

Arizona

UNIFORM APPLICATION

FY 2016/2017 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

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

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 10/02/2015 5.50.12 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year 2016

End Year 2017

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, Grants Management and Information Systems

Mailing Address 150 N. 18th Avenue; Suite 240

City Phoenix, AZ

Zip Code 85007

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

First Name Cara

Last Name Christ

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 Cara.Christ@azdhs.gov

State CMHS DUNS Number

Number 804745420

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 220

City Phoenix

Zip Code 85007

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

First Name Kelly

Last Name Charbonneau

Agency Name Arizona Department of Health Services

Mailing Address 150 N. 18th Avenue, Suite 220

City Phoenix

Zip Code 85007

Telephone 602-364-1356

Fax

Email Address kelly.charbonneau@azdhs.gov

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

From

To

IV. Date Submitted

Submission Date 9/1/2015 7:36:17 PM

Revision Date 10/2/2015 5:48:31 PM

V. Contact Person Responsible for Application Submission

First Name Kelly

Last Name Charbonneau

Telephone 602-364-1356

Fax

Email Address Kelly.Charbonneau@azdhs.gov

Footnotes:

State Information

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

Fiscal Year 2016

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
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Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION 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). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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

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

Name of Chief Executive Officer (CEO) or Designee: Cara Christ, MD

Signature of CEO or Designee¹: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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Fiscal Year 2016

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

Name of Chief Executive Officer (CEO) or Designee: Cara Christ

Signature of CEO or Designee¹: 

Title: Director

Date Signed: 08/14/2015

mm/dd/yyyy

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

Footnotes:

State Information

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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
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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.
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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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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.
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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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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.).
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16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION 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). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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

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

Name of Chief Executive Officer (CEO) or Designee: Cara Christ, MD

Signature of CEO or Designee¹: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

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

Footnotes:

State Information

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

Fiscal Year 2016

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 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 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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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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Name of Chief Executive Officer (CEO) or Designee: Cara Christ

Signature of CEO or Designee¹: [Handwritten Signature]

Title: Director

Date Signed: 08/14/2015

mm/dd/yyyy

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

Footnotes:

State Information

Disclosure of Lobbying Activities

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

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

Name	<input type="text" value="Cara Christ, MD"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="Arizona Department of Health Services"/>

Signature: _____ Date: _____

Footnotes:

Please see attachment for signature.

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: Cara Christ
Title: Director
Organization: Arizona Department of Health Services

Signature: *C. M. Christ* Date: 08/14/2015

Footnotes:

Planning Steps

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

Narrative Question:

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, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

B-1 SYSTEMIC STRENGTHS AND NEEDS

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 (SABG), as well as the State Mental Health Authority (SMHA) for the Community Mental Health Services Block Grant (MHBG). 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 treatment 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 Department of Child Safety (DCS), 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.

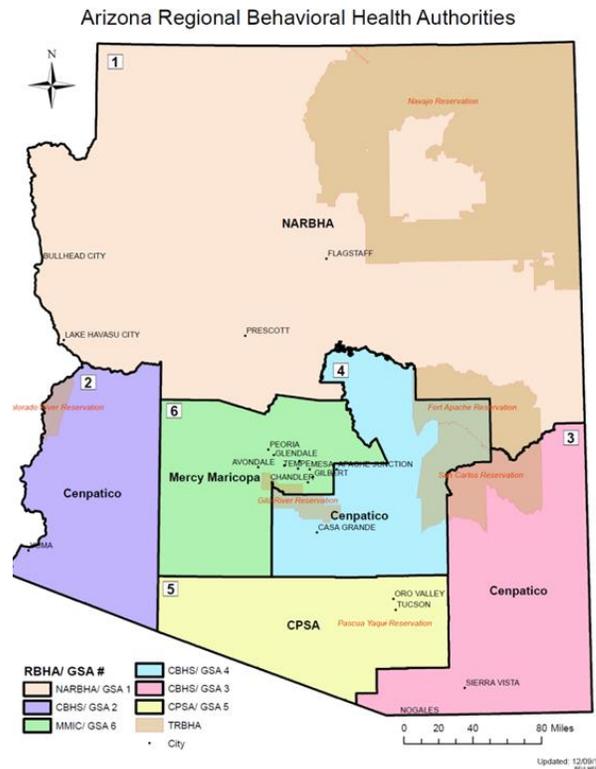
ADHS/DBHS contracts with Regional Behavioral Health Authorities (RBHAs) and Tribal Regional Behavioral Health Authorities (TRBHAs) to administer integrated managed care delivery services in six distinct geographic service areas (GSAs) throughout the State (please see map, next page). The T/RBHAs, in 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 DCS and those in foster care.

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 the ADHS/DBHS staff. Additionally, the ADHS/DBHS regularly contracts

B-1 SYSTEMIC STRENGTHS AND NEEDS

with outside consultants for independent system-wide, or population-specific, evaluations, as required by Federal regulations.

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).



System Transformation

Arizona is undergoing a large scale system shift to better serve individuals within the public health system. In 2015, Arizona legislation was passed for Administrative Simplification which combines the oversight and contract functions of the ADHS/DBHS with the state Medicaid authority, Arizona Health Care Cost Containment System (AHCCCS) by July 1, 2016. While behavioral health services and medical services have been bifurcated in the past, the recently awarded contracts were for an integrated, behavioral health and acute care system. With the integration, Administrative Simplification will remove a layer of contracting, allowing for more direct contact with service providers. This shift will impact the SABG and MHBG as the SSA and MHA designation will move to AHCCCS so that the continuation of braided funding between state and federal funds can continue.

Continuum of Care

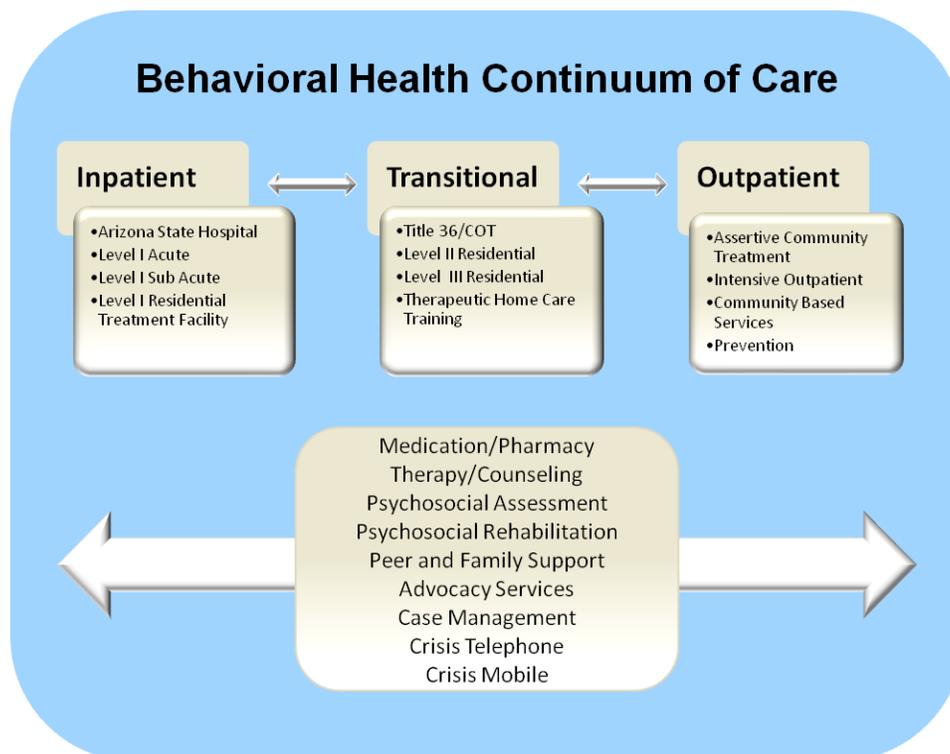
Arizona has been recognized as a leader in the public behavioral health field in its managed care approach to service delivery. ADHS/DBHS focuses its efforts and energies toward providing

B-1 SYSTEMIC STRENGTHS AND NEEDS

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, the ADHS/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, the ADHS/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 that the network is capable of sufficiently addressing the disparate needs of various groups, including racial and ethnic minorities, the LGBTQ community, and other historically underserved populations.



Crisis services are available to anyone, regardless of eligibility, 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

B-1 SYSTEMIC STRENGTHS AND NEEDS

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.

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.

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.

B-1 SYSTEMIC STRENGTHS AND NEEDS

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' System of Care Plan to assess identified network development and/or enhancement needs. The plan is evaluated by the ADHS/DBHS System of Care staff and feedback regarding progress, barriers, and priorities are shared with the T/RBHA.

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. The outcome of this analysis determines whether the current network is sufficient for each RBHA. Each RBHA

B-1 SYSTEMIC STRENGTHS AND NEEDS

develops a network report and plan, which is extensively reviewed by the ADHS/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 March, 2015, is summarized in the table below.

Service Type	Provider Billing Type	GSA 1	GSA 2	GSA 3	GSA 4	GSA 5	GSA 6	Total # of Contracted Providers
Inpatient (w/organized psych unit) & Sub-acute	02, 71, A6, B5	23	14	1	3	33	89	*122
Level I Residential Facility	78, B1, B2, B3	6	4	0*	1	7	9	*12
Behavioral Health Residential Facility	74, A2, B8	52	19	4	9	68	146	*298
Behavioral Health Outpatient Facility	77	99	66	31	40	191	354	*618
Pharmacy	3	1178	999	32	49	1091	1125	*1237
PCP (Integrated RBHA only)							2264	*2264
Dental Services (Integrated RBHA only)							280	*280

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.¹

Health Integration

¹ SABG 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).

B-1 SYSTEMIC STRENGTHS AND NEEDS

In order to improve the delivery of integrated health services, ADHS/DBHS has implemented a Demonstration project for Medicaid-eligible adults with an SMI in Maricopa County which began April 1, 2014. 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 high risk groups with a particular focus on care and disease management for select conditions, including diabetes, chronic obstructive pulmonary disease (COPD) and cardiac disease.

Planning Steps

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

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

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](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, 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.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)¹⁸ HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

¹⁸ <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

The 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 Tribal and Regional Behavioral Health Authorities (T/RBHAs) to ensure that efficient resource allocation permits system capacity to correlate with service demand. The ADHS/DBHS continues to work towards a data driven decision-making process when assessing prevention, subvention, and treatment needs for both mental health and substance use disorders. The State has received the recommendations from the May, 2014 Combined Core Technical Review and has begun work to incorporate comments such as improving reporting measures and expanding membership of the Behavioral Health Planning Council. 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) provides the underlying methodology used by the ADHS/DBHS to quantify substance abuse treatment need in Arizona.¹ 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 SABG, 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. In Arizona, in Fiscal Year (FY) 2014, there were over 221,000 individuals enrolled in the public behavioral health system. Of those, 24,749 or 11.2 percent received substance abuse treatment services.

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. 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:

¹ 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.

- 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.

The SEOW seeks to develop the capacity of community coalitions, policy advisors, and other key stakeholders to make policy and programming decisions informed by data. This is achieved through the development of the Community Data Project (CDP) and by providing training and technical assistance to guide a data-driven decision-making process that utilizes the CDP and other data sources. To enhance a data-driven decision-making approach in Arizona, the CDP website was created as an interactive, user-friendly central repository for state, county, and community-level indicators that highlight the misuse and abuse of alcohol, tobacco, prescription, and illicit drugs, the associated consequences, and the context in which substance misuse/abuse occurs. Data are displayed at multiple levels, across demographics, and over time. Output options include tables, graphs, maps, and downloadable data files to cover a variety of reporting and visualization needs.

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 the ADHS/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.

The 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.

Tool	Administration Method	Frequency of Administration	Theme	Important Findings
<p>Arizona Department of Health Services Title V needs assessment Affordable Health Care Act Maternal, Infant, and Early Childhood Home Visiting Program</p> <p>Arizona Needs Assessment 2010</p>	<p>Includes a review of epidemiological data combined with community input.</p>	<p>Once</p>	<p>Behavioral and physical needs of women</p>	<p>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.</p>
<p>Arizona Health Status and Vital Statistics 2010</p> <p>http://www.azdhs.gov/plan/report/ahs/ahs2010/toc10.htm</p>	<p>Collection of data</p>	<p>Statistics are updated annually</p>	<p>Morbidity and mortality of Arizonans</p>	<p>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.</p>
<p>Arizona Behavioral Health Epidemiology Profile 2011</p> <p>http://sirc.asu.edu/evaluations-contracts/pdfs-for-reports/arizona-behavioral-</p>	<p>Compilation of state and community level statistics</p>	<p>One time</p>	<p>Substance Abuse</p>	<p>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</p>

Tool	Administration Method	Frequency of Administration	Theme	Important Findings
health-epidemiology-profile				<p>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.</p> <p>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.</p>
<p>Arizona Youth Survey</p> <p>http://www.azcjc.gov/ACJC.Web/sac/AYSReports/2012/AYS%2012%20Report%20Final%2012%2031%202012.pdf</p>	8 th , 10 th , and 12 th grade students	Every 2 years	Substance use, risk and protective factors	<p>Alcohol is the most prevalently used substance for youths in AZ.</p> <p>In 2010 there was a dramatic statewide rise in 30 day use of Marijuana among Arizona 8th, 10th, and 12th grade students.</p>
<p>St Luke's Health Initiative 2010 Arizona Health Survey</p> <p>http://www.arizonahealthsurvey</p>	Adults	One time only	Substance Abuse & Mental Health needs of	Veterans have higher rates of alcohol use than general public

Tool	Administration Method	Frequency of Administration	Theme	Important Findings
.org/wp-content/uploads/2011/05/ahs-2010-veterans-May11.pdf			Arizonans	
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	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

Tool	Administration Method	Frequency of Administration	Theme	Important Findings
			to serve patients.	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

Tool	Administration Method	Frequency of Administration	Theme	Important Findings
				Arizona reporting this behavior declined from 34.8 percent in 2003 to 27.4 percent in 2009.
Arizona Community Data Project http://www.bach-harrison.com/arizonadataproject/Indicators.aspx	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 by reviewing prior utilization data, understanding trends in treatment expenditures and working with partner agencies to identify areas of need. In FY2014, ADHS/DBHS served 74,050 children and 147,322 adults, of which 45,521 were determined to have a SMI diagnosis. It important to note that this data represent those who receive services through 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 there may be substantially higher estimates for a statewide count looking at the entire population.

Assessing the Overall Enrollment Population

Collecting and reviewing past years’ behavioral health enrollment data in comparison to available needs assessment information allows the ADHS/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.² In FY 2014 the ADHS/DBHS provided behavioral health services to over 221,000 individuals

FY 2014 Enrollment

Counties	T/RBHA	Number Enrolled	Percent of Clients Enrolled Statewide
Apache	Northern Arizona Regional Behavioral Health Authority (NARBHA)	27,184	12.3%
Coconino			
Mohave			
Navajo			
Yavapai			
La Paz	Cenpatico Behavioral Health	28,739	13.0%

² Consumer Enrollment and Demographic data is available in October for the preceding state fiscal year.

Yuma	Services (CBHS)		
Cochise			
Gila			
Graham			
Greenlee			
Santa Cruz			
Pinal			
Pima	Community Partnership of Southern Arizona (CPSA)	51,462	23.3%
Maricopa	Magellan of Arizona/ Maricopa Integrated Care*	110,981	50.1%
Tribal Authority	Navajo Nation	602	0.3%
Tribal Authority	Gila River Indian Community	1,589	0.7%
Tribal Authority	Pascua Yaqui	763	0.3%
Tribal Authority	White Mountain Apache	52	0.02%

Behavioral Health Category (FY 2014)		
Client Group	Count	Percent of Total
Child / Adolescent	74,050	33.5%
Adult—SMI	45,521	20.6%
Adult—GMH	77,052	34.8%
Adult—SA	24,749	11.2%

FY 2014 Client Demographics

Client Financial Eligibility		Age Distribution		Race and Ethnicity	
Title XIX:	84.5%	Birth –5:	5.2%	African American:	6.5%
Title XXI:	0.4%	6-12:	15.7%	American Indian:	4.3%
Non-Title XIX/XXI:	15.1%	13-17:	12.6%	Asian:	0.6%
		18-21:	5.9%	Native Hawaiian:	0.3%
Gender		22-30:	14.0%	White:	74.4%
Male:	49.4%	31-45:	21.6%	Multiracial:	1.4%
Female:	50.6%	46-54:	12.4%		
		55+:	12.7%	Hispanic/Latino:	27.3%
		Median Age:	28.9 Years	***Unspecified:	12.6%

*As of April 1, 2014, Maricopa County’s RBHA transitioned

from Magellan to Mercy Maricopa Integrated Care.

**<http://www.azdhs.gov/bhs/reports/annual.htm>

***12.6% of members did not specify their race or ethnicity.

It is also important to note that an analysis showed evidence that past State initiatives around increasing enrollment for women who may be pregnant or have dependent children, a SABG priority population, have been successful. Despite this performance, ADHS/DBHS will continue to focus on outreach and engagement efforts for this priority group as well as ensure gender-specific services are available and readily accessible.

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

The 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:

- 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

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
Total in Population		22,580	40,999	213,588
Median Age (Years)		12.46	47.23	28.35
Gender	Male	64.1%	44.5%	48.8%
	Female	35.9%	55.5%	51.2%

Race	White	85.1%	87.7%	85.2%
	Black	8.0%	7.6%	7.4%
	Native American	3.2%	2.2%	4.8%
	Asian	0.4%	1.2%	0.7%
	Hawaiian	0.3%	0.2%	0.3%
	Multiracial	3.0%	1.1%	1.7%
Ethnicity	Hispanic	39.5%	17.5%	31.8%
	Not-Hispanic	60.5%	82.5%	68.2%
Percent Attending School		92.1%	11.0%	36.3%
Percent with HS Diploma / GED or Greater		0.7%	69.4%	45.0%
Employment Status	Employed	0.2%	12.8%	13.0%
	Unemployed	2.2%	31.0%	31.0%
	Not in Labor Force ³	97.6%	56.2%	56.0%
Percent with a Recent Arrest		4.5%	6.9%	6.3%
Housing Status	Homeless	0.3%	2.9%	2.4%
	Not Homeless	99.7%	97.1%	97.6%
Primary Substance Type	Heroin	0.1%	1.5%	3.2%
	Methamphetamine	0.2%	4.8%	4.8%
	Alcohol	1.9%	16.8%	13.3%
	Crack/Cocaine	0.1%	3.0%	1.6%
	Marijuana	6.3%	8.3%	8.8%
	Other Opiates	0.1%	1.3%	1.8%

³ 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.).

	Other Substances	0.1%	2.1%	1.1%
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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, the ADHS/DBHS has utilized the evidenced-based practice, Community-Based Participatory Research (CBPR), in initiatives such as Raise Your Voice Project.

Additionally, in an effort to improve service delivery for SMI adults, the ADHS/DBHS 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 SAMHSA's definition, ADHS/DBHS 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.⁴

In April, 2011, the Arizona State Legislature passed legislation creating a State Housing Trust Fund, operated by the ADHS/DBHS specifically for adults with serious mental illness. The Governor signed the bill into law and it became effective July 1, 2011. This law required ADHS/DBHS to develop a permanent housing program and submit their first report to the legislature and Governor by September 2011 and continues to be completed annually. Over \$2 million is appropriated to the ADHS/DBHS State Housing Trust Fund on an annual basis. These monies are 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 are deed restricted for the sole use of housing adults with serious mental illnesses for a twenty

⁴ 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>

five year period. This program has been specifically designed to integrate individuals in recovery with their community.

Each year ADHS/DBHS appropriates funds for community-based, recovery-oriented behavioral health services for individuals with an SMI. These funds allow ADHS/DBHS 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

To support the intent of offering permanent housing for those with a SMI, the ADHS/DBHS has developed the Housing Desktop Manual which outlines roles and responsibilities of those managing housing units. The following guidelines outline the expectations:

- T/RBHAs must use supported housing allocations for individuals with a SMI and according to any restrictions pertaining to the funding source. For example, a particular allocation may require it be used for TXIX/XXI persons, while another allocation may require it be used for Non-TXIX persons.
- Housing must be safe, stable, and consistent with the member's recovery goals and be the least restrictive setting necessary to support the member. Shelters, hotels, and similar temporary living arrangements do not meet this expectation.
- T/RBHAs must not actively refer or place individuals determined to have SMI in a shelter, licensed Supervisory Care Homes, unlicensed board and care homes, or other similar facilities.

- T/RBHAs may not utilize any funding source provided by ADHS/DBHS toward any type of rental subsidies, acquisitions, or property improvements for boarding homes and similar places.
- T/RBHAs may charge up to, but not greater than, 30% of a tenant's income towards rent. If a rent payment is increased in state funded housing programs, the T/RBHA must provide the tenant with a 30 day notice at the time of the tenant's annual recertification.
- T/RBHAs must not use supported housing allocations to pay for telephones or telephone usage fees.
- T/RBHAs must not use supported housing allocations for room and board charges in residential treatment settings. However, T/RBHAs may allow residential treatment settings to establish policies which require that persons earning income contribute to the cost of room and board.
- T/RBHAs may provide move-in assistance and eviction prevention services to those members in permanent housing. When move-in assistance is provided, T/RBHAs must prioritize assistance with deposits and payment for utilities over other methods of assistance, such as move-in kits or furnishings. T/RBHAs are encouraged to seek donations for necessary move-in/home furnishing items whenever possible. T/RBHAs must not use supported housing allocations or other funding received from ADHS/DBHS (including block grant funds) to purchase furniture.
- For appeals related to supportive housing services, T/RBHAs and providers must follow requirements in Policy and Procedures Section 1804, Notice and Appeal Requirements (SMI and Non-SMI/Non-Title XIX/XXI).
- Housing related grievances and requests for investigation for persons determined to have SMI must be addressed in accordance with Policy and Procedures Section 1803, Conduct of Investigations Concerning Persons with Serious Mental Illness.
- T/RBHAs must additionally submit T/RBHA plans describing the T/RBHA housing programs and submit periodic reports on housing programs, as outlined in the T/RBHA contracts and intergovernmental agreements

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 (CFT) Practice Model all provide a solid framework for continued system development. The ADHS/DBHS has worked to improve care for children with the most complex needs to reduce the use of out of home treatment. This is done through the use of a number of initiatives such as the High Needs Case Management Initiative and the development of the Generalist Direct Support program.

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. The ADHS/DBHS continues to promote the use of the CASII to increase fidelity and to examine ways to use the tool as a measure of functional improvement.

Priority Populations

In FY 2014 there were 63,452 individuals enrolled in Arizona’s public behavioral health system for substance abuse treatment. Of the number enrolled, 51.9 percent were women. Alcohol remained the most common substance used by those in treatment in FY 2014 with 31.2 percent of individuals citing this as their primary substance. 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
Total in Population		10,979	6,684	75,115
Median Age (Years)		31.98	35.27	34.44
Gender	Male		61.4%	55.9%
	Female	100.0%	38.6%	44.1%
Race	White	81.0%	93.6%	83.1%
	Black	7.3%	2.3%	7.1%
	Native American	9.8%	2.7%	7.8%
	Asian	0.3%	0.2%	0.4%
	Hawaiian	0.3%	0.5%	0.3%
	Multiracial	1.3%	0.7%	1.3%
Ethnicity	Hispanic	25.0%	24.7%	26.5%
	Not-Hispanic	75.0%	75.3%	73.5%

Percent Attending School		10.5%	5.1%	15.4%
Percent with HS Diploma / GED or Greater		64.4%	69.7%	59.6%
Employment Status	Employed	20.9%	17.7%	18.3%
	Unemployed	57.7%	60.3%	50.4%
	Not in Labor Force	21.4%	22.0%	31.3%
Percent with a Recent Arrest		10.6%	14.2%	14.1%
Housing Status	Homeless	3.5%	9.0%	5.1%
	Not Homeless	96.5%	91.0%	94.9%
Primary Substance Type⁵	Heroin	7.3%	75.7%	9.7%
	Methamphetamine	25.2%	18.0%	14.2%
	Alcohol	29.6%	0.1%	35.2%
	Crack/Cocaine	4.4%	1.4%	4.8%
	Marijuana	20.3%	0.1%	26.1%
	Other Opiates	8.6%	4.0%	5.3%
	Other Substances	2.9%	0.7%	3.1%

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, and includes 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 residential treatment program that serves both pregnant/post-partum women and women with dependent children. This program places emphasis on the multi-dimensional

⁵ Primary Substance Types includes both illicit and licit substances.

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.
- **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.

In order to ensure timely placement and the provision of interim services, Arizona utilizes a capacity management online waitlist system for priority populations. This real time system ensures that there is no a delay between the time a non-Medicaid priority population member (pregnant or parenting female, and Injection Drug User) is placed on a waitlist and ADHS/DBHS being notified. The system sends an alert to the RBHA and the 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). 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 standard and intensive outpatient programs. Furthermore, the ADHS/DBHS has been working to address the lack of available childcare options for these individuals. 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.

Persons who use drugs by injection

ADHS/DBHS ensures adequate capacity management for the Intravenous Drug User (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, the ADHS/DBHS has identified two areas of need for the injection drug using population. To begin, the 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 buprenorphine and Suboxone. The lack of access to prescribers 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.

Arizona uses the State Opioid Treatment Authority (SOTA) position to work with providers to improve treatment outcomes for those utilizing MAT services. This includes identifying barriers to accessing treatment such as lack of transportation as well as monitoring the opening of new clinics. Due to the opiate epidemic (in AZ), there has been an increased demand for MAT; thus, MAT has and continues to be, a matter of great importance for the State.

Adolescents with substance abuse and/or mental health problems

In FY 2014 there were 74,050 children and adolescents enrolled in Arizona's public behavioral health system. The ADHS/DBHS 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 is to continue 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. 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 focuses on 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 joining of the Adult System of Care, Children's System of Care and Prevention Office which occurred in 2013. 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, in 2012 ADHS/DBHS began encouraging children's providers and

requiring adult providers to use the American Society of Addiction Medicine Patient Placement Criteria 2R (ASAM PPC-2R) as a screening tool. The ADHS/DBHS has offered free trainings on the use of the tool in increase clinicians' abilities to accurately assess and place individuals with a SUD.

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. 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. To increase positive outcomes for children and youth, the ADHS/DBHS has collaborated with the school system to develop and train on Positive Behavioral Interventions and Supports (PBIS). Finalized in 2014, the training was rolled out statewide and attended by behavioral health staff to provide an understanding of the roll of the education system in the continuum of care. Items covered included assessing for cultural preferences, Department of Education policies and procedures, and general expectations around participation in services. Services offered in schools by the behavioral health system focus on direct support and creating a successful environment for the child.

In an effort to reunite children with their parents who are 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 is being provided, regardless of eligibility, in order to keep families together.

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.

Decreasing Youth Access to Tobacco

The 2015 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 the weighted

Retailer Violation Rate (RVR) was 4.0 percent of attempted tobacco purchases made by minors were successful. This is well below the federally established of 20 percent.

