education (Pre-Employment)	\$ 250,000	\$	\$	\$250,000	\$250,000			\$250,000
5. Program Development	\$ 50,000	\$	\$	\$50,000	\$30,000			\$30,000
6. Research and Evaluation	\$ 350,000	\$	\$	\$350,000	\$500,000			\$500,000
7. Information Systems	\$ 250,000	\$	\$	\$250,000	\$100,000			\$100,000
8. Enrollment and Provider Business Practices (3 percent of BG award)	\$	\$ 1,096,734	\$	\$1,096,734				
9. Total	\$1,016,000	\$1,096,734	\$	\$2,112,734	\$1,016,000			\$1,016,000

Footnotes:

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	\$ <input type="text"/>
MHA Planning Council Activities	\$ <input type="text"/>
MHA Administration	\$ <input type="text" value="488,321"/>
MHA Data Collection/Reporting	\$ <input type="text"/>
Enrollment and Provider Business Practices (3 percent of total award)	\$ <input type="text" value="292,992"/>
MHA Activities Other Than Those Above	\$ <input type="text"/>
Total Non-Direct Services	\$781313
Comments on Data: <input type="text" value="MHA Planning Council Activities included in MHA Administration."/>	

Footnotes:

## IV: Narrative Plan

### C. Coverage M/SUD Services

#### Narrative Question:

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Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

With limited restrictions, all non-acute service types identified in aforementioned Continuum of Care (see Planning section), and Table 3 of this application are currently covered by Medicaid in Arizona’s public behavioral health system.<sup>1</sup> For reference, service categories and examples are indicated in the table below.<sup>2</sup>

<b>Service Domain</b>	<b>Description</b>
<i>Treatment Services</i>	Individual and group counseling, therapy, assessment, evaluation, screening, and other professional services; most typically rendered in an outpatient environment.
<i>Rehabilitation Services</i>	Living skills training, cognitive rehabilitation, health promotion, and ongoing support to maintain employment; most typically rendered in an outpatient environment.
<i>Medical and Pharmacy</i>	Medications prescribed to address mental health disorder and/or relieve symptoms of addiction and/or promote or enhance recovery from addiction
<i>Support Services</i>	Case management, self-help/peer support services and transportation; most typically rendered in an outpatient environment.
<i>Crisis Intervention</i>	Stabilization services provided in the community, hospitals and residential treatment facilities. Also includes Mobile Crisis Dispatch Teams and 24/7 Crisis Warm-Lines.
<i>Inpatient Services</i>	Inpatient detoxification and treatment services delivered in hospitals and sub-acute facilities, including Level I residential treatment centers that provide 24-hour supervision, an intensive treatment program, and on-site medical services.
<i>Residential</i>	Residential treatment with 24-hour supervision in Level II and III facilities.
<i>Behavioral Health Day Programs</i>	Skills training and ongoing support to improve the individual’s ability to function within the community. Specialized outpatient substance abuse programs provided to a person, group of persons and/or families in a variety of settings. Intensive outpatient programs.

Beginning in early 2014, Medicaid-eligible individuals in Maricopa County, with a diagnosed Serious Mental Illness (SMI) enrolled in the public behavioral health system will also receive physical (acute) care services under an integrated model. While it is anticipated that this model will be adopted in other regions of the state in future years, the Maricopa County pilot will provide integrated services to approximately 17,000 adults at onset. Programs will focus on disease and care management for the most at-risk individuals – including those SMI members with diabetes, chronic obstructive pulmonary disease (COPD), obesity, renal disease and cardiac disease – and include those services detailed under “Healthcare Home / Physical Health” in Table 3 of this application; however, since this benefit package is not currently operationalized, and will be limited only to Medicaid members, potential block grant utilization cannot be readily determined at this time.

The full continuum of behavioral health services will be available to our non-integrated, Medicaid-eligible members, including those with a General Mental Health Disorder (GMH), a Substance Use Disorder (SUD), or children with, or without, a Serious Emotional Disturbance (SED). Meanwhile, non-Medicaid eligible members with an SMI will receive a limited benefit package funded primarily through state general funds, consisting of medications, rehabilitation and peer support services. However, non-Medicaid eligible members with an SUD are able to receive all behavioral health services currently available to the Medicaid population as funding permits.<sup>3</sup>

<sup>1</sup> Medicaid coverage does not include select services, such as room and board, Flex Funds, acupuncture, Supported Housing or interpretation – these services are rendered using state or federal dollars.

<sup>2</sup> The complete listing of approved services is documented in the ADHS Covered Behavioral Health Services Guide at <http://www.azdhs.gov/bhs/covserv.htm>

<sup>3</sup> The SAPT Block Grant is utilized to provide these services in accordance with all funding restrictions and priority population limitations.

The Division monitors enrollment and utilization for mental health and substance abuse service utilization rendered under the public behavioral health system. Enrollment penetration is calculated by both population type and financial eligibility on a monthly basis and is published on the Department's website (please see <http://www.azdhs.gov/bhs/reports/monthly.htm>).

Section D of this application details the progress Arizona has made in recent months in establishing and operational Health Insurance Exchange / Health Insurance Marketplace, including the restoration Medicaid services and the selection of the Essential Health Benefits Package (EHBP).<sup>4</sup> Although it is anticipated that enrollment will naturally increase with the implementation of Health Care Reform, the exact level of participation in the public system is currently under evaluation. Because individuals may opt to receive services from a provider outside of the public network, it is likely those individuals will not be captured in the Department's enrollment reports.

Complaints or violations relating to mental health parity will be reviewed by both the Arizona Health Care Cost Containment System (AHCCCS) and the Department of Health Services' Office of Human Rights. The monitoring and review process for this currently under development.

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<sup>4</sup> Please see Section D of this application for potential changes the state will make to account for implementation of the EHPB.

## IV: Narrative Plan

### D. Health Insurance Marketplaces

#### Narrative Question:

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Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

Under the leadership of the Governor's Office for Health Insurance Exchange, multiple system partners including the Arizona Department of Insurance, the Arizona Health Care Cost Containment System (AHCCCS – the State's Medicaid Authority), the Arizona Department of Economic Security and the Arizona Department of Health Services (ADHS) are coordinating as necessary to ensure the State is actively participating in a Health Insurance Marketplace by January 1, 2014.<sup>1</sup> As a result of this collaborative effort, the State had made significant progress in developing the programs, policies and agreements as needed to meet the requirements within Section 1311 the Patient Protection and Affordable Care Act pertaining to Health Insurance Exchanges.

To begin, Arizona has recently made three significant decisions that will directly influence the future of patient care in both the physical and behavioral health care systems. First, In October 2012, Governor Brewer selected the State of Arizona's Employee Benefit Plan to be the State's benchmark for the Essential Health Benefits Package (EHPB) to be offered as an option to purchase through the Marketplace. This plan, also referred to as the "silver plan", is currently offered through United Healthcare as an Exclusive Provider Organization (EPO) Plan.

Second, in November, 2012, Arizona opted to participate in the Federally-Facilitated Health Information Exchange (FFE). This decision was made after extensive research and communication with subject matter experts, including Arizona hospitals, health providers, insurers, tribal groups and other members of the health care community.<sup>2,3</sup>

Third, the Governor's Office proposed restoring Medicaid coverage up to 133 percent of the Federal Poverty Level (FPL), effective January 1, 2014. This decision was deliberated and approved by the State Legislature in June, 2013; it is anticipated that this action will restore health care to the "childless adult" population which was previously approved by voters, but had its enrollment frozen due to the recession. Overall, enacting Medicaid restoration would serve about 300,000 additional low-income Arizonans. Without the State's participation in Medicaid expansion, these individuals would most likely be left without any health coverage even after the Affordable Care Act is fully implemented – due to the fact that people with incomes under 100 percent of the poverty level won't qualify for the insurance premium tax credits and subsidies for cost-sharing available to those who enroll for coverage through the Marketplace.

Although there are still a number of unknown factors, including the availability of federal services pertaining to the Marketplace, Arizona remains committed in working with the Department of Health and Human Services to move forward in providing quality health care for our members. Ultimately the Arizona Department of Health Services' activities and service provision in the behavioral health arena during the upcoming years are dependent on these presently unknown variables. The most recent enrollment forecasts estimate that by 2016 as many as 1.3 million more individuals will enroll in health insurance through the Exchange or AHCCCS; these individuals will be eligible for, but not necessarily seek, services within the public behavioral health system.<sup>4</sup>

Arizona's movement to restore Medicaid to 133 percent of FPL, in conjunction with a high level of participation and enrollment in the federally-facilitated Health Information Exchange, will require ADHS to focus on communicating and marketing available services to those individuals who are now eligible to

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<sup>1</sup> <http://www.azgovernor.gov/Marketplace/>

<sup>2</sup> <http://www.azgovernor.gov/Marketplace/documents/QuickLinks/PressReleaseGovernorBrewersDecision.pdf>

<sup>3</sup> <http://www.azgovernor.gov/Marketplace/documents/QuickLinks/GovernorBrewersDeclarationLetter.pdf>

<sup>4</sup> <http://www.azgovernor.gov/Marketplace/documents/Grants/UpdatedBackgroundResearchReport.pdf>

receive care within the public behavioral health system. This will largely be accomplished through a joint venture of our established peer support network, in which individuals who are currently receiving services, or have received services in the past, conduct outreach and communicate with the larger community and encourage individuals to seek treatment, and the Arizona's Navigator program, which will raise awareness of the availability of qualified health plans and facilitate enrollment in these plans (currently in development). The overall impact of these activities will be assessed as part of our routine review and analysis of member enrollment and participation in the public system; because individuals who enroll through the Marketplace may opt to receive services outside of the public behavioral health system, ADHS will assess other information feeds as made available through the Health Insurance Exchange or our sister agencies to better assess changes in enrollment.

Because the Division serves as the behavioral health "carve out" for the Arizona's Medicaid program, as well as the State Mental Health Authority and the Single State Authority for substance abuse, we are in a unique position to ensure Medicaid, QHP and commercial insurance options are maximized prior to any utilization of grant funds. All treatment services provided under the public behavioral health umbrella are rendered by Medicaid-registered providers who must subsequently submit encounters as documentation that said service was rendered.<sup>5</sup> These encounters are adjudicated by the Arizona Health Care Cost Containment System (AHCCCS), where financial responsibility is determined by member enrollment/eligibility at the date of service. Therefore, if an individual is eligible for Medicaid, is insured either by the Marketplace or has commercial insurance, Medicare coverage or any other applicable third-party liability (TPL), those funding sources are billed before any Block Grant funds are utilized. Additionally, should a member gain Medicaid eligibility retroactively, any encounters previously billed to the Block Grant will be recycled and appropriately billed to Medicaid or the applicable third party.

Future utilization of Block Grant funds is largely dependent on the impact of Medicaid restoration and the degree of participation in the Health Insurance Exchange. Those members who neither qualify for Medicaid, nor meet the standards for Marketplace participation, will continue to receive mental health and substance abuse treatment services; however, their benefit package may differ than that of today depending on availability of funding and priority population affiliation, i.e. pregnant / parenting women or injection drug users. Accordingly, the Block Grants would likely be used to supplement non-covered services to members who become Medicaid eligible or participate in the Marketplace, dependent on the Essential Health Benefits Package. For example, a crisis safety net is necessary to cover individuals during a time of crisis regardless of insurance coverage. Additionally, other services such as peer and family support, respite care and supportive employment, although Medicaid-reimbursable, would not be covered under the EHBP; therefore it is possible that Block Grant funds could be used to provide those services to bring parity to the system.

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<sup>5</sup> All organizations identified in Table 8 of the FY2012 MHBG and SABG Report as receiving treatment dollars are registered to manage services under the State's Medicaid Program and will continue to have this designation in FY2014 and FY2015.

## IV: Narrative Plan

### E. Program Integrity

#### Narrative Question:

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The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
  - a. Budget review;
  - b. Claims/payment adjudication;
  - c. Expenditure report analysis;
  - d. Compliance reviews;
  - e. Encounter/utilization/performance analysis; and
  - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

#### Footnotes:

In order to achieve the goals of deterring and detecting fraud and program abuse and to ensure compliance with applicable laws, rules, regulations, contract requirements and guides and manuals related to program integrity, the Arizona Department of Health Services, Division of Behavioral Health Services has established a comprehensive corporate compliance program. This program is administered by the designated Corporate Compliance Officer, within the Bureau of Corporate Compliance, who is responsible for the general administration of the compliance program and management and direction of the Office of Program Integrity (OPI) and the Office of Audit and Evaluation (OAE).

The Bureau of Corporate Compliance's Office of Audit and Evaluation, in consultation with the Bureau of Financial Operations, reviews the Regional Behavioral Health Authorities' compliance with block grant requirements and program integrity. During this review, which occurs bi-annually, auditors follow a pre-established audit program designed to determine if the contractor has adequate controls in place to ensure the efficient and effective use of SAPT and CMHS funds. This includes monitoring of subrecipient's activities to ensure that Federal awards are only used for authorized purposes and performance goals are achieved, and ensuring subrecipients expending \$500,000 per year or more in Federal awards during the fiscal year complete an OMB A-133 Report.

Block Grant funds are allocated to RBHAs and T/RBHAs based on historical allocations, financial performance, and programmatic need. In some cases, RBHAs and T/RBHAs submit a proposal that is reviewed and approved through several internal channels within DBHS. Detailed information may be reviewed at that time which could include financial performance and recent utilization data.

Prevention services, which are not encounterable, are monitored through a variety of mechanisms. Each T/RBHA submits an annual plan to the state at least two months prior to the commencement of the state fiscal year. The plan shows how prevention funds will be allocated in the upcoming year to each program including a breakdown by strategy. NPN staff review and approve or deny the proposed allocations. The state conducts annual prevention site visits to each T/RBHA; these site visits include a review of financial information.

RBHAs conduct at least one visit to each prevention site or providers each year, with additional visits as needed. Site visits include interview(s) with program staff, observation of program activity, and review of training and supervision records. Supervision records consist of documentation that prevention specialists receive regular and on-going supervision. RBHAs must participate in site visits by DBHS as requested. ADHS must approve the program monitoring protocol of each RBHA before it is used. RBHAs submit their program monitoring protocol with their program descriptions each year for the following fiscal year.

Two months following the close of the state fiscal year, each T/RBHA and prevention program submits a description of how funds were expended by strategy. Non T/RBHA contractors submit monthly or quarterly contractor expenditure reports and/or invoices to show how funds were expended in order to receive payment for services rendered.

The RBHAs are required to submit monthly, quarterly, & annual financial statements. Monthly and quarterly statements are due thirty (30) days after month-end or quarter-end; and forty (40) days after the last quarter of the contract year. The TRBHAs are required to submit quarterly year-to-date Revenue and Expense Reports forty-five (45) days after quarter-end. Draft audited financial statements are due seventy-five (75) days after contract year-end and final audited financial statements are due one hundred (100) days after contract year-end.

Because the Arizona Department of Health Services, Division of Behavioral Health Services, serves as the behavioral health “carve out” for the State’s Medicaid program, as well as the State Mental Health Authority, and the Single State Authority for substance abuse, we are in a unique position to ensure Medicaid, QHP and commercial insurance options are maximized prior to any utilization of grant funds. All treatment services provided under the public behavioral health umbrella are rendered by Medicaid-registered providers who must subsequently submit encounters as documentation that said service was rendered.<sup>1</sup> These encounters are adjudicated by the Arizona Health Care Cost Containment System (AHCCCS – the State’s Medicaid authority), where financial responsibility is determined by member enrollment/eligibility at the date of service. Therefore, if an individual is eligible for Medicaid, is insured either by the HIX or has commercial insurance, Medicare coverage or any other applicable third-party liability (TPL), those funding sources are billed before any Block Grant funds are utilized. Additionally, should a member gain Medicaid eligibility retroactively, any encounters previously billed to the Block Grant will be recycled and appropriately billed to Medicaid or the applicable third party

The financial statements and Revenue and Expense Reports are reviewed monthly, quarterly and annually to determine if the funds are properly accounted for and appropriately expended in accordance with federal guidelines and grant requirements. In addition, T/RBHAs are required to submit an annual SAPT and CMHS Distribution Report by October 15th of each year. These reports depict how SAPT and CMHS funds were distributed to providers, by category, during the previous contract year. The reports are reviewed for reasonableness in relation to the service expenses reported by the T/RBHA in their financials for the corresponding contract year.

The T/RBHA’s are required to submit annual audited financial reports. In addition, T/RBHAs are required to have a Single Audit conducted in accordance with the provisions of OMB Circular A-133 if they expend federal funding of \$500,000 or more during their fiscal year. RBHAs submit draft audit reports and supplemental schedules seventy-five (75) days after the contract year-end ; and their final audits are due one hundred (100) days after contract year-end. TRBHAs Audited Financial Reports are due nine (9) months after the Tribe’s fiscal year-end. TRBHAs are required to audit SAPT and CMHS Block Grants as major programs. Audits are reviewed for areas of non-reporting or non-compliance. Areas of concern are addressed with each TRBHA until appropriate corrective action has been performed.

CMHS and SAPT Block grant funds are paid out on a 1/12 monthly basis to the T/RBHAs and RBHAs. Grant Payments are reconciled to actual expenditures through monthly and quarterly financial statements noted previously. The RBHA Statement of Activities identifies each fund source and category of service.

ADHS reviews and approves in writing all RBHA solicitations and amendments for prevention services 14 days before they are released publicly. ADHS must be involved in the selection of proposals for prevention. ADHS must approve in writing the process for review and selection of proposals to provide prevention services.

Subcontract formats for prevention services must be approved in writing by ADHS at least 30 days prior to the state fiscal year in which the contract will be in effect. Prevention subcontracts must contain at minimum the following provisions:

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<sup>1</sup> All organizations identified in Table 8 of the FY2012 MHBG and SABG Report as receiving treatment dollars are registered to manage services under the State’s Medicaid Program and will continue to have this designation in FY2014 and FY2015.

- Specification of the work to be performed; type, and number of participants served.
- Description of the evaluation methods and instruments to be used and specific reporting requirements.
- Description of the method and amount of payment for satisfactory completion of services.
- The name of the state outcome evaluation instrument used or a copy of any approved alternative evaluation instrument.
- RBHA contracts must not prohibit providers from communicating with ADHS staff.
- Leveraging of funds from various sources is supported by DBHS and may not be prohibited by RBHAs.

T/RBHAs ensure that the prevention programs and staff do not endanger the health, safety, or welfare of persons served by their programs. Services provided by prevention professionals will be respectful and non-exploitive.

The following are *minimum* requirements from ADHS for RBHAs in the area of safety. T/RBHAs and all of their subcontracted providers are contractually obligated to meet these safety requirements.

#### Fingerprinting and background checks

RBHAs confirm that all staff, contractors, volunteers or other persons delivering prevention services to persons under the age of 18 have applied for or received a class I fingerprint clearance card by the Arizona Department of Public Service, before providing prevention programs (per Arizona Revised Statutes 36-425.03). Individuals who have been denied a class I fingerprint clearance card may not provide unsupervised services to **youth** in a program contracted by DBHS.

#### Incidents and Accidents<sup>2</sup>

Types of incidents to be reported to ADHS include but are not limited to:

- Sexual abuse perpetrated by a prevention provider or T/RBHA employee or volunteer. Any abuse perpetrated by provider employees or volunteers on a program participant must be reported to law enforcement immediately and to ADHS within 24 hours.
- Death of a prevention program participant or staff while involved in prevention activities
- Suicide completion or attempt of prevention program participants or staff.

#### CPR/First Aid

RBHAs confirm that at least one staff member current in First Aid Certification and at least one staff member current in Cardio Pulmonary Resuscitation Certification (CPR) is present at all times on facility premises, on field trips, or while transporting children in a facility's motor vehicle or a vehicle designated by the licensee to transport children. A staff member with current certification in both first aid and CPR may meet this requirement. Prevention programs will maintain a first aid kit accessible to staff members. First aid kits should be available in vehicles when transporting participants.

#### Prohibited Objects/ Substances

RBHAs prohibit the use or possession of the following items when a prevention program participant is on facility premises, during hours of operation, or in any motor vehicle when used for transportation of program participants:

- Any beverage containing alcohol

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<sup>2</sup> Please see Provider Manual section 7.4, "Reporting of Incident, Accidents, & Deaths." Accessed from [http://www.azdhs.gov/bhs/provider/sec7\\_4.pdf](http://www.azdhs.gov/bhs/provider/sec7_4.pdf)

- A controlled substance
- A firearm or other lethal weapon

#### Facilities

RBHAs confirm that the following health and safety inspections take place for any facilities owned, leased, or rented by that provider to provide prevention services, according to the following schedules, and make any repairs or corrections stated on an inspection report.

- Sanitation inspections, conducted a minimum of every 12 months by a local health department.
- Gas inspections, conducted a minimum of every 12 months by a plumber holding a plumbing business license issued by a local government.
- Fire inspections, conducted a minimum of every 36 months by a local fire department or the State Fire Marshal.

#### Transportation

When providing transportation to program participants in a motor vehicle, providers and tribal contractors must:

- Ensure that the motor vehicle has insurance and a current registration with the Arizona Department of Transportation.
- Not permit any person to be transported in a truck bed, camper, or trailer attached to a motor vehicle.
- Require all vehicle passengers to use age and size appropriate restraint systems.
- Carry a first aid kit, fire extinguisher, and water sufficient for the needs of each passenger.
- Carry active, written consent from a parent or guardian for each youth transported.

## IV: Narrative Plan

### F. Use of Evidence in Purchasing Decisions

Narrative Question:

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SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
  - a) What information did you use?
  - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
  - a) Educating State Medicaid agencies and other purchasers regarding this information?
  - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

Prevention and Treatment evidence-based or promising practices are tracked through the Arizona Department of Behavioral Health Services (ADHS), Division of Behavioral Health Services (DBHS) Office Chief for Prevention Services as well as through the system of care staff with expertise in substance abuse treatment. In 2012 DBHS completed the Comprehensive Assessment and Treatment of Adults with Substance Use Disorders Practice Protocol, which describes currently recommended evidence-based practices in substance abuse treatment; additionally, information is sent out via e-mail list serves throughout the year.

ADHS/DBHS has used information regarding evidence-based practices in directing policy decisions. All Regional Behavioral Health Authorities (RBHAs) are contractually required to use evidence-based practices in substance abuse treatment, which are articulated in proposal requests issued every 3 to 5 years. Regional Behavioral Health Authorities report utilizing evidence-based practices via an Annual Network Report. This report lists each staff person working in substance abuse treatment by name and includes the evidence-based practice methods used. Among those treatment practices documented are Motivational Interviewing, Cognitive Behavioral Therapy, Contingency Management, ASAM-PPC and CRAFT.