Arizona has identified several challenges pertaining to enforcing Youth Tobacco Laws; namely, while the Office of the Attorney General (AG) conducts the majority of tobacco enforcement inspections, actual citations may only be issued by local law enforcement entities. 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 address these issues, the ADHS/DBHS has partnered with the Bureau of Tobacco and Chronic Disease (BTCD) within the Department of Health Services. BTCD conducts inspections both with Federal Drug Administration (FDA) funding as well as with the AG. Partnering with BTCD avoids duplication and leverages resources.

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

Addressing the mental health and substance dependence needs of service members and veterans is a major priority for the ADHS/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.⁶

Data from the CIS reflects a similar trend. Since the 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%

⁶ 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>

Alcohol Dependence	7.1%
Post-Traumatic Stress Disorder	6.6%
Mood Disorder	5.0%
Paranoid Schizophrenia	4.8%

The 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. 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. The ADHS/DBHS has also sponsored, provided, or arranged trainings with mental health professionals, or other providers, on Traumatic Brain Injury (TBI) for returning veterans or their family members. Additionally, Mental Health First Aid (MHFA) which focuses 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 has been made available throughout the state. These trainings continue to be well attended and shed light on how to better assist veterans.

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.

To achieve this objective in the upcoming years, the ADHS/DBHS collaborates with the Arizona Coalition for Military Families, Arizona Department of Veterans Services (ADVS), and stakeholders to develop advanced training in cultural competency with military families for clinicians, 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 families in recognizing signs of Post-Traumatic Stress Disorder (PTSD) and TBI and the referral process. Specifically, in FY 2014, the ADHS/DBHS was able to provide funding to 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. Both agencies focus on disseminating tools and resources in order to assist service members in accessing services.

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

The geographic diversity of Arizona requires the 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, the 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.⁷

In addition, the 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 the ADHS/DBHS' ongoing commitment to treating individuals in the least restrictive community setting.

The 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 10 miles from a Behavioral Health Outpatient Clinic. The following are observations from that analysis:

- More than 90% of clients with a known street address (not homeless) reside within 10 miles of an outpatient clinic.
- GSA 6 missed compliance with network requirements for residential facilities by one percent. At this time, the ADHS/DBHS is attributing the one mile difference to a statistical margin of error (+/1 mile) which should be taken into account for poor member and provider location reporting.
- GSA 5 was non-compliant with the 10 mile network for both Level I Residential Facilities and Inpatient services. The five and six mile excess is speculated to be attributed to a large rural population.

Although this analysis reflects sufficient placement of outpatient facilities across the state, and while the majority of Arizona's substance abuse prevention coalitions are located in rural communities, 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 suicide⁸, drug-induced deaths⁹, and emergency department visit rates for substance abuse were highest

⁷ The Network Inventory was included in the first section of this application.

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

⁹ *Rates of Substance Abuse in 2010 by County*. Accessed from http://www.azdhs.gov/plan/report/ahs/ahs2010/pdf/6b1_10.pdf

in Northern Arizona¹⁰. Finally, in the rural counties there are few opportunities for advanced, in-person, prevention trainings.

Starting in 2012, the 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 counties¹¹, 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, the 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 Applied Suicide Intervention Skills Training (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 unavailability of data necessary 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

¹⁰ *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>

¹¹ The Northern Arizonan 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>

bring into the treatment setting. Likewise, the cultures of the clinician and the service system influence diagnosis, treatment, and service delivery.¹²

To this extent, the 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. 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. The ADHS/DBHS reviews multiple data feeds on a recurring basis, conducts extensive demographic and service utilization reviews, and publishes various reports detailing system performance.

Through methods of data collection and community collaboration, the 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, the 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.

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. Accordingly, past reports have revealed a need for increased outreach and collaboration with the tribes. To address this, the 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.

The 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.

- Continue the development and maintenance of ongoing trainings for diverse populations in Cultural Competence, CLAS standards, LEP and special populations.

¹² *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>

Workgroups will be created to update cultural competency curriculums and trainings to include current national trends. In order to create awareness of special populations, the cultural competency educational series will focus on racial/ethnic minorities, persons who speak in languages other than English, HIV/AIDS, LGBTQ, military members, Deaf and Hard of Hearing, disabled persons, Blind and Visually Impaired, and Tribal Populations. Recently, the ADHS/DBHS developed and implemented a cultural competency curriculum, Cultural Competency 101: Embracing Diversity, which was included in the list of required trainings for T/RBHAs and their providers.

- Identifying needs and enhancing services for treatment and prevention related to the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) populations. Participation in the LGBTQ Advisory committee allows collaborative efforts that resulted in trainings, educational forums and workgroups specific to LGBTQ populations. The ADHS/DBHS, in collaboration with University of Arizona, conduct comprehensive statewide assessments and climate surveys for organizational and staff level individuals to provide a baseline and trending of data, on LGBTQ populations. As the ADHS/DBHS will use the Gender Identity and Sexual Orientation data collection elements which will assist in identifying LGBTQ population treatment and prevention service needs, as well as inform requirement recommendations in policy, contract amendments and monitoring.
- Facilitating the increase and improvement of American Indian access to behavioral health services. RBHAs Tribal Liaisons will develop and promote American Indian initiatives, collaborate with tribes in intergovernmental agreement negotiations, and establish formal agreements to ensure the provision of behavioral health services on Indian reservations. The Division will respond to tribal requests for assistance in addressing issues related to behavioral health services; review the AHCCCS Provider Requirements Non-IHS/638 behavioral health Service Providers on Tribal reservation lands, and; collaborate with other federal (VA & IHS), State, tribal, and private agencies to improve access to behavioral health services for American Indian Veterans. Additionally, workgroups will identify any improvement needs for substance abuse/behavioral health services by Tribal Nations, and use this information to develop and establish programs and/or services for Tribal Nations.

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. The 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 Arizona Department of Health Services, Office of Division of Licensing Services (DLS). 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, 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 174 reported cases of TB in Arizona in FY 2013. 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. The 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 Federal Fiscal Year (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.

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

The ADHS/DBHS works with its State partners and contractors to provide needed services to homeless individuals. To begin, on an annual basis, the 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. The table below is the 2015 street count broken out by each county within Arizona.

County	Unsheltered: Number of Households
Apache	4
Cochise	86
Coconino	91
Gila	15
Graham	21
Greenlee	3
La Paz	240
Maricopa	1279
Mohave	231
Navajo	35
Pima	345
Pinal	57
Santa Cruz	17
Yavapai	103
Yuma	41

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 approximately 29,170 homeless people in Arizona in FY 2014, 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.¹³

The ADHS/DBHS 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 Community Mental Health Block Grant– 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 SABG 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 shelters.
- State General Fund Revenue– State general funds allocated as a match for Projects for Assistance in Transition from Homelessness (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.

The 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.

¹³ *Homelessness in Arizona Annual Report, 2014*. Accessed from https://www.azdes.gov/InternetFiles/Reports/pdf/des_annual_homeless_report_2014.pdf

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.

Despite the progress made by the 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. Additionally, there is a need for specialty providers to offer services to the older homeless population. Finally, individuals are often discharged from hospitals and the criminal justice system without sufficient follow-up for services. As the aging population increases and as aging homeless individuals experience barriers to accessing services, especially housing, these individuals will spend more time in a state of homelessness. As a result, their health issues will 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. 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.

System of Care Plan Development

The 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. Each fall, staff from the various functional units within the 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 year and outlines 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

- Improve overall quality, effectiveness, and access to services, for individuals with a substance use disorder;
- Reduce the overall suicide rate in Arizona;
- 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.

Allocation of SABG/MHBG funds

In previous years, block grant dollars were allocated based primarily on population. The ADHS/DBHS recognizes the need to allocate based on both population as well as identified need within a particular region. To better understand need throughout Arizona, the ADHS/DBHS met with numerous stakeholders including RBHA representatives, tribal workgroup members, the Planning Council, and Prevention leaders. In addition to gathering this input, a comprehensive review of allocation methods developed and used by other states was completed. From this review a tool was formulated 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 SABG 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 MHBG 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 the ADHS/DBHS use each year. Beginning in FY2015 SASABG/MHBG, funds will be allocated to each RBHA based on the following formula:

Allocation Percentage = 80% (population) + 10% (unmet need) + 10% (rural differential)

The amount for each county is calculated based on the formula with the exception of Tribal regions which are determined separately. To minimize the impact on the system, ADHS/DBHS uses 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.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

B-1 QUALITY AND DATA COLLECTION READINESS

Data

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) is capable of reporting Client-Level Information with some limited restrictions, including the information necessary to populate the Uniform Reporting System (URS) tables and the Treatment Episode Data Set (TEDS).

The most 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, the Division is not readily able to specifically identify which funding source was used to provide services to each member.

The 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.

The 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.¹ The database allows the Division 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

The 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

¹ 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.

B-1 QUALITY AND DATA COLLECTION READINESS

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 the 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-diem, depending on service type), the total dollar value for that service session, and the provider offering the service. This reporting standard allows the ADHS/DBHS to measure service utilization, by service type and provider, at the client level; in other words, the 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 the 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.

Quality

In effort to oversee and promote the effective use of resources in a timely manner that ensures effective use of resources, the ADHS/DBHS monitors numerous performance, process and outcome-oriented metrics. The following sections detail current review practices and indicators used as they pertain to prevention and treatment services:

The Regional Behavioral Health Authorities (RBHAs) conduct at least one visit to each prevention site or providers each year, with additional visits occurring 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.

B-1 QUALITY AND DATA COLLECTION READINESS

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, the ADHS/DBHS has partnered with Health Services Advisory Group Inc., an external quality review organization, to conduct case file review of behavioral health records. The ADHS/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.

The ADHS/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 either because the client completed treatment, the client declined future services, or there was a lack of contact and the client was not enrolled in a RBHA.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1
Priority Area: Youth
Priority Type: SAT
Population(s): Other

Goal of the priority area:

Increase the number of youth in the behavioral health system identified as having a diagnosed substance use disorder.
Note- Goal is in progress and will be continued from previous submission.

Objective:

Implement programs that are inclusive of education, implementation, and monitoring/oversight.

Strategies to attain the objective:

The Regional Behavioral Health Authorities (RBHAs) will continue efforts to promote access to substance abuse treatment services for adolescents during meetings with providers and collaborators, and through school and community-based trainings. Trainings provided by the RBHAs have included components on how to screen for substance abuse in the adolescent population, and effective substance abuse treatment such as ACRA and other evidence-based practices targeting the adolescent population. Additionally, providers continue to utilize SA screening tools, including ASAM and CRAFFT.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) will monitor enrollment numbers for youth diagnosed with a substance use diagnosis within the system of care.

The RBHAs will continue to collaborate and meet regularly with child/adolescent providers to share information on substance abuse screening, trends and best practices.

The ADHS/DBHS and the RBHAs will provide and promote access to substance abuse training initiatives available to child/adolescent providers- including those employed through other agencies such as the Department of Child Safety (DOCS) and Juvenile Justice. The ADHS/DBHS will also provide education to providers and teachers.

The 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.

The ADHS/DBHS will ensure the availability of a standardized, parent-friendly, screening tool to identify substance use/abuse in children and adolescents.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) will monitor enrollment numbers for youth diagnosed with a substance use diagnosis within the system of care.

The Regional Behavioral Health Authorities (RBHAs) will continue to collaborate and meet regularly with child/adolescent providers to share information on substance abuse screening, trends and best practices.

The ADHS/DBHS and the RBHAs will provide and promote access to substance abuse training initiatives available to child/adolescent providers- including those employed through other agencies such as the Department of Child Safety (DOCS) and Juvenile Justice. The ADHS/DBHS will also provide education to providers and teachers.

The 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.

The ADHS/DBHS will ensure the availability of a standardized, parent-friendly, screening tool to identify substance use/abuse in children and adolescents.

Indicator #: 1
Indicator: Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement: Baseline measurement, FY15 7% of those under the age of 18, in the behavioral health system who were diagnosed as having a substance use disorder or dependence.
First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2016), 7.5%
Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2017), 8%

Data Source:

CIS enrollment numbers/data.

Description of Data:

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

Data issues/caveats that affect outcome measures::

No data related issues anticipated.

Priority #: 2
Priority Area: Older Adults
Priority Type: SAT
Population(s): Other (Entire population over the age of 55.)

Goal of the priority area:

Increase screenings, outreach, engagement and enrollment of adults over the age of 55 with a diagnosed substance use disorder.

Objective:

Implement the Screening, Brief Intervention and Referral to Treatment (SBIRT) program in Northern Arizona.

Strategies to attain the objective:

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) will track and trend individuals screened for substance use and abuse in the Northern Regional Behavioral Health Authority (NARBHA) by age.

The ADHS/DBHS will evaluate the number of individuals over 55 who received a Brief Intervention/Brief Treatment related to their substance use/abuse.

The ADHS/DBHS will track and trend the number of individuals who were referred to a treatment provider for substance use/abuse.

The Arizona Department of Health services will educate the rest of the state on the Screening, Brief Intervention and Referral to Treatment (SBIRT) program.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Annual Performance Indicators to measure success on a yearly basis. .
Baseline Measurement: In Fiscal Year 2016, 8% of those with a substance use disorder or dependence were over the age of 55.
First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2016), 8.5%
Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2017), 9%

Data Source:

CIS enrollment data and SAIS data.

Description of Data:

Data in both systems can be stratified by age, diagnosis, and service received.

Data issues/caveats that affect outcome measures::

SAMHSA has elected to eliminate the SAIS system and has rolled out the DCI. It is unclear how this will impact data collection and reporting.

Priority #: 3
Priority Area: Service members and veterans
Priority Type: MHS
Population(s): Other

Goal of the priority area:

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

Objective:

Increase collaboration with stakeholders who provide services to individuals in the military and veterans.

Strategies to attain the objective:

Enrollment of service members and veterans for substance abuse services out the total number enrolled in the behavioral health system increased from 0.6% in FY2012 to 1.1% in FY2013. Please note, the percent of service members and veterans out of the number of individuals enrolled in the Arizona behavioral health system for substance abuse services is 3.5%.

Our Regional Behavioral Health Authorities (RBHAs) have been collaborating in various capacities, including holding memberships in ACMF's Resource Network and ACMF Leadership Council, and collaborating on ACMF's Resource Navigator training and the VA's Veteran's Summit. Additionally, Rally Point Tucson, a program of CPSA, staffed by experienced veterans continues to help veterans and their families in Pima County navigate and access various resources. Providers throughout the state have been engaged in multiple trainings that are specific to the needs of service members, such as Mental Health First Aid for Military, Veteran and Their Families, Trauma Informed Care, PTSD, Traumatic Brain injury, and employment assistance.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) will continue to be engaged in the Arizona Coalition for Military Families, and will conduct outreach efforts to connect service members, veterans and family members to services throughout the State. The ADHS/DBHS will disseminate information to all levels of service and will encourage collaboration for the provision of culturally competent care.

The ADHS/DBHS will assist the Regional Behavioral Health Authorities (RBHAs) in establishing a relationship their local Veterans Affairs (VAs) in order to coordinate care and participate in trainings.

The ADHS/DBHS and RBHAs will educate 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: Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement: Baseline measurement, FY 2016 1278/205000 (.6%)
First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2016), Increase FY16 data by 6%
Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2017), Increase FY17 data by an additional 2% from the outcome for 2016.

Data Source:

Client Information System (CIS) data.

Description of Data:

Data can be stratified by military and veteran status, diagnoses, and services received.

Data issues/caveats that affect outcome measures::

No data related issues anticipated.

Priority #: 4
Priority Area: Healthcare Integration
Priority Type: SAT, MHS
Population(s): SMI

Goal of the priority area:

Increase Behavioral Health staff knowledge of health related topics and connection between physical and mental health, and improve the coordination of care between behavioral health providers and the recipients' Primary Care Physician.

Note- goal is continued.

Objective:

Implement an integrated program that is comfortable and capable of meeting the medical and behavioral health needs of individuals living with a serious mental illness.

Strategies to attain the objective:

ADHS will monitor and assist Maricopa County with the pilot healthcare integration program to provide behavioral and physical health care in one location for Seriously Mentally Ill (SMI) members in FY14. MMIC, the RBHA for Maricopa County has assigned Care Management staff at each Adult Provider Network Organization (APNO) direct clinic in order to provide a direct link to education and technical assistance; this has allowed an increase in awareness of the medical health related needs, service utilization monitoring, identify gaps, and provide educational resources related to coordination of care with medical providers. The Care Management staff also ensures the treatment goals in the members' Care Plans address both their physical and behavioral health needs. Efforts to increase Primary Care Providers (PCP) knowledge of behavioral health needs is also being addressed through the Integrated Care Training Academy which occurs quarterly, and includes topics such as the SBIRT process.

Effective October 2015, the state of Arizona will have integrated physical and behavioral health care for individuals diagnosed with a serious mental illness (SMI). The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) will track the overall health for these individuals.

The ADHS/DBHS will work closely with 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: Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement: Statewide SMI coordination of care in FY16 - 90%
First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2016), 95%
Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2017), 100%

Data Source:

Case review

Description of Data:

The ADHS/DBHS performs a random sample case file review for coordination of care for those with a seriously mentally ill diagnosis. Review will contain specific elements that will evaluate coordination of care activities.

Data issues/caveats that affect outcome measures::

No data related issues anticipated.

Priority #: 5
Priority Area: Suicide Rate

Priority Type: MHS

Population(s): Other (Entire population)

Goal of the priority area:

Original goal achieved.

New Goal. Reduce the Arizona Suicide Rate to 14% per 100,000 by calendar year ending 2016.

Objective:

Promote suicide awareness through the use of technology and trainings.

Strategies to attain the objective:

The Arizona Department of Health Services/Division of Behavioral Health will research and implement strategies to reduce the suicide rate. Strategies will include but are not limited to: social media messaging, social market/public awareness, youth leadership programs, gatekeeper trainings, improved data surveillance, and ongoing collaboration with stakeholders or systemic improvement.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: The suicide rate in Arizona for CY14 was 16.2 per 100,000 population.

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2016), 15.2 per 100,000

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2017), 14.2 per 100,000

Data Source:

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

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 2016 data will be made available in fall 2017). This number is then aggregated across the general population to establish a suicide rate per 100,000 persons.

Data issues/caveats that affect outcome measures::

No data related issues identified.

Priority #: 6

Priority Area: IV Drug Users

Priority Type: SAT

Population(s): IVDUs, Other (Entire Substance Abuse Population)

Goal of the priority area:

Increase the availability and service utilization of Medication-Assisted Treatment (MAT) options for individuals with a substance use disorder. The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) will focus on reaching out to the IV drug use population.

Note- goal is in progress. Arizona has worked to improve MAT access and availability through provider network monitoring to assess needs, expanding lists of approved MAT medications, and increasing convenience of locations and hours. Providers and their prescribers receive training on the availability and use of MAT services, as well as education on MAT medications. Additionally, there is now Methadone and Suboxone Directories available for Maricopa County to assist in making appropriate referrals.

Objective:

Educate providers and individuals on Medication-Assisted Treatment Options.

Strategies to attain the objective:

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

The ADHS/DBHS and Regional Behavioral Health Authorities (RBHAs) will provide education for healthcare practitioners on best practices and availability of MAT services.

The ADHS/DBHS will 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: Annual performance measurement for outcomes.
Baseline Measurement: 2014 measurement of individuals who are IVDU who received MAT services.
First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2016), 51%
Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2017), 53%

Data Source:

Client Information System (CIS) data.

Description of Data:

CIS report on the number of injecting clients with a SUD receiving MAT services out of number of injecting clients

Data issues/caveats that affect outcome measures::

No data related issues anticipated.

Priority #: 7
Priority Area: Pregnant women and women with dependent children.
Priority Type: SAP, SAT
Population(s): PWWDC

Goal of the priority area:

Ensure that women have easy access to SAPT services.

Note- Goal is in progress. Strategies utilized by RBHAs and providers for collaborations include the following: creating a protocol for pregnant females using drugs intravenously in order to ensure MAT medications are appropriately prescribed for this population; collaboration with Arizona's Family First Program which provides substance use treatment services to parents who have involvement with DCS due to abuse of substances; and collaboration through the Women's Services Network who are currently developing tools for outreach to women in the community. In addition to statewide use of updated SABG posters, a Women's Services Directory was developed this last year that lists all treatment providers with treatment services and programs that are gender specific to women, and the Women's Treatment Group is developing a pamphlet and short video summarizing women's services that will be displayed for incarcerated women in jails, hospitals, and domestic violence shelters. Monitoring of the number of women in substance abuse treatment (particularly those on the waitlist), encounter values is being conducted statewide.

Objective:

Increase outreach and educate the community about services available to pregnant women and women with dependent children.

Strategies to attain the objective:

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) and the Regional Behavioral Health Authorities (RBHAs) will collaborate on ways to expand public awareness campaigns directed towards the priority populations.

The RBHAs and the ADHS/DBHS staff will regularly monitor treatment waitlists to ensure access to care.

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

The ADHS/DBHS and RBHAs will monitor the utilization of services for this priority population.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Annual Performance Indicators to measure success on a yearly basis.
Baseline Measurement: Number of pregnant and parenting women with dependent children within the system receiving SA treatment in 2015.
First-year target/outcome measurement: Increase the FY 15 enrollment by 3%
Second-year target/outcome measurement: Increase the FY 16 enrollment by 2%

Data Source:

Client Information System (CIS) data

Description of Data:

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

Data issues/caveats that affect outcome measures::

No data related issues anticipated.

Priority #: 8
Priority Area: Underage Drinking
Priority Type: SAP
Population(s): Other (Criminal/Juvenile Justice, Youth under the age of 21.)

Goal of the priority area:

Note- original goal was achieved.

New goal- Increase the percentage of youth who perceive 5 or more drinks of alcohol per day harmful to 2%, as measured by the Arizona Youth Survey

Objective:

Utilize the media and outreach to schools to reduce youth perception of alcohol use.

Strategies to attain the objective:

Conduct youth driven media campaigns to promote positive youth values and community pride. Campaigns will include: youth developed social messaging (radio; PSA poster contests; billboards; murals and alcohol free pledges.

- Collect samples of youth written letters to the editor with anti-alcohol messages.
- Host a statewide youth UAD prevention media display and recognition event.
- Verify that all prevention programs incorporate education on perception of harm into their prevention programs.

Implement afterschool and leadership programs for youth.

- Implement alcohol prevention focused peer leadership programs such as: SAD, YES, Sources of Strength, University leadership organizations.
- Host annual statewide and regional conferences/retreats/youth camps.
- Develop a statewide venue for recognition of youth UAD prevention projects and other successes.

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

- Community media campaign/Draw the Line (DTL)/Hasta Aqui Implementation.
- Collect data on Inclusion of DTL.
- Identify programs needed to increase incorporation of DTL in their parenting program.
- Meet with Regional Behavioral Health Authorities (RBHAs) Prevention Administrators to determine a means for inclusion of DTL in their programs.
- Distribution of DTL materials to RBHAs during alcohol awareness month.

Annual Performance Indicators to measure goal success

Indicator #: 1

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

Baseline Measurement: 2014 data reflects 78.9% of youths perceive having five or more alcoholic beverages in a row once or twice a week is of great risk.

First-year target/outcome measurement: 2% increase from baseline per post tests administered at the end of the year. 80.9 -2015 Arizona Youth Survey

Second-year target/outcome measurement: 2% increase from baseline per post tests administered at the end of the year. 82.9%- 2016 Arizona Youth Survey

Data Source:

Pre and post test

Description of Data:

Data will be obtained from the Pre and Post Tests (Adolescent Core Measure) that is part of the Arizona Youth Survey

Data issues/caveats that affect outcome measures::

Due to a change in AYS reporting, the indicator used in this report will need to change from the perception of 1 to 2 alcoholic drinks as harmful to the perception of 5 or more drinks in a row as harmful. As a result,

Priority #: 9

Priority Area: TB Screenings

Priority Type: SAT

Population(s): TB

Goal of the priority area:

Increase the number of clients entering substance abuse treatment who are screened for tuberculosis to 18% by CYE 2017.

Note- Goal is in progress. The Arizona Department of Health Services/Division of Behavioral Health Services did not achieve its goal to increasing each year by 5%.

Objective:

Increase documentation around screenings for TB and related services.

Strategies to attain the objective:

Focus on developing mechanisms to document and verify TB screening of those entering substance abuse treatment were implemented this last year. Strategies providers are and will continue to implement include: integrating education on TB (along with other communicable diseases) into client orientations, providing educational materials on TB to clients, providing clients with referral handouts for TB and HIV testing at specified locations, as well as including elements to capture TB screening documentation in contractors' audit tools.

In addition, the Arizona Department of Health Services/ Division of Behavioral Health Services (ADHS/DBHS) to provide guidance to the Regional Behavioral Health Authorities (RBHAs) regarding accurate documentation on screening and referrals for TB services.

Annual Performance Indicators to measure goal success

Indicator #: -1

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

Baseline Measurement: FY14 data on the number of patients receiving substance abuse treatment with documentation of TB services documented in their chart. Current baseline will be 14.6

First-year target/outcome measurement: First-year target/outcome measurement (Progress to end of SFY 2016), Increase FY15 data by 2%

Second-year target/outcome measurement: Second-year target/outcome measurement (Final to end of SFY 2017), Increase FY 16 data by 2%

Data Source:

Independent Case Review

Description of Data:

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

Data issues/caveats that affect outcome measures::

No data related issues anticipated.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	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	\$29,659,619		\$0	\$0	\$0	\$0	\$0
a. Pregnant Women and Women with Dependent Children*	\$3,500,777		\$0	\$0	\$0	\$0	\$0
b. All Other	\$26,158,842		\$0	\$0	\$0	\$0	\$0
2. Substance Abuse Primary Prevention	\$7,909,232		\$0	\$0	\$0	\$0	\$0
3. Tuberculosis Services	\$0		\$0	\$0	\$5,938	\$0	\$0
4. HIV Early Intervention Services	\$0		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$1,977,308		\$15,024,967	\$1,675,906	\$7,200	\$0	\$0
13. Total	\$39,546,159	\$0	\$15,024,967	\$1,675,906	\$13,138	\$0	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

The following totals should be included on line 1:

C. Medicaid \$265,744,392

D. Other Federal Funds \$5,656,837

E. State Funds \$17,703,011

F. Local Funds \$1,689,871

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	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			\$1,900,000	\$0	\$114,364,206	\$8,148,010	\$0
6. Other 24 Hour Care		\$773,132	\$588,219,035	\$0	\$32,094,650	\$21,545,204	\$0
7. Ambulatory/Community Non-24 Hour Care		\$8,891,015	\$2,480,634,754	\$0	\$135,349,416	\$90,860,342	\$0
8. Mental Health Primary Prevention**		\$0	\$0	\$0	\$0	\$0	\$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		\$536,897	\$0	\$0	\$0	\$0	\$0
10. Administration (Excluding Program and Provider Level)		\$536,897	\$26,252,415	\$266,000	\$1,194,007	\$3,241,856	\$0
13. Total	\$0	\$10,737,941	\$3,097,006,204	\$266,000	\$283,002,279	\$123,795,412	\$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	\$	\$
General and 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;		
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	\$	\$
Individual 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	\$	\$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health 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	\$	\$
Total	\$0	\$0

Footnotes:
Requested, not required.