While the Office for Prevention Services does not require evidence-based practices (EBP), teams are assembled on an annual basis every fall to evaluate all subcontracted prevention programs. Each EBP Review Team consists of a member of ADHS/DBHS, one or two provider representatives, a RBHA representative and a research representative. One team is composed of individuals with tribal expertise as well as prevention experience, which provides a better understanding of culturally specific evidence-based practices used by Tribal prevention programs. The teams complete a thorough review utilizing a standard tool to make a determination as to whether or not the program is evidence-based. ADHS/DBHS RBHA defines a “program” as ‘a set of prevention strategies, which address a common set of goals and objectives for a common target audience in one county’. This broad definition is intended to encompass many strategies used by a provider. The information viewed under this definition which combined all prevention strategies, activities and/or curriculum under one program. Reviewers use the program logic model (when available) and program descriptions, strategies, and outcomes to assess whether the overall program meets evidence-based criteria. Evidence-based criteria are based upon SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP) criteria, including three criteria which use expert panels and four guidelines as the basis for assessment.

For evidence-based practice, a program/strategy must meet one of the following three criteria.

1. Included on Federal Lists or Registries of evidence-based interventions; OR
2. Reported (with positive effects) in peer-reviewed journals; OR
3. Documented effectiveness supported by other sources of information and the consensus judgment of informed experts:
  - Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual mode; 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 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.

In addition to the above criteria, ground rules are set for how the groups formulate their expert judgments.

- a) The team must come to a “yes” consensus.
- b) No consensus is needed for a no. (An “I don’t know,” “I’m not sure,” “I can’t judge this,” or “I need more information” is categorized as a “no”.)
- c) Program funding and jobs are not in jeopardy if a program receives a “no”.
- d) Programs which would be “yes” due to Criteria 1 or 2 still must demonstrate a logical grounding.

In addition to fulfilling Block Grant requirements, the evidence-based practice review also provides an opportunity for learning and improvement within Arizona’s prevention community. Data on the percent of clinical treatment staff using evidence-based practices was used to establish goals for improvement in the adult system of care profile. The EBP review allows teams to gather information on strengths of the program and provide constructive recommendations. ADHS/DBHS summarizes the information in a written report which is shared with the provider organization, or program lead. For programs that are not deemed to be evidence-based, training and technical assistance is offered to help programs meet evidence-based criteria. ADHS/DBHS does not use information regarding EBP to educate State Medicaid agencies (or other purchasers), or to make decisions about what is bought with funds (that are under ADHS control); though the list of evidence-based practice methods used, as reported in the Annual Network Report, assists in establishing the types of practices used.

## IV: Narrative Plan

### G. Quality

#### Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

#### Footnotes:

The Arizona Department of Health Services, Division of Behavioral Health Services currently monitors numerous performance, process and outcome-oriented metrics in effort to oversee and promote the effective use of resources in a manner that ensures quality treatment and prevention services to our members. As such, DBHS looks forward to SAMHSA releasing its annual Behavioral Health Barometer and incorporating its metrics into Arizona's current oversight practices as applicable. The below section details current review practices and indicators used as they pertain to prevention and treatment services:

### ***Prevention***

As discussed in Section E of this application, the RBHAs conduct at least one visit to each prevention site or providers each year, with additional visits as needed. Site visits include interview(s) with program staff, observation of program activity, and review of training and supervision records documenting regular and on-going supervision of prevention specialists. The RBHA must provide written feedback to each prevention sub-contractor noting successes and providing recommendations for improvement. RBHAs must monitor and evaluate entire programs rather than individual strategies. Individual strategies do not have goals or objectives and are not evaluated. On monitoring visits, RBHAs must refer back to original program plan which was submitted to ADHS for approval the previous year. Changes to program plans may be made mid-year only with prior written approval by the ADHS/DBHS Office of Prevention Services.

RBHAs must participate in site monitoring visits from Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) Office of Prevention staff as requested. DBHS Office of Prevention monitoring visits are an opportunity for developing the capacity of providers with DBHS staff providing feedback and acknowledgement of accomplishments and failures. DBHS staff programming recommendations will be given in written form to RHBAs, and implementation of recommendations will be monitored throughout the funding year.

While the Office for Prevention Services does not require evidence-based practices (EBP), teams are assembled on an annual basis every fall to evaluate all subcontracted prevention programs. The teams complete a thorough review utilizing a standard tool to make a determination as to whether or not the program is evidence-based. Reviewers use the program logic model, program descriptions, strategies, and outcomes to assess whether the overall program meets evidence-based criteria. In addition to fulfilling Block Grant requirements, the evidence-based practice review also provides an opportunity for learning and improvement within Arizona's prevention community. The EBP review allows teams to gather information on strengths of the program and provide constructive recommendations. ADHS/DBHS summarizes the information in a written report which is shared with the provider organization, or program lead. For programs that are not deemed to be evidence-based, training and technical assistance is offered to help programs meet evidence-based criteria.

The Office for Prevention also provides performance and guidance to RHBA administrators during monthly meetings held at DBHS offices. RHBA administrators give updates on program implementation success and challenges in their geographic area, giving an opportunity for feedback from fellow administrators and DBHS staff. DBHS staff discusses statewide successes, challenges and emerging best practices offering technical assistance in order for RHBAs to reach goal stated program plans.

### **Treatment**

In January 2011, Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) officially launched a public behavioral health system Outcomes Framework and Performance Dashboard. The dashboard is posted on the ADHS/DBHS website (<http://www.azdhs.gov/bhs/dashboard/index.htm>), and is a robust, uniform, and comprehensive approach to system evaluation. Presented in an easy to read format, and separated in four unique categories - Outcomes, Access, Service Delivery and Coordination/Collaboration; the Outcomes Framework and Performance Dashboard assess ADHS/DBHS service delivery (see below). These categories, and their respective components, were strategically selected due to their unique ability to serve as system performance indicators at each level of the service delivery network, as well as their interdependence and influence on one another.

For example, monitoring the system's ability to provide services in a timely manner at convenient locations (Access), providing individuals an opportunity to participate in their treatment planning (Service Delivery), and interacting with the behavioral health recipient's primary care physician (Coordination/Collaboration), should ultimately result in an improved quality of life for those in the behavioral health system (Outcomes). The categories include data from a variety of sources - demographic data provided by clients on a regular basis, individual and family survey data, analysis of claims data, audits of client records and data reported by the RBHAs.

#### **OUTCOMES: Has quality of life improved for individuals served by the behavioral health system?**

<b>Individuals...</b>	<b>Adults Statewide</b>	<b>Children Statewide</b>
Drug/alcohol use history, now reduced or no use	51.7%	55.4%
Are not homeless	95.9%	99.7%
Are employed	31.9%	9.3%
Attend school	11.8%	84.4%
Have no recent criminal justice system involvement	90.3%	96.6%
Participate in self-help groups	12.1%	3.9%

#### **ACCESS TO SERVICES: Do individuals and families have access to recovery and resiliency oriented services?**

<b>Individuals...</b>	<b>Adults Statewide</b>	<b>Children Statewide</b>
Are satisfied with their access to services	86.2%	83.1%
Receive timely services	91.7%	88.4%
Live within 15 miles of an outpatient clinic	98.8%	98.5%

**SERVICE DELIVERY: Are services provided based on the needs of individuals and families?**

Individuals...	Adults Statewide	Children Statewide
Participate in their treatment planning	90.0%	91.8%
Have current and complete service plans	70.0%	70.7%
Receive services identified on their service plan	80.0%	88.6%

**COORDINATION AND COLLABORATION: Do individuals and families get seamless behavioral and medical care coordination?**

Individuals...	Adults Statewide	Children Statewide
Have their care coordinated with their medical doctor	88.1%	86.7%
Return to a psychiatric hospital	16.3%	9.8%
Stay in a psychiatric hospital an average of...	9.3	9.0

The ADHS/DBHS, T/RBHAs and contracted service providers jointly conduct statewide consumer surveys during each fiscal year. ADHS/DBHS has established the Consumer satisfaction survey as a quality metrics of the entire DBHS client population. Information collected from the satisfaction survey is represented in each category of the Outcomes Framework and Performance Dashboard. Randomly selected clients complete the survey on the impact on SAPT funded services.

Each year, two surveys are administered based on the Substance Abuse and Mental Health Services Administration's (SAMSHA's) Mental Health Statistics Improvement Program (MHSIP) consumer surveys: The Adult Consumer Survey and The Youth Services Survey for Families (YSS-F). The surveys request independent feedback from Title XIX/XXI adults and families of youth receiving services through Arizona's publicly funded behavioral health system. The surveys measure consumers' perceptions of behavioral health services in relation to the following domains: General Satisfaction, Access to Services, Service Quality/Appropriateness, Participation in Treatment, Outcomes, Cultural Sensitivity, Improved Functioning, and Social Connectedness.

Additionally, ADHS/DBHS has partnered with Health Services Advisory Group Inc., an external quality review organization, to conduct case file review of behavioral health records. DBHS has chosen to review case files of individuals enrolled in substance abuse treatment programs, which are contracted through the RBHAs. The objective of the review is to determine the extent to which substance abuse treatment programs use nationally recognized best practices in the areas of screening, assessment, treatment, engagement, and retention in accordance with the terms of their contracts and state and federal regulations. This Independent Case Review (ICR) is conducted to complete the requirements outlined in Goal 15 of the former SAPT Block Grant application – this review will continue annually.

DBHS developed the case file review tool which contains clinical measures ranging from assessments to discharge planning and re-engagement. In addition, the tool includes the collection of National Outcome Measures. Two-hundred cases are randomly selected for review based on: the time a client was enrolled in a treatment facility; that the client was at least 18-years-old during treatment; that the client was not diagnosed with a serious mental illness; that the client was disenrolled due to either the

client completed treatment, the client declined future services, or there was a lack of contact and the client was not enrolled in a TRBHA.

## IV: Narrative Plan

### H. Trauma

#### Narrative Question:

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In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

At present, the Division of Behavioral Health Services (DBHS) does not have a policy requiring providers to screen members for instances of trauma. However, DBHS recognizes the importance of Trauma Informed Care and has included its promotion in the three year strategic plan for the Adult System of Care.

The Trauma-Informed Care Taskforce embarked on promoting the Trauma Informed Care (TIC) philosophy to the public behavioral health system through a Dialogue/Focus Group combination. The goal of this project was to develop a statewide TIC needs assessment, and to spread awareness concerning trauma informed care, particularly around sanctuary trauma. The Arizona Stigma Reduction Committee conducts statewide Arizona Dialogues (patterned after SAMHSAs participatory dialogues). The Arizona Dialogues are conducted by trained Co-Facilitators and have been very successful in engaging groups in deep discussion and exploration of a variety of aspects of community inclusion and stigma. The goal of Arizona Dialogues is to raise awareness and affect positive changes in attitude and behavior toward persons with mental illness/substance use disorders and their families. Additionally, the Committee has developed presentations, which include experience sharing, to raise awareness of the negative effects of stigma and positive benefits of inclusion. The Committee conducts these programs all over the state and also has a presence at many health/wellness fairs and is an exhibitor at local conferences. TIC Dialogues offer an avenue in which peer and family members become active participants in systems transformation by sharing their experiences and speaking about their needs and those of the community related to trauma. Ten Dialogues were conducted across the state in FY 2011 and 14 Dialogues were conducted in FY 2012. In 2012 the TIC Taskforce and DBHS completed a needs assessment analysis based on Trauma Informed Care Dialogues. This assessment drives future activities around Trauma Informed Care.

A wide variety of trainings and conferences have been completed throughout the state reaching both providers as well as the public. These conferences have reached over 2200 individuals; the following events have been held with the focus on increasing the Trauma Informed Care message:

- Trauma Informed Care Summit
- Healing Neen – evening event in partnership with Phoenix Children’s Hospital, and the Arizona Adverse Childhood Experiences (ACE) Consortium
- 13th Annual Summer Institute – Mission Wellness: Business and Service Alignment for Health Outcomes (Raul Almazar keynote speakers on TIC and also there were several breakout sessions on this topic)
- Southwest Schools – we exhibited and also connected Michelle with several of their keynote speakers who spoke on TIC
- ACEH Conference – sponsored keynote speaker Tonier Cain plus several breakout sessions on TIC
- Social Determinants of Health – discussed ACE Study including the effects of trauma and need for identification/screening and treatment to address trauma
- State-wide ACE study workshop for prevention work force development

## IV: Narrative Plan

### I. Justice

#### Narrative Question:

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The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.<sup>42,43</sup> Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.<sup>44</sup>

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

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42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

#### Footnotes:

Through the Single State Authority's (SSA) leadership at Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS), there has been active involvement in the joint activities between the behavioral health system and Arizona's criminal and juvenile justice systems. Annually updated Collaborative Protocols and System of Care Plans provide structure for the agencies to cooperatively work together. Regularly occurring meetings take place at the state level and at the local levels to focus on policy development and implementation, improving communication, identification of system barriers and problem solving. Collaborative development activities such as Drug Courts and Mental Health Courts and Juvenile Detention Alternatives (JDAI) are examples of some of the work occurring in Arizona.

While Arizona does not have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions, screening and treatment are provided prior to adjudication and/or sentencing for individuals with mental health, substance use, or co-occurring disorders. Both the State Department of Corrections and the Counties Detention Centers provide a mental health and substance use disorder screening as a part of their intake protocols.

The Regional Behavioral Health Authorities (RBHAs) maintain active and annually updated collaborative protocols with their respective justice agencies in their Geographic Service Areas (GSA) to ensure that enrolled members or eligible persons that come in contact with the Justice system, to the extent possible, have their mental health and substance abuse treatment needs assessed, addressed and relevant issues communicated and coordinated with the judiciary and justice personnel. RBHAs maintain co-located staff at both Juvenile and Adult Courts and Detention Centers in order to provide coordination of care between the behavioral health system and the justice systems in meeting the enrolled members' needs.

Criminal and Juvenile Justice Liaisons and other co-located behavioral health staff are trained to work specifically with individuals involved in the criminal and juvenile justice systems and their living environments. As a result, the staff is able to address issues specific to these individuals. By assisting members with navigating the justice system, advocating for their individualized needs, assisting the justice system staff and judiciary and accessing behavioral health and substance abuse treatment for clients, staff are better able to identify the appropriate range of services.

Enrollment and care coordination activities specifically designed for this population are established in Collaborative Protocols jointly developed by the RBHAs and the local courts, parole offices and probation departments. These protocols define activities and timeframes for care coordination, screening and enrollment, preparation for services post release, communication and participation on individual Child and Family Teams (CFTs) and Adult Recovery Teams (ARTs) for service planning activities. Behavioral Health Case Managers facilitate CFTs and ARTs and maintain active and ongoing communication with Probation and Parole Officers. Behavioral Health Individual Service Plans (ISPs) are designed to incorporate goals included in probation and parole plans and reviewed and updated at CFTs and ARTs attended by probation and parole officers.

To address difficulties in receiving services after incarceration due to disenrollment, one county in Arizona has established an Intergovernmental Agreement (IGA) to allow an individual to become covered on the day they are released from the detention center. The Pima County and Arizona Health Care Cost Containment System (AHCCCS) IGA has established a process where a person's AHCCCS eligibility is "suspended" during any period that they are incarcerated in the Pima County Adult Detention Center (PCADC). The IGA allows an individual's AHCCCS enrollment to be reinstated on the day the person is released from the PCADC. To work on this problem throughout the rest of the state, in May 2011, Arizona Behavioral Health Planning Council composed and distributed letters to each county describing the issue, Pima County's IGA and the benefits of this agreement. ADHS/DBHS will continue to work with the counties to encourage collaboration to reduce lapse in coverage when individuals are released from incarceration.

In order to increase capacity of personnel working with individuals with behavioral health issues involved in the system, RBHAs provide regular cross trainings for their local courts on the behavioral health system including the CFT process, medical necessity determination for out-of-home placement and other behavioral health topics requested by the courts in their coordination meetings. In addition, the Juvenile Detention Alternatives Initiatives (JDAI) has facilitated cross-system training and collaboration, most recently around the issues specific to Trauma Informed Care.

## IV: Narrative Plan

### J. Parity Education

Narrative Question:

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SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

With the implementation of Health Care Reform and the gradual transition toward integrated physical and behavioral health care in Arizona for select populations, the Arizona Department of Health Services is currently looking at various mechanisms for communicating awareness about Mental Health Parity. To begin, ADHS will add parity education to its annual communications plan beginning in FFY 2014. The Plan will include dissemination of parity requirements via social media, the agency web site and the *Recovery Works* newsletter.<sup>1</sup>

The Office of Prevention has created and disseminated a decision tree for health care providers containing health care parity information as well as referral information from multiple systems, including the Veterans' Administration and Indian Health Services. The decision trees have been disseminated across various sectors for health care providers. Additionally, ADHS is working with the Arizona Coalition for Military Families in rolling out its system navigator program across the state. These system navigators will have in-depth knowledge pertaining to health benefits from multiple sectors for service members, veterans, and their family members.

The Division of Communications is responsible for oversight of providing information and education to the public as well as tracking communication activities supported by the Division of Behavioral Health Services. In order to achieve this, DBHS has created a comprehensive work plan with ongoing, monthly, and annual events. Through conferences, printed material, electronic communications and social media, DBHS ensures that a broad audience is reached and that the messages directed at increasing awareness about physical and mental health services available as well as general information to further the mission of ADHS/DBHS *Health and Wellness for all Arizonans*. The information presented crosses over the entire population.

The Arizona Department of Health Services, Division of Behavioral Health Services has developed an annual work plan to promote health services within the community. The following four objectives drive the plan and provide a foundation for the annual goals.

- **Objective 1:** To support DBHS' role as the Mental Health Authority for the State of Arizona (respond to, promote, and educate Arizonans about behavioral health issues and mental health).
- **Objective 2:** To promote the importance of mental health as part of physical health and vice versa.
- **Objective 3:** To decrease stigma associated with mental illness.
- **Objective 4:** To support DBHS' role as administrator of Arizona's Public Behavioral Health System (engage stakeholders; conduct outreach, education and/or promotion of behavioral/physical health topics relevant to the stakeholder).

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<sup>1</sup> Please see <http://www.azdhs.gov/bhs/com.htm>. In addition, steps regarding education of the community regarding parity will be added to the 2014-2015 System of Care Plans.

## IV: Narrative Plan

### K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

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Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
  - a. heart disease,
  - b. hypertension,
  - c. high cholesterol, and/or
  - d. diabetes.

Footnotes:

The Arizona Department of Health Services/Divisions of Behavioral Health Services (ADHS/DBHS), Public Health Services, Licensing Services, as well as the Arizona State Hospital, recognize the interconnectivity of an individual's physical health and behavioral health and the importance to assist and promote whole body healthcare for all Arizonans. ADHS has supported integrated healthcare through various activities including educating healthcare providers, policy makers and the community as well as addressing systemic barriers to integration.<sup>1</sup>

In order to expand integrated healthcare efforts in Arizona, the ADHS strategic plan addresses a number of current and future integration activities that can be achieved through collaboration within the Department, external partnerships, and stakeholders.

### **Addressing Systemic Barriers to Integration**

**Behavioral Licensing Rulemaking:** The Division of Licensing Services is working to streamline the licensing process for proposed integrated health programs by evaluating issues with the current behavioral licensing rules that inhibit integration as well as how licensing rules could be modified to properly address these issues.

### **Educating Healthcare Providers, Policy Makers, and the Community**

**Moving Forward: Implementing Integrated Models of Care in AZ:** This 1.5 day forum took place on August 23-24, 2012 at The Mercado at Arizona State University, Downtown Phoenix campus. Approximately 130 primary care and behavioral health care providers and policymakers gathered to share successful models for integrated behavioral health services that are being implemented in Arizona and nationally. Panelists included leaders from within Arizona and from the national level who are knowledgeable about integrated behavioral health initiatives. One of the goals of this invite-only event was to identify and develop strategies to replicate some of those successful models in Arizona's own healthcare settings, or adapt them for our providers' particular needs. View slides from the various topics presented.<sup>2</sup>

### **No Health without Mental Health**

A poster presentation for the Arizona Public Health Association Conference in 2011 to show why behavioral health is a public health issue and how focusing on behavioral health, leading to whole body healthcare, aligns with the goal of public health to protect and improve the health of communities through education and promotion of healthy lifestyles. This poster presentation is also an opportunity to discuss ADHS/DBHS' role in promoting whole body healthcare.

### **Arizona Integrated Models of Care in Behavioral Health and Primary Care Forum**

Sponsored by the Milbank Memorial Foundation, the Forum provided a series of presentations with strategies to address the unmet physical and behavioral health needs of individuals. Various national and local models of integration, lessons learned, and challenges for the future were presented and discussed. A report was produced discussing research, practice, and potential: The Arizona Integrated Models of Care Forum 2011.<sup>3</sup>

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<sup>1</sup> [http://www.azdhs.gov/diro/admin\\_rules/behavioralhealth.htm](http://www.azdhs.gov/diro/admin_rules/behavioralhealth.htm)

<sup>2</sup> <http://www.azdhs.gov/diro/integrated/forums/2012.htm>

<sup>3</sup> <http://www.azdhs.gov/diro/documents/integration/AZIntegratedModelsOfCareForum2011.pdf>

### **Quarterly Health Initiatives**

Each quarter, ADHS/DBHS partners with a physical health content expert as well as the Tribal and Regional Behavioral Health Authorities (T/RBHAs) to introduce particular health topics of concern to individuals receiving behavioral health services. A "kit" for each topic is developed and includes a member handout, a provider handout, and a webinar. All kit materials are archived and available for use at any time.<sup>4</sup>

### **Traumatic Brain Injury (TBI) E-learning**

ADHS/DBHS will soon offer the opportunity for 12 hours of credited education to behavioral health practitioners (Medical, Clinical, Case Management staff) to learn about TBI assessment, screening, diagnosing and related topics. Referral pathways are being created between the behavioral health system and the acute care health plans to address the needs of individuals diagnosed with TBI.

### **Emergency Departments (EDs) Initiative**

In the summer of 2010, ADHS/DBHS launched an initiative to partner with hospital emergency departments (ED) throughout Arizona to educate their staff on various behavioral health topics. The goal of the initiative is to provide proper interventions and referrals to treatment, recovery and other support services to all Arizonans who present to EDs for help with behavioral health disorders. ADHS/DBHS initiated an online, interactive training specifically for ED doctors and nurses designed to conduct substance abuse screening and suicide assessments for those presenting in the ED.

### **Whole Health Peer Based Programs**

ADHS/DBHS spearheaded two whole-health peer-based initiatives to offer whole health services to members in Maricopa and Pima counties. Both initiatives consisted primarily of education and peer-based support teaching members topics such as nutrition, exercise, healthy habits, and many others. Members in both initiatives were monitored during the pilot phase for their progress and changes in several health metrics including weight, blood pressure, glucose levels, and others. This initiative was funded through a Transformation Transfer Initiative grant from SAMHSA and NASHMPD. The grant funding "pilot" period ended in March 2011 and produced a summary report with more details about both programs. Both programs were successfully established and tested during the pilot period and have continued to grow and become sustainable through other funding sources.<sup>5</sup>

### **Demonstration Project**

As mentioned earlier, the new Demonstration will facilitate service delivery through pre-established provider networks and payment arrangements. The Demonstration affects coverage for certain specified mandatory State plan eligible individuals by requiring enrollment in coordinated, cost effective, health care delivery systems. In this way, the Demonstration will test the use of managed care entities to provide cost effective care coordination, including two pilot projects that will test the effect of integrating behavioral and physical health services for two populations – individuals residing in Maricopa county with serious mental illness and children participating in the Children's Rehabilitative Services program. The Demonstration also provides coverage to limited groups the State does not currently cover under its Medicaid State plan, including adults without dependent children, and a limited number of children with incomes above the levels under the Medicaid State plan and at or below 175 percent of the FPL, which will show the benefits of such coverage using these approaches to a wider population. In

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<sup>4</sup> <http://www.azdhs.gov/bhs/qhi/>

<sup>5</sup> [http://www.azdhs.gov/diro/documents/integration/Arizona\\_TTIFinalReport2011.pdf](http://www.azdhs.gov/diro/documents/integration/Arizona_TTIFinalReport2011.pdf)

addition, the Demonstration will provide for payments to IHS and tribal 638 facilities to address the fiscal burden of uncompensated care for services provided in or by such facilities to individuals with income up to 100 percent of the FPL. This authority will enable the State to evaluate how this approach impacts the financial viability of IHS and 638 facilities and ensures the continued availability of a robust health care delivery network for current and future Medicaid beneficiaries.

Finally, the Demonstration will allow the State to also test the effects of increasing personal financial responsibility on utilization and health outcomes on some populations by permitting cost sharing. Specifically, the Demonstration will test the effects of the imposition of mandatory co-payments on adults without dependent children in the following areas:

- Utilization of needed preventive, primary care, and treatment services;
- Appropriate utilization of emergency room care, and appropriate, cost and clinically effective use of generic and brand name drugs;
- State and Federal expenditures (per enrollee) in the short and long term; and
- Physician participation, including physician willingness to accept appointments from the adults without dependent children population.

## IV: Narrative Plan

### L. Health Disparities

#### Narrative Question:

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In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

ADHS/DBHS utilizes various reports to track, monitor and assist in analysis of needs, including the Cultural Competency and Workforce Development Quarterly Report and the Annual Diversity Report. Access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age are tracked through various methods of data collection and community collaboration.

The *Cultural Competency and Workforce Development Quarterly Report* analyzes efforts impacting diverse communities and assists in monitoring of initiatives and deliverables throughout the year. Using a report template provided by ADHS/DBHS, which includes data and analysis specific to their region, T/RBHAs submit reports to the ADHS/DBHS within categories defined by the Cultural Competency Work Plan Initiatives section: Education and Training, Collaborative Partnerships with Community-Based Organizations, System Health Integration, Communication/Marketing and Outreach, Data Collection and Report Production, and Policies, Procedures and Regulations. Information reported connects data to initiatives and activities occurring within specific geographic service regions. In addition, data is provided within categories of race, ethnicity and age groups; providing insight into areas working both effectively and ineffectively. The reports are then reviewed and utilized by the Cultural Competency Committees to assist in the development and implementation of cultural and linguistically appropriate services.

*The Annual Diversity Report* is a comprehensive analysis of the racial and ethnic populations served by ADHS/DBHS. Information is pulled from the Client Information System (CIS) with a focus on demographic, programmatic, and service utilization. The information allows the ADHS/DBHS and its contractors the ability to explore the diversity of the population receiving services, while providing the opportunity to initiate further discussions on the importance of race, ethnicity, gender culture, and socio-economic influences as vital elements in the provision of services, and how to provide culturally and linguistically effective care for diverse cultural and racial groups. Furthermore, ADHS/DBHS is developing a four-year analysis report of the Annual Diversity Report.

The Culturally Linguistically Appropriate Services (CLAS) standards were established to correct inequities that currently exist in the provision of health and social services and to be more responsive to the individual needs of all members, particularly the language needs of disparity-vulnerable subpopulations. In an effort to proactively incorporate all fourteen (14) CLAS Standards, four (4) of which are currently required, ADHS/DBHS has continued to develop a cultural competency plan inclusive of Language Access Services (LAS), Cultural Competent Care and Organizational Supports as outlined in the framework mandates, guidelines and recommendations of CLAS Standards.

In addition, ADHS/DBHS utilizes the *Semi-Annual Language Services Report* that captures linguistic needs, including the following: primary language, Deaf and Hard of Hearing, sign language services, interpretive services, translation services, traditional healing services, and mental health services and provides comprehensive lists of translator and interpreter language abilities and unit usage. The report is produced on a semi-annual basis by the T/RBHAs, and a workgroup tracks and trends the information throughout the year to assist with planning of activities based on need.

ADHS/DBHS has a Language Access Workgroup to identify areas of unmet needs and provide summary analyses to findings to leadership. The workgroup includes the ADHS/DBHS collaborative efforts of Audit and Evaluation, Business Information Systems, Compliance, Finance, Quality Management and Workforce Development who provide continued monitoring of culturally and linguistically relevant services in the areas of language access services, member complaints, member grievances, network, and

consumer satisfaction. The committee identifies needs/gaps specific to cultural and linguistic needs and make recommendations for resolution.

Culture, stigma, geographic service areas, and society play pivotal roles in accessing mental health, mental illness, and behavioral health services. Understanding the wide-ranging roles of culture and society enables the mental health field to design and deliver services that are more responsive to the needs of underserved and underrepresented. Utilizing reports such as the aforementioned, ADHS/DBHS has determined disparities and/or gaps still exist with regard to the inclusion of: tradition, cultural beliefs, diverse cultures, race, ethnicity, language needs, age, sex (gender), gender identity, sexual orientation, and socio-economic factors as vital elements involved in the quality of care and the effectiveness of services provided. For this reason, ADHS/DBHS continues to develop a comprehensive service structure designed to address the needs of Arizona's richly diverse and multicultural population including: racial and ethnic minorities, persons with disabilities, various age groups, LGBTQ populations and other underserved and underrepresented populations with a focus on data driven outcomes and targeted initiatives to promote comprehensive, inclusive and high quality services for all individuals accessing and/or receiving services within Arizona's geographic regions.

ADHS/DBHS has created a data driven and outcome based Cultural Competency Plan (CCP) to address disparities in access, services use and outcomes for identified disparity-vulnerable subpopulations. The CCP is a comprehensive document which includes: Centers for Medicare and Medicaid Services (CMS) requirements, Arizona Health Care Cost Containment System (AHCCCS) contract requirements, AHCCCS Policy requirements, AHCCCS Corrective Action Plan requirements, Grant requirements, Culturally and Linguistically Appropriate Services (CLAS) and Limited English Proficiency (LEP) standards. In addition, the Tribal/Regional Behavioral Health Authorities (T/RBHAs) are contractually required to create, implement and monitor a cultural competency plan detailing how culturally and linguistically appropriate services are delivered as outlined in the ADHS/DBHS Cultural Competency Policies and Plans.

Implementing a system-wide cultural competency plan, in a complex service delivery structure such as, Arizona, requires effective oversight, monitoring and analysis processes. For this reason, ADHS/DBHS reviews multiple data feeds on a recurring basis, conducts extensive demographic and service utilization reviews, and publishes various reports detailing system performance. As a result, the Cultural Competency Plan (CCP) is a "living" document consisting of three components: Narrative Report, Work Plan Requirements Guide and Work Plan Initiatives. The CCP was developed with input of national level standards, contract requirements, stakeholder input and experts in cultural competency. Modifications are made to the CCP throughout the year as projects/activities are completed, gaps are analyzed and needs are identified.

The *Annual Effectiveness Review of the Cultural Competency Plan Report* provides insight to the strengths, gaps and needs of cultural competency service implementation. The primary focus is to address areas identified as a gap and/or need in the previous year's plan and assists in developing the upcoming cultural competency plan. The report assists in the monitoring of the T/RBHAs' goals as attainable and accomplished with an understanding of their geographical service area. A focus on data and measurable outcomes is imperative in understanding what drives a system and in providing culturally relevant services to persons accessing the behavioral healthcare system.

The overall goal of cultural competency is to continue to develop and enhance the provision of culturally relevant services to all members accessing and receiving behavioral health services across Arizona, for these reasons the Block Grant funds are essential in the continuation of and improvement of mechanisms to develop, implement, monitor, and track a comprehensive cultural competency structure. Funds assist and support the behavioral healthcare system to continue developing, maintaining and monitoring for cultural competence, CLAS standards, LEP and special populations inclusion. This ensures cultural relevance and increases cultural awareness, for population categories such as: Blind and Visually Impaired, Deaf and Hard of Hearing, Ethnicity, Gender Identity, LGBTQ (Lesbian, Gay, Bisexual, Transgender, and/or Questioning), Military, Race, Sensory/Cognitive/Physical Disabilities, Sex (Gender), Sexual Orientation, Tribal Nations and Various Age Groups. Workgroups successfully continue to develop, maintain and monitor trainings, curriculums, systemic needs specifically in the areas of cultural competency. In addition, DBHS will continue to monitor, tracking and reporting updates to include modifications, additions, deletions and/or content analysis with current national trends, adult learning principals, continuing education criteria, and professional development opportunities related to underrepresented/underserved populations.

## IV: Narrative Plan

### M. Recovery

#### Narrative Question:

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SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

### Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

### Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system. In completing this response, state should consider the following questions:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

### Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

The Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS) endorses a comprehensive, person/family supportive, and recovery oriented system of care for people in need of publicly funded behavioral health treatment. To ensure this vision of recovery is achieved in a manner that promotes a *good and modern* mental health and addiction system, DBHS maintains a firm commitment to increasing access to care and reducing barriers to treatment; collaborating with the greater community; cultural competency; effective innovation and program evaluation, and; emphasizing consumer and family involvement in an individual's treatment program.

Under the direction of the Chief Medical Officer and Deputy Director, DBHS has published several clinical practice protocols, based on best practices, to assist behavioral health providers in increasing the use of peer and family involvement. The Clinical and Recovery Practice Protocol, "Peer Workers/Recovery Support Specialists within Behavioral Health Agencies" was developed to provide guidance to behavioral health agencies in implementing peer worker/recovery support services within their organizations, and to enhance the effectiveness of mental health and substance use disorder services through the expansion of peer-delivered services. Likewise, Family & Youth Involvement in the Children's Behavioral Health System of Care clinical and practice protocol does the same for family and youth/young adult employee and volunteer roles in the Children's System of Care.

The ADHS/DBHS Office of Individual and Family Affairs (OIFA) was created in 2006 to advance empowerment of individuals, family members and youth in the recovery process and to ensure that their voice is heard and included in all major decisions pertaining to Arizona's behavioral health systems of care. OIFA ensures that individuals, family members and youth are equal partners at all levels in initiating and sustaining improvements in Arizona's behavioral health system, and provides information, education and support for children, youth, families, adults and older adults who are challenged by mental illness or substance use. Peers and family members now actively participate on committees and other initiatives including the Adult and Children's System of Care development, Systems Transformation, Stigma Reduction, Trauma-Informed Care, and Health Care Integration.

In addition, each RBHA has established an Individual and Family Affairs unit (IFA) to further ensure that behavioral health recipients are involved in all levels of the system. The RBHA IFAs' mission is to educate members and their families to better advocate for needed services; to recruit a diverse group of members, youth and family members to participate in decision making at the RBHA and provider levels; and to ensure that their participation is meaningful and has impact on the decisions made. This is accomplished by building partnerships with individuals, families and youth to promote recovery, resiliency and wellness. It is important to increase the individual and family voice in areas of leadership and service delivery. Additional important tasks are to partner with individuals and families to identify and remove barriers to service and educate the behavioral health workforce on the practices and benefits of peer/family involvement in service planning, service delivery and system transformation.

The RBHAs have consistently provided training and support to adult peer and family mentors across the state. Magellan's Recovery and Resiliency team initiated the startup of the Clinic Advisory Councils at each clinic in its system to serve as a place where the clinical staff, service recipients, administration, family members and community members meet monthly to discuss and make decisions as to what is working and where improvements can be made. The Clinic Advisory Councils were developed to ensure the voice of the consumer was heard.

OIFA and the IFAs work closely with peer/family run organizations throughout Arizona to develop strategies and collaborate on recovery/wrap-around projects, including transition age youth and family and peer involvement in the behavioral health system. ADHS/DBHS contracts with some peer and family run organizations for specific projects, such as NAMI Arizona, Recovery Innovations of Arizona and the Family Involvement Center.

Peer and family support partners/specialists assist service recipients and their family members in understanding the service planning process and their responsibilities in developing a service plan that meets their needs. Additionally, Warm Lines staffed by peers and family members provide reminders that the service recipient should take ownership of their treatment and can connect callers to natural supports within their own communities. Furthermore, peer/family organizations provide workshops and groups on self-determination, self-advocacy, WRAP planning and leadership development programs.

Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including: peer support; recovery support coaching; recovery support center services; supports for self-directed care; peer navigators; and other recovery supports and services (e.g., warm-lines, recovery housing, consumer/family education, supported employment, peer-based crisis services, respite care, etc.). ADHS/DBHS spearheaded two whole health peer-based initiatives to offer whole health services to members in Maricopa and Pima counties. Both initiatives consisted primarily of education and peer based support, teaching topics such as nutrition, exercise, healthy habits, and many others. Pilot participants were measured at the beginning of the program and routinely to monitor weight loss, lifestyle changes, body mass index, blood pressure, etc. Members are also encouraged to communicate/ask questions to their PCPs regarding the health topics they are learning about and the lifestyle changes they are experiencing or committing to make. This initiative was funded through a Transformation Transfer Initiative grant from SAMHSA and NASMHPD. The grant funding pilot period ended in March 2011, but both programs have continued to grow and become sustainable through other funding sources. There is also a peer-based whole health program in Pinal County.

Furthermore, ADHS/DBHS implemented its Quarterly Health Initiative (QHI), a program to educate consumers and providers on particular physical health topics affecting the behavioral health population. Through "QHI Kit" materials, consumers are prompted to ask health related questions to their behavioral health provider during their next visit. The QHI Kit materials, at the same time, provide behavioral health providers education to answer health related questions asked by the consumer and/or provider appropriate material referral to a specialist or PCP.

The Arizona Peer and Family Coalition, created in 2010, is comprised of peers and family members who advocate for full inclusion and participation in the decision-making processes at the state level. Members of the Coalition have teamed with OIFA to travel around the state and introduce the Coalition to rural communities. These trips to places such as Payson, Flagstaff, Sierra Vista and Yuma have been well received, because it allows the participants to see ADHS/DBHS and the Coalition as being proactive in hearing what successes and shortcomings people experience in these rural and remote areas. The Arizona Peer & Family Coalition is collaborating with the Office of Individual and Family Affairs to develop an orientation for volunteer peers and family members that will cover learning about the structure of our behavioral health system, how it is funded, its covered services through the T/RBHAs, how the funding flows, along with how to be an effective committee, council or board member. Upon successful completion of the orientation, peers and family members will be placed on internal decision-making ADHS/DBHS and T/RBHA committees, councils, and boards.

OIFA promotes trainings and conferences that are offered throughout the state on cultural competence, recovery, advocacy, stigma reduction, etc. for peers and family members as well as behavioral health professionals on a weekly basis through its list serve, on its Arizona Happenings Events online calendar and in the DBHS Recovery Works newsletter. OIFA also hosts national webinars and invites community members and behavioral health workers to join us for viewing the webinar and discussion afterwards.

In order to deliver peer services within licensed behavioral health agencies in Arizona, peer workers must meet the minimum staffing requirement as a behavioral health paraprofessional. Peer workers that meet the paraprofessional requirements may work in any position for which they are qualified within the organization. In addition, peer employees hired by a certified Community Service Agency (CSA) must also meet minimum staffing requirements for paraprofessionals within licensed behavioral health agencies, as defined in Arizona Administrative Code to deliver supportive services identified on a treatment plan.

ADHS/DBHS supports a model for assessment, service planning, and service delivery that is strength-based, family friendly, culturally sensitive and clinically sound and supervised. The model is based on three equally important components: input from the person and family/significant others regarding their special needs, strengths and preferences; input from other individuals who have integral relationships with the person; and clinical expertise.

The model incorporates the concept of a “team”, established for each person receiving behavioral health services. At a minimum, the team consists of the person, family members in the case of children, and a qualified behavioral health clinician. As applicable, the team would also include representatives from other state agencies, clergy, other relevant practitioners involved with the person and any other individuals requested by the person. In addition, the model is based on a set of clinical, operative and administrative functions, which can be performed by any member of the team, as appropriate. At a minimum, these include:

- An initial assessment process performed to elicit strengths, needs and goals of the individual person and his/her family, identify the need for further or specialty evaluations that support development of a service plan which effectively meets the person’s needs and results in improved health outcomes;
- Ongoing engagement of the person, family and others who are significant in meeting the behavioral health needs of the person, including active participation in the decision-making process;
- Continuous evaluation of the effectiveness of treatment through the ongoing assessment of the person and input from the person and his/her team resulting in modification to the service plan, if necessary;
- Provision of all covered services as identified on the service plan that are clinically sound, including referral to community resources as appropriate and, for children, services which are provided consistent with the Arizona vision and principles;
- Ongoing collaboration, including the communication of appropriate clinical information, with other individuals and/or entities with whom delivery and coordination of covered services is important to achieving positive outcomes, (e.g., primary care providers, school, child welfare, juvenile or adult probations, other involved service providers), and;
- Development and implementation of transition plans prior to discontinuation of behavioral health services.

In addition to the recent economic crisis, a long-standing class action lawsuit, *Arnold vs. Sarn*, which focused specifically on care for adults with an SMI, was placed “on stay” through June of 2012 and all parties involved were instructed to agree on a more outcome-oriented manner of assessing treatment effectiveness.

The first and most important step was to include peers and family members in the process of evaluating and developing improvements to the system, and ascertain what services peers and family members felt were needed from the behavioral system. ADHS/DBHS began its work in FY 2011 by forming a DBHS System Transformation Work Group in which peers and family members are actively involved. Working from existing court orders and related documents, the workgroup developed a list of questions to gather peer and family member opinion. Furthermore, ADHS/DBHS has moved toward the SAMHSA model used in the Evidence-Based Practices Kit series, including Permanent Supported Housing. This toolkit will be mandatory for the Maricopa County RBHA, and strongly recommended for the additional three RBHAs. ADHS/DBHS is in the initial stage of evaluating how the Maricopa County RBHA will report on the fidelity tool.

In collaboration with peers/families, the Raise Your Voice Project was created utilizing the Community Based Participatory Research (CBPR) – a recognized evidenced-based practice. Peers and family members were trained and facilitated 26 statewide peer and family focus groups where 370 participants decided what recovery meant to them; what services were most important; when, where and how they wanted services to be delivered; and how they expected behavioral health staff to respond to their needs. This qualitative data was then entered, verbatim, by peers and family members and then categorized and trended with SPSS Text Analysis software. Analysis of the data revealed eight consistent themes for Arizona’s behavioral health system: individualized care, supportive services, peer support services, community-based resources, living arrangements, transportation, crisis services and integrated health services. The workgroup compiled a written and statistical report on the findings of this project which has been made available statewide in July 2011. ADHS/DBHS will use the information and recommendations from the Raise Your Voice Project to make improvements, wherever possible.

ADHS/DBHS sponsored the “Peer and Family Driven Conference”, also called “Respect is Free: Peers and Family Members Joining Together to Promote Diversity and Build Community” in August 2012. The conference’s purpose was to train behavioral health service recipients and their family members; to become educated and empowered, and network with each other. It is essential that this population gain optimal benefit from the changes coming to the Maricopa County behavioral health system in 2013, and to the overall health care system in 2014 with the Affordable Health Care Act.

The changes that are anticipated in behavioral health in the next two years can be viewed as a threat to peers and family members, but these changes can also be viewed as an opportunity. The two-day training provided an opportunity to empower individuals who receive services and their family members, in order to make positive changes for themselves, the behavioral health system, and the community as a whole. Special emphasis was placed on outreach to minority populations, including women, African Americans, Latinos, Native Americans, the lesbian, bisexual, gay, transgender and questioning population (LBGTQ); and transition age youth.

Dr. Laura Nelson, former ADHS/DBHS Deputy Director, opened the conference and welcomed over 250 individuals from across the state. There were 25 workshops, geared to the interests of persons working in the adult or children’s system as Peer Support Specialists and as Family Support Partners, as well as sessions for persons who receive behavioral health services. Many networking opportunities were

offered as well. Topics included Trauma Informed Care; Resiliency Skills for Reducing Compassion Fatigue; Medication and Healthy Lifestyles, Peers and Family Members Taking the Lead; Leadership training, and the Impact of the Affordable Care Act. There was also a panel discussion comprised of family members and peers who shared their stories of struggling and succeeding through the system to get care for their children. The conference reflected the priority that ADHS/DBHS places on peers and family members as partners in achieving the most recovery and resiliency oriented behavioral health system possible.

In fiscal year 2011 ADHS/DBHS developed Guiding Principles for the adult behavioral health system, which are designed to provide a shared understanding of the key ingredients needed for promoting recovery in the adult behavioral health system. System development efforts, programs, service provision, and stakeholder collaboration are guided by these principles. The principles are also used to guide the State's decision making process and interactions.

The Guiding Principles were influenced by the SAMHSA Consensus Statement, the U.S. Psychiatric Rehabilitation Association Core Principles, ADHS/DBHS Vision Statement, Arizona's Five Principles for Person Centered Treatment Planning, and Arizona's 12 Principles for Children's Behavioral Health Care. Peer-run agencies and RBHAs in all regions of the state held focus groups with peers to dialogue around the needed ingredients for a recovery oriented system and to seek input in the development of the principles. The Statewide Family Committee also provided feedback and input. A particular emphasis was placed on ensuring that the principles correlated with and complemented the 12 Principles for Children's Behavioral Health Care. The Arizona Behavioral Health Planning Council and its Community Advisory Committee took the lead in gathering all input; the Committee hosted additional input and discussion sessions over the course of a year, opening the sessions up to all individuals and family members from around the state.