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$29,659,619
2 . Substance Abuse Primary Prevention	\$7,909,232
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	\$1,977,308
6. Total	\$39,546,159

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy		IOM Target	FY 2016
		SA Block Grant Award	
Information Dissemination	Universal		\$1,207,283
	Selective		\$100,000
	Indicated		\$90,000
	Unspecified		
	Total		\$1,397,283
Education	Universal		\$1,000,000
	Selective		\$500,000
	Indicated		\$100,000
	Unspecified		
	Total		\$1,600,000
Alternatives	Universal		\$1,000,000
	Selective		\$50,000
	Indicated		\$10,000
	Unspecified		
	Total		\$1,060,000
Problem Identification and Referral	Universal		\$60,000
	Selective		\$10,000
	Indicated		\$5,000
	Unspecified		
	Total		\$75,000

Community-Based Process	Universal	\$1,200,000
	Selective	\$100,000
	Indicated	\$100,000
	Unspecified	
	Total	\$1,400,000
Environmental	Universal	\$1,000,939
	Selective	\$200,000
	Indicated	\$100,000
	Unspecified	
	Total	\$1,300,939
Section 1926 Tobacco	Universal	\$60,000
	Selective	
	Indicated	
	Unspecified	
	Total	\$60,000
Other	Universal	\$1,000,000
	Selective	\$6,000
	Indicated	\$10,000
	Unspecified	
	Total	\$1,016,000
Total Prevention Expenditures		\$7,909,222
Total SABG Award*		\$39,546,159
Planned Primary Prevention Percentage		20.00 %

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

Footnotes:

Expenditures based on historical information and subject to change.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	\$3,264,111	
Universal Indirect	\$3,264,111	
Selective	\$966,000	
Indicated	\$415,000	
Column Total	\$7,909,222	
Total SABG Award*	\$39,546,159	
Planned Primary Prevention Percentage	20.00 %	

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

Footnotes:
Expenditures based on historical information and subject to change.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: Planning Period End Date:

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

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$56,000	\$0	\$0	\$56,000
2. Quality Assurance	\$30,000	\$0	\$0	\$30,000
3. Training (Post-Employment)	\$50,000	\$0	\$0	\$50,000
4. Education (Pre-Employment)	\$250,000	\$0	\$0	\$250,000
5. Program Development	\$30,000	\$0	\$0	\$30,000
6. Research and Evaluation	\$500,000	\$0	\$0	\$500,000
7. Information Systems	\$100,000	\$0	\$0	\$100,000
8. Total	\$1,016,000			\$1,016,000

Footnotes:

Expenditures based on historical information and subject to change.



Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	
MHA Administration	\$536,897
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	
Total Non-Direct Services	\$536,897
Comments on Data:	
<div style="border: 1px solid black; padding: 2px;"> Behavioral Health Planning Council Activities included in Mental Health Block Grant Administration. </div>	
Footnotes:	

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.²⁶ Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.²⁷ It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.²⁸ Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of “risk factors” and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices^{29 30} that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.³¹ Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.³² In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.³³ Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.³⁴ Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.³⁵ In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.³⁶

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.³⁷ Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.³⁸ Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes³⁹ and ACOs⁴⁰ may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.⁴¹ Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.⁴²

One key population of concern is persons who are dually eligible for Medicare and Medicaid.⁴³ Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.⁴⁴ SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.⁴⁵ Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.⁴⁶ SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.⁴⁷ It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.⁴⁸

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.⁴⁹ Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.⁵⁰

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.⁵¹ However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

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 charged with coordinating 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 consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
 - Regular screening with a carbon monoxide (CO) monitor
 - Smoking cessation classes
 - Quit Helplines/Peer supports
 - Others _____
11. The behavioral health providers screen and refer for:
 - Prevention and wellness education;
 - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
 - Recovery supports

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

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²⁸ Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014;71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

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³⁰ A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: <http://circ.ahajournals.org/>

³¹ Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>: <http://www.cdc.gov/socialdeterminants/Index.html>

³² Depression and Diabetes, NIMH, <http://www.nimh.nih.gov/health/publications/depression-and-diabetes/index.shtml#pub5>; Diabetes Care for Clients in Behavioral health Treatment, Oct. 2013, SAMHSA, <http://store.samhsa.gov/product/Diabetes-Care-for-Clients-in-Behavioral-Health-Treatment/SMA13-4780>

³³ J Pollock et al., Mental Disorder or Medical Disorder? Clues for Differential Diagnosis and Treatment Planning, *Journal of Clinical Psychology Practice*, 2011 (2) 33-40

³⁴ C. Li et al., Undertreatment of Mental Health Problems in Adults With Diagnosed Diabetes and Serious Psychological Distress, *Diabetes Care*, 2010; 33(5) 1061-1064

³⁵ TIP 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders, SAMHSA, 2012, <http://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671>

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http://www.nami.org/Content/NavigationMenu/State_Advocacy/About_the_Issue/Integration_MH_And_Primary_Care_2011.pdf; Abrams, Michael T. (2012, August 30). *Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and challenges*. Baltimore, MD: The Hilltop Institute, UMBC.

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³⁷ Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

³⁸ Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, SAMHSA, 2009, <http://store.samhsa.gov/product/Characteristics-of-State-Mental-Health-Agency-Data-Systems/SMA08-4361>; Telebehavioral Health and Technical Assistance Series, <http://www.integration.samhsa.gov/operations-administration/telebehavioral-health> State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/docs/default-source/policy/ata-best-practice---telemental-and-behavioral-health.pdf?sfvrsn=8>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>; telemedicine, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

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⁴⁰ New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

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⁴² What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

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⁴⁴ Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

⁴⁵ BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

⁴⁶ TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014;71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013;70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

⁴⁷ <http://www.nrepp.samhsa.gov/>

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⁵¹ Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-1 HEALTH SYSTEM AND INTEGRATION

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/DBHS has supported integrated healthcare through various activities including educating healthcare providers, policy makers and the community as well as addressing systemic barriers to integration.

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

Access to Care and Oversight of Service Availability

The ADHS/DBHS ensures eligible members have access to mental, physical, substance use services through the oversight of its contractors. Contractors collect and analyze data on their providers' ability to provide urgent and routine appointments. This data is reported to the ADHS/DBHS on a quarterly basis. The Division conducts oversight activities to confirm that the data reported is accurate and reliable.

The Division also monitors access to care through its Network Management and Geo-Mapping activities. This process allows the Division to determine the availability of services (by provider type) within the members' geographical area. Contractors are required to report changes that may impact their network prior to the change occurring.

MHPAEA Violations

Both the ADHS/DBHS and its contractors maintain a Customer Services Department where anyone can submit a complaint about any issue. The Customer Services Department investigates the complaints and takes the necessary action to resolve the issue. If there is a concern that a MHPAEA violation has occurred, the Division ensures the member's need is met and then addresses the violation at the contractor level. In such cases, the contractor is generally required to investigate the complaint, determine the prevalence of the issue, and then develop a plan to correct the behavior so it does not happen again. Should the issue not be resolved, the ADHS/DBHS reserves the option to issue financial sanctions.

EHB and Covered Services

As of October 1, 2015 there will be a significant change in the services covered by the Division's contractors because the state will move to an integrated care model. The change will have the most impact on individuals living with a serious mental illness (SMI) who have historically received mental and physical health services through a bifurcated system. As of October 1st, members living with a serious mental illness will be able to receive their services through a single contractor throughout the State. Although the covered services package will remain the same for the individual, the Division's contractors will now be responsible for the provision of both medical and mental health services for this population.

C-1 HEALTH SYSTEM AND INTEGRATION

Coordination of Care Collaborations

The ADHS/DBHS recognizes the importance of coordination of care both within its system and with other organizations. The ADHS/DBHS has policies that clearly define how and when care is to be coordinated. The Division's contractors are required follow these policies and must monitor and report their providers' adherence to them. Contractors are also required to submit Medical Management Plans that outline both goals and objectives specific to care coordination. The ADHS/DBHS and its contractors work with contracted Medicaid providers and non-affiliated agencies such as the Veterans Service Organizations to develop processes that promote responsible and safe coordination practices.

Collaboration with Primary Care Associations and FQHC

The ADHS/DBHS has many departments that collaborate with Primary Care Associations and FQHCs. The agency's collaboration efforts have intensified significantly over the past five years due to the integration of behavioral and mental health treatment for individuals living with a serious mental illness. The Division's contractors are affiliated with various provider committees and coalitions where issues specific to care provided by public health providers and agencies are discussed. In some cases, agency medical directors continue to see patients in FQHCs and private offices.

As required by Federal Preparedness guidelines, the Division and its contractors are also members of the Arizona Coalition for Healthcare. This coalition consists of agency and provider (including individual, hospitals, and agencies) representatives who have developed policies and procedures for responding to and recovering from an emergency or disaster. There are presently three Coalitions for Healthcare; one in Central Arizona, one in Southern Arizona, and one in Northern Arizona. Their response objectives are heavily focused on information sharing and coordination.

Nicotine/Smoking Cessation Aides

According to the Phoenix Business Journal, *Vanguard*, *Magellan team on Arizona mental health contract*, Arizonans who are living with the most serious mental health illnesses will die thirty years earlier than the average American (Gonzales, 2012). Ongoing research has presented a clear picture of why this is true. People with a serious mental illness experience a high prevalence of modifiable risk factors including tobacco use, alcohol and other drug use, poor eating habits and lack of exercise which puts them at greater risk for disease and premature death (Connolly, M., & Kelly, C., 2002). While only 22% of the general population smokes, more than 75% of those with serious mental illness are smokers (*Time*, December 2008). The importance of developing and implementing systems of health care that address lifestyle and modifiable risk factors for those with mental illness cannot be understated.

Arizona recognizes that smoking, like substance use, is an addiction. Quitting tobacco use is not easy and the average tobacco user is more likely to quit with assistance. ADHS/DBHS is committed to providing affordable treatment options including but not limited to free counseling

C-1 HEALTH SYSTEM AND INTEGRATION

lines; FDA-approved medications and online resources; and, for those who are eligible for Medicaid, free medications, classes, hotlines, counseling, and nicotine replacement therapies.

Arizona, as a whole, is considered a smoke-free state. The Smoke-free Arizona act (36-601-01) prohibits smoking inside and within 20 feet of entrances, open windows, and ventilation systems of most enclosed public places including places of employment in Arizona. The Arizona State Mental Health Hospital (AZSH) became smoke free on July 1, 2008. Prior to this date, tobacco breaks were written into patient care plans and schedules. The AZSH not only banned smoking for patients, but the initiative extended to include staff, visitors and vendors. The AZSH was awarded a QUITZone Certificate of Excellence at the Great American Smoke Out event on November 19, 2009.

Screening for Tobacco Use

The ADHS/DBHS contractors regularly screen for smoking as part of the Early and Periodic Screening, Diagnostic and Treatment requirements for members under the age of 22, and through the standard evaluation process for individuals who are 22 and older. When a member expresses the desire to stop smoking, they are offered cessation aides (as appropriate), and cessation related goals and objectives are incorporated into the member's Individual Service Plan.

Addressing Medical Health Risks

The ADHS/DBHS promotes services that are provided by both medical staff and peers. Education, prevention of co-morbidities, and treatment are essential to the care of members, and the Division has taken a multi-faceted approach to educating members. In some cases education is initiated by physicians and medical staff; while in others, recipients are involved in classes that are peer-based. In both cases, recipients benefit from education about health risks, recovery, and medical supports. Members attend classes where topics such as nutrition, exercise, prevention of co-morbidities and other health risks are discussed. Members also receive evaluations that incorporate screenings for weight, blood pressure, glucose levels, and others.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)⁵², [Healthy People, 2020](#)⁵³, [National Stakeholder Strategy for Achieving Health Equity](#)⁵⁴, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).⁵⁵

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."⁵⁶

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.⁵⁷ This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.⁵⁸ In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. 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. For states to address the potentially disparate impact of their block grant funded efforts, they will 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).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

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

⁵²http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵³<http://www.healthypeople.gov/2020/default.aspx>

⁵⁴<http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

⁵⁵<http://www.ThinkCulturalHealth.hhs.gov>

⁵⁶http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

⁵⁷<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

⁵⁸http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

2. HEALTH DISPARITIES

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) acknowledges that its membership demographics fluctuate and it is the Agency's responsibility to take an evolutionary position in its delivery of a cultural competent program. All ADHS/DBHS contractors are required to submit a Cultural Competency (CC) Plan that documents goals, incorporates objectives to meet the goals, and is inclusive of timelines and activities that are measurable and easily understood. This work plan is a "living" document that permits modifications needed to ensure goals are achieved. This document also encompasses a gap analysis used to identify areas within our Contractor's program that require improvement and ultimately fosters the identification of goals. The ADHS/DBHS believes cultural competency starts at the top; subsequently, the Division also develops an annual *Cultural Competency Plan* inclusive of the activities geared to eliminate health disparities and promote the delivery of culturally and linguistically competent services.

The ADHS/DBHS analyzes and monitors both its internal and contractors' provision of culturally competent services through a variety of mechanisms, including but not limited to: the conduction of needs assessments; the submission of quarterly reports reflecting the types of services received; and the use of surveys. Data received is stratified by race, language, ethnicity, gender, LGBTQ and age. These oversight tools allow the Division to track the system and modify it to best meet the needs of the community. In addition to oversight through deliverables, the ADHS/DBHS and its contractors also maintain a pulse on the cultural needs of the community through ongoing collaborative efforts with community stakeholders.

The ADHS/DBHS develops an *Annual Diversity Report* and a *Semi-Annual Language Services Report* that are used in concert with the *Cultural Competency Plan* to assist in the early identification of barriers/disparities. *The Annual Diversity Report* is comprised of a comprehensive analysis of the racial and ethnic populations served by the Division. Information is pulled from the Client Information System (CIS) which focuses 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.

Through the analysis of its demographic and enrollment data set, the *Semi-Annual Language Services Report* is a key resource in evaluating how well interpretation and translation services align with member needs. This Report captures utilization of language services for individuals whose primary language is not English, individuals who are deaf and/or hard of hearing; and who use sign language services, interpretive services, and translation services as part of receiving mental health services.

2. HEALTH DISPARITIES

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 promote cultural competency and eliminate disparities.

Environmental Factors and Plan

3. Use of Evidence in Purchasing Decisions

Narrative Question:

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP⁵⁹ is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General⁶⁰, The New Freedom Commission on Mental Health⁶¹, the IOM⁶², and the NQF.⁶³ The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."⁶⁴ SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)⁶⁵ are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)⁶⁶ was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
 - a. Leadership support, including investment of human and financial resources.
 - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
 - c. Use of financial incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

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

⁵⁹ [Ibid, 47, p. 41](#)

⁶⁰ United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

⁶¹ The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

⁶² Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press.

⁶³ National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

⁶⁴ <http://psychiatryonline.org/>

⁶⁵ <http://store.samhsa.gov>

⁶⁶ <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-3 USE OF EVIDENCE-BASED IN PURCHASING DECISIONS

The use of Evidenced Based Practices (EBPs) is primarily driven by clinical areas within Arizona Department of Behavioral Health Services; Division of Behavioral Health Services (ADHS/DBHS) though is supported by all areas within the Division to ensure compliance. The ADHS/DBHS/DBHS contractually requires the utilization of EBPs both for substance abuse prevention and treatment services. Since 2012, the ADHS/DBHS/DBHS has used the *Comprehensive Assessment and Treatment of Adults with Substance Use Disorders Practice Protocol*, to drive requirements for high quality services. This protocol encompasses requirements for treating individuals with a Substance Use Disorder including an overview of assessment, treatment planning and the use of EBPs.

ADHS/DBHS has used information regarding evidence-based practices in directing policy decisions and funding of new programs. All Regional Behavioral Health Authorities (RBHAs) submit contractually required documentation of offered EBPs on a quarterly and annual basis. This documentation contains information regarding the specific EBPs offered throughout a particular region as well as identification of efforts to monitor fidelity to a particular program. Among those treatment practices documented are Motivational Interviewing, Cognitive Behavioral Therapy, Contingency Management, ASAM-PPC and CRAFFT. Monitoring the information provided is a collaborative effort between the multiple offices within the ADHS/DBHS. Contract Compliance receives deliverables and assists in identifying deficiencies as well as provides guidance in drafting corrective action notices, Finance provides a reconciliation between program allocation and reported expenditures, Program Operations reviews deliverable reports and assesses for accuracy as well as follow up to verify information reported. This collaboration ensures that all areas have an opportunity to respond to information provided.

The ADHS/DBHS recognizes that multiple EBPs are needed throughout the state to meet the various cultural, age, or demographics of a particular area. In addition, the ADHS/DBHS understands that promising and best practices are frequently updated and new areas are regularly added. To accommodate these needs, the ADHS/DBHS is not prescriptive in the EBPs which are selected for implementation but does require regular reporting in order to accurately assess network capacity for any particular program. In regards to substance abuse prevention, the ADHS/DBHS requires the completion of a needs assessment every five years or at the beginning of a contract period in order to ensure that the demographics of an area are understood. When additional funding is identified, the ADHS/DBHS determines whether to add this to the larger RBHA contracts or offer opportunities to fund unique programs. In instances when the ADHS/DBHS will be funding unique programs, a request for proposals is released and respondents identify the population and number to be served, the EBP to be utilized, the cost, as well as the outcome measurements. Selected candidates are then required to submit deliverables documenting this information back to the ADHS/DBHS for review. This method of providing additional funding has allowed the ADHS/DBHS to retain the larger infrastructure of the RBHA

C-3 USE OF EVIDENCE-BASED IN PURCHASING DECISIONS

system which is capable of serving the entire state while providing opportunities to implement a new EBP on a smaller scale. This has also assisted programs to encourage thoughtful purchasing and an understanding of goals for outcomes.

Environmental Factors and Plan

4. Prevention for Serious Mental Illness

Narrative Question:

SIMs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.⁶⁷ The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.⁶⁸ In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.⁶⁹ The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.^{70 71} This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

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

⁶⁷ Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

⁶⁸ Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

⁶⁹ Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

⁷⁰ van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

⁷¹ McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-4 PREVENTION FOR SERIOUS MENTAL ILLNESS

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) has been involved in expanding prevention for Serious Mental Illness (SMI) primarily through the work of the University of Arizona's Early Psychosis Intervention (EPI) program. While the Mental Health Block Grant (MHBG) does not currently provide for the provision of services prior to a SMI or Serious Emotional Disturbance (SED) diagnosis, the 2014 set aside has driven opportunities to review evidenced based practices which would benefit individuals at an earlier point in treatment.

In November, 2014 ADHS/DBHS approved proposals submitted by two Arizona Regional Behavioral Health Authorities (RBHAs) for the implementation of EPI programs. EPI programs consist of specialized services that are designed to impact patients with who are early in their treatment of psychotic disorders such as: Bipolar Disorder, Schizophrenia, Schizoaffective disorder, etc. Treating patients early in the course of their illness has been correlated to better outcomes and improved ability to meet the demands of day to day life.

In Pima County the implementation of EPI was awarded to the Community Partnership of Southern Arizona (CPSA), and in Maricopa County to Mercy Maricopa Integrated Care (MMIC). The contract cycle for the two site implementations was identified as November 1, 2014 through June 30, 2015.

ADHS/DBHS initially focused efforts on the EPI program as this was already established within the community and was being evaluated for outcomes. As ADHS/DBHS has seen that this program continues to thrive, efforts will be undertaken to explore additional promising practices in order to expand services available for individuals at risk of an initial psychosis episode. ADHS/DBHS issued a statewide, integrated behavioral and acute care contract for SMI individuals in 2014 and will expand statewide in October, 2015. The integration has the goal of improving health outcomes and positions ADHS/DBHS to further expand into prevention and early intervention.

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.⁷² SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded [Recovery After an Initial Schizophrenia Episode \(RAISE\) initiative](#)⁷³, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

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

⁷² <http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>

⁷³ http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-5 EVIDENCE-BASED BEST PRACTICES FOR EARLY INTERVENTION

In September, 2014 the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) created a statewide RFA for implementation of *Early Psychosis Intervention* best practices programming under direction provided by SAMHSA for the 5% MHBG withhold.

In November, 2014 two proposals were approved by ADHS/DBHS and subsequently by SAMHSA. These proposals were sponsored by two Arizona Regional Behavioral Health Authorities (RBHAs). In Pima County the award was made to the Community Partnership of Southern Arizona (CPSA), and in Maricopa County to Mercy Maricopa Integrated Care (Mercy Maricopa). The contract cycle for the two site implementations was identified as November 1, 2014 through June 30, 2015.

The program proposal from Pima County was submitted by CPSA in collaboration with the University of Arizona's (U of A) outpatient psychiatric center, which has been sponsoring an EPI-based program; "Epicenter" since 2010. The program has been under the supervision of Nicholas Breitborde, Ph.D., an identified subject matter expert in the field of *Early Psychosis Intervention*. Since July 1, 2014, the program has also worked in partnership with the local RBHA to provide services to members referred from CPSA's affiliated agencies in the community.

The Maricopa County proposal, submitted by Mercy Maricopa Integrated Care (Mercy Maricopa) was also based on the *Early Psychosis Intervention* EBP model, and is intended to be a collaborative effort between the Mercy Maricopa and local provider agencies. This proposal also includes provisions for utilizing Dr. Breitborde from the U of A as a specialty consultant. Unlike the Pima County program, the Mercy Maricopa program will be a "ground-up" creation, since no EPI-based program has been developed in Maricopa County. The focus in Maricopa County will be on the development of an Epicenter-type program, which is intended to be a "one-stop shop" with medical and case management services, as well as supportive services related to educational, vocational and housing needs.

Both RBHAs submitted budgets and year-one timelines for implementation, which together projected costs at a level slightly in excess of the 5% withhold total for Arizona. Pima County's program anticipated a year-one budget of \$360,347.00, with Block Grant funding implementation to begin in January, 2015. The Maricopa County program projected a total year-one cost of \$364,249.00, with implementation to begin in November 2014.

Since the EPI program in Pima County was already operational, block grant funding was marked for the expansion of staffing and services, with the associated costs for the expansion driven primarily by hiring and training these additional staff. However, due to external factors in Pima County, including an impending RBHA transition, hiring processes were delayed until

C-5 EVIDENCE-BASED BEST PRACTICES FOR EARLY INTERVENTION

March/April. As a result, the program site did not begin spending significant amounts of funding until later in the year.

Mercy Maricopa experienced similar delays in implementation, in part due to the more complex logistics of the project. These additional logistical considerations include establishing working collaborations with local provider agencies for the project, as well as identifying and developing physical locations for the program's operation. As a result of the combination of factors noted above, neither program began to incur significant implementation costs until significantly later than expected in year one.

It is worth noting that in spite of delays in Block-Grant funded program implementation, EPI services are already being delivered in Pima County to eligible members and families. Through the partnership with the local RBHA, community behavioral health agencies have also been engaged in referring eligible members to *EPICENTER* programming. As a result of these community collaborations, the *EPICENTER* program has succeeded in building its client base and leveraging alternative funding sources (primarily T-19 Medicaid) to finance delivery of these services. It is anticipated that EPI services and collaborations with local behavioral health agencies will continue to increase as both staffing and client census increases as originally intended. For the Pima County program, this will mean the program will deliver an expanded array of co-locate services at the U of A clinic.

The Maricopa County program will continue its work on establishing its clinic site and hiring staff to begin providing a full array of services including counseling, case management, educational and vocational supports, medical management and supported housing services.

Both sites are responsible for monthly reporting regarding progress on implementation plans, spending and program participation (census). In addition to demographic data, census data also includes information on referral source and funding eligibility; the latter focusing on the maximization of third-party payment sources. In addition to routine submission of deliverables, the U of A also conducts its own outcome evaluation studies which are shared with the ADHS/DBHS on an ongoing basis.

The ADHS/DBHS is actively working with its project officer to identify additional programming opportunities to spend its funding.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-6 PARTICIPANT DIRECTED CARE (voucher program)

The Arizona Department of Behavioral Health Services, Division of Behavioral Health Services' (ADHS/DBHS) service delivery system does not include a Participant Directed Care (voucher program); subsequently, section C-6 does not apply.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

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

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x- 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

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. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered 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 use of behavioral health benefits in light of utilization review, medical necessity, etc. 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Client level encounter/use/performance analysis data; and
 - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-7 PROGRAM INTEGRITY

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) has established a comprehensive corporate compliance program and plan to achieve the goals of deterring and detecting fraud and program abuse and to ensure the compliance with applicable laws, rules, regulations, contract requirements; and guides and manuals related to program integrity. This program is administered by the designated Corporate Compliance Officer within the Bureau of Corporate Compliance. The Corporate Compliance Officer is responsible for the general administration of the compliance program, 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, in consultation with the Bureau of Financial Operations, reviews the Tribal and Regional Behavioral Health Authorities' (T/RBHAs') compliance with block grant requirements and program integrity. Reviewing 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 SABG and MHBG funds. This includes monitoring of sub-recipient's activities to ensure that Federal awards are only used for the four (4) authorized purposes and performance goals are achieved, and ensuring sub-recipients expending \$750,000 per year or more in Federal awards during the fiscal year complete an OMB A-133 Report.

Block Grant funds are allocated to T/RBHAs based on historical allocations, financial performance, and programmatic need. In some cases, T/RBHAs submit a proposal that is reviewed and approved through several internal channels within the Division including; an in-depth review of its contractors' financial performance and 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 (2) 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. The ADHS/DBHS 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.

To ensure providers have adopted policies and processes that promote compliance with program requirements as well as include quality and safety standards, the T/RBHAs conduct at least one visit to each prevention site or providers each year, with additional visits occurring 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. T/RBHAs must participate in site visits at the request of the ADHS/DBHS. The Division must approve the program monitoring protocol of each T/RBHA before it is used. T/RBHAs submit their program monitoring protocol with their program descriptions each year for the following fiscal year.

C-7 PROGRAM INTEGRITY

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. In addition, 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 ADHS/DBHS 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, the Division is in a unique position to ensure Medicaid, Qualified Health Plans (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.¹ 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 Health Insurance Exchange 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 SABG and MHBG Distribution Report. These reports depict how SABG and MHBG 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 \$750,000 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.

¹ 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.

C-7 PROGRAM INTEGRITY

TRBHAs Audited Financial Reports are due nine (9) months after the Tribe's fiscal year-end. TRBHAs are required to audit SABG and MHBG 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.

MHBG and SABG 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 T/RBHA Statement of Activities identifies each fund source and category of service.

The ADHS/DBHS reviews and approves in writing all T/RBHA solicitations and amendments for prevention services 14 days before they are released publicly. The ADHS/DBHS must be involved in the selection of proposals for prevention. The Division 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 the ADHS/DBHS 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:

- 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 the ADHS/DBHS staff; and,
- Leveraging of funds from various sources is supported by the ADHS/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 the ADHS/DBHS for T/RBHAs in the area of safety. T/RBHAs and all of their subcontracted providers are contractually obligated to meet these safety requirements.

C-7 PROGRAM INTEGRITY

Fingerprinting and background checks

T/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 the ADHS/DBHS.