The following Nine Guiding Principles and narratives were crafted and agreed upon as the foundation of Arizona's adult behavioral health system:

1. Respect
2. Persons in recovery choose services and are included in program decisions and program development efforts
3. Focus on individual as a whole person, while including and/or developing natural supports
4. Empower individuals taking steps towards independence and allowing risk taking without fear of failure
5. Integration, collaboration, and participation with the community of one's choice
6. Partnership between individuals, staff, and family members/natural supports for shared decision making with a foundation of trust
7. Persons in recovery define their own success
8. Strengths-based, flexible, responsive services reflective of an individual's cultural preferences
9. Hope is the foundation for the journey towards recovery

Finally, the State's plan includes peer-delivered services designed to meet the needs of specific populations, as follows:

### **LGBTQ Communities**

#### LGBTQ Advisory Committee

ADHS has an LGBTQ advisory committee composed of experts in the LGBTQ community and members of the community. This group assists ADHS in developing services for LGBTQ populations

#### Arizona Institutions of Higher Education Network

Arizona has a subcontract with the University of Arizona which in turn subcontracts to Arizona State University and Northern Arizona University for establishment of substance abuse prevention programs targeting LGBTQ youth. Strategies for this program include peer support groups for LGBTQ students.

#### Sources of Strength

DBHS provides funds for substance abuse prevention programs targeting high school youth who are LGBTQ. These programs use peer education and leadership strategies.

#### Maricopa LGBTQ Consortium

Arizona provides SAPT funds to support the Maricopa LGBTQ Consortium. This consortium of LGBTQ community members and advocates is concerned with reducing alcohol abuse in the LGBTQ community. They have launched a responsible beverage service training targeted for lesbian and gay bars.

### **Latino Communities**

#### Comunidades Saludables (Scottsdale Prevention Institute)

The purpose of this program is to change community behaviors and norms that favor underage drinking in the South Scottsdale Hispanic Community. This program includes the use of promotoras (community lay health workers) to provide peer support and education related to parenting.

#### MANO (Chicanos Por La Causa)

The MANO coalition strives towards creating community level change to reduce accessibility of alcohol for youth in the Creighton, Coronado, and Garfield Communities. This program includes a peer leadership component.

#### COPE Coalition (Terros and Touchstone)

The Community Outreach Prevention Education (C.O.P.E.) coalition serves the Maryvale area of Phoenix. The purpose of this project is to reduce accessibility and availability of alcohol to Hispanic youth under the age of 21. This program includes peer support and leadership.

### **African American Community**

#### TCDC Community Consortium (Tanner Community Development Corporation and Worthy Institute)

The purpose of this project is to prevent substance abuse disorders in Maricopa County African American Communities. The TCDC Community Consortium is a coalition designed to identify and respond to substance abuse and suicide related issues in the African American community. This coalition uses youth to educate other youth about substance abuse.

### **Disability Community**

#### Living Well With Disability (Valley of the Sun YMCA)

The purpose of this program is to build capacity within "disability community" of Maricopa County to change social norms and behaviors that: tolerate, enable and/or actively promote self-medicating with prescription pain killers and/or behavioral health medications, compounded by alcohol. The project emphasis is on adults with physical disabilities, including veterans. The program includes peer-run support groups.

### **Native American Communities**

#### Maricopa County Urban Indian Coalition (Phoenix Indian Center)

The Maricopa County Urban Indian Coalition focuses on substance abuse prevention in urban Native American communities. This coalition uses youth in peer education activities.

#### Guadalupe Centered Spirit Coalition (Pascua Yaqui Tribe)

The goals of this project are prevention of alcohol abuse. This coalition includes youth leaders in project activities.

### **Older Adult Communities**

#### Senior Peer Program (West Yavapai Guidance Clinic)

The Senior Peer Program provides support and education to senior's age 55+ living in Prescott, Prescott Valley and Chino Valley based on a scientifically proven model of peers supporting peers. The major goal of the program is to detect and reduce the severity of depressive symptoms while helping seniors maintain a healthy emotional life. To accomplish this goal the prevention program incorporates proven methods including screening and assessment of depressive symptoms, one-on-one home visits, support groups, community education and training on issues affecting seniors (suicide, prescription drug use/abuse, grief, depression, gambling, etc.). The program offers a home-based prevention program where trained senior volunteers provide services in the privacy and familiarity of the participants' own surroundings.

#### TRIAD (Pinal Gila Council for Senior Citizens)

This program provides education and presentations to Volunteers, faith-based organizations, community professionals and community leaders on topics of substance and prescription medication use and misuse and education on depression and isolation in older adults. Program staff participate in local TRIADS which is a co-operated project composed of seniors to provide additional information and available resources to older adults in order to help improve their quality of life and safety.

### **Military and Veterans**

#### Coalition of Military Families

ADHS is a member of the coalition of military families. This coalition of family members of military and veterans is concerned with reduction of substance abuse and suicide among military and veterans.

## IV: Narrative Plan

### N.1. Evidence Based Prevention and Treatment Approaches for the SABG

#### Narrative Question:

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As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

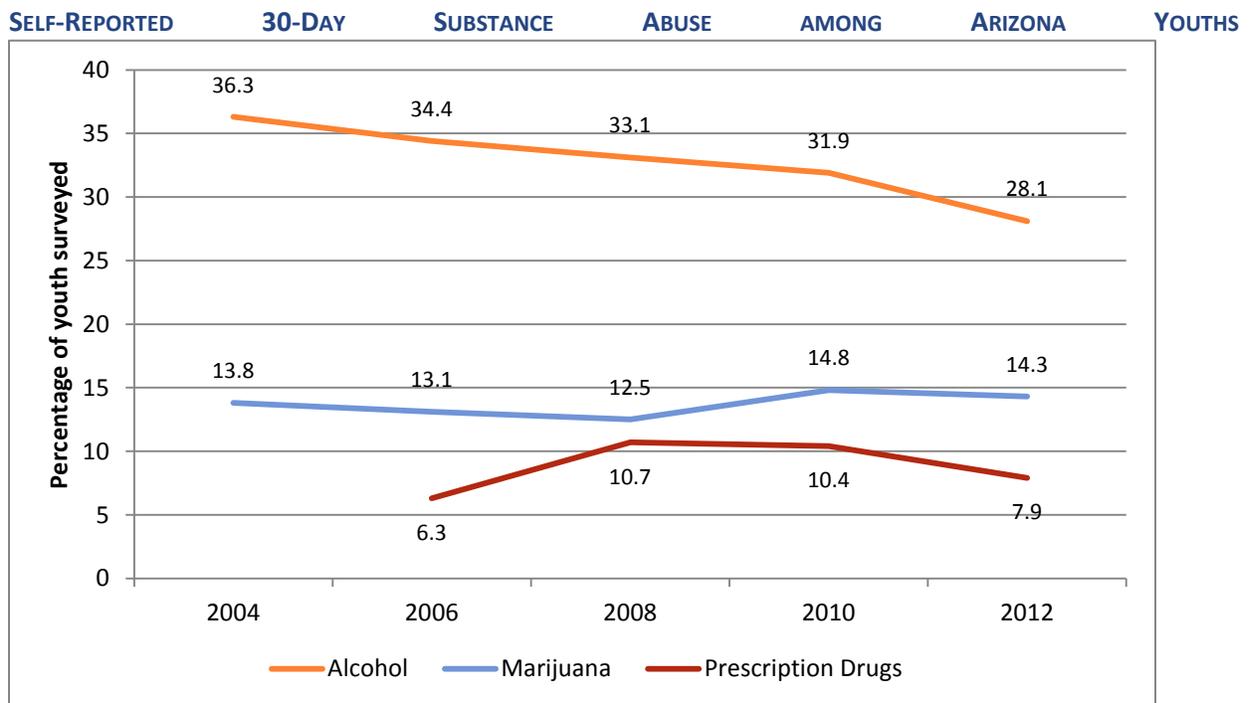
1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
5. How is the state's budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

#### Footnotes:

**1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources, etc.)?**

To establish priority targets for Arizona, ADHS/DBHS reviewed needs assessment data from the Statewide Epidemiology Outcomes Workgroup (SEOW). Prevalence and severity of consequences indicate underage drinking, prescription drug abuse, and marijuana should be Arizona’s highest prevention priorities.

As shown in the figure below, rates of 30 day use of alcohol among Arizona 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> grade students have been steadily decreasing, while rates of both 30 day prescription drug abuse and 30 day marijuana abuse have increased (Arizona Criminal Justice Commission, 2012).



Source: (Arizona Criminal Justice Commission, 2012)

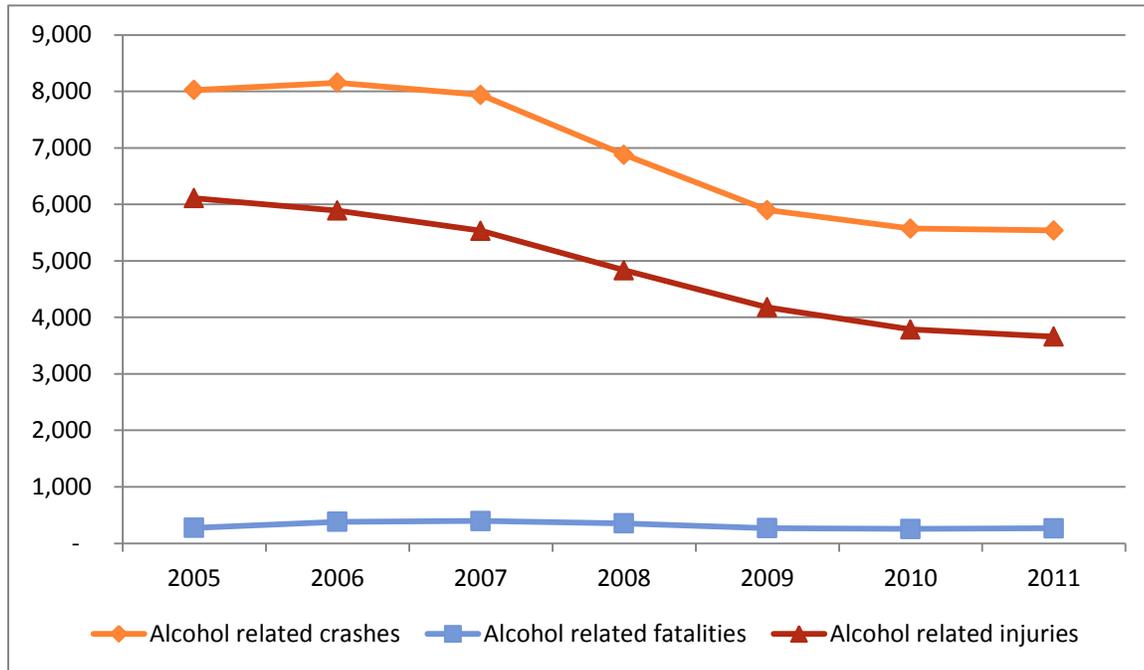
**a) Underage Drinking**

In 2005, the Statewide Epidemiological Workgroup published Arizona’s first epidemiological profile of substance abuse statewide. This study concluded that alcohol is the most prevalent and costly substance of abuse in Arizona (Epidemiology Work Group, 2005). As a result of this study, Arizona established objectives for the reduction of underage drinking prevalence. Arizona’s strategy for long term reduction of alcohol abuse and associated consequences targeted prevention of underage drinking, since onset of regular use in childhood is associated with higher rates of addiction in adulthood (Grant & Dawson, 1997).

Current epidemiology continues to show that alcohol abuse continues to contribute to high demand for treatment, impaired driving, poisoning deaths, juvenile arrests, injuries, and assaults in Arizona (Bach

Harrison, 2010; Mrela & Torres, 2011; Arizona Criminal Justice Commission, 2012; Arizona Department of Health Services, 2012). As use of alcohol among Arizona’s youth has declined, so have some of the consequences associated with abuse of alcohol. As an example, the figure below demonstrates the decreasing trends in numbers of alcohol related car crashes, fatalities, and injuries (Arizona Department of Transportation, 2007).

**TRENDS IN THE NUMBER OF ALCOHOL RELATED CRASHES, FATALITIES, AND INJURIES IN ARIZONA 2005 TO 2011**



Sources: (Arizona Department of Transportation, 2007) (Arizona Department of Transportation, 2011)

Prevention of underage drinking remains a priority for Arizona because the consequences of underage drinking continue to burden the economy. According to the Arizona Department of Transportation (ADOT), in 2011, the state suffered an economic loss of almost \$508 million dollars (\$508,399,416) due to fatalities, incapacitating and non-incapacitating injuries, possible injuries and property damage as a result of DUI (Arizona Department of Transportation, 2011). Additionally, several communities, and subpopulations in Arizona continue to have disparate rates underage drinking and/or associated consequences. For instance, individuals who identified themselves as American Indian or Alaskan Native had the highest rate of alcohol-induced death in 2009 and between 2008 and 2009, Arizonans living in rural areas had a rate of alcohol-induced deaths nearly twice as high as the rate in the state’s urban areas (Mrela & Torres, 2011).

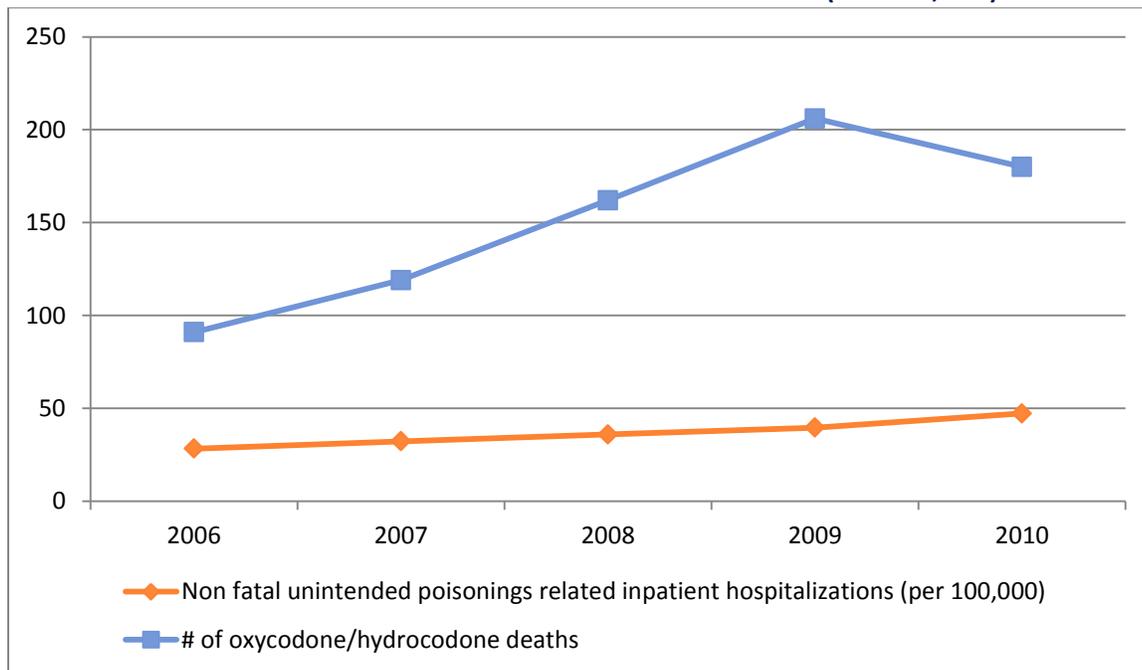
**B) Prescription Drug Abuse**

In Arizona, abuse of prescription drugs and the accompanying consequences of use (death, medical care) have been on the rise since 2006. In 2010, 13% of Arizona adults reported some type of prescription drug misuse in the past 30 days, with half of the misuse related to prescription pain relievers. Likewise, in 2010, 10.4% of Arizona youth reported some type of prescription drug misuse in the past 30 days, with an

alarming 76.7 percent of the misuse involving prescription pain relievers. Arizona has also seen a corresponding, and dramatic, increase in opioid-related cases in Emergency Departments and drug poisoning deaths involving Rx drugs. Between 2006 and 2010, the age adjusted poisoning related mortality rate increased 22% in Arizona. During these same four years, non-fatal poisoning related inpatient hospitalizations increased 43% (Mrela & Torres, 2011).

Oxycodone/ hydrocodone was the second most commonly listed cause of poisoning deaths behind alcohol, Benzodiazepines were third, Methadone and Morphine were fourth (Schacter, 2011). There has been an unprecedented increase in the mortality rate for accidental drug poisoning among middle aged adults from 7.9 deaths per 100,000 in 1997 to 24.8 per 100,000 (Mrela & Torres, 2011).

**DRUG INDUCED DEATHS AMONG ALL ARIZONA RESIDENTS 1999-2009 (PER 100,000)**



While young adults account for a low proportion of total poisoning mortality, the 15-24 age group had the highest age specific incidence of non-fatal ED visits for those over the age of 5. Further, while males consistently have higher mortality rates, females have higher rates of non-fatal ED visits related to poisoning (Mrela & Torres, 2011; Schacter, 2011).

Although mortality rates have been decreasing among African Americans, they had the highest age-adjusted rate of non-fatal poisoning-related emergency department visits in 2010 (239.2/100,000), followed closely by Caucasian (235.1 events per 100,000 residents). Native Americans came in third with a rate of 157/100,000 residents (Bach Harrison, 2010).

The Arizona Youth Survey (AYS) was administered to nearly 64,000 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> graders in 2012 across every county in Arizona. This provides the community with a significant sample to track trends in drug use (among many other variables) amongst Arizona youth. The AYS first asked questions regarding use of prescription pain relievers in 2008. The AYS only found slight decreases in both Lifetime Use and 30-Day Use of Prescription Pain Relievers between 2008 and 2012 (Arizona Criminal Justice Commission, 2012).

In 2010, 8,215 adult heads of household participated in a telephone interview for Arizona Health Survey (AHS), a project of St. Luke's Health Initiative. The AHS found the age group with the highest rates of prescription drug misuse to be 60-69 year-olds (19%). 10.4% used a prescription drug non-medically in their lifetime. 48% stated they used prescription pain relievers, 32% had used sedatives (i.e., barbiturates, sleeping pills), and a mere 3.3% used stimulants (i.e., Ritalin). 13% of those individuals indicated use within the past 30 days. Strikingly, a majority (58%) in the 18-28 age group who misused pain relievers claimed they used prescription pain relievers more than 20 times in the past 30 days (Wolfersteig, Lewis, & Sitzler, 2010).

A.R.S. § 36-2606 requires every medical practitioner who is licensed under Title 32 and who possesses a DEA registration to also maintain registration with the Arizona Board of Pharmacy, as this allows for monitoring. However, there is not a mandate requiring practitioners to request access to PDMP data. As of 7/17/2012, 15.6% (3814) of practitioners had access to the PDMP and 17.6% (1062) of pharmacists had access. Currently, there is an average of 2581 PDMP queries per day and 92 ½% of those queries come from practitioners. A very small portion (.14%) of queries are made by law enforcement (Wright, 2012).

According to data from Arizona's Prescription Drug Monitoring Program, between 2009 and 2011, there were approximately 10 million Class II-IV prescriptions written each year in Arizona, with Rx pain relievers accounting for over half of the drugs dispensed (controlled substances are classified into five possible schedules, or classifications, based on the drug's identified potential for abuse and other medical and safety standards – the higher the likelihood of abuse, the lower the schedule class). As the access and availability of these habit-forming Rx narcotics grows, so too does the likelihood of misuse, and moreover, the costly outcomes related to misuse (Wright, 2012).

### C) Marijuana

Marijuana is the most trafficked drug through Arizona (Office of National Drug Control Policy, 2012). According to the 2010 Arizona Youth Survey (AYS) data, marijuana was the third most prevalent substance used by junior high and high school students in Arizona, after alcohol and cigarettes. Lifetime marijuana use among youth in Arizona decreased consistently from 2004 to 2008; however, the 2010 AYS revealed an increase in lifetime marijuana use (Arizona Criminal Justice Commission, 2010). Use of cannabis during adolescence may induce persistent alterations in brain structure and brain function (Jager & Ramsey, 2008)

Targeting people's perception of the harmfulness of marijuana is important, because when parents have favorable attitudes toward drugs, they influence the attitudes and behavior of their children. Data from the most recent Arizona Youth Survey shows that relatively few youth use marijuana when their parents think it is very wrong to use it, but when adolescents believe that their parents have less strong negative feelings about marijuana use, their probabilities for lifetime use increase substantially (Arizona Criminal Justice Commission, 2012). A more recent longitudinal study by found that attitudes toward use have a clear and direct relationship on both intention to use and on actual use. Marijuana is the most frequently detected illicit drug among adult male arrestees in Phoenix and Tucson. It is also associated with home invasions and violent crimes (National Drug Intelligence Center, 2012; Center for Applied Prevention Technologies, 2012).

**2. What specific primary prevention programs, practices and strategies does the state intend to fund with SABG prevention set-aside dollars and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?**

Arizona conducted statewide strategic planning for prevention of underage drinking and prevention of marijuana use in May 2012. Over 200 people attended each meeting, representing various entities including coalitions, education, law enforcement, military, LGBTQ, medical, and community. Attendees developed the statewide goals, objectives and strategies. Each session culminated in the creation of a statewide strategic plan for prevention of the target substance as well as a work plan, which outlined specific tasks.

Under the leadership of the Office of National Drug Control Policy, High Intensity Drug Trafficking Area project, Arizona conducted statewide strategic planning in October 2011 for prevention of prescription drug abuse. In addition, a number of statewide and regional planning forums were held including: An emergency department prescription drug forum in July 2012 with representatives from prescribers, pharmacies and hospitals.

Arizona’s proposed goals, objectives, and strategies for prevention derive directly from these strategic plans as presented in the following three tables.

**Underage Drinking Prevention Strategic Plan/Logic Model**

BEHAVIORAL HEALTH CONSEQUENCES	BEHAVIORAL HEALTH TRENDS	GOAL	KEY INTERVENING VARIABLES	OBJECTIVES	PROJECTS, INITIATIVES, STRATEGIES
Addiction  Juvenile justice involvement (Bach Harrison, 2010)  Premature Death  High rates of hospitalizations for overdose injuries and disease (Mrela & Torres, 2011)  Taxpayer burden	In 2012, 28.1% of students surveyed reported drinking alcohol during the past 30 days (Arizona Criminal Justice Commission, 2012).	<b>GOAL #1:</b> Reduce the rate of youth self-reported 30 day use of alcohol from 28.1% in 2012 to 22% in 2016 as measured by the Arizona Youth Survey.	Youth social access to alcohol (top 3 sources of access: parties, giving money to an adult to purchase, an adult gave it to them) (Arizona Criminal Justice Commission, 2012).  Low perception of harm and positive attitudes toward youth alcohol use (63.7% of youth think drinking 1 or 2 drinks per day is harmful. 85% of Arizona youth think	<b>OBJECTIVE 1.1:</b> Increase the percentage of youth who indicate it would be hard or very hard to get alcohol to 45% as measured by the 2016 Arizona Youth Survey. (Birkmayer, Holder, Yacoubian, & Friend, 2004)  <b>OBJECTIVE 1.2A:</b> Increase the percentage of youth who perceive 1-2 drinks of alcohol per day harmful to 64% as measured by the Arizona Youth Survey.  <b>OBJECTIVE 1.2B:</b>	1.1.A Raise the cost of alcohol (Birkmayer, Holder, Yacoubian, & Friend, 2004) 1.1.B Alter the alcohol use environment (Jernigan, 2012) 1.1.C Enhanced enforcement of on-premise laws and regulations (Jernigan, 2012) 1.1.D Limit and regulate physical proximity of alcohol in stores (Jernigan, 2012)  1.2.A Conduct youth driven media campaigns to promote positive youth values and community pride 1.2.B After-school and leadership programs for youth 1.2.C Implement an adult targeted media campaign

			<p>their parents would disapprove of their use of alcohol (Arizona Criminal Justice Commission, 2012))</p>	<p>Increase the percentage of youth who perceive that their parents disapprove of youth alcohol use to 89% by 2016 as measured by the Arizona Youth Survey.</p>	<p>to educate parents about the risks</p>
			<p>Access to early intervention and treatment (Jernigan, 2012)</p>	<p><b>OBJECTIVE 1.3:</b> Decrease youth ED visits associated with alcohol use to less than 1200 per year as measured by the Arizona Vital Statistics.</p>	<p>1.3.A Brief intervention with at-risk drinkers (Jernigan, 2012)</p>

**Marijuana Prevention Strategic Plan/Logic Model August 2012 to June 2017**

BEHAVIORAL HEALTH CONSEQUENCES	BEHAVIORAL HEALTH TRENDS	GOAL	KEY INTERVENING VARIABLES	OBJECTIVES	PROJECTS, INITIATIVES, STRATEGIES		
<p>Cannabis dependence syndrome (Hall &amp; Solowij, 1998)</p> <p>Psychological distress. (Hall &amp; Solowij, 1998)</p> <p>Increased chances of developing psychosis (Hall &amp; Solowij, 1998)</p> <p>Alterations in brain structure and brain function (Jager &amp; Ramsey, 2008)</p> <p>Impaired planning and decision-making, increased risk taking &amp; impulsivity, memory impairment.<sup>i</sup></p> <p>Drug related crime (Office of National Drug Control Policy, 2012)</p>	<p>14.4% of Arizona youth used marijuana in the past 30 days (Arizona Criminal Justice Commission, 2012).</p>	<p><b>GOAL #2:</b> Reduce the percentage of youth who have used marijuana in the past thirty days from 14.4% in 2012 to 12.5% by 2016 as measured by the Arizona Youth Survey</p>	<p>Social normalization of marijuana use; Positive attitudes toward marijuana</p>	<p><b>OBJECTIVE 2.1:</b> Increase the percentage of youth who perceive regular use of marijuana to be harmful to 80% by 2016 as measured by the Arizona Youth Survey.</p>	<p>2.1.A Establish a statewide task force on prevention of marijuana abuse</p>		
	<p>Increasing trends in rates of 30 day youth self-reported use of marijuana accompanied by decreases in perception of harm. 74.1% of Arizona youth in 2012 thought their friends would disapprove of their use of marijuana (Arizona Criminal Justice Commission, 2010; Arizona Criminal Justice Commission, 2012).</p>		<p>Personal attitudes toward use</p>		<p>2.1.B Regulation of marijuana promotion</p>		
	<p>The % of youth who report being offered marijuana at least one of more times in the past 30 days increased from 30.46% in 2010 to 30.57 in 2012%. The top 2 sources for marijuana for youth are parties and friends (Arizona Criminal Justice Commission, 2012).</p>		<p>Parental monitoring, establishment of clear standards regarding substance use and consistent enforcement of discipline</p>		<p>2.1.C School based, classroom education inclusive of marijuana prevention topics</p>		
					<p>Access to early intervention and treatment</p>	<p><b>OBJECTIVE 2.2:</b> By 2017, increase adult and community perception of harm of marijuana use (measurement method not developed).</p>	<p>2.1.D Facilitate youth driven awareness and anti-marijuana campaigns.</p>
							<p>2.2.A Conduct an adult targeted anti-marijuana media campaign with accurate facts and messages they can give to youths.</p>
						<p><b>OBJECTIVE #2.3:</b> Increase comfort and knowledge in making referrals to substance abuse assessment, early intervention, and treatment services by 5% as measured by a post-retrospective survey.</p>	<p>2.2.B Family education</p>
					<p>2.3.A Training and education for law enforcement, educators, medical providers and others who have contact with youth about referrals to assessment, early interception, and treatment services.</p>		

**Prescription Drug Abuse Reduction Strategic Plan/Logic Model March 2012 to July 30, 2013**

BEHAVIORAL HEALTH CONSEQUENCES	BEHAVIORAL HEALTH TRENDS	GOAL	KEY INTERVENING VARIABLES	OBJECTIVES	PROJECTS, INITIATIVES, STRATEGIES
<p>Increasing deaths attributable to poisoning (Mrela &amp; Torres, 2011)</p> <p>Between 2008 and 2010, the number of ED visits pertaining to opioid abuse increased by 42% across all ages (Mrela &amp; Torres, 2011)</p>	<p>7.9% of Arizona youth used prescription drugs to get high on at least one occasion in the past 30 days (Arizona Criminal Justice Commission, 2012).</p>	<p><b>GOAL #3:</b> Reduce the percentage of youth who have used prescription drugs in the last 30 days to get high from 7.9% in 2012 to 5.4% in 2016 as measured by the AYS.</p>	<p>28% of Arizona Youth who abused prescription drugs in the past thirty days, obtained them from their own home and 16.5% obtained them from family or relatives (Arizona Criminal Justice Commission, 2012).</p>	<p><b>OBJECTIVE 3/4.1:</b> Decrease the percentage of youth who obtained the prescription drugs from home (i.e. medicine cabinet) to get high from 28% in 2012 to 27.4% in 2016 as measured by the Arizona Youth Survey.</p>	<p>3.1.A Provide permanent prescription drop boxes in every police department</p> <p>3.1.B Provide instructions for proper disposal</p> <p>3.1.C Prescription drug take back events</p> <p>3.1.D Put up signage about importance of proper storage</p> <p>3.1.E Partner with stores to provide short demos about proper lock use and storage at community events and trainings</p>
	<p>13 % of Arizona adults reported some type of Rx drug misuse in the past 30 days, with half of the misuse related to Rx pain relievers.</p> <p>The age group with the highest rates of prescription drug misuse to be 60-69 year-olds (19%).</p>	<p><b>GOAL #4:</b> Reduce the rate of poisoning related deaths in Arizona from a baseline of 18.7 per 100,000 to 17 per 100,000 by 2016 as measured by Arizona Vital Statistics (Mrela &amp; Torres, 2011)</p>	<p>16.1% of Arizona youth who abused prescription drugs in the past 30 days obtained them from a doctor or pharmacy (Arizona Criminal Justice Commission, 2012).</p>	<p><b>OBJECTIVE 3/4.2:</b> Increase use of the prescription drug monitoring project to 80% of prescribers (Center for Substance Abuse Treatment, 2010).</p>	<p>3.4.A Obtain a position statement endorsed by involved parties that requests PDMP compliance for distribution to pharmacists and prescribers</p> <p>3.4.B Implement a system of data feedback to prescribers and pharmacists about PDMP use and prescriber habits</p> <p>3.4.C Train law enforcement to use the PDMP</p>

DBHS contracts with Tribal and Regional Behavioral Health Authorities (T/RBHAs) and Tribal Contractors to administer behavioral health services in the State. Regional Behavioral Health Authorities (RBHAs) are private, non-profit and for profit managed care organizations, subcontracted by ADHS. Their role is to administer a full range of behavioral health services in their contracted region under the guidance and direction of DBHS. T/RBHAs administer the behavioral health service delivery network regionally, including contracting and payment for various prevention services. Each T/RBHA has a regional plan. ADHS has Intergovernmental Agreements (IGAs) with two Arizona Tribal Nations to provide prevention services to their members and surrounding communities.

T/RBHAs conduct regional needs and resource assessments at least once every three years. These comprehensive assessments involve a review of epidemiological information with input from community

stakeholders through key informant interviews, community forums, and/or focus groups to ensure gaps in services are identified and funds are leveraged to maximize effectiveness.

The tables below list non state agency implemented prevention programs by Name and IOM category. The tables include a brief description of the program and the amount of SABG funds they are budgeted to receive for fiscal year 2013.

### Indicated Programs

Program Name	Brief Description	Total SFY 2013 funds allocated
2013 Maricopa LGBTQ Consortium	Prevention of alcohol abuse among the LGBTQ population using strategies such as Responsible Beverage Service.	\$ 141,116
2013 Senior Peer Program	Support and education to older adults in achieving and maintaining healthy emotional lives.	\$ 50,000
Empact Suicide Prevention Program	Implementation of Sources of Strength and other youth leadership programs with homeless LGBTQ youths.	\$ 100,000
Southern Arizona AIDS Foundation	Implementation of Sources of Strength and other youth leadership programs with homeless LGBTQ youths.	\$ 100,000

### Selected Programs

Program Name	Brief Description	Total SFY 2013 funds allocated
2013 AZ City & Oracle TRIAD Coalitions	The Arizona City & Oracle TRIAD coalition promotes education for older adults, community partners, faith-based groups, caregivers and for-profit businesses and agencies that work with older adults in Arizona City, Oracle, and surrounding communities.	\$ 85,867
2013 Family Passages	A comprehensive substance abuse and violence prevention program serving refugee and new immigrant families resettled in Tucson. Best practice family education and support services are offered in participants' first languages.	\$ 170,684
2013 Living Well with Disabilities	Persons with disability experience 2-4 times the rate of substance abuse than does the general population yet they use treatment services less often. This project targets prevention of substance use disorders among people with physical or sensory disabilities.	\$ 125,176
2013 Payson Senior Prevention Coalition	The sub-committee will review the assessment of needs and assets of the community related to older adults and concerns related to prescription medication and alcohol misuse and abuse.	\$ 47,778
2013 San Carlos Traditions & Culture	To promote the Apache way through a connection between Apache language, culture and traditions within the San Carlos community and surrounding areas. The program also involves formation of community-based coalitions working to reduce	\$ 82,689

	alcohol abuse.	
2013 Voz	Voz is a group-level intervention designed to support youth in building life skills and self-efficacy through refusal and harm reduction skills.	\$ 102,265

### Universal Direct Programs

Program Name	Program Description	Amount Allocated for SFY 2013
2013 Douglas Community Coalition	The Douglas Community Coalition is working to prevent substance abuse in the town of Douglas using a variety of comprehensive community based strategies.	\$ 32,711
2013 Gila River Substance Abuse Program	The focus of the Gila River Prevention Program is to prevent youth alcohol and substance use and experimentation and raise awareness about suicide within the Gila River Indian Community.	\$ 445,063
2013 Graham County Substance Abuse Coalition	The Graham County Substance Abuse Coalition provides prevention and intervention resources, support and education to the community.	\$ 46,758
2013 Greenlee County Substance Abuse Coalition	The Greenlee County Substance Abuse Coalition is a community-wide group working to prevent alcohol and medication abuse. The coalition focuses on education and activities that help empower individuals to develop healthy attitudes, and to thrive and succeed.	\$ 38,408
2013 Help Enrich African American Lives (HEAAL)-Tanner	Tanner Community Development Corporation (TCDC) and Worthy Institute facilitate and oversee The Help Enrich African American Lives (H.E.A.A.L.) Coalition which provides community based education and prevention programs that address the issue of substance abuse.	\$ 145,768
2013 Help Enrich African American Lives (HEAAL)-Worthy	Worthy Institute in partnership with Tanner Community Development Corporation (TCDC) facilitate and oversee daily activities of the H.E.A.A.L. Coalition Help Enrich African American Lives (H.E.A.A.L.) Coalition which provides community based education.	\$ 107,990
2013 Hermosa Vida Substance Abuse Prevention Program	This project targets prevention of substance abuse in a Flagstaff neighborhood.	\$ 55,000
2013 Kino Neighborhood Awareness Program	The coalition is a grassroots, community-based group whose mission is bring together residents, organizations and agencies that are committed to serving the Southside neighborhoods by fostering and maintaining a vital drug free community through community development.	\$ 133,000
2013 MACAASA MASH Coalition	Youth in Maricopa and Ak-Chin communities meet on a weekly basis to participate in peer leadership programming and collaborate on substance abuse prevention projects in partnership with the Maricopa, Ak-	\$ 42,000

		Chin, Stanfield, Hidden Valley (MASH) Coalition.		
2013	Making Alliances through Neighborhood Organizing (MANO)	The Making Alliances through Neighborhood Organizing (MANO) Coalition will be engaging activities/strategies to address underage drinking in the Garfield Community located near downtown Phoenix.	\$	115,400
2013	Maricopa County Urban Indian Coalition (MCUIC)	This coalition targets prevention of underage drinking among urban Native American youths.	\$	102,640
2013	Maricopa Elder Behavioral Health Advocacy Coalition (MEBHAC)	The MEBHAC (Maricopa Elder Behavioral Health Advocacy Coalition) has been addressing the issues of changing community attitudes and increasing awareness of medication misuse among older adults.	\$	177,810
2013	Milagro Project	The Milagro Project targets prevention of alcohol use among youth 5 to 18 years of age, and community members living in the rural areas of Marana and the Tohono O'odham Nation.	\$	143,088
2013	Mohave County Project	The Mohave County Project builds and sustains community substance abuse prevention coalitions in Kingman, Lake Havasu City and Peach Springs, Arizona.	\$	70,000
2013	Navajo County Prevention Partnership	Community Bridges, Inc. (CBI) provides substance abuse and suicide prevention resources for youth and adults living in Navajo County.	\$	33,750
2013	Osborn Communities Connect	This project targets improvement of conditions in childcare centers and other early childhood issues.	\$	210,719
2013	PAACE Coalition	PAACE Coalition seeks to reduce underage/binge drinking and prescription drug abuse in the Parker Community.	\$	83,070
2013	Pascua Yaqui Tribe Prevention Program	Pascua Yaqui Tribe Prevention Program consists of the Pascua Yaqui Tribe Prevention Coalition located on Tribal Reservation and Guadalupe Prevention Partnership located in Guadalupe, AZ. The two programs will focus on prevention substance and alcohol abuse among residents of Guadalupe.	\$	170,436
2013	Quartzsite Substance Abuse Prevention Coalition	Quartzsite Substance Abuse Prevention coalition has been working with the youth and public of our community by educating them on the adverse effects of both prescription and over the counter drugs.	\$	55,970
2013	Santa Cruz Community Action Coalition	Community-focused prevention efforts targeting underage drinking, increasing coalition capacity, and promoting healthy, substance-free messages.	\$	40,882
2013	Sierra Vista Community Coalition	Facilitate and coordinate a community coalition to work on problems and issues in the community as well underage drinking.	\$	49,116

2013	Yavapai	Against Substance Abuse Coalition (YASA)	YASAC is focused on underage drinking issues. Main strategies for FY12-13 include a social marketing - public information campaign to continue to educate the community on the consequences of underage drinking, and increasing parental involvement.	\$	100,000
2013	Youth Empowered for Success (YES)		Youth Empowered for Success (YES) helps high school youth become leaders in creating conditions for success" in their schools. Working in partnership with adults youth learn to access their innate common sense and work in partnership with adults.	\$	229,949
2013	Yuma County	Anti-Drug Coalition	The Yuma County Anti-Drug (YCAD) Coalition prevention program identifies the following as its mission: To eradicate the misuse of alcohol, prescription drugs, marijuana and other drugs in Yuma County.	\$	54,000
2013	Apache County	Prevention Partnership	Community Bridges (CBI) provides substance abuse and suicide prevention resources for youth and adults living in Apache County.	\$	33,750
2013	C.O.P.E.	Coalition-TERROS	Underage drinking is a major concern of the Maryvale community. Alcohol is being abused primarily at parties and family celebrations on Friday and Saturday nights in supervised or unsupervised homes; before and after curfew hours. Terros facilitates the COPE coalition broader activities.	\$	167,682
2013	C.O.P.E.	Coalition-Touchstone	Touchstone facilitates neighborhood subcommittee components of the COPE coalition strategic plan.	\$	261,664
2013	Chandler	Coalition On Youth Substance Abuse	Underage drinking is the primary substance being used at parties in the Chandler Redevelopment Area (85225), primarily on Friday and Saturday nights by youth 13-17. Easy social and retail access, cultural and social norms that favor underage drinking are being targeted.	\$	199,452
2013	Family Strengthening		The Pima Prevention Partnership (PPP) Family Strengthening Program consists of an eight session, 3-hour substance abuse prevention program that is conducted over an eight week period, as well as a onetime 4-hour workshop conducted 24 times a year.	\$	115,000
2013	Mesa	Prevention Alliance	This program addresses prevention of alcohol and other substances in youth using a comprehensive approach including environmental and other strategies.	\$	186,961
2013	North Phoenix	Prevention Alliance (NOPAL)	The NOPAL Coalition--in partnership with Valle del Sol Inc.-will be engaging in activities/strategies to reduce youth marijuana use in North Phoenix, AZ (Sunnyslope community).	\$	170,840
2013	Scottsdale	Neighborhoods In Action	The focus of this program is underage drinking prevention, especially social access to alcohol at home/family events; soliciting adults to purchase; and, adults who openly use and offer alcohol to minors.	\$	200,124

<b>2013 South Mountain WORKS Coalition</b>	This program is a comprehensive continuum of services and strategies designed for youth (12-20), adults, families, and diverse cultural populations in the South Mountain community. The Program is designed to address the high rate of alcohol use among youth.	\$ 182,570
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**Universal Indirect Programs**

Program Name	Program Description	Amount Allocated for SFY 2013
<b>2013 MATForce</b>	MATForce has comprehensive substance abuse prevention programs targeting prevention of underage drinking, prescription drug abuse and marijuana. Strategies include community education and environmental approaches.	\$ 55,000
<b>2013 The Alliance</b>	The Alliance Partnerships in Prevention builds community substance abuse prevention by community collaboration with the Page Anti-Drug Alliance (PADA), local businesses, and the faith-based community.	\$ 54,000
<b>Arizonans for Prevention</b>	The Arizona Prevention Fellowship Program has two purposes. One is to implement components of the statewide strategic plans for substance abuse prevention. The other is to introduce recent college graduates and students to prevention as a career.	\$ 260,017
<b>Community Bridges</b>	Community Bridges, Inc. (CBI) Prevention Partnership provides random unannounced inspections of tobacco vendors.	\$ 20,000
<b>Pima County</b>	The purpose of this project is to build prevention capacity among coalitions in Pima County.	\$ 118,332
<b>Pima Prevention Partnership</b>	Community Bridges, Inc. (CBI) Prevention Partnership provides random unannounced inspections of tobacco vendors.	\$ 20,000

**3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?**

The table below is a plan for development of the capacity of the prevention system and prevention workforce.

GOALS	OBJECTIVES	STEPS	COMPLETION DATE	RESPONSIBLE PARTY
<b>GOAL 1:</b> Create long term, sustainable reductions in substance abuse through increased use of environmental strategies	<b>OBJECTIVE 1.1:</b> Increase the number of environmental strategies used by coalitions as measured by an annual inventory of environmental	a) Develop regional workforce development plans	Annually by June 30	T/RBHAs
		b) Organize an on-line series of trainings in environmental strategies for prevention of marijuana, prescription drugs, underage drinking	Annually by January 30	WFD Fellow
		c) Conduct an annual statewide inventory of environmental strategies in Arizona	Annually by December 31	OPS Fellow

	strategies used in Arizona	d) Conduct an annual workforce development assessment for prevention specialists and coalition members	Annually by February 28	OPS and WFD Fellows	
		e) Incorporate an inventory of regional and local environmental strategies	Annually by June 30	DBHS OPS	
<b>GOAL 2:</b> Increase inter-organizational collaboration and leveraging of resources at the sub state level	<b>OBJECTIVE 2.1:</b> Improve coalition functioning in targeted communities as measured by a coalition post-retro test	a) Develop, identify, select, a tool or method for measuring coalition capacity	June 30, 2013	SAPCA Evaluation Committee	
		b) Conduct or develop an assessment of coalition needs, readiness, and capacities	June 30, 2013	ADHS/DBHS	
		c) Obtain CAPT TA on coalition development	June 30, 2013	ADHS/DBHS	
		d) Establish a coalition a mentoring and training program	2015	ADHS/DBHS	
		e) Participate in AZFP education committee	On-going	WFD Fellow	
		f) Organize training on advocacy strategies		WFD Fellow	
		g) Training on Adverse Childhood Experiences	December 31, 2012	Magellan	
		h) CADCA coalition training	May 30, 2012	CPSA	
<b>GOAL 3:</b> Integrate prevention strategies into non SAPT funded systems	<b>OBJECTIVE 3.1:</b> Increase the number of medical organizations adopting SBIRT	a) Continue provision of training and support to integrate the practice of screening and brief intervention practices into medical settings.	Ongoing	ADHS/DBHS	
		b) Collaborate with other state agencies and organizations to obtain funds to support SBIRT	Ongoing	ADHS/DBHS	
		c) Annual inventory of SBIRT use in medical settings	December 31 annually	Interns	
<b>GOAL 4:</b> Increase effectiveness of coalitions and prevention organizations	<b>OBJECTIVE 4.1:</b> Increase the percentage of coalitions who have an array of services deemed evidence based to 90% as measured by Arizona Evidence Based Practice Reviews.	d) Conduct Annual Evidence Based Practice Reviews	November 30 annually	T/RBHAs and ADHS/DBHS	
		e) Review the EBP feedback with each provider and discuss plans for improvement	March 30 annually	T/RBHAs and ADHS/DBHS	
		f) Provide individualized training and technical assistance as needed and requested by programs/coalitions T/RBHAs	Ongoing	T/RBHAs and ADHS/DBHS	
		g) Organize an on-line training on logic models	March 30, 2013	T/RBHAs and ADHS/DBHS	
		<b>OBJECTIVE 4.2:</b> Improve coalition understanding and use of the SPF process as measured by an annual post-retro test.	a) Organize on-line training in the SPF process	March 30, 2013	T/RBHAs and ADHS/DBHS
		b) Facilitate provision of SAPST Training	December 31, 2012	T/RBHAs and ADHS/DBHS	
		c) Establish at least 15 Arizona SAPST trainers	June 30, 2013	T/RBHAs and ADHS/DBHS	
	d) Provide training on how to use the community data project as a tool for needs assessment	On-going	GOCYF and ASU		
	<b>OBJECTIVE 4.3:</b> Increase the	a) Host the IC&RC certification test	August 31, 2013	Arizonans for Prevention	

percentage of Arizona prevention specialists with a credential and/or ICRC certification from 0% to 50% by 2015.	b) Formalize a list of core competencies for prevention specialists.	June 30, 2013	ADHS/DBHS
	c) Scholarship prevention professionals to obtain credentialing in prevention from Arizonans for Prevention	June 30, 2013	ADHS/DBHS, T/RBHAs, Pima County
	a) Develop a training and TA system plan	Annually by June 30	ADHS/DBHS
	b) Create an on-line AA in prevention	2015	ADHS/DBHS GCC
	c) Annual update of directory of degrees in prevention to be shared with NPN WFD Committee	May 30 Annually	ADHS/DBHS OPS Fellow
	d) Continue implementation of the Arizona Prevention Fellowship Program	On-going	ADHS/DBHS AZFP
	e) Sponsor interns in prevention	On-going	ADHS/DBHS and T/RBHAs
	f) Participate in the CSAP Fellowship program as a host site	On-going	ADHS/DBHS

**4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?**

The following are Arizona's statewide outcome goals and objectives for substance abuse prevention. Evaluation data collection is specified for each.