Incidents and Accidents²

Types of incidents to be reported to the ADHS/DBHS 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 the ADHS/DBHS 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

T/RBHAs confirm that at least one staff member is current in First Aid Certification and at least one staff member is current in Cardio Pulmonary Resuscitation Certification (CPR) and 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
- A controlled substance
- A firearm or other lethal weapon

Facilities

² Please see Provider Manual section 7.4, "Reporting of Incident, Accidents, & Deaths." Accessed from http://www.azdhs.gov/bhs/provider/sec7_4.pdf

C-7 PROGRAM INTEGRITY

T/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.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)⁷⁴ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

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

⁷⁴ <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-8 TRIBES

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) follows both the State of Arizona Tribal Consultation Policy as well as the ADHS/DBHS Tribal Consultation Policy to guide collaboration with tribal officials. To ensure inclusion of the Native American population, the ADHS/DBHS facilitates a workgroup for tribal input. The tribal workgroup meets regularly and actively discusses tribal community needs and the applicability of grant funds. The workgroup consists of leaders from the tribes, Indian Health Services (IHS) representatives, Native American providers, and liaisons from within the ADHS/DBHS. The members of the workgroup are 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 tribes' need. In addition to the workgroup, there is Native American representation on the Arizona Behavioral Health Planning Council.

In addition to 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 SABG/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. The ADHS/DBHS reviews the proposals to ensure they comport with grant requirements.

The ADHS/DBHS' commitment to emphasize cooperation and coordination with the state's numerous tribes is evident in its infrastructure. The Division continues to maintain a Tribal Contract Administrator position; 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 ADHS/DBHS.

Additionally, each Regional Behavioral Health Authority (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.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
 - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
 - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
 - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
 - a. A statewide licensing or certification program for the substance abuse prevention workforce;
 - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
 - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does 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)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) 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?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-9 PRIMARY PREVENTION FOR SUBSTANCE ABUSE

Arizona has a very active Statewide Epidemiology Outcomes Workgroup (SEOW). A main data source the SEOW utilizes to determine state priority(s) comes from data collected through the Arizona Youth Survey (AYS). Arizona Revised Statute §41-2416 requires the Arizona Criminal Justice Commission to conduct a statewide survey that is designed to measure the prevalence and frequency of substance abuse by youth, as well as their attitudes toward substance abuse. To comply with Arizona Revised Statute §41-2416 the Arizona Criminal Justice Commission's Statistical Analysis Center conducts a biennial Arizona Youth Survey. This survey is administered to a statewide survey population of 8th, 10th, and 12th grade students attending public and charter middle and high schools throughout Arizona. The Arizona Criminal Justice Commission has been conducting a youth survey for 23 years on a biennial basis; however, notable improvements in the survey model, sampling methods and the increasing levels of participation distinguish the Arizona Youth Surveys administered in 2002 to the present from prior surveys.

The 2014 Arizona Youth Survey (AYS) was administered between January and April 2014 in Arizona public and charter schools. This statewide effort encompassed all 15 counties and 243 schools, which resulted in the participation of 48,244 8th, 10th, and 12th grade students throughout Arizona (figure represents honest/valid participation only). A comparison between the Arizona Youth Survey and the national Monitoring the Future (MTF) survey is another measure for assessing current substance abuse and risk behaviors of Arizona youth. The MTF survey is conducted annually by the University of Michigan and is designed to provide Alcohol Tobacco and Other Drugs use information from a sample of students representative of the United States as a whole. A lower percentage of Arizona survey participants in all grades in 2014 have had lifetime experience with inhalants and prescription stimulants compared to youth in the same grades in the 2013 MTF survey (1.5 percentage points to 2.1 percentage points lower inhalant use for Arizona youth each grade, 2.6 percentage points to 4.0 percentage points lower stimulant use for Arizona youth in each grade). Additionally, a lower percentage of Arizona students have had lifetime experience with marijuana in comparison to youth in the 2013 national MTF survey population (0.8 percentage points to 3.4 percentage points lower marijuana lifetime use for Arizona youth in each grade). Eighth grade Arizona students indicated higher lifetime alcohol use (31.5% for Arizona 8th graders, 27.8% for national 8th graders), and higher lifetime cigarette use rates (15.8% for Arizona 8th graders, 14.8% for national 8th graders). (Arizona Youth Survey State Report, 2014). The AYS utilizes the Communities that Care Model by looking at risk and protective factors as they relate to individuals, peers, families, schools, and communities; the Communities that Care model has been validated in identifying risk and protective factors associated with problems such as substance abuse, teen pregnancy, violence, school dropout, and academic achievement. Survey information is used to provide evidence of need regarding risk and protective factors, inform resource and policy decisions, and assess performance of prevention and intervention efforts at the school, community, city, county, and state levels.

To establish priority targets for the Arizona, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) reviews needs assessment data from the SEOW. The ADHS/DBHS requires its Tribal and Regional Behavioral Health Authorities (T/RBHAs) conduct a comprehensive regional needs assessment once every three years to determine the focus of their SABG prevention efforts. Each T/RBHA contracts with a network of service providers similar to health plans to deliver a range of behavioral health care services, treatment programs for adults with substance abuse disorders, adults with serious mental illness and children with serious emotional disturbance. In Arizona, lifetime use of many substances for students in all grades has significantly decreased since the

C-9 PRIMARY PREVENTION FOR SUBSTANCE ABUSE

2012 survey (Table 1), with alcohol use decreasing 2.2 percentage points to 6.2 percentage points in each grade, cigarette use decreasing 3.9 percentage points to 6.4 percentage points in each grade, inhalant use decreasing 2.0 percentage points to 2.8 percentage points in each grade, prescription pain reliever use decreasing 1.8 percentage points to 5.7 percentage points in each grade, prescription drug use decreasing 1.8 percentage points to 5.2 percentage points in each grade, over-the-counter drug use decreasing 1.2 percentage points to 2.6 percentage points in each grade, and synthetic drug use decreasing 4.6 percentage points to 7.5 percentage points in each grade. Complete lifetime use results can be seen in Table 1 on the following page.

A look at past month substance use (Table 2) reveals that a higher percentage of Arizona youth in the 8th, 10th, and 12th grades have used alcohol and smokeless tobacco than youth in the same grades in the 2013 national MTF survey population. Alcohol use in Arizona was 1.4 percentage points to 3.2 percentage points higher in each grade in comparison to the national MTF survey, and smokeless tobacco use in Arizona was 1.1 percentage points to 2.3 percentage points higher in each grade in comparison to the national MTF survey.

Since the 2012 AYS, 30-day use rates for youth in all grades have decreased by 2.9 percentage points to 4.3 percentage points in all grades for alcohol, decreased 2.1 percentage points to 5.3 percentage points in all grades for cigarettes, decreased 0.8 percentage points to 2.2 percentage points in all grades for prescription pain relievers, and decreased 2.9 percentage points to 4.3 percentage points in all grades for synthetic drugs. The only substance that showed a consistent increase in use across all grades in Arizona was chewing tobacco use, which increased 2.2 percentage points for 8th graders (from 2.1% in 2012 to 4.3% in 2014), 3.6 percentage points for 10th graders (from 3.9% in 2012 to 7.5% in 2014), and 3.8 percentage points for 12th graders (from 6.6% in 2012 to 10.4% in 2014). Complete past month use results can be seen in Table 2 on the following pages (Arizona Youth Survey State Report, 2014).

Table 1

Percentage of Arizona Respondents Who Used ATODs During Their Lifetime by Grade															
Drug Used	Grade 8				Grade 10				Grade 12				Total		
	Arizona	Arizona	Arizona	MTF	Arizona	Arizona	Arizona	MTF	Arizona	Arizona	Arizona	MTF	Arizona	Arizona	Arizona
	2010	2012	2014	2013	2010	2012	2014	2013	2010	2012	2014	2013	2010	2012	2014
Alcohol	45.1	37.3	31.5	27.8	64.1	59.1	52.9	52.1	72.8	69.2	67.0	68.2	58.2	51.7	46.2
Cigarettes	23.8	19.7	15.8	14.8	37.2	31.7	25.6	25.7	46.9	42.1	35.7	38.1	34.0	28.8	23.4
Marijuana	17.8	16.2	14.9	16.5	34.3	34.7	32.4	35.8	44.7	44.8	44.7	45.5	29.9	28.7	27.1
Hallucinogens	2.2	1.7	1.6	2.5	5.9	5.2	4.7	5.4	9.0	8.4	8.0	7.6	5.1	4.4	4.0
Cocaine	2.3	1.5	1.6	1.7	5.3	3.9	3.0	3.3	8.8	7.4	6.2	4.5	5.0	3.7	3.1
Inhalants	14.5	11.4	9.0	10.8	11.8	9.4	6.6	8.7	9.4	7.4	5.4	6.9	12.3	9.8	7.5
Methamphetamines	0.7	0.6	0.5	1.4	1.6	1.5	1.1	1.6	2.5	1.8	1.3	1.5	1.5	1.2	0.9
Heroin	0.9	0.7	0.6	1.0	2.6	1.4	1.1	1.0	3.4	1.8	1.3	1.0	2.1	1.2	0.9
Ecstasy	3.9	2.8	2.1	1.8	8.2	7.4	4.4	5.7	10.6	10.4	7.4	7.1	7.0	6.1	4.1
Steroids	1.6	1.5	1.5	1.1	1.8	1.8	1.9	1.3	1.7	1.9	1.9	2.1	1.7	1.7	1.7
Prescription Pain Relievers†	11.5	8.8	7.0	N/C	18.9	15.6	12.0	N/C	23.1	20.7	15.0	N/C	16.8	13.8	10.4
Prescription Stimulants	3.0	2.0	1.6	4.2	7.0	6.6	5.3	8.1	8.5	9.9	8.4	12.4	5.7	5.3	4.3
Prescription Sedatives†	8.7	4.4	3.9	N/C	11.5	8.0	6.3	N/C	13.4	10.0	7.8	N/C	10.8	6.9	5.5
Prescription Drugs†	16.5	11.1	9.3	N/C	23.7	18.8	15.0	N/C	27.3	23.9	18.7	N/C	21.5	16.6	13.2
Over-the-Counter Drugs†	9.5	7.0	5.8	N/C	13.2	10.6	8.2	N/C	14.1	12.2	9.6	N/C	11.8	9.3	7.4
Synthetic Drugs** †	N/A	6.9	2.3	N/C	N/A	11.1	4.2	N/C	N/A	13.9	6.4	N/C	N/A	9.9	3.8

N/A - Indicates a question that was not asked in the 2010 Arizona Youth Survey.
 ** - Indicates substance categories that were not measured and reported in survey administrations prior to 2012.
 † and NC - Indicate where equivalent category for these substances is not available from the Monitoring the Future survey.

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Table 2

Percentage of Arizona Respondents Who Used ATODs During the Past 30 Days by Grade															
Drug Used	Grade 8				Grade 10				Grade 12				Total		
	Arizona	Arizona	Arizona	MTF	Arizona	Arizona	Arizona	MTF	Arizona	Arizona	Arizona	MTF	Arizona	Arizona	Arizona
	2010	2012	2014	2013	2010	2012	2014	2013	2010	2012	2014	2013	2010	2012	2014
Alcohol	21.9	17.1	13.4	10.2	34.7	32.1	27.8	25.7	45.0	43.5	40.6	39.2	31.9	28.1	24.1
Cigarettes	8.9	7.8	5.7	4.5	15.6	14.0	10.1	9.1	22.9	21.0	15.7	16.3	14.7	12.9	9.4
Chewing Tobacco	2.8	2.1	4.3	2.8	5.7	3.9	7.5	6.4	8.1	6.6	10.4	8.1	5.1	3.8	6.7
Marijuana	8.9	7.7	6.9	7.0	17.4	17.7	16.8	18.0	21.3	22.5	22.9	22.7	14.8	14.3	13.6
Hallucinogens	0.9	0.7	0.7	0.8	2.0	1.7	1.7	1.1	2.4	2.3	2.4	1.4	1.6	1.4	1.4
Cocaine	0.8	0.6	0.6	0.5	1.6	1.2	0.9	0.8	2.2	2.1	2.1	1.1	1.4	1.1	1.0
Inhalants	5.6	4.2	3.1	2.3	3.0	2.0	1.3	1.3	1.5	1.3	0.9	1.0	3.7	2.8	2.0
Methamphetamines	0.2	0.2	0.1	0.4	0.5	0.5	0.4	0.4	0.6	0.5	0.4	0.4	0.4	0.4	0.3
Heroin	0.3	0.3	0.2	0.3	1.1	0.4	0.3	0.3	1.2	0.5	0.5	0.3	0.8	0.4	0.3
Ecstasy	1.7	0.9	0.8	0.5	2.9	1.7	1.3	1.2	3.4	2.0	1.7	1.5	2.5	1.4	1.2
Steroids	0.5	0.5	0.5	0.3	0.7	0.7	0.6	0.4	0.6	0.7	0.8	1.0	0.6	0.6	0.6
Prescription Pain Relievers†	5.7	4.5	3.8	N/C	8.9	7.3	5.4	N/C	9.7	7.9	5.5	N/C	7.7	6.2	4.7
Prescription Stimulants	1.4	0.9	0.8	1.4	2.8	2.7	2.1	2.8	2.5	3.0	2.8	4.1	2.1	2.0	1.6
Prescription Sedatives†	3.6	1.9	1.7	N/C	4.7	3.3	2.6	N/C	4.7	3.2	2.7	N/C	4.2	2.7	2.2
Prescription Drugs†	8.2	5.7	4.9	N/C	11.8	9.3	7.1	N/C	12.4	10.0	8.0	N/C	10.4	7.9	6.3
Over-the-Counter Drugs†	5.4	4.0	3.1	N/C	6.3	4.9	3.7	N/C	6.3	4.3	3.4	N/C	5.9	4.4	3.4
Synthetic Drugs**†	N/A	3.8	0.9	N/C	N/A	5.0	0.8	N/C	N/A	5.2	0.9	N/C	N/A	4.5	0.8

N/A - Indicates a question that was not asked in the 2010 Arizona Youth Survey.
 ** - Indicates substance categories that were not measured and reported in survey administrations prior to 2012.
 † and N/C - Indicate where equivalent category for these substances is not available from the Monitoring the Future survey.

Once priorities are identified, the ADHS/DBHS/DBHS requires its T/RBHAs to identify training and technical assistance needs of their prevention systems through the development of annual training and technical assistance plans. The ADHS/DBHS/DBHS encourages its T/RBHAs to identify any training needs to the ADHS/DBHS/DBHS. The ADHS/DBHS will work with the Center for the Application of Prevention Technologies (CAPT) to secure training and/or technical assistance in the necessary mode whether it is in person or online. Each T/RBHA includes workforce development as a component of their annual prevention plan for funds and provides training and technical assistance to their network of provider as well. Attendance at national conferences is encouraged should funding allow for coalition and T/RBHA staff to attend. The ADHS/DBHS is the recipient of the Strategic Prevention Framework, Partnership for Success Grant 2013 and through this funding the ADHS/DBHS hosts an annual conference where building the capacity of prevention providers is a goal.

In addition to the training and technical assistance the T/RBHA system makes available, the Arizonan's For Prevention (AzFP) Credentialing Committee works to advance prevention science as an effective and recognized field of human services by establishing and promoting professional standards through the credentialing process.

In order to obtain a prevention credential in the State of Arizona, an individual must:

- Possess minimum education and training requirements.
- Possess minimum work and experience requirements.

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- Meet specific competency and ethical conduct requirements and
- Submit a completed credentialing application to the AzFP Credentialing Committee for approval.

The ADHS/DBHS requires each T/RBHA to implement their prevention system in accordance to SAMHSA's Strategic Prevention Framework model therefore assessing community readiness is considered before prevention strategies are implemented in a community.

Each T/RBHA is responsible for developing a regional strategic plan which includes goals and objectives specific to their geographic service area. T/RBHAs submit an annual prevention plan which addresses the National Outcome Measurements. T/RBHAs are encouraged to look at data from NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care and the Arizona Youth Survey. Through this process, T/RBHAs are able to identify the types of primary prevention services that are needed in their area. Many T/RBHAs host local strategic planning sessions where these things are considered.

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 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 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)	In 2012, 28.1% of students surveyed reported drinking alcohol during the	GOAL #1: Reduce the rate of youth self-reported 30 day use of	Youth social access to alcohol (top 3 sources of access: parties, giving money to an adult to purchase, an adult gave it to	OBJECTIVE I.1: Increase the percentage of youth who indicate it would be hard or very hard to get alcohol to 45% as measured by the	1.1.A Raise the cost of alcohol (Birkmayer, Holder, Yacoubian, & Friend, 2004) 1.1.B Alter the alcohol use environment (Jernigan, 2012)

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<p>Premature Death</p> <p>High rates of hospitalizations for overdose injuries and disease (Mrela & Torres, 2011)</p> <p>Taxpayer burden</p>	<p>past 30 days (Arizona Criminal Justice Commission, 2012).</p>	<p>alcohol from 28.1% in 2012 to 22% in 2016 as measured by the Arizona Youth Survey.</p>	<p>them) (Arizona Criminal Justice Commission, 2012).</p>	<p>2016 Arizona Youth Survey. (Birkmayer, Holder, Yacoubian, & Friend, 2004)</p>	<p>1.1.C Enhanced enforcement of on-premise laws and regulations (Jernigan, 2012)</p>
			<p>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 their parents would disapprove of their use of alcohol (Arizona Criminal Justice Commission, 2012))</p>	<p>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.</p> <p>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.</p>	<p>1.1.D Limit and regulate physical proximity of alcohol in stores (Jernigan, 2012)</p> <p>1.2.A Conduct youth driven media campaigns to promote positive youth values and community pride</p> <p>1.2.B After-school and leadership programs for youth</p> <p>1.2.C Implement an adult targeted media campaign to educate parents about the risks</p>
			<p>Access to early intervention and treatment (Jernigan, 2012)</p>	<p>OBJECTIVE 1.3: 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>

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Marijuana Prevention Strategic Plan/Logic Model

BEHAVIORAL HEALTH CONSEQUENCES	BEHAVIORAL HEALTH TRENDS	GOAL	KEY INTERVENING VARIABLES	OBJECTIVES	PROJECTS, INITIATIVES, STRATEGIES
<p>Cannabis dependence syndrome (Hall & Solowij, 1998)</p> <p>Psychological distress. (Hall & Solowij, 1998)</p> <p>Increased chances of developing psychosis (Hall & Solowij, 1998)</p> <p>Alterations in brain structure and brain function (Jager & Ramsey, 2008)</p> <p>Impaired planning and decision-making, increased risk taking & impulsivity, memory impairment.ⁱ</p>	<p>14.4% of Arizona youth used marijuana in the past 30 days (Arizona Criminal Justice Commission, 2012).</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>The % of</p>	<p>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</p>	<p>Social normalization of marijuana use; Positive attitudes toward marijuana</p>	<p>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.</p>	2.1.A Establish a statewide task force on prevention of marijuana abuse
			<p>Personal attitudes toward use</p>		2.1.B Regulation of marijuana promotion
			<p>Parental monitoring, establishment of clear standards regarding substance use and consistent enforcement of discipline</p>		2.1.C School based, classroom education inclusive of marijuana prevention topics
			<p>Access to early intervention and treatment</p>		2.1.D Facilitate youth driven awareness and anti-marijuana campaigns.
				<p>OBJECTIVE 2.2: By 2017, increase adult and community perception of harm of marijuana use (measurement method not developed).</p>	2.2.A Conduct an adult targeted anti-marijuana media campaign with accurate facts and messages they can give to youths.
				<p>OBJECTIVE #2.3: Increase comfort and knowledge in making referrals to substance</p>	2.2.B Family education
					2.3.A Training and education for law enforcement, educators, medical providers and others who have contact with youth about

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<p>Drug related crime (Office of National Drug Control Policy, 2012)</p>	<p>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>abuse assessment, early intervention, and treatment services by 5% as measured by a post-retrospective survey.</p>	<p>referrals to assessment, early interception, and treatment services.</p>
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Prescription Drug Abuse Reduction Strategic Plan/Logic Model

BEHAVIORAL HEALTH CONSEQUENCES	BEHAVIORAL HEALTH TRENDS	GOAL	KEY INTERVENING VARIABLES	OBJECTIVES	PROJECTS, INITIATIVES, STRATEGIES
<p>Increasing deaths attributable to poisoning (Mrela & Torres, 2011)</p> <p>Between 2008 and 2010, the number of ED visits pertaining to opioid abuse</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>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</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</p>	<p>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</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</p>

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increased by 42% across all ages (Mrela & Torres, 2011)	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. The age group with the highest rates of prescription drug misuse to be 60-69 year-olds (19%).	by the	family or relatives (Arizona Criminal Justice Commission, 2012).	measured by the Arizona Youth Survey.	short demos about proper lock use and storage at community events and trainings
		GOAL #4: 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 & Torres, 2011)	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).	OBJECTIVE 3/4.2: Increase use of the prescription drug monitoring project to 80% of prescribers (Center for Substance Abuse Treatment, 2010).	3.4.A Obtain a position statement endorsed by involved parties that requests PDMP compliance for distribution to pharmacists and prescribers 3.4.B Implement a system of data feedback to prescribers and pharmacists about PDMP use and prescriber habits 3.4.C Train law enforcement to use the PDMP

Each RBHA must develop a policy to fund and implement evidence-based practice based on SAMHSA’s criteria. RBHA’s submit their proposed policy to the ADHS/DBHS for review and approval before funding evidence based practices. The strategies included in each strategic plan must be evidence based as approved by the T/RBHA and the ADHS/DBHS. The criteria to be considered evidence-based are based upon the SAMHSA National Registry of Evidence-based Programs and Practices (NREPP) criteria.

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

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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.

Below is not a comprehensive list of **all** of the specific primary prevention programs, practices and strategies the ADHS/DBHS/DBHS intends to fund. Because T/RBHA prevention plans are updated annually, program information may change. It is a contract requirement that the ADH/DBHS is notified when there is any change in the network of prevention providers.

Indicated Programs

Program Name	Brief Description
2015 Maricopa LGBTQ Consortium	Prevention of alcohol abuse among the LGBTQ population using strategies such as Responsible Beverage Service.
2015 Maricopa Elder Behavioral Health Advocacy Coalition	Support and education to older adults in achieving and maintaining healthy emotional lives.

Selected Programs

Program Name	Brief Description
2015 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.
2015 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.

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<p>2015 San Carlos Traditions & Culture</p>	<p>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 alcohol abuse.</p>
<p>2015 Voz</p>	<p>Voz is a group-level intervention designed to support youth in building life skills and self-efficacy through refusal and harm reduction skills.</p>

Universal Direct Programs

Program Name	Program Description
<p>2015 Douglas Community Coalition</p>	<p>The Douglas Community Coalition is working to prevent substance abuse in the town of Douglas using a variety of comprehensive community based strategies.</p>
<p>2015 Gila River Substance Abuse Program</p>	<p>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.</p>
<p>2015 Graham County Substance Abuse Coalition</p>	<p>The Graham County Substance Abuse Coalition provides prevention and intervention resources, support and education to the community.</p>
<p>2015 Greenlee County Substance Abuse Coalition</p>	<p>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.</p>
<p>2015 Help Enrich African American Lives (HEAAL)-Tanner</p>	<p>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.</p>
<p>2015 Kino Neighborhood Awareness Program</p>	<p>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.</p>
<p>2015 MACAASA MASH Coalition</p>	<p>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-Chin, Stanfield, Hidden Valley (MASH) Coalition.</p>
<p>2015 Maricopa County Urban Indian Coalition (MCUIC)</p>	<p>This coalition targets prevention of underage drinking among urban Native American youths.</p>

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<p>2015 Maricopa Elder Behavioral Health Advocacy Coalition (MEBHAC)</p>	<p>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.</p>
<p>2015 Milagro Project</p>	<p>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.</p>
<p>2015 Mohave County Project</p>	<p>The Mohave County Project builds and sustains community substance abuse prevention coalitions in Kingman, Lake Havasu City and Peach Springs, Arizona.</p>
<p>2015 Navajo County Prevention Partnership</p>	<p>Community Bridges, Inc. (CBI) provides substance abuse and suicide prevention resources for youth and adults living in Navajo County.</p>
<p>2015 PAACE Coalition</p>	<p>PAACE Coalition seeks to reduce underage/binge drinking and prescription drug abuse in the Parker Community.</p>
<p>2015 Pascua Yaqui Tribe Prevention Program</p>	<p>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.</p>
<p>2015 Santa Cruz Community Action Coalition</p>	<p>Community-focused prevention efforts targeting underage drinking, increasing coalition capacity, and promoting healthy, substance-free messages.</p>
<p>2015 Sierra Vista Community Coalition</p>	<p>Facilitate and coordinate a community coalition to work on problems and issues in the community as well underage drinking.</p>
<p>2015 MATForce</p>	<p>MATForce is focused on underage drinking issues. Implementing a public information campaign to continue to educate the community on the consequences of underage drinking, and increasing parental involvement.</p>
<p>2015 Youth Empowered for Success (YES)</p>	<p>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.</p>
<p>2015 Yuma County Anti-Drug Coalition</p>	<p>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.</p>
<p>2015 Apache County Prevention Partnership</p>	<p>Community Bridges (CBI) provides substance abuse and suicide prevention resources for youth and adults living in Apache County.</p>
<p>2015 C.O.P.E. Coalition-TERROS</p>	<p>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.</p>
<p>2015 C.O.P.E. Coalition-Touchstone</p>	<p>Touchstone facilitates neighborhood subcommittee components of the COPE coalition strategic plan.</p>

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2015 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.
2015 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.
2015 Mesa Prevention Alliance	This program addresses prevention of alcohol and other substances in youth using a comprehensive approach including environmental and other strategies.
2015 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).
2015 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.
2015 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.

Universal Indirect Programs

Program Name	Program Description
2015 MATForce	MATForce has comprehensive substance abuse prevention programs targeting prevention of underage drinking, prescription drug abuse and marijuana. Strategies include community education and environmental approaches.
2015 The Alliance	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.
Community Bridges	Community Bridges, Inc. (CBI) Prevention Partnership provides random unannounced inspections of tobacco vendors.
Pima County	The purpose of this project is to build prevention capacity among coalitions in Pima County.
Pima Prevention Partnership	Community Bridges, Inc. (CBI) Prevention Partnership provides random unannounced inspections of tobacco vendors.

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The method to The ADHS/DBHS utilizes to ensure SABG dollars are used to fund primary substance abuse prevention occurs through written contract requirements and tracking spending of Prevention (SABG) monies annually to ensure prevention funds are expended according to funding guidelines which include but are not limited to the following: completing site visits and providing training and technical assistance to subcontractors.

Each T/RBHA is required to collect information on the number of participants served both directly and indirectly and by IOM category. T/RBHAs are also required to submit the amount of funding allocated by primary prevention strategy. The funding information is collected both at the planning and reporting phases. T/RBHAs develop surveys to determine participant satisfaction and also collect attendance at educational events. This information is reported to The ADHS/DBHS on an annual basis.

Each T/RBHA is responsible for developing a regional strategic plan which includes goals and objectives specific to their service area. Below are broad goals that The ADHS/DBHS intends to achieve through its T/RBHA prevention system. T/RBHAs submit an annual prevention plan which addresses the National Outcome Measurements.