**GOAL #1:** Reduce the rate of youth self-reported 30 day use of alcohol from 28.1% in 2012 to 22% in 2016 as measured by the Arizona Youth Survey. *(Evaluation data: Arizona Youth Survey 30 day use)*

**OBJECTIVE 1.1:** Increase the percentage of youth who indicate it would be hard or very hard to get alcohol to 45% as measured by the 2016 Arizona Youth Survey. *(Evaluation data: Arizona Youth Survey question regarding how difficult it is to get alcohol)*

**OBJECTIVE 1.2A:** Increase the percentage of youth who perceive 1-2 drinks of alcohol per day harmful to 64% as measured by the Arizona Youth Survey. *(Evaluation data: Arizona Youth Survey question regarding perception of harm; Also a pre-post test will be administered to all middle and high school youth directly involved in SAPT funded prevention programs)*

**OBJECTIVE 1.2B:** Increase the percentage of youth who perceive that their parents disapprove of youth alcohol use to 89% by 2016 as measured by the Arizona Youth Survey. *(Evaluation data: Arizona Youth Survey question regarding how parents would perceive youth use)*

**OBJECTIVE 1.3:** Decrease youth ED visits associated with alcohol use to less than 1200 per year as measured by the Arizona Vital Statistics. *(Evaluation data: Arizona Vital Statistics Emergency Room Admissions due to alcohol)*

**GOAL #2:** Reduce the percentage of youth who have used marijuana in the past thirty days from 14.4% in 2012 to 12.5% by 2016 as measured by the Arizona Youth Survey *(Evaluation data: Arizona Youth Survey 30 day use)*

**OBJECTIVE 2.1:** Increase the percentage of youth who perceive regular use of marijuana to be harmful to 80% by 2016 as measured by the Arizona Youth Survey. *(Evaluation data: Arizona Youth Survey question regarding perception of harm)*

**OBJECTIVE 2.2:** By 2017, increase adult and community perception of harm of marijuana use (measurement method to be developed).

**OBJECTIVE 2.3:** Increase comfort and knowledge in making referrals to substance abuse assessment, early intervention, and treatment services by 5% as measured by a post-retrospective survey. *(Evaluation data: Post-retro survey)*

**GOAL #3:** Reduce the percentage of youth who have used prescription drugs in the last 30 days to get high from 7.9% in 2012 to 5.4% in 2016 as measured by the AYS. *(Evaluation data: Arizona Youth Survey 30 day use)*

**OBJECTIVE 3/4.1:** Decrease the percentage of youth who obtained the prescription drugs from home (i.e. medicine cabinet) to get high from 28% in 2012 to 27.4% in 2016 as measured by the

Arizona Youth Survey. *(Evaluation data: Arizona Youth Survey source of access to prescription drugs)*

**OBJECTIVE 3/4.2:** Increase use of the prescription drug monitoring project to 80% of prescribers. *(Evaluation data: Arizona Board of Pharmacy Prescription Drug Monitoring Program)*

The following table is a plan for outcome evaluation.

TASK	TARGET COMPLETION DATE	RESPONSIBLE PARTY
1) Replace, revise, or update the Arizona Prevention Evaluation Database System (APREDS).	December 31, 2015	ADHS/DBHS and Evaluation Advisory Committee
2) Form an evaluation advisory committee for ADHS/DBHS.	May 30, 2013	ADHS/DBHS
3) Review all statewide required core instruments to determine if they should all remain or should be revised	Annually by May 30	Evaluation Advisory Committee
4) Conduct a statistical analysis of all survey data	Annually by January 30	ADHS/DBHS
5) Write an annual prevention evaluation report summarizing outcome data.	Annually by February 29	ADHS/DBHS
6) Review annual report to discuss and advise systemic changes to the new year	Annually by March 30	Evaluation Advisory Committee and SAPCA
7) Conduct analysis of change in coalition behavior via the coalition core instrument	Annually by January 30	ADHS/DBHS

## 5. How is your budget supportive of implementing the Strategic Prevention Framework?

Arizona uses the Strategic Prevention Framework (SPF) established by the Substance Abuse and Mental Health Services Administration (SAMHSA). In Arizona, the SPF is used to inform the selection, implementation, and evaluation of culturally appropriate and sustainable prevention activities. The components of the SPF (needs assessment, capacity building, planning, implementation, evaluation, cultural competency, and sustainability) are incorporated into the contract with each Regional Behavioral Health Authority.

**6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)**

Arizona retains 5% of the SABG set aside for administrative functions internal to ADHS/DBHS. An additional 298,622 is allocated to other state agencies for direct services, capacity building, and evaluation. The table below lists each state agency, the description of services and amount budgeted/allocated for SFY 2013.

Program Name	Program Description	Amount Allocated for SFY 2013
University of Arizona (LGBTQ Project)	The purpose of this project is to prevention underage drinking and other substance abuse among LGBTQ youth enrolled in Arizona institutions of higher education.	\$ 160,000
University of Arizona (Poison Control)	The purpose of this project is to train poison control center staff to conduct screening and intervention.	\$ 32,622
ASU Evaluation and Training	The purpose of this program is 1) to manage all aspects of the evaluation database, make improvements to the database and provide technical support to users; and 2) to provide staff support to Arizonans for Prevention.	\$ 100,000
ASU Synar Program	The Contractor manages a web based application for data collection and assist in the annual development of the Synar report.	\$ 6,000

**7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.**

A total of \$1,897,859 of the prevention set aside is allocated for evidence based practices in SFY 2013. These programs and their descriptions are listed below.

Program Name	Program Description	Amount Allocated for SFY 2013
2013 Apache County Prevention Partnership	Community Bridges (CBI) provides substance abuse and suicide prevention resources for youth and adults living in Apache County.	\$ 33,750
2013 C.O.P.E. Coalition-TERROS	Underage drinking is a major concern of the Maryvale community. Alcohol is being abused primarily at parties and family celebrations on Friday and Saturday nights in supervised or unsupervised homes; before and after curfew hours. Terros facilitates the COPE coalition broader activities.	\$ 167,682
2013 C.O.P.E. Coalition-	Touchstone facilitates neighborhood subcommittee	\$ 261,664

Touchstone			components of the COPE coalition strategic plan.		
2013 Chandler Coalition On Youth Substance Abuse			Underage drinking is the primary substance being used at parties in the Chandler Redevelopment Area (85225), primarily on Friday and Saturday nights by youth 13-17. Easy social and retail access, cultural and social norms that favor underage drinking are being targeted.	\$	199,452
2013 Family Strengthening			The Pima Prevention Partnership (PPP) Family Strengthening Program consists of an eight session, 3-hour substance abuse prevention program that is conducted over an eight week period, as well as a onetime 4-hour workshop conducted 24 times a year.	\$	115,000
2013 Mesa Prevention Alliance			This program addresses prevention of alcohol and other substances in youth using a comprehensive approach including environmental and other strategies.	\$	186,961
2013 North Phoenix Prevention Alliance (NOPAL)			The NOPAL Coalition--in partnership with Valle del Sol Inc.--will be engaging in activities/strategies to reduce youth marijuana use in North Phoenix, AZ (Sunnyslope community).	\$	170,840
2013 Scottsdale Neighborhoods In Action			The focus of this program is underage drinking prevention, especially social access to alcohol at home/family events; soliciting adults to purchase; and, adults who openly use and offer alcohol to minors.	\$	200,124
2013 South Mountain WORKS Coalition			This program is a comprehensive continuum of services and strategies designed for youth (12-20), adults, families, and diverse cultural populations in the South Mountain community. The Program is designed to address the high rate of alcohol use among youth.	\$	182,570
2013 Tempe Coalition to Reduce Underage Drinking and Drug Use			Comprehensive substance abuse prevention program using environmental and other strategies to target prevention of underage drinking in the City of Tempe.	\$	157,225
2013 Way Out West Coalition-PDFA			DrugFreeAz.org will facilitate and support the Way Out West (WOW) Coalition focused on substance abuse prevention and implement public information/social marketing, community education, and community development strategies that target underage drinking.	\$	222,591

Each fall, ADHS/DBHS assembles several review teams to review and evaluate all subcontracted prevention programs to determine which are evidence based using criteria recommended by SAMHSA (Center for Substance Abuse Prevention, 2007). In addition to fulfilling block grant requirements, the purpose of the evidence based practice review is to provide an opportunity for learning and improvement among Arizona's prevention community.

Each EBP review team consists of a member of ADHS/DBHS, one or two provider representatives, a RBHA representative and a research representative. Each team reviews 8-12 programs. One team is composed of

individuals with tribal expertise as well as prevention. They are therefore better able to understand the culturally specific evidence based practices used by Tribal prevention programs.

The definition of “program” within the ADHS/BHS RBHA system is “a set of prevention strategies, which address a common set of goals and objectives for a common target audience in one county.” This definition is broad and intended to serve as an umbrella to encompass many strategies used by a provider. The information viewed under this definition which combined all prevention strategies, activities and/or curriculum under one program. Reviewers use the program logic model (when available) and program descriptions, strategies, and outcomes to assess whether the overall program meets the criteria of being evidence-based.

Further, the criteria to be considered evidence-based were thus based upon the SAMHSA National Registry of Evidence-based Programs and Practices (NREPP) criteria, and specifically falling under the third criteria that uses expert panels and four guidelines as the basis for assessment.

For evidence-based practice, a program/strategy must meet one of the following three criteria:

1. Included on Federal Lists or Registries of evidence-based interventions; OR
2. Reported (with positive effects) in peer-reviewed journals; OR
3. Documented effectiveness supported by other sources of information and the consensus judgment of informed experts:
  - Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual mode; 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 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.

In addition to the above criteria, ground rules are set for how the groups formulate their expert judgments.

- a) The team must come to a consensus for a ‘yes.’
- b) No consensus is needed for a no. An “I don’t know,” “I’m not sure,” “I can’t judge this,” or “I need more information” is simply a ‘no.’
- c) Program funding and jobs are not in jeopardy if a program receives a ‘no.’
- d) Programs which would be ‘yes’ due to criteria 1 or 2 still must demonstrate a logical grounding.

During the EBP review, review teams gather information on *strengths* of the program and *constructive recommendations*. ADHS/DBHS summarizes the information in a written report which is shared with the

provider organization (program lead). Training and technical assistance is offered to programs which are not deemed to be evidence based for the purpose of helping them to become evidence based.

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## IV: Narrative Plan

### N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

Contingent upon legislative authority; Arizona intends to utilize five percent of the MHBG funds for direct services as well as for training on evidence based practices (EBPs) for prevention and treatment. Arizona currently awards Block Grant funds to four Regional Behavioral Health Authorities (RBHAs) and three Tribal Regional Behavioral Health Authorities (TRBHAs) and Tribal Contractors. RBHA contracts are awarded on a 3-5 year competitive cycle. During the RFP process, bidders indicate EBPs to be offered throughout the network. This information is a factor which is weighed in determining an award and the Block Grant makes up a portion of the publicly-funded behavioral health service system. Additional funding is derived from a variety of sources, including: TXIX (Medicaid), TXXI (Kids Care), federal block grants, state appropriations and agreements with City and County governments.

It is anticipated that the five percent MHBG set aside will be evenly split between the Prevention and Treatment systems and will be distributed through the pre-existing, competitively awarded, contracts to Regional Behavioral Health Authorities (RBHAs) and/or Tribal Regional Behavioral Health Authorities (TRBHAs).

ADHS/DBHS will use these funds to promote evidence-based practices, prevention and early intervention strategies throughout its system, targeting areas where there are gaps in services and resources available. Training will be a key focus for use of these funds, using a variety of programs from the National Registry of Evidence-Based Programs and Practices and the Suicide Prevention Resource Center's Best Practices Registry. Assessing and Managing Suicide Risk: Core competencies for Mental Health Professionals and Addressing Suicidal Thoughts in Substance Abuse Treatment are two curriculums to be included for treatment providers. Additional gatekeeper trainings will be offered for the public including; Question, Persuade, Refer, Signs of Suicide, Applied Suicide Intervention Skills Training, and Kognito At-Risk online trainings. These gatekeeper trainings will be made available in areas of the state that have fewer resources and will be targeted towards special populations, including older adults, tribes, universities and community colleges, refugees, and military.

Funds for training on selected EBP for the treatment system will be managed through a line item allocation to our contractors. RBHAs will select an EBP from SAMHSA's National Registry of Evidence Based Programs and Practices focusing on service provision for individuals with co-occurring disorders. In addition, RBHAs will indicate the procedure which will be used to monitor fidelity. An internal committee at ADHS/DBHS will review the selected EBP to ensure that the needs of clients will be met and that fidelity will be appropriately documented and reviewed. Once approved, trainings will be conducted and reported back to ADHS/DBHS through financial statements as well as through training updates. Supporting documentation including sign in sheets, handouts, and curriculum will be reviewed by the internal committee.

## IV: Narrative Plan

### O. Children and Adolescents Behavioral Health Services

#### Narrative Question:

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Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

# Arizona's System of Care for Children/Adolescents



**Vision:** In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's family's cultural heritage.

- Guiding Principles:**
- Collaboration with the child and family
  - Functional outcomes
  - Collaboration with others
  - Accessible services
  - Best practices
  - Most appropriate setting
  - Timeliness
  - Services tailored to the child and family
  - Stability
  - Respect for the child and family's unique cultural heritage
  - Independence
  - Connection to natural supports

**Context**      **Statewide Strategies**      **Goals/Outcomes**

**Children and Families Served by ADHS**  
 Title XIX, Title XXI and non-Title XIX Children and Youth ages including children with:

- child protective services (CPS) involvement
- substance use involvement
- infants/toddlers ages 0-5
- children with developmental disabilities
- children with juvenile justice involvement

**Statewide Needs Based on 12 Principles**

- Access**
- Accessible services
  - Timeliness
- Service Provision**
- Best practices
  - Most appropriate setting
  - Services tailored to the child and family
  - Acknowledgement of the child and family's unique cultural heritage
  - Connection to natural supports
- Collaboration**
- Collaboration with the child and family
  - Collaboration with others
- Child and Family Outcomes**
- Functional outcomes
  - Stability
  - Independence



1. **Development** of a statewide quality management system for children's services that strengthens practice according to the Arizona 12 Principles
2. **Implementation** of a children's statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice

**Realization of the Vision for Children and Families**

- achieve success in school
- live with their families
- avoid delinquency
- become stable and productive adults
- see a decrease in safety risks
- experience increased stability

3. **Development** of strong technical assistance initiatives to strengthen Child and Family Team Practice in accordance with the Arizona 12 Principles
4. **Involvement** of youth and families in improving the behavioral health system

Modeled after the Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored systems of care described by Shelia Pires and others, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) has built a statewide system of care utilizing an individualized, child and family centered, community based and culturally competent approach to meet the needs of children and their families. Policy, practice protocols, covered services guide and contract language, provides guidance and direction to those working with children and families. Statewide policies regarding the Children's System of Care include The Arizona Vision and Principles, which guides policy and practice as well as the Covered Services Guide which includes one of the widest arrays of services and supports available to Title XIX and XXI members in the country. The Child and Family Team (CFT) Practice Protocol defines the "wrap around" process and how it is to be implemented; collaborative Protocols which define how the behavioral health system and other child serving systems will work together and the work with family-run organizations to engage and support family member and youth voice and choice and involvement in system development. The High Needs Case Management Initiative which provides funding specifically for cadres of case managers with reduced caseloads (1 to 15) in order to work with the most complex needs children and families; the Meet Me Where I Am (MMWIA) Campaign which provided specific funding and direction for development and provision of generalist direct support programming, (available 24 hours per day, 7 days per week) and helps to maintain the most complex needs youth in their homes and communities and out of residential placements. These statewide policies and activities were developed and monitored by the ADHS/DBHS, as well as written into the Regional Behavioral Health Authorities (RBHA) contracts.

In Arizona the "wrap around" approach is called the CFT Practice. For children and families with the most complex needs the CFT Practice model incorporates the services of a High Needs Case Manager (HNCM) also referred to as a CFT Facilitator. HNCMs assist the family with identifying needs and resources (both formal and informal), assembling a unique team of individuals (the CFT) to brainstorm and support the family toward meeting their goals, completes an inventory of Strengths, Needs, and Cultural Discovery and secures services identified by the CFT. Guidelines for individualized care planning for children/youth with mental, substance use and co-occurring disorders are defined in policy and contract. Arizona's Provider Manual and CFT Practice Protocol specifically define the care planning process which is accomplished in the Child and Family Team.

System of care monitoring is accomplished through a number of avenues including Children's System of Care Plans which are developed annually to incorporate current goals and initiatives and reported on by the RBHA's on a quarterly basis. The state's Children's Quality Management (QM) process incorporates a Logic Model developed with assistance of the University of South Florida (see attachment). Additionally, for the past four years Arizona has utilized the System of Care Practice Review (SOCPR) tool, developed by University of South Florida, to measure CFT practice fidelity to system of care values and principles for over 500 complex needs children as well as over 2,500 telephonic Brief Practice Reviews (BPR) for standard needs children. Practice review results are provided at the local level for the provider agencies and compiled at the state level.

Arizona monitors and tracks service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders through the encounter system. Specific service codes are monitored in order to understand what services are being provided. For example, the use of generalist direct supports is of particular interest because of the state's investment in the MMWIA initiative. When the initiative was rolled out there was a requirement for providers to use a special modifier to their encounters so the increases in service utilization could be followed.

Working, signed letters of agreement and annually updated the collaborative protocols are in place for all child and youth serving agencies. The letters of agreement describe mutual support for the system of care vision and values as well as support for provision of services through the CFT process. Collaborative protocols define how behavioral health and system partners will work together, communicate and problem solve. These are developed at the local level so that the RBHA and the system partners in their respective geographic service area (GSA) shape the protocol to meet the specific needs of the area. Collaborative protocols are contract requirements and are monitored at the state and local level via regular and ongoing multiparty meetings.

Co-location and agency specific liaison positions further the collaboration for children's services. RBHAs and their providers maintain co-located positions at juvenile courts and at Child Protective Services (CPS) offices. Liaison positions are maintained at parole offices and juvenile courts to establish single points of contact for system partners to navigate the behavioral health system and problem solve.

ADHS/DBHS promotes the use of evidence based practices (EBP) in mental and substance abuse prevention, treatment and recovery services for children and adolescents and their families through RBHA contracts. Annual Network Inventories are submitted by RBHAs outlining the entire scope of their provider networks, as well as specifying evidence based programs. In the area of substance abuse treatment; Matrix Model, Adolescent Community Reinforcement Approach (A-CRA) and Seven Challenges are examples of EBPs utilized. In other areas, the Transition to Independence Process (TIP) Model for transitioned aged youth and the Building Bridges Model for children transitioning from out-of-home placements into the community represent additional efforts regarding service provision.

## IV: Narrative Plan

### P. Consultation with Tribes

#### Narrative Question:

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SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

#### Footnotes:

The Division follows both the State of Arizona Tribal Consultation Policy as well as the ADHS Tribal Consultation Policy to guide collaboration with tribal officials. On January 18, 2012, ADHS/DBHS engaged in the Statewide Behavioral Health Tribal Consultation Meeting to address areas of concerns and facilitate a discussion on the unique needs of the multiple tribes throughout Arizona. The consultation meeting highlighted the need for further collaborative efforts between ADHS/DBHS and the tribes. To ensure inclusion of the Native American population, ADHS/DBHS developed a work group for tribal input. In September, 2012, the tribal workgroup conducted their initial meeting and began discussion on the needs assessment for the SAPT/CMHS Block Grant allocation formula. This workgroup consisted of leaders from the tribes, Indian Health Services (IHS) representatives, Native American providers, and liaisons from within DBHS. The workgroup has held meetings in an effort to identify available data for the incorporation into the allocation formula. The members of the workgroup have been a vital component in ensuring that the Native American population is accurately accounted for and that the data used for the allocation formula is representative of the need. Once the formula is developed, the workgroup will meet to review and discuss potential changes to the system to meet identified needs. ADHS/DBHS intends to continue regular meetings with the workgroup to focus on the ongoing needs within the tribal community. In addition to the workgroup, there is Native American representation on the Arizona Behavioral Health Planning Council. ADHS/DBHS is requesting technical assistance from SAMHSA for implementation of the allocation formula as well as identifying ways to better serve the Native American population.

In addition to the data provided from the workgroup for the needs assessment, Tribal Regional Behavioral Health Authorities (TRBHAs) have submitted Spending Plan Proposals for grant funds. Submission of Proposals allows TRBHAs to identify immediate areas of need where SAPT/CMHS funds would provide the greatest impact. Proposal requests include; Alcohol Abuse Treatment Specialist training and certification, expansion of prevention partnerships, development of a women's residential treatment program, provision of an intensive outpatient program, development of a day program, and substance abuse treatment services for Navajo Nation individuals. Currently, these proposals are under review to ensure compliance with grant requirements.

ADHS/DBHS has also taken additional steps to further emphasize cooperation and coordination with the state's numerous tribes. This includes maintaining a Tribal Contract Administrator within ADHS/DBHS; this employee, who is also a member of the Navajo Nation, oversees and manages the State's five Intergovernmental Agreements (IGA) designed to provide behavioral health services to members of the respective tribes. American Indians and Alaskan Natives in Arizona receive behavioral health services from Indian Health facilities, 638 Tribal behavioral health programs, and the State's managed care behavioral health providers which are administered by the DBHS.

Additionally, each RBHA is required by contract to employ a dedicated Tribal Liaison responsible for working with the tribes to increase access to the state behavioral health system and its services, administered by the RBHAs, and to coordinate care with tribal, Indian Health Services, and RBHA providers on the uniquely remote and rural tribal reservations.

## IV: Narrative Plan

### Q. Data and Information Technology

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

With limited restrictions, the Arizona Department of Health Services, Division of Behavioral Health Services is capable of reporting Client-Level Information at this time, including the information necessary to populate the Uniform Reporting System (URS) tables and the Treatment Episode Data Set (TEDS).

The significant limitation encountered at present pertains to linking member service provision to specific funding streams, or line-item allocations. Given the structure of the service delivery system, and the various funding sources (Medicaid, Federal Block Grant, Federal Discretionary Grants, State General Fund and County, City or local funds) used to provide services to our members, as it pertains to members who do not qualify for Medicaid Coverage, DBHS is not readily able to specifically identify which funding source was used to provide services to each member.

ADHS/DBHS incorporates client demographic and service utilization data into its daily management, administrative and oversight operations and encourages data-driven decision making throughout all levels of the provider network to improve the quality and timeliness of service delivery.

ADHS/DBHS maintains a Client Information System (CIS), which is comprised of three interdependent databases used for storing client eligibility, demographic, and service encounters information. The three systems utilize a unique identifier (CIS ID) as a primary key for joining, and operate as follows:

#### Enrollment and Eligibility

All clients receiving services must be enrolled in the behavioral health system under one of the defined eligibility categories (State-Only or Medicaid Eligible). The Enrollment and Eligibility database maintains the historical enrollment segments for all clients – based on a HIPAA-compliant 834 submission.<sup>1</sup> The database allows DBHS to determine, and subsequently report, the number of enrolled Medicaid eligible clients, compared to those who would otherwise be funded through other means, including State General Funds, or Federal Block Grants (for more information please see the *Client Information System File Layout Manual*, available at <http://www.azdhs.gov/bhs/gm.htm>).

#### Demographics

ADHS/DBHS policy requires that all behavioral health consumers who remain enrolled in the system for at least 45 days undergo a clinical assessment, administered by a clinician at the provider level. Among the data gathered during this process are several identifiable factors, such as date of birth, race and ethnicity, gender, DSM-IV Axial Diagnoses, National Outcome Measures (NOMs), and reasons for seeking treatment. Furthermore, this information must be updated on an annual basis, at a minimum, or upon a significant change in the client's life - such as gaining employment, or reporting an extended period of substance use abstinence. Lastly, a final assessment of the client is required upon completion of the treatment episode (for more information please see the *Demographic and Outcome Data Set User Guide*, available at <http://www.azdhs.gov/bhs/gm.htm>).

#### Service Encounters

Client service encounter data is also reported by the provider network, and is required to be submitted to ADHS/DBHS no later than 210 days following the date of service. This information includes the type of service being provided, i.e. group counseling, case management, or a clinical assessment, the number of service units the client received in a unique session (typically based on 15-minute increments, or per-

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<sup>1</sup> As of 10/1/2010 all Medicaid-eligible clients are also enrolled in the public behavioral health system and may access services without the need of a separate 834-HIPAA enrollment.

diem, depending on service type), the total dollar value for that service session, and the provider offering the service. This reporting standard allows ADHS/DBHS to measure service utilization, by service type and provider, at the client level; in other words, ADHS/DBHS can report the precise number of service units, and the corresponding dollar value, each consumer received, or each agency provided, within a given timeframe. The encounters database also contains prescription drug utilization information (for more information, please see the *Covered Behavioral Health Services Guide*, available at <http://www.azdhs.gov/bhs/gm.htm>).

The data housed within the Client Information System is vital to ADHS/DBHS' ongoing efforts to ensure the RBHAs and providers are offering services designed to achieve programmatic goals in a manner that is both effective and resource efficient, while determining if behavioral health consumers are moving towards recovery.

EHR implementation is ongoing throughout the state, with many direct service providers using some form of electronic system for maintaining and sharing medical records. The complexities of these systems vary by region, volume of individuals served, and the spectrum of services offered by each provider. To date, the state has focused efforts on streamlining data collection, including the elimination of erroneous or unnecessary data elements from the required information to be collected.

## IV: Narrative Plan

### R. Quality Improvement Plan

#### Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

#### Footnotes:

As indicated in Section R, the QM Plan for Contract Year 2013 is currently undergoing final review and will be uploaded as an attachment to this application upon completion.

The Bureau of Quality Management Operations (BQMO) works collaboratively with all functional areas of Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS) in the ongoing assessment and evaluation of the quality of services provided to behavioral health recipients. Quality Management (QM) administrative oversight and communication activities are conducted through ADHS/DBHS' committees and by sharing data amongst the various functional areas. The several committees are utilized for decision making, performance monitoring, development of performance improvement activities, and as a means for incorporating stakeholder and member feedback into QM activities.

ADHS/DBHS follows the Plan, Do, Study, Act (PDSA) Quality Improvement cycle to evaluate data, assess performance, test interventions and refine activities as necessary. Through its contracts, ADHS/DBHS mandates the use of the PDSA model in every contractor's QM activities. To that end, the Division of Behavioral Health Services developed a standardized QM Report Template and a QM Corrective Action Plan (CAP) Template that incorporates the tenets of this model to assist in the continuous assessment and evaluation of system performance.

Appropriately, the Quality Management Specifications Manual for Contract Year 2013 is designed to achieve improved quality of care for behavioral health recipients utilizing evidenced-based best practices. Activities defined to support QM processes and program goals are delineated in the QM Work Plan. These activities serve to direct and focus the QM program and include clearly defined goals, measurable objectives, data feeds, responsible parties, frequencies of activities and target dates for activities completion. QM activities incorporate contractor, stakeholder and recipient input and serve to further the vision of DBHS.<sup>1</sup> Additionally, the Division of Behavioral Health Services uses Performance Based Contracting (PBM) to further promote, and emphasize the State's commitment to quality improvement; metrics tied to performance incentives include:

- Member employment;
- Member enrollment for historically underserved populations;
- Member satisfaction with services and outcomes, and;
- Members are assessed at least annually.

The QM Plan includes activities designed to meet federal and Medicaid requirements as well as data driven, focused performance improvement activities conducted by our contractors.<sup>2</sup> This includes all quality improvement activities conducted by BQMO and its contractors, including the monitoring and oversight of contractor QM activities. DBHS uses analyses of the behavioral health system's performance, feedback from behavioral health recipients and stakeholders, and evidence based practices to drive the performance improvement activities and new initiatives included in this Plan. Technical assistance is provided to every contractor to ensure compliance with all performance standards and contractual requirements, including ensuring:

- Members have a current assessment and update service plan;
- Members receive services in accordance with their assessment and service plan;
- Members receive services in a timely manner (23-day Access to Care);

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<sup>1</sup> The complete Quality Management Specifications Manual for Contract Year 2013 is available at <http://www.azdhs.gov/bhs/bqmo/bqmo-specifications.htm>

<sup>2</sup> The Quality Management Plan for Contract Year 2013 is currently under review in draft form only. Upon its completion, the State will upload the document as an attachment to this application as noted in the guidance for Section R. In the interim, the most recent, finalized, QM Plan is accessible at [http://www.azdhs.gov/bhs/pdf/qm/Annual-Quality-Management-Plan\\_2010-2011.pdf](http://www.azdhs.gov/bhs/pdf/qm/Annual-Quality-Management-Plan_2010-2011.pdf)

- Members have their care coordinated between the behavioral health provider and their physical care specialist;
- All complaints, grievances and Quality of Care Concerns are reported, tracked and remedied in a timely, legal, manner, and;
- Members discharged from a facility post hospitalization receive follow-up services within 7 and 30 days from discharge (HEDIS Measurement).

The QM Committee ensures ongoing communication and collaboration between Executive Leadership, QM, and other functional areas of the organization, and each functional area is represented on the QM Committee. Members are informed of confidentiality and conflict of interest requirements related to serving on the committee. Sign-in sheets with confidentiality and conflict of interest language are completed at all meetings. The committee reviews, modifies, and updates QM program objectives, policies and procedures at least annually and completes quarterly status reviews of the QM Work Plan.

ADHS/DBHS' QM Committee receives feedback and recommendations for performance improvement activities from various subcommittees, work groups and other functional areas. A QM Coordinators meeting is held quarterly with contractors to disseminate information, provide technical assistance, and receive feedback from the contractors. The Medical Management/Utilization Management (MM/UM) Committee also provides semi-annual updates to ADHS/DBHS' QM Committee on MM/UM activities and makes recommendations to facilitate communication and coordination of improvement activities between QM and MM/UM.

ADHS/DBHS has also established a Peer Review Committee to improve the quality of medical care provided to behavioral health recipients, and provide oversight and direction to contractors in their peer review activities. The scope of peer review activities includes cases where there is evidence of a quality deficiency in the care or service provided, or the omission of care or a service, by a person or entity that subcontracts with ADHS/DBHS. Cases for peer review may be identified through various monitoring processes, including Quality of Care (QOC) concern reviews and incidents and accidents reports.

BQMO's Office of Performance Improvement (OPI) has general responsibility for ADHS/DBHS' QM functions. OPI is staffed with individuals who have the knowledge, experience, and qualifications to perform QM activities including two members of the Arizona Association for Healthcare Quality (AzAHQ) and one member of the American Society of Quality (ASQ). The Chief of BQMO, as well as multiple managers and staff, are Certified Professionals in Healthcare Quality (CPHQ). Furthermore, the Chief of BQMO is supervised by ADHS/DBHS' Chief Medical Officer, who is ultimately responsible for the direction of all QM activities and is accredited by the Utilization Review Accreditation Commission (URAC).

## IV: Narrative Plan

### S. Suicide Prevention

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

Footnotes:

## Suicide Prevention and Early Intervention

The state suicide plan is incorporated into both the Adult and Children’s System of Care plans.

**Adult System of Care Strategic Plan for Suicide Prevention:** The adult SOC plan is reviewed and reported on an annual basis.

<b>Goal:</b> <b>Reduce the Arizona suicide rate from 16.1 per 100,000 (age adjusted) to 14.0 per 100,000.</b>							
Contributing Factors	Objectives	Strategies	Evaluation Tools	Baseline	Target 2012	Target 2013	Target 2014
Early Identification of suicide risk	1. Increase comfort and ability of families and communities to identify potential risk and make referrals to BH treatment	1.1 Provide training for service members, veterans, and their families in recognizing signs of PTSD and TBI and the referral process	Suicide Prevention Training Exit Survey (TES)	To be established fall of 2011	Baseline Mean pre test score	5% increase from baseline	10% increase from baseline
		1.2 Online training for college professors and students in identifying and referring persons potentially at-risk					
		1.3 Collaborate with the Department of Economic Security in distributing awareness materials					
		1.4 Training for medical professionals in screening and assessment for suicide	Early Identification and Referral form (EIRF)	To be established fall of 2011	Baseline # of referrals to TX	5% increase from baseline	10% increase from baseline
	2. Increase comfort and ability of poison control center staff to intervene with attempters and	2.1 Conduct ASIST training with poison control center staff	TES	To be established fall of 2011	Baseline Mean pre test score	5% increase from baseline	10% increase from baseline

	make referrals to BH treatment	2.2 Develop an outreach strategy to reduce multiple overdoses	EIRF	To be established fall of 2011	Baseline # of referrals	5% increase from baseline	10 % increase from baseline
Quality of Service Delivery	3. Increase T/RBHA and BH provider organizations capacity to respond to and provide services after a suicide.	a. Develop DBHS recommendations for responding to and providing services after a suicide	Number of T/RBHA's with a policy or protocol	To be established by spring of 2012	Baseline established	100% of RBHAs	100% of RBHAs and providers
	4. Increase ability and comfort of BH providers to provide culturally competent services for service members, veterans, and their families	b. Collaborate with the Arizona Coalition for Military Families, the VA, and stakeholders to develop advanced training in cultural competency with military families for BH providers  c. Provide access to the At-Risk training for families of veterans	Training post test	To be established	Baseline	5% increase from baseline	10% improvement from baseline
	5. Improve collection of information about suicide attempts and completions	d. Collaborate with State Fatality Review program to adapt or create a standardized checklist for collection of data on adult suicides	Number of organizations adapting the checklist	To be established	Baseline	5% increase from baseline	10% increase from baseline

**Children’s System of Care Plan For Suicide Prevention:**

<b>Goal 5</b>			
Decrease statewide rates of youth suicide completion			
<b>Objective 5.1</b>			
Increase connections to natural supports			
Strategy	Tasks	Responsible Office	Target Completion Date
5.1.1 Promote efforts to create connections to natural supports in service planning	5.1.1a Utilize Statewide CFT Coaches Meetings and Statewide Transition Meetings to provide T.A. around increasing natural supports and the service planning process.	CSOC Bob Crouse	09/30/13
	5.1.1b Incorporate efforts to expand the utilization of natural supports in provider Practice Improvement Plans, as identified by SOCPR and BPR results	CSOC Bob Crouse	09/30/13
5.1.3 Collaborate with stakeholders in youth suicide prevention	5.1.3a Attend Suicide Prevention Coalition Meetings and subcommittees	Prevention Markay Adams	09/30/2013
	5.1.3b Attend the Injury Prevention Advisory Council (IPAC) coalition meetings and subcommittees	Prevention Markay Adams	09/30/2013
5.1.4 After-school and leadership programs for youth	5.1.4a Monitor subcontractor implementation of alcohol prevention focused peer leadership programs such as: <ul style="list-style-type: none"> <li>• SADD</li> <li>• YES</li> <li>• University leadership organizations</li> </ul>	Prevention Markay Adams	6/30/13

**Objective 5.2**

Increase comfort and ability of families, youth, community members, peers, family support organizations, first responders, and prevention providers to intervene in suicide and make referrals to behavioral health services

Strategy	Tasks	Responsible Office	Target Completion Date
5.2.1 Participate in Child Fatality Review to identify preventable causal factors in youth suicide	5.2.1a Participate in Child Fatality Review Committee	Prevention Markay Adams	6/30/13

**Objective 5.3**

Increase competencies of prevention and behavioral health providers to provide effective and culturally responsive care

Strategy	Tasks	Responsible Office	Target Completion Date
5.3.1 Develop advanced trainings in cultural competency and groups with disparities in suicide attempts or completions	5.3.1a Review results of the Arizona State University (ASU) climate survey as it pertains to LGBTQ youth programs with the LGBTQ Advisory Committee	Prevention Lisa Shumaker	09/30/2013
5.3.2 Implement targeted initiatives which target populations at high risk for suicide completion or attempts	5.3.2a Monitor implementation of OUTDoors Camp	Prevention Markay Adams	06/30/2013
5.3.3 Increase education on the importance of cultural (impact/influence) on life experience (analysis of underrepresented/underserved populations)	5.3.3a Analysis of Annual Diversity Report to identify strengths, needs, and gaps of target populations	Cultural Competency/OWD	09/30/13

**Objective 5.3**

Increase competencies of prevention and behavioral health providers to provide effective and culturally responsive care

	5.3.3b Analysis of Language Services Reports to identify areas of strengths, needs and gaps of target populations	Cultural Competency/OWD	09/30/13
	5.3.3c Identify, develop and provide trainings that are specific to culturally competent care, language access services and organizational supports	Cultural Competency/OWD	09/30/13

## IV: Narrative Plan

### T. Use of Technology

Narrative Question:

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In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

The implementation and adoption of new technologies designed to benefit recipients of behavioral health services, and enhance the effectiveness of the treatment network, has been limited to the use of telemedicine and videoconferencing – primarily in the more rural areas of the State. These tools have been instrumental in connecting the DBHS' Administration with their counterparts at the T/RBHAs serving rural Arizona, and allowing for statewide participation in numerous committees – making travel unnecessary in many situations. Telemedicine is also used to connect providers with behavioral health recipients in instances where a doctor or therapist is not immediately available in the local area, or in cases where it is more convenient for either party and will not adversely impact the therapeutic relationship.

At present, the Division of Behavioral Health Services is currently researching a potential enhancement to its telemedicine network through the adoption of BlueJeans (<http://bluejeans.com>) multi-party video conferencing platform, which utilizes commercially-available hardware (i.e. webcams, smartphones, laptops or tablets) to connect various parties within a conference bridge. This innovative technology completely eliminates the need for DBHS, its contractors, or our various system partners to acquire costly, proprietary, telemedicine hardware. The adoption of this software platform is still being debated internally for overall cost-effectiveness and will be largely dependent on available funding sources.

The recent economic downturn has limited the expansion and implementation of new technologies, as the treatment delivery system has focused on ensuring members receive necessary services in a timely manner; however, DBHS is currently exploring new technologies and determining which ones could be effectively adopted across the network, enhancing service provision to our recipients, while also providing the greatest marginal benefit, as a ratio to the costs associated with implementation, to our contractors. Prior efforts to adopt a software platform that would utilize text messaging to improve retention in treatment for clients has been temporarily placed on hold due to HIPPA security and member privacy concerns. Arizona will be including this issue in its request for technical assistance from SAMHSA as part of this grant application.

## IV: Narrative Plan

### U. Technical Assistance Needs

Narrative Question:

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States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) is not currently receiving technical assistance from SAMHSA. Arizona's plan, outlined in this application, has been designed largely to conform to the resources and expertise currently available to ADHS/DBHS, our contractors, and direct service providers; however, there are still some areas in which technical assistance provided by SAMHSA would be greatly appreciated, specifically:

- Implementing the allocation formula based on the completed needs assessment in a way which both maximizes the benefits for individuals receiving mental health and substance abuse prevention and treatment services across Arizona's diverse population subsets while minimizing the impact to the current network of providers;
- How to most efficiently and effectively monitor utilization of selected services at the recipient level, given the structure of Arizona's behavioral health system;
- Increased coordination and collaboration with the various Tribal Authorities of Arizona to improve treatment outcomes and build network capacity.
- Implementation of a software platform that would utilize text messaging to improve retention in treatment for clients while accounting for HIPPA security and member privacy concerns.

In addition to the above listed areas, technical assistance for behavioral health providers would be appreciated in regards to:

- Integrating behavioral health service utilization data with that of the acute care system to successfully develop and maintain a responsive disease management program;
- Improving coordination of care between the acute and behavioral health systems in cases where a recipient with a substance use disorder refuses to permit providers to contact their primary care physician – especially in cases involving the prescribing of various medications that may adversely affect the individual if taken in concert with those medications prescribed by a PCP;
- How to increase the prevalence of recipient-driven service planning while also moving towards a service delivery system that holds providers more accountable for achieving positive changes in numerous outcome measures.

Health care reform will bring new challenges to the State and represents an area which behavioral health constituents would benefit from SAMHSA's technical assistance. More specifically, ADHS/DBHS would request technical assistance regarding:

- Training elements to be included in Training of Trainers for individuals who will become peer advocates for individuals accessing integrated health care services;
- Communicating with the public the benefits of health care reform to encourage enrollment and raise awareness;
- Reaching populations with disparate treatment or prevention outcomes such as tribes, older populations and youth.

ADHS/DBHS has made, or is attempting to make, progress in several of the above areas identified. Most notable is the comprehensive, statewide needs assessment completed by an outside consultant. The information from this needs assessment has led to the development of an allocation formula for Block Grant funds based on need. DBHS recognizes that a shift in allocation will have system wide impacts and will need to address the concerns of the providers.

An additional area where ADHS/DBHS is making progress is in reviewing service encounter data. These reviews are designed to determine over and underutilization, are conducted on a recurring basis; however, given the allowed reporting window for submitting encounter claims, it is difficult to

accurately identify instances of high utilization in a timely manner and act appropriately given the circumstances. In the area of peer involvement, ADHS/DBHS is collaborating with individual communities to better understand which methods of communication is most effective in connecting with individuals regarding integrated health care. This information will be used in marketing changes in health care benefits.

## IV: Narrative Plan

### V. Support of State Partners

#### Narrative Question:

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The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.<sup>45</sup> This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
  - The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
  - The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
  - The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
  - The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.
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<sup>45</sup> SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

#### Footnotes:

The Division partners with other State agencies, including the Department of Economic Security, Juvenile and Adult Corrections, Department of Education, the Administrative Office of the Courts, the Governor's Office, and the Arizona Health Care Cost Containment System (Medicaid), to provide a comprehensive array of publicly funded services to children and adults through memoranda of understanding, intergovernmental service agreements or informal relationships. Formal partnerships include:

- Intergovernmental Agreement between ADHS/DBHS and the Department of Economic Security, Rehabilitation Services Administration (DES/RSA): An agreement exists between these two state agencies in order to increase coordination and facilitate the expansion of vocational rehabilitation services.
- Intergovernmental Agreement between ADHS/DBHS and Pima County Board of Supervisors: This agreement states that ADHS/DBHS shall provide a comprehensive, community-based system of mental health care for persons residing in Pima County with serious mental illness.
- Interagency Services Agreement between ADHS/DBHS and the Department of Economic Security, Division of Developmental Disabilities (DES/DDD): The two agencies collaborated to finalize a practice improvement protocol for "Pervasive Developmental Disorders and Developmental Disabilities". ADHS/DBHS provides training and technical assistance to the T/RBHAs around the protocol as needed or requested.
- Interagency Services Agreement between ADHS/DBHS and the Arizona Department of Housing (ADOH): This agreement was developed with the purpose of outlining duties to be performed by ADOH to provide technical assistance, project underwriting, and risk assessment analysis, as well as making final recommendations to ADHS/DBHS on the feasibility of funding particular housing projects for persons with serious mental illness.
- Intergovernmental Agreement between ADHS/DBHS and Maricopa County Board of Supervisors
- The Arizona Substance Abuse Partnership (ASAP): The Arizona Substance Abuse Partnership serves as the single statewide council on substance abuse issues. ASAP brings together stakeholders at the federal, state, tribal and local levels to improve coordination across state agencies; address identified gaps in prevention, treatment and enforcement efforts, and; improve fund allocation. ASAP utilizes data and practical expertise to develop effective methods for integrating and expanding services across Arizona, maximizing available resources. ASAP also studies current policy and recommends relevant legislation for the Arizona Legislature's consideration.
- Arizona Suicide Prevention Coalition: T/RBHAs, contracted providers, and DBHS are all active participants in the Arizona Suicide Prevention Coalition. This group conducts research and gathers data, creates publicity and works to make policy changes. Areas of focus include the media, Native Americans, older adults, and youth.
- Arizona Children's Executive Committee (ACEC): ACEC brings together multiple state and government agencies, community advocacy organizations, and family members of children/youth with behavioral health needs to collectively ensure that behavioral health services are being provided to children and families according to the Arizona Vision and 12

Principles. ACEC strives to create and implement a successful system of behavioral health care in Arizona by serving as a state-level link for local, county, tribal and regional teams.