Goal# 1: Prevent the onset and reduce the progression of underage drinking and prescription drug misuse.

Goal #2: Reduce alcohol and prescription drug-related consequences among adolescents and young adults.

The outcome data will be used to analyze the states prevention system through the data collected by the T/RBHA. Each T/RBHA is responsible for data collection and evaluation of their SABG funded prevention programs. The evaluation requirements are outlined in contract requirements. The ADHS/DBHS reviews this data on an annual basis.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-10 QUALITY MANAGEMENT

The Bureau of Quality and Integration (BQ&I), formerly known as the Bureau of Quality Management Operations, works collaboratively with all functional areas of Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) in the ongoing assessment and evaluation of the quality of services provided to behavioral health members. Quality Management (QM) administrative oversight and communication activities are conducted through ADHS/DBHS' committees and by sharing data amongst the various functional areas. The 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.

The BQ&I Specifications Manual for Contract Year 2015 is designed to achieve improved quality of care for behavioral health members utilizing evidenced-based 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, frequency of activities and target dates for activities completion. QM activities incorporate contractor, stakeholder and recipient input and serve to further the vision of DBHS. 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. This includes all quality improvement activities conducted by BQ&I 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 members 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:

C-10 QUALITY MANAGEMENT

- 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 (7 & 23-day Access to Behavioral Health Provider);
- Members have their care coordinated between the behavioral health provider and their physical care provider or specialist;
- All complaints, grievances and Quality of Care Concerns are reported, tracked and remedied in a timely legal, manner, and;
- Members discharged from an inpatient hospital receive follow-up services within 7 & 30 days post discharge (HEDIS Measurement).

The Executive QM Committee ensures ongoing communication and collaboration between Executive Leadership, QM, and other functional areas of the organization, which are represented at the Executive 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 at least annually and completes quarterly status reviews of the QM Work Plan.

ADHS/DBHS' Executive QM Committee receives feedback and recommendations for performance improvement activities from various subcommittees, work groups and other functional areas. A T/RBHA QM Committee meeting is held quarterly with contractors, Community Agency Providers, members/Peers/Family to disseminate information, provide technical assistance, and receive feedback from the contractors and community representatives.

ADHS/DBHS has also established a Peer Review Committee to improve the quality of medical care provided to behavioral health members, 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.

BQ&I'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.

C-10 QUALITY MANAGEMENT

Each year ADHS/DBHS contracts with a third-party consultant to conduct Brief Practice Reviews on selected cases of members in Arizona's behavioral health system who were enrolled in substance abuse programs. Arizona state law requires a system wide review to determine treatment effectiveness. ADHS/DBHS continues to utilize the ICR as a mechanism both to comply with state law as well as identify potentials gaps.

Last year, 200 randomly selected charts of those receiving substance abuse treatment services in 2014 were included in the review. The ICR utilized a tool developed by ADHS/DBHS to assess a variety of areas including the use of nationally recognized best practices, screening, assessment, treatment, engagement, retention, and contract and regulation compliance. Additionally, the ICR collected data pertaining to National Outcome Measures. After reviewing all cases, the consultant developed a comprehensive report which provided information regarding each RBHA as well as the State overall. ADHS/DBHS then reviewed this report internally and identified areas which would require additional follow up.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma⁷⁵ is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems⁷⁶. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To 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 approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”.⁷⁷ 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 supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma⁷⁸ paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

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

75 Definition of Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.

76 <http://www.samhsa.gov/trauma-violence/types>

77 <http://store.samhsa.gov/product/SMA14-4884>

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-11 TRAUMA

At present, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) does not have a policy requiring providers to screen members for instances of trauma. However, ADHS/DBHS recognizes the importance of Trauma Informed Care (TIC) and has included its promotion in contracts with Regional Behavioral Health Authorities (RBHAs) as well as DBHS' strategic plan for the System of Care. ADHS/DBHS currently contracts with four Regional Behavioral Health Authorities (RBHAs) to provide direct services and included in these contracts with the RBHAs. ADHS/DBHS requires that a RBHA's treatment networks include services that are culturally appropriate, maximize personal and family voice and choice, and incorporate a trauma-informed care approach into all treatment.

The Trauma-Informed Care Taskforce promotes the TIC philosophy to the public behavioral health system through a Dialogue/Focus Group combination. The TIC task force developed a statewide TIC needs assessment and continues to host TIC and Stigma Reduction dialogues across the state with the goal of spreading awareness concerning trauma informed care, particularly around sanctuary trauma.

ADHS/DBHS requires that the RBHAs annually submit to ADHS/DBHS for approval a provider network management plan that includes a description of specialty service providers, including providers with expertise to deliver services to children, adolescents and adults with developmental or cognitive disabilities; sexual offenders; sexual abuse trauma victims; individuals with use disorders; individuals in need of dialectical behavior therapy; and infants and toddlers under the age of five (5) years. Some examples of evidence-based trauma-specific interventions available at various providers throughout the state are Seeking Safety, Dialectical Behavior Therapy, and Eye Movement Desensitization and Reprocessing (EMDR).

ADHS/DBHS requires the RBHAs to provide trainings to develop and promote the implementation of Trauma Informed Care throughout the state in DBHS' annual System of Care plan. DBHS reviews training rosters of the RBHAs quarterly to monitor the delivery of TIC specific trainings. Additionally the TIC Taskforce has made a wide variety of trainings and conferences available throughout the state reaching both providers as well as the public. The TIC Taskforce is involved in the Arizona Adverse Childhood Experiences Consortium, has held a TIC meeting with the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, as well as hosted TIC dialogues and workshops with staff and patients at the Arizona State Hospital. The TIC Taskforce hosted a Trauma Informed Care and Resiliency Conference in 2014 and has collaborated with RBHAs to ensure the progression of TIC trainings and services across the state.

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

C-11 TRAUMA

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.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.⁷⁹

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 use 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.^{80 81} 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 use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.⁸²

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. 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 a 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 consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate 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. Are cross-trainings provided 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?

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

⁷⁹ <http://csqjusticecenter.org/mental-health/>

⁸⁰ The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

⁸¹ 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.

⁸² 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, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-12 CRIMINAL AND JUVENILE JUSTICE

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. In our Children's Behavioral Health System, there are State level representatives from both Juvenile Corrections and Juvenile Probation sitting on the Arizona Children's Executive Committee (ACEC). The 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.

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. These staff are also available to assist in enrolling individuals if they have not previously been identified as having mental health or substance abuse treatment 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 is better able to identify the appropriate range of services.

C-12 CRIMINAL AND JUVENILE JUSTICE

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. To work on this problem throughout the state, the 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.

Finally, peer support is a priority of the state as well as the RBHAs and currently there are peers embedded within SUD treatment facilities as well as dedicated peer-run organizations to ensure a comprehensive peer support network throughout the state. Further, many peer support agencies have developed cross-agency collaboration initiatives and collaborate with jails to assist individuals being released with enrolling in/coordinating treatment services, prior to their release so they are able to smoothly transition back into the community and begin treatment as soon as possible.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.⁸³

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.⁸⁴

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

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.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

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

⁸³ <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

⁸⁴ Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-13 STATE PARITY EFFORTS

With the implementation of Health Care Reform and the transition to integrated physical and behavioral health care in Arizona, the Arizona Department of Health Services, Division of Behavioral Health (ADHS/DBHS) continues to evaluate and explore new ways to promote awareness about Mental Health Parity. The ADHS/DBHS has several parity education elements on its 2015 the ADHS/DBHS Communications Plan. The Plan includes ongoing dissemination of parity requirements through social media, the agency web site and the *Recovery Works* newsletter.¹

Still, the ADHS/DBHS has recognized several areas for improvement in its education efforts on Parity. The ADHS/DBHS has solicited the assistance of the Behavioral Health Planning Council to find ways to promote information. The Planning Council acknowledged the importance of educating the public about Parity and has agreed to assist the ADHS/DBHS with its efforts. For starters, the Planning Council has agreed to make recruitment of an individual from the insurance commission/public insurance company one of its goals for 2016. The selected candidate will not merely be a guest at the Council, but will be offered the opportunity to serve as a Planning Council member. It is expected that the candidate will bring unique perspectives on Parity to the Planning Council, and the addition will provide an opportunity for the Council and ADHS/DBHS to become stronger advocates for this very important law.

¹ 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.

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40⁸⁵, 43⁸⁶, 45⁸⁷, and 49⁸⁸. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

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

⁸⁵ <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

⁸⁶ <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

⁸⁷ <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

⁸⁸ <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-14 MEDICATION ASSISTED TREATMENT

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) serves as the single state authority to provide coordination, planning, administration, regulation and monitoring of all facets of the state public behavioral health system. The Division contracts with community-based organizations, known as Regional Behavioral Health Authorities (RBHAs), to administer behavioral health services. Regional Behavioral Health Authorities operate much like a health maintenance organization. Each RBHA contracts with a network of service providers similar to health plans to deliver a range of behavioral health care services, treatment programs for adults with substance abuse disorders, adults with serious mental illness and children with serious emotional disturbance. Currently these RBHAs maintain provider directories to ensure that all substance abuse treatment program information is located in one area that is accessible to mental and medical providers and the public. Currently there are Community Coordinators employed by RBHAs that go to meetings and various behavioral health events in the community and promote services available under SABG. Additionally there are outreach workers employed by RBHAs that promote services available under SABG in the community (i.e., store fronts, libraries, post offices) in efforts to engage and refer people into services.

Currently within the RBHAs there are requirements in place for providers (including outpatient, residential, and OTP) that receive SABG funds have annual outreach plan that identify what community coalitions they interact with, how often they are working with coalitions, and their outreach goals (ex- increase use of SABG, treatment for at-risk underserved populations, and improving community partnership and collaboration). RBHA hosts community forums where services available through SABG funding are presented to community stakeholders (including community members, probation, corrections, and a variety of interested state and county agencies).

ADHS/DBHS recognizes the important role medication-assisted treatment (MAT) plays in the treatment of substance use disorders and has collaborated with Arizona State University's Center for Applied Behavioral Health Policy to host MAT Symposiums across the state. The MAT Symposiums were provided at no-cost to attendees and included attendees from treatment providers, corrections, probation, the state's Medicaid agency, and other community stakeholders to educate and raise awareness within the Arizona community regarding what MATs are and their availability throughout the state.

ADHS/DBHS houses the State Opioid Treatment Authority (SOTA). The role of the SOTA in Arizona is to coordinate with the Drug Enforcement Administration (DEA), SAMHSA's Center for Substance Abuse Treatment (CSAT), and the State of Arizona's Division of Licensing Services to oversee the licensing/accreditation of outpatient Opioid Treatment Providers (OTPs). Clinics licensed as OTPs must adhere to the DEA and CSAT guidelines regarding FDA-approved medications, safeguards against diversion, and provision of psychosocial treatments. Additionally, the RBHAs have procedures in place to evaluate the fidelity of best practices and evidence-based programs providers are utilizing, including programs and medications.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)⁸⁹,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

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

⁸⁹Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-15 CRISIS SERVICES

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) Crisis Service Plan spans multiple modalities of service provision including: availability of crisis services 24 hour/day seven (7) days per week, crisis hotline, mobile assessment services, and crisis stabilization services. The philosophy of care for the provision of crisis services is to keep individuals safe, stabilize them as quickly as possible, assist them in returning to their baseline level of functioning, and support the transition of care from a state of crisis into ongoing treatment in the community. The ADHS/DBHS' contractors' crisis response system endorses a perspective that is recovery-oriented, culturally competent and trauma-informed.

In an effort to improve the crisis system the ADHS/DBHS has elected to focus on transitioning individuals into community-based services rather than treating the crisis as an isolated incident. Prompt implementation of community services can address the member's immediate issues, as well as reduce costs and inappropriate utilization of emergency visits and hospitalizations. It can also improve long-term outcomes, decreasing the need for additional law enforcement interventions and crisis services in the future. Additionally, expanding provider networks that are capable of providing a full array of crisis services geared toward the member is expected to maintain health and enhance quality of life. To ensure the crisis response system is operating to its fullest potential the following services and supports must be prevalent:

Assess and Refer

Assess the individual needs, identify the supports and services that are necessary to meet those needs, and connect the individual to appropriate services such as peer and family support services.

Intervene

Provide solution-focused and recovery-oriented interventions in the least restrictive but safe environment such as outpatient treatment centers, Observation/Stabilizations facilities, and Substance Abuse Transitional facilities.

Involve Recovery Supports

Engage peer and family support services in the provision of crisis services, including roles for advocacy, skills development, and discharge planning.

Provide timely response

Ensure members have access to immediate crisis intervention and require crisis teams to respond on-site within an average of 90 minutes of receipt of the crisis call.

Promote ease of access

Provide crisis services without the need for prior authorization and develop a network which includes the implementation of stabilization services to prevent unnecessary transportation outside of the community where the crisis is occurring.

Data Sharing

C-15 CRISIS SERVICES

Implementation of a health information exchange data sharing system that connects crisis providers. The system has the ability to analyze, track and trend crisis service utilization data. Furthermore, the system ensures information sharing for timely access to Court Ordered Evaluation services. This data is aggregated, analyzed, trended and utilized for the purpose of improving the State's crisis system.

Collaboration

Maintain collaborative relationships with community partners such as: local fire and police departments, emergency medical services, hospital emergency departments, and providers of public health and safety services.

Educational Support

Provide Mental Health First Aid training to first responders to give them the necessary skills to de-escalate a member experiencing a mental health crisis.

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- | | | |
|--|---|--|
| • Drop-in centers | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators | • Peer-run respite services |
| • Peer specialist/Promotoras | • Peer wellness coaching | • Person-centered planning |
| • Clubhouses | • Recovery coaching | • Self-care and wellness approaches |
| • Self-directed care | • Shared decision making | • Peer-run crisis diversion services |
| • Supportive housing models | • Telephone recovery checkups | • Wellness-based community campaign |
| • Recovery community centers | • Warm lines | |
| • WRAP | • Whole Health Action Management (WHAM) | |
| • Evidenced-based supported | | |

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

Recovery is based on the involvement of consumers/peers and their family members. States should 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 engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. 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?
4. 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? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

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The Arizona Department of Behavioral Health Services, Division of Behavioral Health Services (ADHS/DBHS) has adopted and embraced the values of recovery. The recovery of each individual served is just that, individual. It is a deeply personal process and has no single, universally accepted definition. In the simplest sense, recovery is a lived experience of moving through and beyond the limits of one's disorder; living a life outside of one's illness. In this process, hope, empowerment, self-responsibility and a meaningful role in life are key components. The significant characteristics of recovery are personal and individualized, and are not defined by a treatment agency. The recovery progression moves beyond symptom reduction and relief; it embraces both the process of healing and discovery. (i.e. having meaningful connections in their community, overcoming specific skill deficits, and establishing a sense of quality and well-being). In recovery it also encompasses the possibility for individuals to test, make mistakes, and try again.

Nine Guiding Principles were developed in partnership with peers, family members, providers and other stakeholders to provide a shared understanding of the key elements to promote a Recovery Oriented System of Care (SOC) ensuring recovery values are embedded in the structure as the foundation of the system itself. The Nine Guiding Principles are: *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.* These principles serve as reminders of our values and vision when considering future innovations.

Each Regional Behavioral Health Authority (RBHA) is required by contract, to have an Office of Individual and Family Affairs (OIFA) that is a counterpart of the OIFA at ADHS/DBHS. The chief of this office must be either an individual with lived experience of behavioral health services and/or a family member. Likewise, the remaining office staff must also be peers and/or family members. The mission of each OIFA is to bring the voice of the community into the decision-making process through direct engagement of those who will be most affected by any future changes. This assists in the promotion of leadership roles for people in recovery.

ADHS/DBHS supports a model for assessment, service planning, and service delivery that is strength-based, person-centered, family friendly, culturally and linguistically appropriate, and clinically sound and supervised. ADHS/DBHS Policy 105-*Service Assessment and Service Planning*; requires each person served in Arizona's public behavioral health system have an Individual Service Plan (ISP). This model is based on four equally important components: *1)*

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Input from the person regarding their individual needs, strengths, and preferences; 2) Input from other persons involved in the person's care who have integral relationships with the person; 3) Development of a therapeutic alliance between the person and behavioral health provider that fosters an ongoing partnership built on mutual respect and equality; and 4) Clinical expertise.

Treatment and recovery support services are coordinated for all individuals receiving behavioral health services through a variety of mechanisms, including the completion of an Individual Service Plan (ISP). This plan identifies services and supports that are designed and selected to help individuals to achieve their chosen goals. When an individual is engaged in the system, referrals to Peer and Family Run Organizations, as well as the support of a case manager are provided to assist and support treatment goals. Case management services are provided to enhance treatment effectiveness and include activities such as assistance in obtaining, monitoring and modifying services and communication/coordination of care. Peer support services are designed to provide greater structure and intensity of services than is available through community-based recovery groups. Peer support is provided by persons who are or have been consumers of the behavioral health system and are qualified as behavioral health professionals, technicians or paraprofessionals.

ADHS/DBHS Policy 201-*Covered Health Services*; identifies requirements for coverage of behavioral health services and physical health services established through contracts with ADHS/DBHS and the RBHAs. Included are a variety of recovery services and supports to meet individualized needs of each individual. Support Services include: Personal Care, Self-Help/Peer Services (Peer Support), Family Support, and both Supervised and Therapeutic Day Programs, members and Supported Housing. Rehabilitative services include: Skills Training and Development, Behavioral Health Prevention/Promotion Education, and Psycho-Educational Services and Ongoing Support to Maintain Employment. Many peer/recovery support specialists are qualified to provide these services and commonly do so with such job titles as "Recovery Coach".

In January of 2014, ADHS/DBHS adopted four (4) Evidence-Based Practices fidelity tools developed by the Substance Abuse Mental Health Services Administration (SAMHSA) to evaluate Assertive Community Treatment (ACT), Supported Employment, Supportive Housing and Peer and Family Services (Consumer-Operated Services (COS)). Arizona's peer-run organizations are evaluated annually by third-party contractors using the Fidelity Assessment Common Ingredients Tool (FACIT). ADHS/DBHS contracted with SAMHSA to provide training on each of these tools to providers and interested community members.

Since October of 2012, Arizona has received Medicaid-reimbursement for provision of peer/recovery support services. This was made possible by ADHS/DBHS Policy 404-*Peer Support Training, Certification and Supervision*. This product is a collaborative development by the State, peer support providers, members, and Peer/Recovery Support Specialists. The document includes the 25 Core Elements required of a Peer/Recovery Support Employment

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Training Program. These elements are program standards which have allowed for a great diversity and availability of training programs in Arizona. Although many of the trainings are very different in scope and focus, they all meet state standards. A certificate from any accredited program operator is applicable statewide. These programs are re-evaluated every three years. The first program re-evaluation will occur in November, 2015. Arizona's Peer/Recovery Support Program(s) is an ongoing effort.

Arizona was selected as the first state in a national study for peer/recovery support programs and services by an expert panel organized by the University of California, San Francisco. In early July 2015, a team of four researchers visited three different peer/recovery support programs that best reflected the wide diversity allowed for by "The Arizona Model" of peer/recovery support services. A collaborative and ongoing study on the effectiveness of services delivered in peer-run settings between Stand Together and Recover (STAR) Centers, a peer-run organization, and the Arizona State University Center for Applied Behavioral Health Policy. The outcomes show great improvements made in quality of life and overall health of members who partake in the services offered by peer-run organizations. The ADHS/DBHS Office of Individual and Family Affairs is gathering data on utilization and employment in the field of peer/recovery support. Identifying the variables influencing productivity demand and job tenure will lead to the design of healthy, productive, and successful workplaces for Peer/Recovery Support Specialists. The collection and analysis of data regarding the delivery of peer/recovery support services will identify determining factors and best-practices to ultimately lead to a decreased turnover rate, increased job tenure and satisfaction; and overall effectiveness of peer support services. "Support for those who provide support."

ADHS/DBHS Policy 409-*Family and Youth Involvement in the Children's Behavioral Health System*, identifies in detail the incorporation and involvement of service recipients and their family members in the planning, design and improvement of Arizona's behavioral health system. Although it is specifically written for the children's branch of our behavioral health system, the same practices of engagement and inclusion take place in the Adult Behavioral Health System.

During the Greater-Arizona RBHA transition, ADHS/DBHS, in partnership with the RBHAs, fostered the formation of Community Engagement Committees to be led and operated by members of the community: peers, family members, other stakeholders, etc. As the southern half of the State was becoming unified into a single Geographic Service Area, there was a need to connect with communities that would now become "far-flung" due to the re-alignment of geographic scope. A very strong and well-organized coalition of peer and family supports has operated in Pima County for many years. This coalition changed its name to the "Southern Arizona Peer and Family Coalition", and took over the operation of the "Southern Arizona Transition Collaborative"; the Collaborative being community engagement regarding the upcoming RBHA changes in Southern Arizona.

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On an annual basis, ADHS/DBHS in collaboration with the RBHAs, administers two statewide surveys: the Mental Health Statistics Improvement Program (MHSIP) consumer survey for adults; and the Youth Services Survey for Families (YSS-F) for children. The survey is a request for independent feedback from eligible adults and families of youth receiving services through Arizona's public behavioral health system. The purpose is to measure consumers' perceptions in relation to the following domains: General Satisfaction, Access to Services, Service Quality/Appropriateness, Participation in Treatment Planning, Outcomes, Cultural Sensitivity, and Improved Functioning and Social Connectedness.

Consumer Survey results are presented during the Executive Quality Management (QM) Committee and the RBHA QM Committees. The critical information obtained from these surveys is a major source for driving system improvements through RBHA contracts and QM Plans. RBHAs scoring less than 70% in any of the above mentioned domains are required to complete a Corrective Action Plan to address areas for system change opportunities. Survey outcomes are disseminated to stakeholders and consumers through the Performance Dashboard on the ADHS/DBHS website and submitted to national organizations as part of the federal grant requirements for use in national reporting and evaluation. Satisfaction with service Outcomes on the Annual Consumer Survey is a performance incentive for RBHAs. A score of 70% or greater on the Outcomes domain of the Consumer Survey makes up 25% of the incentive award. Adult and youth survey results are evaluated independently, each contributing to half of the award. ADHS/DBHS believes that assisting members in the identification and tracking of treatment outcomes is imperative to improving behavioral health members' overall perception of the quality of services they receive.

ADHS/DBHS recognized the need to create a system able to address the whole person; preventative, acute, and behavioral health needs for individuals receiving services. In 2014, the implementation of an integrated health system for those with a serious mental illness (SMI) in Maricopa County (Central region/metropolitan) was implemented. As of October 1, 2015, the integrated model will be implemented in the Northern and Southern regions. The goal for the integrated health system is to reduce the co-morbid health conditions, which leads to substantially shorter life expectancy caused by treatable medical conditions caused by modifiable risk factors like smoking, obesity, substance abuse, and not accessing primary and acute medical care. The RBHAs are and will be responsible for delivering preventative, acute and primary care along with recovery-based behavioral health services for individuals in the public health system. Along with the change in service delivery, the ADHS/DBHS has established new performance measures to identify outcomes related to integrated care. The ADHS/DBHS reviews seven (7) behavioral health measures and twenty-six (26) acute medical measures. The seven behavioral health measures, (Inpatient Hospitalization Utilization, Emergency Department Utilization, Re-admission Rate, Follow-up after inpatient hospital stay within 7 days, Follow-up after inpatient hospital stay within 30 days, Access to a Behavioral Health Provider within 7 days of an assessment, and Access to a Behavioral Health Provider within 30 days of an assessment) are

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Statewide measures for the SMI, general mental health, substance abuse, and child populations. Rates by RBHA for each measure will be compared with the Minimum Performance Standards (MPS) specified in the contract in effect during the measurement period.

ADHS/DBHS is committed to ensuring that the housing needs of individuals are met in the least restrictive setting and in a supportive community. Funding is provided to each RBHA for housing, which includes rental subsidies, acquisition, and renovation/rehab. Consistent with the Substance Abuse and Mental Health Services Administration (SAMHSA) definition of Permanent Supportive Housing, the ADHS/DBHS defines housing as decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord tenant laws and is linked to voluntary and flexible support and services designed to meet tenants' needs and preferences to remain in the housing they have chosen. The following items demonstrate actions ADHS/DBHS has taken to ensure that appropriate and supportive housing programs are implemented for individuals:

- Guidelines were established on the use of a property to house no more than 8 persons (Rule of 8) with serious mental illness or no more than 25% of an apartment complex (Density Rule), whichever is greater, to avoid recreating “mini institutions” in the community. The ADHS/DBHS also understands that this is difficult to abide by in more rural areas in Arizona, and special requests to waive the Density Rule can be made by the T/RBHAs.
- ADHS/DBHS has shifted to a “Housing First” approach, which is founded on the belief that housing is a basic human right for all persons regardless of disability. The program provides individuals with housing first while other services are being determined. The individual chooses where he or she wants to live, and housing is not dependent upon their participation in a “program” or “treatment.” Rents are subsidized and supportive services are provided on a voluntary basis to help the individual to remain successfully housed in the community.
- According to the DBHS Housing Desktop Manual:
 - Housing must be safe, stable, and consistent with the member’s recovery goals and be the least restrictive setting necessary to support the member. Shelters, hotels, and similar temporary living arrangements do not meet this expectation.
 - T/RBHAs must not actively refer or place individuals determined to have SMI in a shelter, licensed Supervisory Care Homes, unlicensed board and care homes, or other similar facilities.
 - T/RBHAs may not utilize any funding source provided by ADHS/DBHS toward any type of rental subsidies, acquisitions, or property improvements for boarding homes and similar places.
 - T/RBHAs must not use supported housing allocations for room and board charges in residential treatment settings. However, T/RBHAs may allow residential treatment settings to establish policies which require that persons earning income contribute to the cost of room and board.

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ADHS/DBHS provides employment and educational programs to support individuals' goals for independence and self-sufficiency. ADHS/DBHS provides funding through an Intergovernmental Agreement (IGA) with Vocational Rehabilitation (VR). In FY2014, ADHS/DBHS provided approximately \$2.4 million, which VR uses to draw down four to one federal monies, making the total \$11.4M. The funding goes toward staffing and client services. Some of the key components of the IGA are:

- The federal mandate to determine someone eligible for services is 60 days. For the purposes of the IGA, for RBHA enrolled SMI clients, it is 30-days.
- There are specialty VR Counselors for individuals with a SMI, assigned to each RBHA Provider site.
- There is no need for a signed Release of Information to share verbal and written information between the RBHA Providers and VR.
- VR Counselors shall have "functional workspace" at the RBHA provider site, which includes a private area to meet with clients, access to a desk and telephone, and access to a computer and/or internet.
- In conjunction with the RBHAs, regular meetings are to be held within each region (minimum of quarterly).
- Collaborative Protocols are developed between each RBHA and VR to address the specific service delivery responsibilities within each RBHA service area.
- Time-limited Job Coaching services are provided by and funded by VR. This is called Supported Employment (not to be confused with SAMHSA's Evidence-Based Practice of Supported Employment). Also, during the end of a client's VR case, Extended Job Coaching services are to be provided by and funded by the RBHA, and this may last for as long as the client needs them. This is called Extended Supported Employment (ESE).

ADHS/DBHS System of Care has established the following employment-related strategies and tasks:

- Increase education/training for Providers
 - Social Security Work Incentives (Ticket to Work Program, Freedom to Work Program, and Disability Benefits 101 {DB101}).
 - Employment Codes within the Demographic User Guide (DUG)
- Increase the utilization of pre-vocational services
 - Provide pre-vocational and job coaching services as indicated in the AHCCCS Covered Services Guide.
 - Increase number of referrals made to RSA Vocational Rehabilitation.
 - For members who successfully close from RSA services, provide Extended Supported Employment services (job coaching).
- Identify at least one fully dedicated vocational/rehab staff to be assigned to each direct care clinical team.
 - Assign at least one employment/rehab staff member for each adult direct care clinical team whose duties are only to include employment-related activities (i.e. Rehab activities, both paid and unpaid, and meaningful community involvement activities. - Due to staff availability and/or

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regional location, the employment/rehab staff member may cover more than one clinical team).

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-17 COMMUNITY LIVING AND THE IMPLEMENTATION OF OLMSTEAD

The Arizona Department of Health Services collaborated with other government divisions and community stakeholders to review the state Olmstead plan. The result is a collaborative approach and agreement ensuring Arizonans are provided appropriate housing and to meet their needs. There is no on-going litigation against Arizona regarding Olmstead. The draft of this report is still pending approval by officials at the state health plan; we anticipate having it posted by the end of calendar year 2015.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.⁹⁰ Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.⁹¹ For youth between the ages of 10 and 24, suicide is the third leading cause of death.⁹²

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.⁹³ Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 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.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.⁹⁴

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care⁹⁵:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious 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 consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious 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?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

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

⁹⁰ Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

⁹¹ Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

⁹² Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

⁹³ The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

⁹⁴ Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

⁹⁵ Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-18 CHILDREN AND ADOLESCENT BEHAVIORAL HEALTH SERVICES

As a result of the Olmstead Decision (Olmstead v L.C., 119 S.Ct.2176(1999), the Arizona Health Care Cost Containment System Administration (AHCCCS), the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) and the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) determined it would be appropriate, and in the consumers' best interest, to convene a public planning process that would review the accomplishments of the state and identify areas for future endeavors to improve opportunities for consumers to live in the most appropriate integrated setting possible. These agencies convened a workgroup in 2000 to start the planning process. The state agencies recognized that this was part of a continuous improvement process in which each agency was already involved prior to the Olmstead Decision and would continue to engage in. The preparation of the plan was also consistent with the Executive Order issued by President George W. Bush on June 18, 2001 in support of the Olmstead Decision.

Developed in 2001, Arizona's Olmstead Plan provided a comprehensive approach to demonstrating the State of Arizona's historical emphasis on principles that are found in the Olmstead Decision and its desire to continue to ensure persons who are elderly and persons with disabilities have appropriate access and choice regarding community-based services and placements.

Although the Supreme Court did not require states to develop a plan, Arizona believed this was an opportunity for advocates, agencies, consumers and community stakeholders to collaborate on a plan that would guide the State toward improving access to home and community-based settings and services. The state agencies that design, fund and provide services to persons with disabilities – AHCCCS, ADES/DDD and the ADHS/DBHS, have a history of working under the premise that people should live in an appropriate integrated setting within the community. Since the original plan was developed, Arizona has continued expanding and developing its capacity for providing community-based services, including peer and family support services, supported employment and supportive employment services.

In the Children's System, this expansion has been supported by the collaborative efforts of the Arizona Children's Executive Committee (ACEC). The 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*.

In January 2014, the ADHS/DBHS initiated a plan calling for an increase of services in four areas: Assertive Community Treatment, Supported Employment, Supportive Housing and Peer and Family Services. The initiative also provides for the use of several tools to evaluate services provided in Maricopa County, including a quality service review (QSR), network capacity analysis and SAMHSA fidelity tools. The strengthening of Assertive Community Treatment (ACT) in Arizona, along with the well-established Child and Family Team practice, has been

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important in improving outcomes for children and adults when they transition from hospitals to community based care.

Modeled after the SAMHSA sponsored systems of care described by Shelia Pires and others, the ADHS/DBHS has built a statewide system of care utilizing an individualized, family centered, youth guided, community-based and culturally competent approach to meet the needs of children and their families. Policy, practice protocols, covered services guide, and contract language provide 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; and 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) Clinical Guidance Tool* defines the "wrap around" process and how it is to be implemented; collaborative Protocols 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* provides funding specifically for cadres of case managers with reduced caseloads (1 to 20) in order to work with the most complex child and family needs; the *Meet Me Where I Am Campaign (MMWIA)* provides 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, developing a crisis plan, completing an inventory of strengths, needs, and cultural discovery, and securing 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 Clinical Guidance Tool 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 by the RBHAs 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. Additionally, for the past five years Arizona has utilized the *System of Care Practice*

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Review (SOCPR) Tool, developed by University of South Florida, to measure CFT practice fidelity to system of care values and principles for over 900 complex needs children as well as over 3,500 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. Agencies are required to develop Practice Improvement Plans (PIPs) to target areas of practice where opportunities for improvement have been identified through the SOCPR/BPR process.

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 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 Department of Child Safety (DCS) 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. Although there is no official designee to the Arizona Department of Education (ADE) from the ADHS/DBHS, the Division participates, along with ADE and other state agencies, in two statewide groups that have the goal of enhancing collaboration between ADE and the ADHS/DBHS. The Arizona Community of Practice on Transition (AzCoPT) and the Positive Behavioral Interventions and Supports Advisory Committee (PBIS-AZ) both work to identify school aged children and youth with mental health/substance abuse needs and provide them with appropriate services.

The 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*

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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.

Young Adults in Arizona transition from the Children's behavioral health service system to the Adult system when they turn 18 years of age. This process is described in the ADHS/DBHS Clinical Guidance Tool "*Transition to Adulthood*" (see attached). This document provides instruction to provider agencies regarding the States expectations with respect to the transition process and it includes detailed guidance for the transition of youth in foster care. In addition, the ADHS/DBHS provides guidance for working with foster youth in the Clinical Guidance Tool "*The Unique Behavioral Health Service Needs of Children, Youth and Families involved with Child Protective Services*" (see attached).

TRANSITION TO ADULTHOOD

Finding safe and affordable housing that meets housing quality standards for young adults with mental illness can be an ongoing challenge. Frequently, they experience barriers such as a lack of affordable housing options which could restrict them from transitioning from out of home treatment services into an independent living setting with or without supports.

AREAS FOR CONSIDERATION WHEN ADDRESSING HOUSING

- **Safety:** While safe housing is important for everyone, it is especially critical for an individual with mental illness. Locks on the doors and windows, smoke detectors, cleanliness, and adequate lighting are a few safety factors important to a well-maintained living environment.
- **Location:** Ideally, a housing location is close to a bus route, shopping, parks, grocery stores, pharmacies, libraries and other venues that provide opportunities for socialization, including proximity to family members, informal supports, and behavioral health service settings.
- **Cost:** Programs that help cover the cost of rent may be essential in assisting individuals with low-income to live independently.
- **Age Limitations:** An individual must be 18 years of age or a legally emancipated minor in order to apply for many of the state and federally subsidized housing programs or to sign a lease.
- **Lack of or poor rental and credit history:** Most rental properties require a credit report and previous rental history. If applicable, consider the use of a responsible party (e.g., family member) to co-sign the lease or provide the landlord with letters of reference that show the young adult's trustworthiness in situations where an individual has not yet obtained a rental or credit history.
- **Structure/Support/Socialization:** Tailor living arrangements with the necessary structure and support for individuals to manage their ongoing recovery, treatment responsibilities, and self-sufficiency. Individuals who are developing their social networks may benefit from a living environment where social activities are included.

LIVING WITH FAMILY OR WITH A ROOMMATE

One option is to live with family (e.g., parents or extended family members) or with a roommate. The obvious advantage is cost savings, medication education/monitoring when needed (e.g., roommates can serve as peer mentors), and the opportunity to socialize with people who are understanding and supportive of their recovery. Considerations when living with others can be a lack of privacy and potential over-involvement by others that may hinder the young adult's development of self-sufficiency. Should an individual decide to live with someone, s/he should have a frank discussion concerning household rules and privacy expectations before agreeing to share a residence and/or signing a lease agreement.

Addressing the following areas before signing any lease agreement will help clarify each household member's responsibilities:

- equal division of rent
- payment of utility bills
- sharing cleaning and household chores
- meal planning, buying and storing food, cooking responsibility
- agreements on handling parties and overnight guests, etc.

The following form may be a helpful guide for individuals when seeking a roommate.

Describe Yourself	✓	Describe the Type of Person You Would Like to Live With	✓
Neat		Neat	
Messy		Messy	
Gets up early		Gets up early	
Gets up Late		Gets up late	
Mostly on time		Mostly on time	
Usually late		Usually late	
Likes loud music		Likes loud music	
Likes quiet music		Likes quiet music	
Likes to be alone or with a few people		Likes to be alone or with a few people	
Likes to be with a lot of people		Likes to be with a lot of people	
Has trouble saying “no” to others		Has trouble saying “no” to others	
Reliable		Reliable	
Not Reliable		Not Reliable	
Has a criminal background		Has a criminal background	

QUESTIONS TO CONSIDER WHEN LOOKING FOR AN APARTMENT

1. How much is the rent?
2. Is a security deposit required? How much?
3. Is there an application fee? How much?
4. What forms of identification are required to apply?
5. What are the terms of the lease? How long is the lease for?
6. Are any utilities covered in the rent? What utilities does the tenant pay for?
7. Is the apartment furnished or unfurnished?
8. What are the private or shared areas (e.g., kitchen, bathroom, laundry)?

9. Is a refrigerator or washer/dryer provided? Private or shared?
10. Is the apartment complex under a Home Owners Association (HOA)? Applicable fees?
11. Is the apartment complex managed by an individual owner or a management company?
12. Does the complex allow pets? If so, is there a pet deposit? A monthly pet fee?

ARIZONA RESIDENTIAL LANDLORD AND TENANT ACT¹

The Arizona Residential Landlord and Tenant Act specifies general provisions, landlord and tenant obligations, and remedial and retaliatory actions that pertain to renting residential dwellings in the State of Arizona (see [A.R.S. § 33-10](#)). Before renting there are certain actions persons can take to protect their rights and avoid problems. The [Arizona Tenants' Rights and Responsibilities Handbook](#) was designed by Community Legal Services and outlines these actions, as well as the rights and obligations of tenants in Arizona. Information pertaining to the eviction process, non-payment of rent, and unlawful seizure of a tenant's personal property are also contained in this handbook.

The **Landlord/Tenant Act** and this handbook do not apply to the following situations:

- tenants in mobile homes (unless tenants rent both trailer and lot from the same person or company);
- tenants in public housing projects or public institutions;
- occupancy under a sales contract if occupant is the purchaser;
- transitional occupancy in a hotel, motel, or recreational lodging;
- occupancy by a person employed by the landlord as manager or custodian if the right to occupy is conditional upon employment in and about the premises; and
- certain other conditions found in [A.R.S. § 33-1308](#) and [A.R.S. § 33-1310\(3\)](#).

Information regarding legal provisions for individuals who are pursuing housing in a mobile home setting is outlined in the [Arizona Mobile Home Parks Residential Landlord and Tenant Act](#) per [A.R.S. § 33-11](#).

FAIR HOUSING DISCRIMINATION

There are both state and local laws that prohibit discrimination in all aspects of housing: rental, sales, services, advertising, etc. It is illegal to treat people differently on the basis of their race, color, national origin, religion/creed, sex/gender, physical/mental disability, familial status (pregnant or children under age 18), or retaliation. Individuals who believe they may have been discriminated against can contact the Arizona Attorney General's Office: Civil Rights Section at 1275 West Washington Street, Phoenix, Arizona 85007, by calling (602) 542-5263 or 1-877-491-5742, or by filing a complaint online at http://www.azag.gov/civil_rights/complaint.html.

¹ http://www.azsos.gov/public_services/publications/residential_landlord_tenant_Act/

HOUSING OPTIONS AND PROGRAMS

A comprehensive housing continuum is one that offers a full array of options that meets the unique needs and preferences of behavioral health enrolled adults. Housing that provides structure and consistency enhances the person's recovery process while being flexible enough to meet the changing needs of youth in transition. Integrating and maintaining young adults in community based services and settings are critical tasks for transition planning. When young adults experience safe, stable, and familiar living arrangements they are able to benefit from their clinical treatment, employment opportunities, and social activities.

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) provides adults with a Serious Mental Illness (SMI), who are enrolled with Tribal and Regional Behavioral Health Authorities (T/RBHAs), the opportunity to access various affordable housing options with and without supports based on eligibility and funding sources. These housing options are for adults who are being released from the Arizona State psychiatric hospital and jails, living in inappropriate environments, experiencing extended utilization of out of home treatment services, and/or frequently using the crisis system. Additionally, adults who are homeless, living in shelters and/or on the streets, as well as youth who are transitioning from the children's behavioral health service system to the adult service system can also benefit from a team's exploration of these housing options. There is limited funding of housing programs for behavioral health enrolled adults categorized as general mental health or substance abuse (GMH/SA).

This Tool Attachment lists a continuum of housing options, defines these options, and offers criteria for state and federal housing programs. Clinical teams are encouraged to explore other housing resources and opportunities in addition to the ones listed here.

To access the housing services listed below, an individual must be Medicaid eligible, enrolled and case managed in the T/RBHA's service delivery system as an adult with a serious mental illness and be a legal resident of the United States. The clinical team, including the housing specialist, will assist the individual and his/her family, if involved, with identifying the type of housing that best fits that person's circumstances.

HOUSING OPTIONS

Independent Community Housing

In this housing type tenants live, either alone or with a roommate, in a home or apartment setting. While they receive minimal to no ongoing supervision from behavioral health staff, individuals continue to receive support and services from the behavioral health system. Types include state housing programs, federal Section 8 and Public Housing programs through local Public Housing Authorities (PHA), subsidized housing through local non-profit organizations, and federal and state funded Supportive Housing Programs that are administered by contracted housing providers. Units are not licensed and tenants pay up to 40% of their adjusted income towards rent.

Semi-independent Community Living

This housing type focuses on providing maximum benefit to adults who are transitioning from more restrictive out of home treatment services. Two community housing models are the House Model and Apartment Model. Both use community based supportive service providers to assist tenants with managing their psychiatric symptoms and tasks of daily living, eventually leading toward the goal of independent living. Dwellings are unlicensed and tenants pay up to 40% of their adjusted income towards rent. A single house or apartment complex cannot house more than eight T/RBHA enrolled persons at a given time.

ADHS/DBHS: RBHA Permanent Housing Program

This program focuses on specialized permanent community living with and without supports for tenants who can live independently. State General funds are used to purchase property that provides housing to adults with serious mental illness. Units are unlicensed and tenants pay up to 40% of their adjusted income towards rent.

State Community Housing Support Services

This type is for tenants who require minimal support and prompts with their independent living skills and recognition of safety/hazardous situations. Support services are voluntary and include, where needed, support with independent living skills, group and family counseling, money management, community integration, vocational training, and employment.

STATE FUNDED HOUSING PROGRAMS

While each T/RBHA's criteria for state sponsored housing differs, the case management team will be able to assist the individual in obtaining the most appropriate type of housing. To apply for a state funded housing program an individual must be Medicaid eligible and determined to have a Serious Mental Illness before contacting his/her case manager to arrange a staffing where they can explore the person's housing needs and available options.

Sponsor Based Rental Assistance

A subsidy for rental assistance is provided through the housing provider (sponsor) to the landlord. The housing sponsor leases the dwelling unit, pays the full amount of rent directly to the landlord/owner, and holds all liability for damages and loss. The landlord/owner performs rental history, credit, and criminal background checks on the sponsor rather than the tenant, yet may perform them on each prospective tenant prior to and/or during tenancy. Tenants are obligated to pay up to 40% of their adjusted income to the housing sponsor for their share of the monthly rent. Tenants may select the location according to space availability and the landlord's/owner's willingness to participate in the program.

Tenant Based Rental Assistance

A subsidy for rental assistance is provided to the tenant who signs the lease with a landlord/owner. Tenants lease the dwelling unit and pay up to 40% of their adjusted income for rent directly to the landlord/owner; the housing provider pays the remainder of the rent directly to the landlord/owner. Tenants are responsible for damages and loss and may be required to meet the landlord's/owner's credit history and criminal background checks prior to and during

tenancy. Tenants can choose location of the dwelling unit. Units must be within the area's Fair Market Rent (FMR) and pass a Housing and Urban Development (HUD) Housing Quality Standards (HQS) inspection.

Project Based Housing (Community Living Housing Programs)

There are two program models, a House Model and an Apartment Model. Each model has in-home or community based services available to tenants up to 24 hours per day, depending on their needs as listed in their Individual Service Plan. Service providers teach living skills and monitor the tenant's recovery. Skill training can include meal preparation, housekeeping, personal hygiene, budgeting, medication monitoring, community integration, and social recreation. Unlike the voucher program, the rent subsidy is tied to the complex and cannot be transferred. Tenants pay up to 40% of their adjusted income towards rent.

Bridge Subsidy Rental Assistance

A subsidy for rental assistance is provided to the tenant who signs the lease with a landlord/owner that is administered through a local Public Housing Authority. Tenants lease the dwelling unit and pay 30% of their adjusted income for rent directly to the landlord/owner; the Public Housing Authority pays the remainder of the rent directly to the landlord/owner. Tenants are responsible for damages and loss and may be required to meet the landlord's/owner's credit history and criminal background checks prior to and during tenancy. Tenants can choose the location of the dwelling unit.

FEDERALLY FUNDED HOUSING PROGRAMS

Section 8 Housing

This Housing Choice Voucher program is federally funded and designed to provide safe, affordable, and permanent independent housing that meets housing quality standards for persons with low-income. This income driven housing program provides a rental assistance subsidy to tenants through local public housing authorities, normally operated by units of government who have statutory authority to manage these programs for the U.S. Dept. of Housing and Urban Development (HUD). Tenants choose the location of the dwelling, lease the unit, and pay 30% of their adjusted income for rent directly to the landlord/owner through the Voucher. Tenants are responsible for damages and loss, and are required to meet the landlord's/owner's credit history and criminal background checks prior to and annually during tenancy. Programs are based on a crime free/drug free lifestyle. Persons with a recent criminal background may not be eligible for this program.

HUD Section 202

This federally funded housing program is designed for persons who are elderly and/or have a disability. Through this program HUD provides capital advances to finance the construction, rehabilitation, or acquisition of structures that will serve as supportive housing. HUD also provides rent subsidies for the project to maintain its affordability. Tenants maintain their self-sufficiency through independent living that develops and fosters community supports. They pay 30% of their adjusted income towards rent; HUD provides the rent subsidy.

HUD Section 811

Section 811 is designed for adults with disabilities. Through this program HUD provides capital advances to finance the construction, rehabilitation, or acquisition of structures that will serve as supportive housing for very low-income tenants with disabilities. Additionally, HUD provides rent subsidies for the project to make and keep housing affordable. Tenants maintain independent living while developing and fostering community supports in order to maintain their self-sufficiency. They pay 30% of their adjusted income towards rent; HUD provides the rent subsidy.

HUD Mainstream Homeless and Shelter Plus Care

These federally funded affordable housing programs are designed for persons with disabilities who are homeless. Through these programs HUD provides housing vouchers similar to those mentioned in the Section 8 Housing Choice Voucher Program listed earlier. It provides very low-income people, who are disabled, with options that allow them to live independently in an environment that provides support activities that foster self-sufficiency. Tenants pay 30% of their adjusted income towards rent; HUD provides the rent subsidy.

OTHER HOUSING OPTIONS

Some local non-profit organizations offer housing for people with disabilities. Refer to the [U.S. Department of Housing and Urban Development](#) and the [Arizona Department of Housing](#) for additional resources.

TRANSITION TO ADULTHOOD

ADVOCACY & YOUTH VOICE

- <http://www.cwla.org/advocacy/indlivtest991013.htm> (**Child Welfare League of America**)
- <http://www.advocatesforyouth.org/peereducation.htm> (**Advocates for Youth**)
- <http://www.tapartnership.org/COP/transitionAgedYouth/default.php> (**Technical Assistance Partnership for Child and Family Mental Health**)
- <http://youthintransitionnews.blogspot.com/> (**Youth in Transition**)
- <http://www.unicef.org/voy/> (**UNICEF: Voices of Youth**)
- <http://www.youngminds.org.uk/> (**Voice for Young People's Mental Health and Well-being**)
- <http://www.youthhood.org> (**Teens prepare for life after high school**)
- <http://www.youthengagementandvoice.org/> (**Resources**)
- <http://www.tash.org> (**Equity, Opportunity and Inclusion for People with Disabilities**)
- <http://rtckids.fmhi.usf.edu/rtcpubs/FamExp/lgbt-mono.pdf> (**2009 Publication: *Asset-Based Approaches for Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and Two-Spirit [LGBTQI2-S]: Youth and Families in Systems of Care***)
- <http://swhiv.org/resources/documents/Youth%20Transitions%20Manual.pdf> (**2009 Publication: *Transitioning HIV Positive Youth into Adult Care***)
- <http://www.abil.org/youth-transitions-adulthood> (**Arizona Bridge to Independent Living: Youth Transitions to Adulthood**)
- <http://www.youthmovenational.org/> (**Youth M.O.V.E. National**)
- <http://us.reachout.com/> (**Reach Out.Com: Get Through Tough Times**)

EDUCATION

- <http://tip.fmhi.usf.edu/> (**University of South Florida/Department of Child and Family Studies: Transition to Independence Process (TIP) system**)
- <http://www.ncset.org/> (**National Center on Secondary Education and Transition**)
- <http://www.kyspin.com/Young%20Adult.pdf> (**Transition Across the Lifespan: The High School & Young Adult Years**)
- <http://www.act.org> (**ACT: Resources for Education and Workplace Success**)
- <http://www.collegeboard.com> (**College Board**)
- <http://ldaamerica.org> (**Learning Disabilities Association of America**)
- <http://www.ade.state.az.us/ess/> (**Arizona Dept. of Education/Exceptional Student Services**)
- <http://www.azwestern.edu> (**Arizona Western College**)
- <http://www.cochise.edu> (**Cochise College**)

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- <http://www.coconino.edu> (Coconino Community College)
- <http://www.dinecollege.edu> (Diné College-Navajo Nation)
- <http://www.eac.edu> (Eastern Arizona College-Thatcher, Arizona)
- <http://www.gilacc.org> (Gila Community College)
- <http://www.asu.edu/drc> (Arizona State University: Disability Resource Center)
- <http://www.nau.edu/ihd/aztap> (Northern Arizona University: Institute for Human Development)
- <http://www.nau.edu/dss/> (Northern Arizona University: Disability Resources)
- <http://www.maricopa.edu> (Maricopa Community Colleges)
- <http://www.mohave.edu> (Mohave Community College)
- <http://www.npc.edu> (Northland Pioneer College)
- <http://www.pima.edu> (Pima Community College)
- <http://www.yc.edu> (Yavapai College)
- <http://drc.arizona.edu/> (University of Arizona: Disability Resources)
- <http://www.ahead.org/> (Association on Higher Education and Disability)

FAMILY RESOURCES

- <http://www.raisingpecialkids.org> (Raising Special Kids)
- <http://www.azed.gov/special-education/deputy-associate-superintendent/parent-information-network/> (Arizona Dept. of Education: Parent Information Network)
- <http://www.familyinvolvementcenter.org> (Family Involvement Center)
- <http://www.azdhs.gov/phs/ocshcn/family-resource-coordination.htm> (Arizona Dept. of Health Services: Office for Children with Special Health Care Needs)
- <http://www.mikid.org/> (Mentally Ill Kids in Distress)
- http://www.azdhs.gov/phs/ocshcn/crs/crs_az.htm (Arizona Dept. of Health Services: United Healthcare Arizona Physicians IPA-Children's Rehabilitative Services)
- <http://www.nami.org/> (National Alliance on Mental Illness)

FOSTER CARE

- <http://www.npr.org/news/specials/housingfirst/whoneeds/fostercare.html> (National Public Radio: Youth Leaving Foster Care)
- <http://www.iimcaseyouth.org/> (The Jim Casey Youth Opportunities Initiative)
- http://www.pewtrusts.org/our_work_detail.aspx?id=8 (Pew Commission: Foster Care Reform)

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GAMBLING

- <http://www.problemgambling.az.gov/index.htm> (Arizona Office of Problem Gambling)

GOVERNMENT & UNIVERSITY SPECIFIC SITES

- <http://www.ada.gov/> (Americans with Disabilities Act)
- <http://depts.washington.edu/healthtr/> (University of Washington, Seattle: Adolescent Health Transition Project)
- <http://www.beachcenter.org> (University of Kansas: Beach Center on Disability)
- <http://www.dmhas.state.ct.us/youngadults.htm> (Connecticut: Dept. of Mental Health and Addiction Services)
- <http://www.iidc.indiana.edu> (Indiana University, Bloomington: Center for Disability Information)
- <http://www.dcfhs.utah.gov/tal.htm> (Utah Division of Child and Family Services: Transition to Adult Living)
- <http://www.transad.pop.upenn.edu/> (The Network on Transitions to Adulthood)
- <http://www.calyouthconn.org/> (California Youth Connection)
- <http://www.voices4kids.org> (Voices for Illinois Children)
- <http://www.azdes.gov/DDD/> (Arizona Dept. of Economic Security/Division of Developmental Disabilities)
- <http://www.azed.gov/> (Arizona Dept. of Education)
- <http://www.azdhs.gov/bhs/4recipients.htm> (Arizona Dept. of Health Services/Division of Behavioral Health Services)
- <http://www.azcommerce.com/services/skilled-workforce.aspx> (Arizona Commerce Authority: Workforce Assistance)

GUARDIANSHIP

- <http://www.arcarizona.org> (The Arc of Arizona)
- <http://www.acdl.com/> (Arizona Center for Disability Law)
- <http://www.sc.pima.gov/Default.aspx?tabid=169> (Arizona Superior Court in Pima County: *Petition for Appointment of Guardian(s) of Minor(s)*)
- <http://www.superiorcourt.maricopa.gov/sscDocs/packets/JGT1.PDF> (Superior Court of Arizona in Maricopa County: *Temporary/Emergency Orders for Guardianship of Minors*)

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HOUSING

- <http://www.abil.org> (**Arizona Bridge to Independent Living**)
- <http://www.newhorizonsilc.org> (**New Horizons Independent Living Center**)
- <http://www.huckhouse.org/FromOurHouse/Youth%20In%20Transition.htm> (**From Our House to Yours: Youth in Transition: Helpful Hints for Success**)
- <http://literacyworks.org/fmfhome/index.html> (**Fannie Mae Foundation: How to Buy a Home: Lessons for Adult Learners**)
- <http://www.npr.org/news/specials/housingfirst/whoneeds/mentallyill.html> (**National Public Radio: People with Mental Illness**)
- <http://www.huduser.org/publications/homeless/permhsgstudy.html> (**U.S. Dept. of Housing and Urban Development publication**)
- <http://www.nhchc.org/Publications/101905YoungHomelessAdults.pdf> (**National Health Care for the Homeless Council: Homeless Young Adults Ages 18-24: Examining Service Delivery Adaptations**)
- <http://www.housingaz.com/> (**Arizona Dept. of Housing**)
- <http://www.socialserve.com/> (**Affordable Housing Resource**)
- <http://www.hud.gov/> (**U.S. Dept. of Housing and Urban Development**)
- http://www.azsos.gov/public_services/publications/Residential_Landlord_Tenant_Act/residential.pdf (**Arizona Dept. of State/Office of Secretary of State: Residential Landlord and Tenant Act**)
- <http://www.housingaz.com/ShowPage.aspx?ID=151> (**Arizona Dept. of Housing: Special Needs Programs**)
- <http://www.housingaz.com/ShowPage.aspx?ID=160> (**Arizona Dept. of Housing: Tribal Resources**)
- <http://www.housingaz.com/ShowPage.aspx?ID=187> (**Arizona Dept. of Housing: Section 8 Housing Programs**)
- <http://www.hud.gov/offices/pih/pha/contacts/states/az.cfm> (**U.S. Dept. of Housing and Urban Development: Public Housing Agency: Arizona Public & Indian Housing**)
- <http://phoenix.gov/CITZASST/affrent.html> (**City of Phoenix Housing Department**)
- <http://mentalhealth.samhsa.gov/publications/allpubs/ken98-0048/default.asp> (**Substance Abuse and Mental Health Services Administration [SAMHSA] National Mental Health Information Center: Housing Options for People with Mental Illness**)

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MENTAL HEALTH

- <http://www.whatadifference.org> (SAMHSA Initiative for supporting mental health recovery with young adults)
- <http://www.healthyminds.org/> (American Psychiatric Association: Healthy Minds. Healthy Lives.)
- <http://www.geeg.npi.ucla.edu/advocacy.html> (Support and Advocacy Groups)

NATIONAL RESEARCH

- <http://www.bazelon.org/News-Publications.aspx> (Bazelon Center for Mental Health Law Publications: *Youth in Transition*)
- <http://www.ncset.org/publications/essentialtools/teams/> (National Center on Secondary Education and Transition [NCSET]: *Interagency Transition Team Development and Facilitation*)
- https://www.naphs.org/youth_services/lewinpaper (National Association of Psychiatric Health Systems: *Enhancing Youth Services*)
- <http://www.ncd.gov> (National Council on Disability)
- http://www.nasmhpd.org/general_files/publications/ntac_pubs/networks/mnf_98.html (National Technical Assistance Center [NTAC]: Newsletter addresses transition from child to adult behavioral health service systems)
- <http://www rtc.pdx.edu/pgFPS01TOC.php> (Research and Training Center at Portland State University: *Focal Point Spring 2001 issue: Transitions*)
- <http://www.prb.org/pdf05/TransitionToAdulthood.pdf> (Population Reference Bureau and Child Trends May 2005: *The Transition to Adulthood: Characteristics of Young Adults Ages 18 to 24 in America*)
- http://www.unodc.org/youthnet/youthnet_action_good_practice_net_for_dap.html (The Global Youth Network: *Good Practices: Drug Abuse Prevention*)

PEER AND FAMILY ORGANIZATIONS

- <http://azpfc.org/> (Arizona Peer and Family Coalition)
- <http://www.cheeers.org/> (Center for Health Empowerment Education Employment Recovery Services)
- <http://familyinvolvementcenter.org/> (Family Involvement Center)
- <http://www.hopetucson.org/index.html> (HOPE: Helping Ourselves Pursue Enrichment, Inc.)
- <http://www.mikid.org/> (Mentally Ill Kids in Distress)
- <http://www.nazcare.org/> (Nazcare, Inc.)