Representatives from many of these organizations are members of, and actively participate on, the Arizona Behavioral Health Planning Council. Per the new guidelines of the National Block Grant requirements, and in response to the recommendations of the Substance Abuse and Mental Health Services Administration (SAMHSA), Arizona's Behavioral Health Planning Council moved to incorporate substance abuse prevention and treatment subject matter expertise in fiscal year 2012. The Council is tasked with the following responsibilities:

- Reviewing plans and submitting to the State any recommendations for modification.
- Serving as an advocate for adults with a serious mental illness and children who are seriously emotionally disturbed, including individuals with mental illnesses or emotional problems.
- Monitoring, reviewing, and evaluating, not less than once per year, the allocation and adequacy of mental health services in Arizona.
- Participating in improving mental health services within Arizona.

## IV: Narrative Plan

### W. State Behavioral Health Advisory Council

#### Narrative Question:

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Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

#### Footnotes:

The Arizona Behavioral Health Planning Council has a strong, positive relationship with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS). Arizona has had an integrated public behavioral health system for many years and continues to strive for integration improvement. The Deputy Director (also known as Commissioners in other states) and CEO of the state hospital are active members of the Council; attending meetings, providing reports, and requesting feedback on initiatives or concerns. The Council meets across Arizona to consult with local area community members and behavioral health service providers to learn of local accomplishments and issues; the Council then provides this information to ADHS/DBHS, with recommendations for resolving these identified issues.

The Planning Council has had integrated representation between mental health and substance abuse since 1999 with the participation of a substance abuse provider. The Council recognizes the importance of increasing its expertise of substance abuse particularly with the integration of mental health and substance abuse funding through the Block Grant. A poll of the Council membership in September, 2012 demonstrated that 80 percent of Council members work in the substance abuse field, were a person in substance abuse recovery, or have a family member with substance abuse challenges. The Council has a strong utilization of persons experienced in substance abuse treatment, and continually strives to improve representation among its members. The Council conducted a review of its current membership and determined to dedicate six identified vacancies to persons who have substance abuse expertise. Thus far, one new Council member with expertise in this area has joined. Recruitment efforts for more candidates with substance abuse background are proceeding.

The Council strives to ensure that its membership is reflective of the diverse cultures in Arizona. Currently, the Council has one American Indian individual, who is the family member of an adult with a Seriously Mentally Ill (SMI) diagnosis, and includes representation of African American members, older adults, and family members of young children. Additionally, the Council recruits and retains individuals throughout the state, including individuals from Tucson, Southeastern Arizona (Sierra Vista, San Manuel), and Northern Arizona (Lake Havasu City). However, the Council understands the importance of its membership being representative of the state and continues its recruitment efforts, particularly when meeting in rural and remote locations; this allows membership that is mixed between urban and rural participants.

One of the Council's priorities is monitoring behavioral health services to Arizona's American Indian population. Meetings have been scheduled over the years at various Arizona Indian reservations. In 2013, the Council met with the Colorado River Indian Tribe (located in Parker, Arizona), Pascua Yaqui Tribe (located in southern Arizona, southwest of Tucson), and the Gila River Indian Health Care Authority (located south of the Phoenix area). The Council listened to presentations and the challenges the tribes face in delivering behavioral health services on their reservations, and share the information with ADHS/DBHS at Council meetings, or via white/position papers.

The first Arizona Mental Health Planning Council was created in 1988 in response to Public Law 99-660. Members were appointed by the Governor to serve a term until September 30, 1990, the date P.L. 99-660 expired. No action was taken by the Governor to reappoint or otherwise reconstitute the Council. Recognizing the need for a Planning Council, the Department Director appointed a new Behavioral Health Planning Council, expanding membership and roles to encompass planning for not only adults with a serious mental illness and seriously emotionally disturbed children, but also for individuals with substance abuse disorders.

The Council is charged with the mission of:

- Reviewing plans and submitting to the State any recommendations for modification.
- Serving as an advocate for adults with a serious mental illness and children who are seriously emotionally disturbed, including individuals with mental illnesses or emotional problems.
- Monitoring, reviewing, and evaluating, not less than once per year, the allocation and adequacy of mental health services in the State.
- Participating in improving mental health services within the State.

Appointments to the Arizona Behavioral Health Planning Council are made in several ways (depending on the membership requirements). For consumers, family members, parents and service providers, the Planning Council's Executive Committee finds and nominates individuals to join membership. After the nomination has been brought to the full Council for approval, the Council submits a letter of recommendation to the ADHS/DBHS Deputy Director, who determines if the nominee will be appointed. RBHAs may appoint a representative from their service area who is knowledgeable about behavioral health services in the geographic area they represent. When more than one urban or rural RBHA or wish to be represented on the Council, the current RBHA representative will serve their three year term and then rotate to a different RBHA. One Tribal Regional Behavioral Health Authority (TRBHA) may also participate on the Council, though that position is currently vacant.

Each Council member serves for three (3) years. If the individual is not automatically re-appointed after the three year term, there is a "grace period". This grace period of 180 days allows for the Council's Executive Committee to review all the representatives who are due for reappointment at a specific time period as defined in the Council By-Laws. The Executive Committee reviews members' terms at Committee meetings in April and October. During this time, members with expiring terms will be identified, and member recommendations will be made by the Chair to the ADHS/DBHS Deputy Director. Re-appointments and new appointments will be based on participation, mandated representation and willingness of Council members to serve on both the Council and its Committees.

The Arizona Behavioral Health Planning Council meets monthly, with the exception of July and August. The Planning & Evaluation Committee meets during the summer to complete the Mental Health Plan portion of the Block Grant application. Meetings are held in the state capitol (Phoenix) as well as various locations around the state. Meetings held in local communities allow the Council to meet with the agencies that provide behavioral health services, as well as with recipients of such services. The Council's standing committees also meet regularly and are used to assist the Council in its responsibilities by reviewing specific issues or concerns and by developing recommendations.

The Council is active in reviewing and tracking state and federal legislation relating to mental health services; this work is then turned into the development and dissemination of position papers, providing testimony at legislative hearings, and advocating for the populations the Council is appointed to serve. The Council is also kept abreast of current issues, programs, upcoming grants, and other topics in the behavioral health field, and acts as an advisory body to the State. Reports on the Block Grant are included on the Planning and Evaluation Committee as well as the full Council agendas for discussion and feedback to the State.

The Council meets with ADHS/DBHS staff who are directly involved in the statistical and financial data collection, and subsequent Block Grant development. This happens during regularly scheduled Council meetings as well as specially scheduled sessions to develop the Community Mental Health Services (CMHS) and Substance Abuse Prevention and Treatment (SAPT) Block Grant. These meetings provide an

opportunity to share updates and feedback on priorities, issues, and other relevant topics related to the Block Grant.

The Council develops a letter annually to accompany the Block Grant application; the letter identifies the activities and accomplishments of the Council during the calendar year, as well as challenges and issues that face Arizona's public behavioral health system. Recommendations are included in the letter for improving the system. A letter is also developed in conjunction with the annual Block Grant Implementation Report.

Adult and Children System of Care Plans provide a mechanism for planning and implementation of mental health and substance abuse services within the state. Multiyear plans are developed and updates are submitted to ADHS/DBHS staff biannually. Beginning in FY14, the Planning Council will be included in this process with the System of Care Plans being disseminated for review and feedback. The process allows the Council, ADHS/DBHS, and RBHAs to develop effective and efficient plans through a series of reviews and feedback provisions. Information gathered from the review and planning process is shared with the Planning Council; any requests for recommendations, comments, and concerns from the Council are made by ADHS/DBHS.

ADHS/DBHS staff met with the Council's Planning and Evaluation Committee in the fall of 2012 to discuss the new priority areas in the FY 2014-2015 Combined Planning Application and proposed timeline. ADHS/DBHS staff received feedback from the Committee regarding the new priorities and data needed to respond to them. Throughout 2012, ADHS/DBHS staff also worked with the Council regarding a proposed change in the funding allocation methodology for the SAPT/CMHS Block Grant. The ADHS/DBHS Chief Financial Officer met with the Planning and Evaluation Committee to discuss some of the changes the State is envisioning in the methodology. In addition, the Council met with the Community Partnership of Southern Arizona's (CPSA) Chief Financial Officer to learn how CPSA allocates its funding and how it may impact its potential new allocations.

# ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL

150 North 18<sup>th</sup> Avenue, 2<sup>nd</sup> Floor

Phoenix, Arizona 85007

April 1, 2013

Ms. Barbara Orlando  
Grants Management Specialist  
Division of Grants Management, OPS  
SAMHSA  
1 Choke Cherry Road, Room 7-1091  
Rockville, MD 20850

Dear Ms. Orlando:

The Arizona Behavioral Health Planning Council is required by Public Law 103-321 to review Arizona's Mental Health and SAPT Services Plan for Children and Adults for Fiscal Year 2014. This must occur before it is submitted to the United States Department of Health and Human Services (DHHS) so that Arizona may receive the federal Mental Health Block Grant and the federal SAPT Block Grant for 2014. The Planning Council is submitting this letter to the Center for Mental Health Services with comments and recommendations regardless of whether they have been accepted by the State.

Arizona continues to experience challenging economic circumstances. The Planning Council continues to be concerned with the impact of the situation on those with behavioral health needs. In SFY 2013, \$39 million was restored to fund services directed toward Non-Title XIX eligible adults deemed to be Seriously Mentally Ill. Although these restored funds increased the range and scope of services for this group, the system thus far has had difficulty engaging this population. Non-Title XIX persons with SMI have become isolated and distrustful of the system that had abandoned them. This leaves more work to do. Because of this situation Emergency Room visits have become the route that this population has resorted to at the price of losing coordinated and more comprehensive services now becoming available. Also, incarcerations of persons with SMI are up.

The state's freeze on AHCCCS Care enrollment for the childless adult program was the source of the serious impact on the SMI population but it also was detrimental to the Arizona Child Protective Services program. When CPS must remove children from the home due to abuse or neglect, if the family were receiving behavioral health services, once the children are removed from the home, most parents will lose their AHCCCS eligibility and the behavioral health services that they were receiving. CPS has seen an increase in its expenditures for behavioral health and substance abuse treatment since the economic crisis began.

**"...to advise, review, monitor, and evaluate all aspects of the development of the State Plan"  
(Public Laws 99-660, 100-639, and 102-321)**

The economic crisis has placed families in greater risk. The foster care population has increased from 10,707 in October 2010 to 14,111 in October 2012. While this greater burden has fallen on the child welfare system, foster homes are scarcer and worker caseloads have ballooned. Recently, the Arizona Legislature has begun taking steps to increase Children's Protective Services staffing to address this problem.

A positive development in the children's area is that Arizona's freeze on KidsCare (Title XXI) was relaxed with a limited reopening of the program in SFY 2013.

In the housing area, Arizona's State Housing Trust Fund which was created in 2011, continues to develop permanent housing for adults with SMI and has also provided very much needed emergency funding for homeless shelters.

A potentially positive development is a rebidding process that just recently resulted in selection of a new organization that will manage behavioral health services for all service recipients in Maricopa County and integrated behavioral and primary health care for Title XIX persons with Serious Mental Illness. This new development is intended to address the significant disparity between life expectancy for a person with SMI versus the general population. Many changes will come with this new system of care. The Council is hopeful for the prospects that this new system of care may offer.

While Arizona has struggled with serious funding pressures, there have been areas where service development has been occurring. One area has been around the need to better support youth who transition from the children's behavioral health system to the adult behavioral health system. Several programs have been developed to help make the transition less difficult. But much more work needs to be done in this area.

The children's behavioral health system has been utilizing the Child and Family Team (CFT) process for over a decade. There were some changes made in SFY 2011 to relax some requirements in the process for children who have less complex needs. These changes were welcomed throughout the system; however, concerns have developed about fidelity to the CFT process within the system. The long period of time of applying these principles statewide appears to have resulted in a stale and less robust process than is intended.

As a result of the tragedy in Tucson in January 2011 resulting in the shooting of Congresswoman Gabrielle Giffords and 17 others, the ADHS implemented Mental Health First Aid (MHFA). The program is a public education effort to teach the public to identify, understand, and respond to signs of mental illnesses and substance use disorders.

The 12-hour course presents an overview of mental illness and substance use disorders. Students are introduced to risk factors and warning signs of mental health problems and common treatments.

Just as CPR training helps one assist someone following a heart attack, MHFA training helps individuals assist someone experiencing a mental health crisis, such as contemplating suicide. Trainees are taught how to apply a five-step strategy in a variety of situations, such as helping someone through a panic attack or assisting someone who has overdosed.

[Mental Health First Aid](#) teaches a five-step action plan - *ALGEE* - to help to someone who may be in crisis.

- Assess for risk of suicide or harm
- Listen nonjudgmentally
- Give reassurance and information
- Encourage appropriate professional help
- Encourage self-help and other support strategies

ADHS/DBHS has certified 2,628 community members since the roll-out, who are known as "MHF-Aiders".

Another valuable development in the Arizona Behavioral Health System has been the introduction of Trauma Informed Care (TIC) dialogues and training. Research has indicated that most consumers of mental health services are trauma survivors and that their trauma experiences help shape their responses to outreach and services. Trauma Informed Care (TIC) is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma has played in their lives. The Regional Behavioral Health Authorities conducted a series of TIC Dialogues throughout Arizona in 2011-2012, and provided ADHS with valuable information of the needs and assets in the community. A needs assessment is being developed and will assist in formulating an implementation plan for the coming years.

Under SAPT funding, ADHS funds a robust prevention program that has achieved important progress in reducing alcohol and prescription drug abuse among teens. An area which has developed as a challenge has been Marijuana Use where Arizona has seen an increase. The Council assumes that this increase is related to recent voter approval of Medical Marijuana legislation. The conflict between what is seen as a legal activity and what is also seen as harmful to youth, has been a challenge to the work of the SAPT-funded prevention programs.

The Council continues its work to identify needs and issues in the behavioral health system. A combined committee of the Community Advisory Council and the Children's Committee has reviewed a "Safety Card" which was originally developed for children or their parents to carry to identify their diagnosis, contact information and directions about best interventions in the case of a behavioral health crisis. The committees have revised the card for more general use in the behavioral health population and are currently seeking funding to have the cards printed.

In conjunction with the process of review of the Block Grant Plans, the Council has undertaken broader responsibilities to review implementation of services in adult and children's behavioral health. The Council will be reviewing Adult and Children's System of Care Plans for each Regional Behavioral Health Authority (RBHA). Then, the Council will track performance for the RBHAs against their plans. This role will better integrate Council activities to the overall implementation of services that are funded by the block grants.

The Planning Council continues to work to be an effective and efficient working group. Over the past two years, the Council has sought to add members who have substance abuse background. One has been added and three more are in the process of application and screening. The Council continues to travel to rural areas of the state as well as meeting in metropolitan areas of Phoenix and Tucson to provide members with an overview of the existing system and has facilitated input from all regions into state planning activities.

The Planning Council continues to work to be an effective and efficient working group. Its membership extends across the state and also reflects the diversity of our state and the diversity of the populations served in the Arizona behavioral health system.

Thank you for the opportunity to provide comment on the State Mental Health and SAPT Plan. The Council continues its mission to review, monitor and evaluate all aspects of the development of this plan.

Sincerely,

*AER for*

*Vicki L Johnson*

Vicki L. Johnson  
Chair Planning Council  
Chair, Planning and Evaluation Committee

## IV: Narrative Plan

### Behavioral Health Advisory Council Members

Start Year:   
 End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Vicki Johnson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		5409 West Siesta Way Laveen, AZ 85339 PH: 480-236-2552	vlj30@cox.net
Tonya Greenler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		11481 W. Rock Village Street Marana, AZ 85658	TonyaGreenler@comcast.net
Jannifer Alewelt	State Employees	AZ Center for Disability Law		jalewelt@azdisabilitylaw.org
John Baird	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1036 3rd Avenue San Manuel, AZ 85651 PH: 520-385-2667	johnbaird1@hotmail.com
Karia Basta	State Employees	AZ Department of Housing		karia.basta@azhousing.gov
Deanna Bellinger	Parents of children with SED		1201 East Fry Boulevard Sierra Vista, AZ PH: 520-452-0080	deannab@seacrs.com
Andrea Benkendorf	State Employees	DES/Rehabilitation Services		abenkendorf@azdes.gov
Michael Carr	State Employees	DES-DCYF		mcarr@azdes.gov
Steve Carter	Providers	NOVA, Inc		scarter144@aol.com
Julia Engram	Parents of children with SED		12841 West Aster Drive El Mirage, AZ 85335 PH: 623-875-7607	juliaengram@cox.net
Gita Enders	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		7791 East Osborn Road, Apt. 182E Scottsdale, AZ 85251 PH: 928-301-4789	genders@gmail.com
Kristin Frounfelker	State Employees	AHCCCS		kristin.frounfelker@azahcccs.gov
Sue Gilbertson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		3023 East Pershing Phoenix, AZ 85032 PH: 602-867-0310	sgilbertson@cox.net
Phyllis Grant	Parents of children with SED		4500 East Speedway, Suite 58 Tucson, AZ 85712 PH: 520-882-0142	phyllisg@mikid.org
Dan Haley	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1200 North Country Club Drive Tucson, AZ 85716 PH: 520-770-1197	danielhaley@hopetucson.org

Sandra Koloske	Family Members of Individuals in Recovery (to include family members of adults with SMI)	447 South Meadowood Lane Sierra Vista, AZ 85635 PH: 520-678-4541	sandilkn@msn.com
Alida Montiel	Family Members of Individuals in Recovery (to include family members of adults with SMI)	2214 North Central Ave #100 Phoenix, AZ 85004 PH: 602-258-4822	alida.montiel@ictaonline.com
Cory Nelson	State Employees	Arizona State Hospital	cory.nelson@azdhs.gov
Susan Ramsey	Others (Not State employees or providers)	3555 Indian Peak Drive Lake Havasu City, AZ	bethhj@frontiernet.net
Dr. James Wilson	Family Members of Individuals in Recovery (to include family members of adults with SMI)	2123 West Chambers Street Phoenix, AZ 85041 PH: 602-332-2249	

Footnotes:

## IV: Narrative Plan

### Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	30	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	4	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	5	
Parents of children with SED*	3	
Vacancies (Individuals and Family Members)	<input type="text" value="8"/>	
Others (Not State employees or providers)	1	
Total Individuals in Recovery, Family Members & Others	21	70%
State Employees	6	
Providers	1	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="2"/>	
Total State Employees & Providers	9	30%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="4"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="0"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	4	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="0"/>	

\* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

The Arizona Behavioral Health Planning Council has reviewed this planning application per Public Law 103-321. Please see section W for additional information regarding the Planning Council's involvement in the Arizona Behavioral Health System.

Footnotes:

## IV: Narrative Plan

### X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

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Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

The Division of Behavioral Health Services is preparing to allocate 3 percent of both the Community Mental Health Services, and Substance Abuse Prevention and Treatment (CMHS/SAPT) Block Grants to our contractors with the explicit purpose of expanding provider capacity to promote and streamline member enrollment into the service delivery system and enhance provider capacity to bill public and private insurance.<sup>1</sup>

It is our intent to allow the Regional Behavioral Health Authorities to best determine how these monies are used to provide the greatest net benefit to both our members, as well as the provider community; since the provider organizations are at differing levels of implementation readiness for the Affordable Care Act, it is likely that the 3 percent set-aside will be directed toward the following key objectives:

- Providing Infrastructure enhancements to current billing systems;
- Providing expert, impartial, technical assistance on member enrollment practices;
- Training staff on the new financial screening process, including how to assist members in applying for coverage through the Health Insurance Marketplace, and;
- Hiring peer navigators to work with members as they enroll for services and apply for coverage.

The Governor's Office for Health Insurance Exchange is also working diligently to implement a statewide navigator program under the requirements of the Patient Protection and Affordable Care Act. This program is expected to issue grant applications in early 2014 and will award to qualified groups throughout Arizona.

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<sup>1</sup> The 3 percent set-aside is pending Congressional approval at the time of this application. Should Congress fail to approve the set-aside, the State has requested that SAMHSA not disallow expenditures incurred to meet the expectations of this section.

## IV: Narrative Plan

### Y. Comment on the State BG Plan

Narrative Question:

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Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

The Joint Block Grant Planning Application for 2014-2015 was released for public comment, and posted on the ADHS/DBHS website (<http://www.azdhs.gov/bhs>), on March 1, 2013, upon the conclusion of the initial drafting process. Pertinent stakeholders, including State partner agencies, the Regional and Tribal Regional Behavioral Health Authorities, members of the Arizona Behavioral Health Planning Council, peer and family run organizations, and front-line services providers were notified via email, and during in-person meetings, of its availability and were encouraged to review its contents and submit comments as necessary. This included more than 4,000 individuals subscribing to the ADHS/DBHS' Office of Individual and Family Affairs' list serve.

Additionally, as seen below, ADHS/DBHS took the added step of broadcasting the application's availability via multiple social-media outlets, including an announcement, or "tweet" on the Arizona Department of Health Services Twitter account ([@AZDHS](https://twitter.com/AZDHS)) which has approximately 5,700 active followers), and posting on the Department's Facebook page (<http://www.facebook.com/azdhs>) - approximately 2,530 followers.



A screenshot of a Facebook post from the Arizona Department of Health Services. The post header includes the department's logo and name, "Arizona Department of Health Services", and the time "40 minutes ago". The main text of the post reads: "We welcome your input! We currently have our substance abuse and general mental health block grant planning application available for public comment. You can provide your comments any time until the end of March. For more details: <http://1.usa.gov/ZqyLfR>". At the bottom of the post, there are buttons for "Like", "Comment", and "Share".



A screenshot of a tweet from the Arizona Department of Health Services (@AZDHS). The tweet header shows the department's logo and name, "AZ Dept. of Health @AZDHS", and the time "50 mins". The main text of the tweet reads: "Behavioral health block grant planning application available for public comment now! [1.usa.gov/ZqyLfR](http://1.usa.gov/ZqyLfR)". Below the text is an "Expand" link.



STATE OF ARIZONA

JANICE K. BREWER  
GOVERNOR

EXECUTIVE OFFICE

May 17, 2010

Barbara Orlando  
Grants Management Specialist  
Division of Grants Management, OPS  
SAMHSA  
1 Choke Cherry Road, Room 7-1091  
Rockville, Maryland 20857

Dear Ms. Orlando:

I am designating Will Humble, Director at the Arizona Department of Health Services, as the signature authority for the Substance Abuse Prevention and Treatment Block Grant, the Projects for Assistance in Transition from Homelessness (PATH) and Community Mental Health Services Block Grant. The authority includes the signing of any standard federal forms such as the Assurances, Certifications and Disclosure of Lobbying Activities. I also designate that Mr. Humble shall have signature authority during my term as Governor of Arizona.

If you have any questions, please contact Mr. Humble at (602) 542-1027.

Sincerely,

A handwritten signature in cursive script that reads "Janice K. Brewer".

Janice K. Brewer  
Governor

JKB:bkl