5

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- <http://www.recoveryempowermentnetwork.com/start/> (**Recovery Empowerment Network**)
- <http://www.thestarcenters.org/> (**Stand Together and Recover Centers**)
- <http://phxhope.org/> (**Visions of Hope Arizona**)

SOCIAL SECURITY/AHCCCS/MEDICAL INSURANCE

- http://www.urban.org/UploadedPDF/411168_ChildSSIRecipients.pdf (**The Urban Institute May 2005: *Choices, Challenges, and Options: Child SSI Recipients Preparing for the Transition to Adult Life***)
- <http://www.ssa.gov/> (**Social Security Online**)
- <http://www.azahcccs.gov/> (**Arizona Health Care Cost Containment System**)
- <https://www.azdes.gov/common.aspx?menu=180&menuc=162&id=2520> (**Arizona Dept. of Economic Security: Medical Assistance**)
- <http://www.abil.org/> (**Arizona Bridge to Independent Living**)

SUBSTANCE ABUSE

- <http://www.drugrehabtreatment.com/peer-group-treatment.html> (**When Young Adults Face Addictions, Treatment Works Best in Peer Groups**)
- <http://www.facesandvoicesofrecovery.org/> (**Faces and Voices of Recovery**)
- <http://www.drugfree.org/> (**The Partnership at Drugfree.org**)

VOCATIONAL EMPLOYMENT

- <http://www.ed.gov/about/offices/list/osers/rsa/index.html> (**U.S. Dept. of Education/Office of Special Education and Rehabilitative Services**)
- <http://www.dcdt.org/> (**Division on Career Development and Transition**)
- <https://www.azdes.gov/rsa/> (**Arizona Dept. of Economic Security/Rehabilitation Services Administration**)
- <https://www.goodwillaz.org/jobs/jobs-at-goodwill> (**Goodwill of Central Arizona**)
- <http://www.abil.org/> (**Arizona Bridge to Independent Living**)
- <http://www.azcommerce.com/services/skilled-workforce.aspx> (**Arizona Commerce Authority: Workforce Assistance**)

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**DBHS Practice Tool
Transition to Adulthood**



**Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services**

Effective Date: 1/1/2008

Revision Date: 6/26/2012

Revised: 3/12/15

TITLE

Transition to Adulthood

GOAL/WHAT DO WE WANT TO ACHIEVE THROUGH THE USE OF THIS TOOL?

To strengthen practice in Arizona's public behavioral health system and promote continuity of care through collaborative planning by:

- supporting individuals transitioning into early adulthood in ways that reinforce their recovery process;
- ensuring a smooth and seamless transition from the children's behavioral health service system to the adult service system; and
- fostering an understanding that becoming a self-sufficient adult is a process that occurs over time and can extend beyond the age of eighteen.

TARGET AUDIENCE

This Tool is specifically targeted to Tribal and Regional Behavioral Health Authorities (T/RBHAs) and their subcontracted network and provider agency behavioral health staff who participate in assessment and service planning processes, provide case management and other clinical services, or who supervise staff that provide service delivery to adolescents, young adults and their families.

TARGET POPULATION(S)

All adolescents and young adults enrolled with a T/RBHA who are or will be experiencing transition at the age of 18.

ATTACHMENTS

[Attachment A: Housing](#)

[Attachment B: Resources](#)

DEFINITIONS

[Adult Recovery Team](#)

[Caregiver](#)

[Annual Update](#)

[Child and Family Team](#)

[Assessment](#)

[Family](#)

[Behavioral Health Category Assignment](#)

[Family Involvement](#)

[Family Member](#)

[Peer/Recovery Support](#)

[Guardian](#)

[Person Centered Planning](#)

[Individual Service Plan \(ISP\)](#)

[Serious Mental Illness \(SMI\)](#)

[Natural Support](#)

[Special Assistance](#)

BACKGROUND

The psychological and social development of adolescents transitioning into young adulthood is challenged by the economic, demographic, and cultural shifts that have occurred over several generations. Sociologist researcher, Frank F. Furstenberg, Jr., as Network Chair of the Network on Transitions to Adulthood stated, “Traditionally, early adulthood has been a period when young people acquire the skills they need to get jobs, to start families, and to contribute to their communities. But, because of the changing nature of families, the education system, and the workplace, the process has become more complex. This means that early adulthood has become a difficult period for some young people, especially those who are not going to college and lack the structure that school can provide to facilitate their development.”¹ While some individuals adapt well as they transition into the responsibilities of adulthood, others experience challenges such as those youth who have mental health concerns.

In 2002, one study found that about three-fourths of young adults with a diagnosable mental health condition at the age of 26 had first been diagnosed while in their teens.² Adolescents with mental health concerns are at a higher risk of dropping out of high school, not finishing college, abusing drugs or alcohol, having unplanned pregnancies, being unemployed, and are more likely to have a criminal past. Approximately 24 to 39 percent of adolescents with mental health disorders experience at least one of the above noted outcomes compared to 7 to 10 percent of their peers without disorders.³ Among 18-25 year olds, the prevalence of serious mental health conditions is high, yet this age group shows the lowest rate of help-seeking behaviors.⁴

As the transition to adulthood has become more challenging, youth with mental health needs struggle to achieve the hallmarks of adulthood such as finishing their education, entering the labor force, establishing an independent household, forming close relationships, and potentially

¹Furstenberg, F. The Network on Transitions to Adulthood. Retrieved November 25, 2009, from <http://www.transad.pop.upenn.edu/about/index.html>

² J. Kim-Cohen et al. (2002). Prior Juvenile Diagnoses in Adults with Mental Disorder. *Archives of General Psychiatry*, 60, 709-17.

³ Osgood, D. Wayne, Foster, E. Michael, Flanagan, Constance & Ruth, Gretchen R., editors. (2005). *On Your Own without a Net: the Transition to Adulthood for Vulnerable Populations* (Chapter 10, J. Heidi Gralinski-Bakker et al., and Chapter 11, Phillip M. Lyons, Jr. & Gary B. Melton).

⁴ Retrieved from <http://www.whatadifference.samhsa.gov/>

getting married and becoming parents.⁵ While these may be considered the trademarks of adulthood from a societal viewpoint, some studies suggest that youth may conceptualize this transition in more “intangible, gradual, psychological, and individualistic terms.”⁶ Top criteria endorsed by youth as necessary for a person to be considered an adult emphasized features of individualism such as accepting “responsibility for the consequences of your actions,” deciding one’s “own beliefs and values independently of parents or other influences,” and establishing “a relationship with parents as an equal adult.”⁷

Oftentimes, youth who successfully transition to adulthood are those that acquire a set of skills and the maturational level to use these skills effectively. Transition planning can emphasize interpersonal skill training through a cognitive-behavioral approach to help youth develop positive social patterns, assume personal responsibility, learn problem-solving techniques, set goals, and acquire skills across various life domains.⁸

With transition to adulthood occurring at later ages and over a longer span of time, many young people in their 20’s may still require the support of their families. Involving families in the transition planning process and identifying the individual support needs of their children recognizes the diversity that is needed when accessing services and supports. Youth who have been enrolled in government programs due to family hardship, poverty, physical, or mental health challenges are often the least prepared to assume adult responsibilities. For others, such as youth leaving foster care, they must acquire housing without the financial support of a family.⁹

Eligibility for public programs, such as Medicaid, Social Security, and vocational rehabilitation, as well as housing and residential services, may engender planning for changes at the age of 18. Youth who have disabilities that significantly impact their ability to advocate on their own behalf may require a responsible adult to apply for guardianship. Other youth may benefit from a referral to determine eligibility for services as an adult with a serious mental illness (SMI). Thus, it is the responsibility of the behavioral health system to ensure young adults are provided with the supports and services they need to acquire the capacities and skills necessary to navigate through this transitional period to adulthood.

⁵ Osgood et al. (2005). *On Your Own without a Net: the Transition to Adulthood for Vulnerable Populations* (Chapter 10, J. Heidi Gralinski-Bakker et al., and Chapter 11, Phillip M. Lyons, Jr. & Gary B. Melton).

⁶ Arnett, Jeffrey Jensen. (1997). Young People’s Conceptions of the Transition to Adulthood. *Youth & Society*, 29(1), 3-23.

⁷ Ibid.

⁸ Osgood, D. Wayne, Foster, E. Michael, Flanagan, Constance & Ruth, Gretchen R., editors. (2005). *On Your Own without a Net: the Transition to Adulthood for Vulnerable Populations* (Chapter 3, He Len Chung, et al., and Chapter 4, David Altschuler).

⁹ Osgood, D. Wayne, Foster, E. Michael, Flanagan, Constance & Ruth, Gretchen R. (February 2005, Issue 18). Network on Transitions to Adulthood Policy Brief. *Programs and Policy Goals for Helping Vulnerable Youth as They Move into Adulthood*.

PROCEDURES

I. POLICY REQUIREMENTS

Persons receiving services in Arizona's public behavioral health system may experience various transitions during the course of their care and treatment. Please refer to [ADHS/DBHS Policy and Procedures Manual Policy 901, Transition of Persons](#) for policy requirements when overseeing the following types of transition:

- 3.17.7-A. *Transition from child to adult services*
- 3.17.7-B. *Transition due to a change of the Behavioral Health Provider or the behavioral health category assignment*
- 3.17.7-C. *Transition to Arizona Long Term Care System (ALTCS) Program Contractors*
- 3.17.7-D. *Inter-T/RBHA Transfer*
- 3.17.7-E. *Transitions of persons receiving court ordered services*
- 3.17.7-F. *Transitions of persons being discharged from inpatient settings*
- 3.17.7-G. *Transitions of persons receiving behavioral health services from Indian Health Services (IHS)*

The purpose of this tool will be to address the recommended practice for transitioning youth from the children's behavioral health service system to the adult service system with a focus on the activities that will assist youth in acquiring the skills necessary for self-sufficiency and independence in adulthood. T/RBHAs and their subcontractors are expected to follow the procedures clearly outlined in [ADHS/DBHS Policy and Procedures Manual Policy 901, Transition of Persons](#), which require that **transition planning begins when the youth reaches the age of 16**. However, if the Child and Family Team (CFT) determines that planning should begin prior to the youth's 16th birthday, the team may proceed with transition planning earlier to allow more time for the youth to acquire the necessary life skills, while the team identifies the supports that will be needed. Age 16 is the latest this process should start. For youth who are age 16 and older at the time they enter the behavioral health system, planning must begin immediately. It is important that members of the CFT look at transition planning as not just a transition into the adult behavioral health system, but also as a transition to adulthood.

When the adolescent reaches the **age of 17** and the CFT believes that the youth may meet eligibility criteria as an adult with a Serious Mental Illness (SMI), the T/RBHA and their subcontracted providers must ensure the young adult receives an eligibility determination as outlined in the [ADHS/DBHS Policy and Procedures Manual Policy 106, SMI Eligibility Determination](#). If the youth is determined eligible, or likely to be determined eligible for services as a person with a Serious Mental Illness, the adult behavioral health services case manager is then contacted to join the CFT and participate in the transition planning process. **After obtaining permission from the parent/guardian, it is the responsibility of the children's behavioral health service provider to contact and invite the adult behavioral health services**

case manager to upcoming planning meetings. When more than one T/RBHA and/or behavioral health service provider agency is involved, the responsibility for collaboration lies with the agency who is directly responsible for service planning and delivery.

If the young adult is not eligible for services as a person with a Serious Mental Illness, it is the responsibility of the children's behavioral health provider, through the CFT, to coordinate transition planning with the adult general mental health provider. Whenever possible, it is recommended that the young adult and his/her family be given the choice of whether to stay with the children's provider or transition to the adult behavioral health service provider. The importance of securing representation from the adult service provider in this process cannot be overstated, regardless of the person's identified behavioral health category assignment (SMI, General Mental Health, Substance Abuse). The children's behavioral health provider should be persistent in its efforts to make this occur.

Requirements for information sharing practices, eligible service funding, and data submission updates are outlined in the following policies:

- Prior to releasing treatment information, the CFT, including the adult service provider, will review and follow health record disclosure guidelines per:
 - [ADHS/DBHS Policy and Procedures Manual Policy 1401, Confidentiality.](#)
- If the young adult is not Medicaid eligible, services that can be provided under Non-Medicaid funding will follow policy guidelines per:
 - [ADHS/DBHS Policy Manual Policy 110 Special Populations;](#) and
 - [ADHS/DBHS Policy and Procedures Manual Policy 601, Co-payments.](#)
- The behavioral health provider will ensure that the behavioral health category assignment is updated along with other demographic data consistent with:
 - [ADHS/DBHS Policy and Procedures Manual Policy 1601, Enrollment, Disenrollment and other Data Submission.](#)

Youth, upon turning age 18, will be required to sign documents that update their responsibilities with relation to their behavioral health treatment as an adult. Some examples include a new consent to treatment and authorizations for sharing protected health information to ensure that the team members can continue as active participants in service planning. A full assessment is not required at the time of transition from child to adult behavioral health services unless an annual update is due or there have been significant changes to the young adult's status that clinically indicate the need to update the Assessment or Individual Service Plan (ISP).

II. KEY PERSONS FOR COLLABORATION

Team Coordination

When a young person reaches age 17 it is important to begin establishing team coordination between the child and adult service delivery systems. Per [ADHS/DBHS Policy and Procedures Manual Policy 901](#), this coordination must be in place no later than 4-6 months prior to the

youth turning age 18. In order to meet the individualized needs of the young adult on the day s/he turns 18 a coordinated effort is required to identify the behavioral health provider staff who will be coordinating service delivery, including the services that will be needed and the methods for ensuring payment for those services. This is especially critical if the behavioral health provider responsible for service planning and delivery is expected to change upon the youth's transition at the age of 18.

Orientation of the youth and his/her family to potential changes they may experience as part of this transition to the adult behavioral health system will help minimize any barriers that may hinder seamless service delivery and support the youth's/family's understanding of their changing roles and responsibilities. It might be helpful to engage the assistance of a liaison (e.g., family and/or peer mentor) from the adult system to act as an ambassador for the incoming young adult and his/her involved family and/or caregiver.

As noted in the [ADHS/DBHS Practice Tool Child and Family Team Practice](#), the young adult, in conjunction with other involved family members, caregivers or guardian, may request to retain his/her current Child and Family Team until the youth turns 21. Regardless of when the youth completes his/her transition into the adult behavioral health system, the CFT will play an important role in preparing the Adult Recovery Team (ART) to become active partners in the treatment and service planning processes throughout this transitional period. Team collaboration between the child and adult service provider for transition age youth is more easily facilitated when agencies are dually licensed to provide behavioral health service delivery to both children and adult populations.

Family Involvement/Cultural Considerations

Family involvement and culture must be considered at all times especially as the youth prepares for adulthood. Although this period in a young person's life is considered a time for establishing his/her independence through skill acquisition, many families and cultures are interdependent and may also require a supportive framework to prepare them for this transition. With the assistance of joint planning by the child and adult teams, families can be provided with an understanding of the increased responsibilities facing their young adult while reminding them that although their role as legal guardian may change, they still remain an integral part of their child's life as a young adult. It is also likely that the youth's home and living environment may not change when they turn 18 and are legally recognized as an adult.

During this transitional period the role that families assume upon their child turning 18 will vary based on:

- individual cultural influences;
- the young adult's ability to assume the responsibilities of adulthood;
- the young adult's preferences for continued family involvement; and
- the needs of parents/caregivers as they adjust to upcoming changes in their level of responsibility.

Understanding each family's culture can assist teams in promoting successful transition by:

- informing families of appropriate family support programs available in the adult behavioral health system;
- identifying a Family Mentor who is sensitive to their needs to act as a "Liaison" to the adult behavioral health system;
- recognizing and acknowledging how their roles and relational patterns affect how they view their child's movement toward independence; and
- addressing the multiple needs of families that may exist as a result of complex relational dynamics or those who may be involved with one or more state agencies.

Some youth involved with the child welfare system may express a desire to reunite with their family from whose care they were removed. In these situations it is important for the CFT to discuss the potential benefits and challenges the youth may face.

System Partners

Coordination among all involved system partners promotes collaborative planning and seamless transitions when eligibility requirements and service delivery programs potentially change upon the youth turning 18. Child welfare, juvenile corrections, education, developmental disabilities, and vocational rehabilitation service delivery systems can provide access to resources specific to the young adult's needs within their program guidelines. For example, students in special education services may continue their schooling through the age of 21. Youth in foster care may be eligible for services through a program referred to as the Arizona Young Adult Program (AYAP) or Independent Living Program (ILP)¹⁰ through the Arizona Department of Economic Security/Department of child safety (ADES/DCS).¹¹

System partners can also assist young adults and their families/caregivers in accessing or preparing necessary documentation, such as:

- birth certificates;
- social security cards and social security disability benefit applications;
- medical records including any eligibility determinations and assessments,
- Individualized Education Program (IEP) Plans;
- certificates of achievement, diplomas, GED¹² transcripts, and application forms for college;
- case plans for youth continuing in the foster care system;
- treatment plans;
- documentation of completion of probation or parole conditions;
- guardianship applications; and
- advance directives, etc.

¹⁰ Refer to <https://www.azdes.gov/main.aspx?menu=150&id=1944> for eligibility requirements, services, and resources.

¹¹ Refer to *ADES/DCSDCS Policy Manual Chapter 16: Independent Living Services and Supports* at <https://app.azdes.gov/DCYF/CMDPS/DCS/POLICY/SERVICEMANUAL.HTM>.

¹² Commonly referred to as a General Education Diploma or General Equivalency Diploma.

Natural Support

Maintaining or building a support structure will continue to be important as the youth transitions to adulthood and has access to new environments. This is especially relevant for young adults who have no family involvement. For some youth, developing or sustaining social relationships can be challenging. The child and adult teams can assist by giving consideration to the following areas when planning for transition:

- identify what supports will be needed by the young adult to promote social interaction and relationships;
- explore venues for socializing opportunities in the community;
- determine what is needed to plan time for recreational activities; and
- identify any special interests the youth may have that could serve as the basis for a social relationship or friendship.

Personal Choice

Although young adults are free to make their own decisions about treatment, medications, and services, they are generally aware that their relationships, needs, and supports may not feel different following their 18th birthday. They may require assurance that their parents are still welcomed as part of their support system, that they still have a team, rules still apply, and that information will be provided to assist them with making their own treatment decisions. However, some young adults may choose to limit their parent's involvement, so working with youth in the acquisition of self-determination skills will assist them in learning how to speak and advocate on their own behalf. This may involve youth developing their own understanding of personal strengths and challenges along with the supports and services they may need. When planning for transition, teams may also need to provide information to young adults on how the behavioral health service delivery systems operate in accordance with the following:

- the [Arizona Vision and 12 Principles](#) in the children's system, and
- the [Guiding Principles for Recovery Oriented Adult Behavioral Health Services and Systems](#).

III. CLINICAL AND SERVICE PLANNING CONSIDERATIONS

ADHS/DBHS supports clinical practice and behavioral health service delivery that is individualized, strengths-based, recovery-oriented, and culturally sensitive in meeting the needs of children, adults, and their families. Transitioning youth to adulthood involves a working partnership among team members between the children's behavioral health service system and the adult service system. This partnership is built through respect and equality, and is based on the expectation that all people are capable of positive change, growth, and leading a life of value. Individuals show a more positive response when there is a shared belief and collaborative effort in developing goals and identifying methods (services and supports) to meet their needs.

Crisis and Safety Planning

The team is responsible for ensuring that crisis and safety planning is completed prior to the youth's transition as outlined in the [ADHS/DBHS Practice Tool Child and Family Team Practice](#). For some youth, determining potential risk factors related to their ability to make decisions about their own safety may also need to be addressed. Collaboration with the adult case manager and/or ART will ensure that the transitioning young adult is aware of the type of crisis services that will be available through the adult behavioral health system and how to access them in his/her time of need.

Special Education Planning

The Individuals with Disabilities Education Act of 2004 (hereafter referred to as IDEA)¹³ ensures that all children with disabilities have available to them a "free appropriate public education" (FAPE) that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment, and independent living. Per IDEA, school districts are required to assist students with disabilities to make the transition from school to work and life as an adult. This postsecondary transition must be addressed not later than the student's first IEP to be in effect when the youth turns 16, or younger if determined appropriate by the IEP team. Measurable postsecondary goals for education/training, employment, and independent living, when appropriate, include a coordinated set of activities that addresses the following areas:

- instruction;
- daily living skills;
- related services;
- functional evaluation;
- post school adult living;
- community experiences; and
- employment.

While IDEA mandates services and programs while the youth with disabilities remains in school (which can be up to the age of 22), there are no federal mandates once the individual leaves the school system.

For any youth who is currently being served under an IEP plan, collaboration with the IEP team¹⁴ in transition planning is imperative to ensure the alignment of IEP goals with the goals contained in the behavioral health ISP. The CFT, in conjunction with the adult service provider, would consult with the minor's parent/legal guardian or the young adult, if age 18 or older, to obtain their permission to participate in the IEP meeting for the purpose of coordinating transition planning and services between the behavioral health and education systems. For young adults, age 18 and older, where legal guardianship has been established or the right to make educational decisions has been delegated to another responsible person, permission to participate in IEP meetings is obtained from the student's identified legal representative.

¹³ <http://idea.ed.gov/>

¹⁴ <http://idea.ed.gov/explore/view/p/%2Croot%2Cdynamic%2CTopicalBrief%2C9%2C>

Transition Planning

The length of time necessary for transition planning is relevant to the needs, maturational level, and the youth's ability to acquire the necessary skills to assume the responsibilities of adulthood. When planning for the young person's transition into adulthood and the adult behavioral health system, a transition plan that includes an assessment of self-care and independent living skills, social skills, work and education plans, earning potential, and psychiatric stability must be incorporated into the ISP.¹⁵ Living arrangements, financial, and legal considerations are additional areas that require advance planning.

1. Self-care and Independent Living Skills

As the youth approaches adulthood the acquisition of daily living skills becomes increasingly important. Personal care and hygiene can include grooming tasks such as showering, shaving (if applicable), dressing, and getting a haircut. Learning phone skills, how to do laundry and shop for clothes, cleaning and maintaining one's personal living environment, use of public transportation or learning how to drive are other suggested areas for transition planning. Acquisition of various health-related skills includes fitness activities such as an exercise program, nutrition education for planning meals, shopping for food, and learning basic cooking techniques. Planning around personal safety would address knowing their own phone number and address, who to contact in case of emergency, and awareness of how to protect themselves when out in the community.

2. Social and Relational Skills

The young adults' successful transition toward self-sufficiency will be supported by their ability to get along with others, choose positive peer relationships, and cultivate sustainable friendships. This will involve learning how to avoid or respond to conflict when it arises and developing an understanding of personal space, boundaries, and intimacy. Some youth may require additional assistance with distinguishing between the different types of interactions that would be appropriate when relating to strangers, friends, acquaintances, boy/girlfriend, family member, or colleague in a work environment. For example, teams may want to provide learning opportunities for youth to practice these discrimination skills in settings where they are most likely to encounter different types of people such as a grocery store, shopping mall, supported employment programs, etc. Planning for youth, who have already disclosed to the behavioral health service provider their self-identity as gay, lesbian, bisexual, or transgender, may include discussions about community supports and pro-social activities available to them for socialization. Adolescents who do not have someone who can role model the differing social skills applicable to friendship, dating, and intimate relationships may need extra support in learning healthy patterns of relating to others relevant to the type of attachment.

3. Vocational/Employment

¹⁵ ADHS/DBHS Policy and Procedures Manual 901, Transition of Persons.

An important component of transitioning to adulthood includes vocational goals that lead to employment or other types of meaningful activity. While a job can provide financial support, personal fulfillment, and social opportunities, other activities such as an internship or volunteering in an area of special interest to the young adult can also provide personal satisfaction and an opportunity to engage socially with others. The CFT along with involved system partners work together to prepare the young adult for employment or other vocational endeavors. It is imperative that a representative from the adult behavioral health system be involved in this planning to ensure that employment related goals are addressed before, during, and after the youth's transition to adulthood.

Service planning that addresses the youth's preparation for employment or other meaningful activity can include:

- a) utilizing interest inventories or engaging in vocational assessment activities to identify potential career preferences or volunteer opportunities;
- b) identifying skill deficits and effective strategies to address these deficits;
- c) determining training needs and providing opportunities for learning through practice in real world settings;
- d) learning about school-to-work programs that may be available in the community and eligibility requirements;
- e) developing vocational skills such as building a resume, filling out job applications, interviewing preparation, use of online job sites, etc.; and
- f) learning federal and state requirements for filing annual income tax returns.

Youth involved in school based work activities (paid or non-paid) are able to "test the waters" of the work world, develop a work history, better understand their strengths and weaknesses, explore likes and dislikes, and begin to develop employment related skills necessary for their success in competitive work settings. School based work activities can start as early as middle school yet should begin no later than the youth's freshman year of high school. Once youth reach the age of 17, they can be given work experience in the community, whether it is through a volunteer or internship experience. It is best for school and community-based work experience to be short term, so that youth can experience a variety of employment settings and perform different job duties in more than one vocation to assist them in identifying possible career choices. These work related opportunities will assist teams in determining where the youth excels or struggles in each type of work undertaken, the types of supports that might be needed, and what the best "job match" might be in terms of the youth's personal interests and skill level.

As youth narrow their career focus, it is useful to tour employment sites, job shadow, and interview employers and employees who work in the youth's chosen fields of interest. It may be necessary to plan for on-going support after a job has been obtained to assist the young adult in maintaining successful employment. Identifying persons in the job setting who can provide natural support such as supervisors and co-workers, as well as employer related accommodations may be necessary to ensure that the young adult can continue to perform his/her job duties.

Vocational/Employment Considerations for Youth with Disabilities

For youth who have a disability, regardless of whether or not they are in Special Education, may be eligible for services through the Arizona Department of Economic Security/Rehabilitation Services Administration (ADES/RSA) under a vocational rehabilitation (VR) program¹⁶ when transitioning from school to work. The high school can refer youth with a disability to the VR program within two years before they leave school, if VR and the school have jointly funded programs, or within one year following the youth's exit from school if the provision of VR services is expected to occur after the youth leaves school. Planning for employment is done in conjunction with the youth's VR counselor through the development of an Individual Plan of Employment (IPE). Including the VR counselor in the school's IEP planning that might involve VR services is necessary since only VR personnel can make commitments for ADES/RSA program services. Refer to ADES/RSA¹⁷ for information on the VR process regarding intake/eligibility, planning for employment, services, and program limitations.

4. Education

Collaboration between the CFT and the education system is helpful with preparing youth and their parents/caregivers in developing an understanding of what happens as young adults transition from secondary education to adult life. In 2008, the Arizona State Board of Education approved Education and Career Action Plans (ECAP)¹⁸ for all Arizona students in grades 9-12. The ECAP reflects a student's current plan of coursework, career aspirations, and extended learning opportunities in order to develop the young adult's individual academic and career goals. Asking the youth to share his/her ECAP with the rest of the team may provide information to assist with transition planning.

Education Considerations for Youth with Disabilities

Section 504 of the *Rehabilitation Act of 1973*¹⁹ protects the civil rights of individuals with disabilities in programs and activities that receive federal funds. Recipients of these funds include public school districts, institutions of higher education, and other state and local education agencies. This regulation requires a school district to provide adjustments that can be made by the classroom teacher(s) and other school staff to help youth benefit from their education program through a 504 Plan that outlines these services and accommodations.

While youth are in secondary education, IDEA requires public schools to include transition plans for each student with a disability beginning with the IEP that is in effect when the youth reaches the age of 16. These transition plans are required to include the following eight components:

¹⁶ <https://www.azdes.gov/main.aspx?menu=32&id=1300>

¹⁷ https://www.azdes.gov/main.aspx?menu=32&id=1602&ekmense1=349952e0_32_122_1602_6#

¹⁸ <http://www.azed.gov/career-technical-education/student-education-career-action-plans/>

¹⁹ <http://www2.ed.gov/about/offices/list/ocr/docs/edlite-FAPE504.html>

1. Measurable Postsecondary Goals (MPGs) in the areas of:
 - a. Education/Training,
 - b. Employment, and
 - c. Independent living (if needed);
2. MPGs are updated annually;
3. Age appropriate transition assessment;
4. Coordinated activities;
5. Course of study;
6. Annual goals that are aligned to the MPGs;
7. Student invitation to these meetings is required; and
8. Outside agency participation with prior consent from the family or student that has reached the age of majority.

Transfer of Rights' Requirement for Public Education Agencies

Under Arizona State law, a child reaches the age of majority at 18. The right to make informed educational decisions transfers to the young adult at that time.

According to IDEA,²⁰ "beginning not later than one year before the child reaches the age of majority under State law, a statement that the child has been informed of the child's rights under this title, if any, that will transfer to the child on reaching the age of majority under section 615(m)"²¹ must be included in the student's IEP. This means that schools must inform all youth with disabilities on or before their 17th birthday that certain rights will automatically transfer to them upon turning age 18.

In order to prepare youth with disabilities for their transfer of rights, it is necessary for parents/caregivers to involve their child in educational decision making processes early. The CFT, in conjunction with the adult behavioral health provider, can assist the youth/parent/caregiver with the following:

- a) having the youth actively participate in IEP and transition planning to ensure his/her voice is heard;
- b) assisting the youth in developing positive relationships with involved school personnel and other agency service providers;
- c) discussing potential decisions before IEP meetings so the youth is informed and can actively participate in advocating for his/her wishes; and
- d) including the youth in decisions that impact his/her life inside and outside the school setting.

"A student with a disability, between the age of 18 and 22 who has not been declared legally incompetent and has the ability to give informed consent may execute a *Delegation of Right to Make Educational Decisions*. The Delegation of Right allows the student to appoint his/her parent or agent to make educational decisions on his/her

²⁰ Federal law dealing with the education of children with disabilities.

²¹ Per IDEA Part B Sec. 614(d)(1)(A)(i)(VIII)(cc) at: <http://idea.ed.gov/download/statute.html>

behalf. The student has the right to terminate the agreement at any time and assume his/her right to make decisions.”²² Additional information pertaining to a special education transfer of parental rights and an example of a *Delegation of Right to Make Educational Decisions* form is provided in the Arizona Center for Disability Law’s *Legal Options Manual*.

For additional information related to special education transitions refer to the publications posted by the Arizona Department of Education (ADE).²³

Summary of Performance

A Summary of Performance (SOP)²⁴ is completed for every young adult whose special education eligibility terminates due to graduation from high school with a regular diploma or due to exceeding the age eligibility for FAPE²⁵ under State law. A public education agency (PEA) must provide the youth with a summary of his/her academic achievement, functional performance, and recommendations on how to assist in meeting the young adult’s postsecondary goals.

Postsecondary Education Considerations

When postsecondary education is the goal for young adults, transition planning may include preparatory work in the following areas:

- a) identify academic strengths to assist with matching the young adult’s interests with the right school;
- b) determine the best fit between the young adult’s needs and the type of postsecondary setting (e.g., university, community college, technical or trade school, etc.);
- c) assist in the identification of and application process for various financial resources (e.g., scholarships, financial aid, student loans, etc.);
- d) discover the types of proficiency testing or assessments that are required for admission such as the Scholastic Aptitude Test (SAT) or American College Testing (ACT);
- e) assist with skill development to ensure the young adult is able to organize school assignments, manage his/her time, identify and set priorities, and break projects down into manageable steps;
- f) consider potential summer school courses or other options to determine an area of study or vocational interest;
- g) attend informational meetings at a local college and network with current students; and
- h) promote the development of the young adult’s self-advocacy skills to support his/her success in a postsecondary setting.

²² <http://www.azed.gov/wp-content/uploads/PDF/TR05.pdf>

²³ <http://www.azed.gov/ess/SpecialProjects/transition/>

²⁴ <http://www.azed.gov/ess/SpecialProjects/transition/6-09SUMMARYOFPERFORMANCE-Instructions.pdf>

²⁵ Free appropriate public education (FAPE)

5. Medical/Physical Healthcare

Planning can include assisting the youth with:

- a) transferring healthcare services from a pediatrician to an adult health care provider, if pertinent;
- b) applying for medical and behavioral health care coverage, including how to select a health plan and a physician;
- c) preparing an application for submission at age 18 to the Arizona Health Care Cost Containment System (AHCCCS) for ongoing Medicaid services²⁶;
- d) obtaining personal and family medical history (e.g., copies of immunization records, major illnesses, surgical procedures, etc.)²⁷;
- e) information on advance directives, as indicated in the [ADHS/DBHS Policy and Procedures Manual Policy 801, Advance Directives](#);
- f) methods for managing healthcare appointments, keeping medical records, following treatment recommendations, and taking medication;
- g) how to identify healthcare concerns, address questions during appointments, and consult with doctors regarding diagnosis, treatment, and prognosis; and
- h) assuming responsibility for understanding and managing the symptoms of their mental illness and obtaining knowledge of the benefits, risks, and side effects of their medication.

6. Living Arrangements

Where young adults will live upon turning age 18 could change based on their current housing situation (e.g., living at home with family, with a relative, in a residential treatment center (RTC), other out of home treatment setting, etc.) or whether or not they decide to choose housing on-site while pursuing their postsecondary education. Youth who do not have the support of their parents or extended family, or who may be under the care and custody of the child welfare system, may require intensive planning to evaluate their ability to live independently, identify the level of community supports needed, and match the type of living environment to their individual personality and preferences. Each situation will require planning that specifically uses the young adult's strengths in meeting his/her needs and addresses any personal safety concerns. The most common types of living situations range from living independently in one's own apartment with or without roommates to a supported or supervised type of living arrangement. If needed, the team may assist the young adult with completing and filing applications for public housing or other subsidized housing programs. Refer to [Tool Attachment A: Housing](#) for further information on housing options, state and federally funded programs, and other areas for consideration when addressing housing needs.

²⁶ Youth at age 18 who remain in foster care are enrolled in Young Adult Transitional Insurance through the Arizona Division of Children, Youth, and Families, rather than being enrolled in Medicaid services through AHCCCS.

²⁷ For youth in foster care, teams work with Department of Child Safety's personnel to obtain personal and family medical history as this information will be requested at future medical appointments.

Youth living in a Level 1 RTC at the time they turn age 18 can continue to receive residential services until the age of 22 if they were admitted to the RTC before their 21st birthday and continue to require treatment. A licensee of a Level 1 RTC may also admit individuals who are younger than age 21. Refer to [A.A.C.R9-20-505](#) for further information on requirements for Level 1 RTCs and limitations related to contact between minors and adults residing within the same treatment facility. [ADHS/DBHS Policy and Procedures Manual Policy 1101, Securing Services and Prior Authorization](#) provides procedural information and criteria for services that require authorization.

Licensed residential agencies may continue to provide behavioral health services to individuals age 18 or older if the following conditions are met per [A.A.C.R9-20-404](#):

- person was admitted to the agency before his/her 18th birthday and is completing high school or a high school equivalency diploma, or is participating in a job training program; or
- through the last day of the month of the person's 18th birthday.

7. Financial

Assessing the financial support needed will include identifying how much money is required to support the young adult's living situation and how s/he will obtain it. This will include determining whether the income from employment will pay the bills or if Social Security disability programs (SSDI²⁸ or SSI²⁹), food stamps, or other emergency assistance will cover the young adult's financial responsibilities. Depending on the special needs of the young adult, arranging for a conservator or guardian may also be necessary.

Together, the team should review and update any federal and/or state financial forms to reflect the young adult's change in status to ensure there is no disruption in healthcare or financial assistance services. Youth who are eligible for SSI benefits as a child will have a disability redetermination during the month preceding the month when they attain age 18. This determination will apply the same rules as those used for adults who are filing new applications for SSI benefits.³⁰ The team can assist the young adult and his/her family/caregiver with identifying any changes related to Social Security benefits, including opportunities for Social Security Work Incentives.³¹

Young adults who learn about financial matters prior to age 18 have a better opportunity to acquire the skills necessary for money management. Skill development can include:

- a) setting up a simple checking and/or savings account to learn how it can be used to pay bills, save money, and keep track of transactions;
- b) identifying weekly/monthly expenses that occur such as food, clothes, school supplies, and leisure activities and determining the monetary amount for each area;

²⁸ Social Security Disability Insurance

²⁹ Supplemental Security Income

³⁰ <http://www.socialsecurity.gov/ssi/text-cdrs-ussi.htm>

³¹ <http://www.ssa.gov/disabilityresearch/wi/generalinfo.htm>

- c) learning how to monitor spending and budget financial resources;
- d) education on how credit cards work and differ from debit cards, including an understanding of finance charges and minimum monthly payments; and
- e) understanding the short and long term consequences of poor financial planning (e.g., overdrawn account [Non-Sufficient Funds fee], personal credit rating, eligibility for home and/or car loans, potential job loss, etc.).

8. Legal Considerations

Transition planning that addresses legal considerations ideally begins before the youth turns 18 to ensure the young adult has the necessary legal protections upon reaching the age of majority. This can include the following:

Document Preparation

Some families/caregivers may decide to seek legal advice from an attorney who specializes in mental health, special needs and/or disability law in planning for when their child turns 18 if they believe legal protections are necessary. Parents, caregivers or guardians may choose to draw up a will or update an existing one to ensure that adequate provisions have been outlined for supporting their child's continuing healthcare and financial stability. Other legal areas for consideration can include:

- guardianship;
- conservator;
- special needs trust; and
- advance directives (e.g., living will, powers of attorney).

Legal Considerations for Youth with Disabilities

Persons with developmental disabilities, their families and caregivers may benefit from information about different options that are available when an adult with a disability needs the assistance of another person in a legally recognized fashion to help manage facets of his/her life. Refer to the Arizona Center for Disability Law's *Legal Options Manual* for access to information and forms. This publication also addresses tribal jurisdiction in relation to the guardianship process for individuals who live on a reservation. While this resource is focused on planning for individuals with disabilities, teams can utilize this information to gain a basic understanding of the legal rights of individuals as they approach the age of majority.

9. Transportation

A training program, whether a formal or informal one, may be useful in helping the young adult acquire the skills necessary for driving or when using public transportation. Planning can include assisting the youth with test preparation and acquiring a driver's permit. Use of a qualified instructor, family member, or other responsible adult can provide the youth with "behind the wheel" driving experience including how to read maps or manage roadside emergencies. If obtaining a driver's license is not feasible, skill training activities

for using public transportation can include reviewing bus schedules, planning routes to get to a designated location on time, and learning how to determine the cost and best method of transportation for getting to and from work or scheduled appointments.

When transitioning to the adult behavioral health system, educate the family and young adult on the transportation options available through the adult service delivery system. This will help support the young adult's continued attendance at behavioral health treatment appointments, as well as assist the team with identifying and planning for other transportation needs that are not necessarily associated with accessing medical or behavioral health services.

10. Other Considerations

Some young adults may need assistance with acquiring proof of personal identification if they have not done so by the age of 18. Additionally, young adults may require further information explaining the mandatory and voluntary registrations that become effective at the age of majority.

Personal Identification

The team can assist the youth with acquiring a State issued identification (ID) card in situations where the young adult may not have met the requirements for a driver's license issued by the Arizona Motor Vehicle Division.³² An identification card is available to all ages (including infants), however, the youth may not possess an Arizona identification card and a valid driver's license at the same time.

Mandatory and Voluntary Registrations

Selective Service registration³³ is required for almost all male U.S. and non-U.S. citizens who are 18 through 25 years of age and residing in the United States. Registration can be completed at any U.S. Post Office and a Social Security number is not needed. When a Social Security number is obtained after registration is completed, it is the responsibility of the young adult male to inform the Selective Service System.

Upon turning age 18 the young adult can register to vote. Online voter registration is available through Arizona's Office of the Secretary of State.³⁴

11. Resources

Refer to [Attachment B: Resources](#) for access to additional information that may assist the CFT and adult behavioral health service provider with transition planning activities.

³² <http://www.azdot.gov/mvd/>

³³ <http://www.sss.gov/>

³⁴ <http://www.azsos.gov/election/voterregistration.htm>

TRAINING AND SUPERVISION RECOMMENDATIONS

This Practice Tool applies to T/RBHAs and their subcontracted network and provider agency behavioral health staff who participate in assessment and service planning processes, provide case management and other clinical services, or who supervise staff that provide service delivery to adolescents, young adults and their families. Each T/RBHA shall establish their own process for ensuring that all staff have been trained and understand how to implement the practice elements as outlined in this document. Whenever this Practice Tool is updated or revised, T/RBHAs must ensure their subcontracted network and provider agencies are notified and required staff is retrained as necessary on the changes. Each T/RBHA, upon request from ADHS/DBHS, is required to provide documentation demonstrating that all required network and provider agency staff have been trained on this tool. In alignment with [A.A.C. R9-20-205 Clinical Supervision](#) requirements, the supervision of this Practice Tool is to be incorporated into other supervision processes which the T/RBHA and their subcontracted network and provider agencies have in place for direct care clinical staff.

ANTICIPATED OUTCOMES

- Coordinated planning for seamless transitions from the children's behavioral health service system to the adult service system
- Active collaboration between CFTs and ARTs for the purpose of transition planning
- Increased opportunities for youth to acquire the necessary skills to assume the responsibilities of adulthood
- Engagement of families in the transition planning process that recognizes the diversity that is needed in identifying the individual support needs of their young adult
- Improved self-advocacy skills in transition age youth

DBHS Practice Tool

The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS



**Developed by the
Arizona Department of Health Services
Division of Behavioral Health Services**

**Effective October 1, 2006
Revised April, 2007
Revised December 8, 2008
Revised March 12, 2015**

NOTE:

This DBHS Practice Tool has required implementation elements. Providers are required to implement the identified Service Expectations, as clearly identified in this document.

Title

The Unique Behavioral Health Service Needs of Children, Youth and Families Involved with DCS

Goal/What Do We Want to Achieve Through the Use of this Tool?

- To provide an understanding of the unique behavioral health service needs of children involved with the Department of Child Safety (DCS) and to provide guidance to Child and Family Teams (CFTs) in responding to those needs
- To outline the clinical considerations for serving children involved with DCS, their families, and other caregivers
- To delineate the Urgent Response procedures that must be followed when a child is removed from their home by DCS

Target Audience

- Individuals involved with the provision of behavioral health services to children and families
- DCS Specialists and their supervisors
- DCS Mental Health Specialists
- Division of Developmental Disabilities (DDD) Child Welfare/Support Coordinators¹ and their supervisors

Target Population

Families referred by DCS for behavioral health screening, assessment, and services including:

- All children under the age of 21 who are involved with DCS (including those living with their own families, in foster care, kinship care, adoptive families, and independent living situations),
- Parents, relatives, and other adults living within the home, and
- Adults accepting temporary or permanent placement of a child removed by DCS.

Definitions

[Urgent Response](#)

[Child and Family Team \(CFT\)](#)

[Team Decision Making \(TDM\)](#)

[Preliminary Protective Hearing \(PPH\)](#)

¹ In some (but not all) cases involving foster children enrolled in the Division of Developmental Disabilities, CPS transfers child welfare/CPS functions to DDD case managers called DDD child welfare/support coordinators. These staff perform child welfare functions for children with developmental disabilities who have been adjudicated dependent. When DDD assumes ongoing case management responsibilities for children in foster care, it is required to follow Title 8 statutes and CPS policy.

Background

During the past 40 years, a growing body of research has identified some of the risk factors that predispose children and adults to mental disorders.² Risk factors are those characteristics, variables, or hazards that, if present, make it more likely that an individual will develop a disorder than someone selected at random from the general population. Risk factors can reside in the individual (such as a genetic vulnerability) or within the family, community, or institutions that surround the individual. Some risk factors play a causal role while others merely mark or identify the potential for a disorder. The degree of risk – and the likelihood of developing a mental disorder – is also shaped by the accumulation and timing of risk factors across the lifespan.

An adverse childhood exposure or a biologic vulnerability may increase the risk for certain mental disorders, such as alcohol abuse, depression, and juvenile conduct disorder; however, other risk factors may also be necessary for the illness to be expressed. Studies of conduct disorder have consistently confirmed that as the number of adverse conditions accumulate, the risk of disorder onset increases proportionately; however, certain risk factors, such as low income, are a more significant predictor in children aged 4 to 11 than in older adolescents.

Finally, understanding the complex interrelationships of individual, family, and community risk factors in the onset of mental disorder is also shaped by the presence of protective factors – personal qualities, familial rituals and relationships, and social/peer group norms among other variables -- that contribute to individual resilience or the capacity to cope with significant stressors.

Across the two most common mental disorders in the U.S. today – depression and alcohol abuse/dependence -- situational stressors and adverse family conditions including a significant loss, traumatic exposure, and family conflict or violence are significantly associated with later onset of the condition, particularly in children whose close biologic relatives also suffer depression or alcoholism.³ In a survey testing for associations between adverse childhood experiences and health risk behaviors and chronic disease among 9,500 adults at a large California HMO, the study's authors found a strong association between individuals exposed to a variety of negative environmental risk factors as children and the likelihood of smoking, suffering chronic pulmonary disease, use of illicit drugs, and attempting suicide as adults.⁴ The categories of exposure reviewed included experiencing emotional, physical, or sexual abuse, witnessing domestic violence, parental separation, or divorce, living in a household characterized by substance abuse, or with an adult with mental illness, and incarceration of one or more parents.⁵

While any child might experience trauma, loss, or anxiety, children in the child welfare system tend to be exposed to an accumulation of adverse childhood experiences and life transitions to which children from other families may never be exposed. The mission of the

² National Academy of Sciences. *Reducing Risks for Mental Disorders: Frontiers for Preventive Intervention Research*. (1994)

³ Ibid.

⁴ Anda, RF, Croft JB, Felitti VJ, et al. "Adverse Childhood Experiences and Smoking During Adolescence and Adulthood." *Journal of the American Medical Association*. 1999. 282:1652-1658.

⁵ Felitti, Vincent J., MD, "The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead," in: *Praxis der Kinderpsychologie und Kinderpsychiatrie* (2003), 52: 547-559 [English translation].

child welfare system and DCS is to ensure children experience safety, permanency, and wellbeing. This mandate can be supported through strong partnerships between DCS and Arizona's behavioral health system to provide rapid behavioral health assessment, treatment, and services for referred families that may also reduce the risk of future mental disorder among children experiencing abuse or neglect.⁶

Procedures

1. Working in Partnership

Efforts to meet the unique service needs of children and families referred by DCS are best supported when all involved agencies work collaboratively through a unified service planning process that upholds the 12 Arizona Principles [<http://www.azdhs.gov/bhs/children/pdf/JK/principles.pdf>]. Partner agencies may include a variety of health, social service, and justice system organizations, including the behavioral health system, DCS, juvenile justice, DDD, and allied service providers (including pediatricians and day care providers). The CFT provides the platform for unified assessment, service planning, and delivery based on the individual needs of the children and other family members. Allied agencies, including the DCS caseworker and juvenile justice probation officer (if the child is a dual ward/dually adjudicated) should be invited as members of the team where indicated by family need in order to align efforts of the CFT with the child welfare case plan or other agency service plans. The CFT must strive to fully understand the unique needs of each child and family. Continuity of team membership and its clinical representative(s) is particularly important during the child's transitions and subsequent placement. Integrated service plans among agencies involved with the child should be developed by the CFT and jointly implemented. The Regional Behavioral Health Authorities (RBHA's) may also place links to their DCS collaborative tool on their respective websites.

Referrals from the child welfare system can be initiated through an urgent behavioral health response after a child's removal from his/her home, or by referral from DCS (e.g., as part of an in-home intervention plan or when behavioral health needs of removed children and/or family members warrant re-assessment and potential intervention). In all cases, the behavioral health system must begin to address the child and family's need for behavioral health treatment and service at the earliest moment in order to understand, shape, and align its efforts with the child welfare case plan. For example, if the child is removed from his/her family of origin with a case plan focused on reunification, behavioral health services are expected to support that plan by providing services directed toward the behavioral health treatment needs of the child. For children under three and their siblings, A.R.S. §§ [8-113](#), [8-553](#), [8-824](#), [8-829](#), [8-847](#), [8-862](#) expedites the time in care requirement to 6 months; this highlights the need for timely behavioral health services as part of the reunification plan through DCS. Services should also be provided to the parent(s), when necessary, to help them address their own behavioral health treatment needs. This may require separate enrollment of the parent(s) in the behavioral health system when eligible. If the child is placed with temporary caregivers (e.g., an uncle, a foster family), behavioral health services should support the child's stability with those caregivers by addressing the child's treatment needs; identifying any risk factors for placement disruption and providing support to minimize the risk; and anticipating crises that might develop and indicating specific strategies and services to be employed if a crisis occurs. Behavioral health services must

⁶ See *J.K. v. Eden et al.*, No. CIV 91-261 TUC JMR (6/26/01), Paragraph 21.

be designed to help the child remain stable in the temporary, protective placement to minimize or eliminate the risk of placement disruption and to avoid the use of the police and the criminal justice system. In particular, behavioral health services must anticipate and plan for transitions in the child's life that may create additional stressors, such as transitions to new schools or transitions to a permanent family living situation.

The behavioral health system is expected to support the DCS caseworker by:

- establishing a CFT to identify and describe the strengths, needs, and important cultural considerations of the child and family,
- using the CFT to assess clinical risks, symptoms, and behaviors indicating a need for extended assessment or more intensive treatment services for both children and adults,
- using the CFT to develop a behavioral health service plan, crisis plan, and to present recommendations and options to the court as appropriate; and
- furnishing information and reports about the provision of behavioral health services to allied agencies including DCS and the juvenile court.

Service Expectations: Behavioral health service plans must be developed by the CFT to address the behavioral health treatment needs of the child, and should strive to be consistent with service goals established by other agencies serving the child and/or family. The team should seek the active participation of other involved agencies in the planning process.

2. Addressing Needs in the Context of Each Child's Family

The involvement of DCS indicates the presence of significant safety and risk concerns within the family unit. The family circumstances that lead to involvement by DCS can be expected to create needs for behavioral health treatment for most children and may also reflect behavioral health treatment needs of other family members. It is important that the CFT understand these concerns and their clinical implications and explore opportunities where behavioral health services can help to mitigate them. This can be accomplished through assessment and referral of adult family members for substance abuse and behavioral health services and by identifying those strengths and resources within the family and community that can fortify the child's abilities to cope with problems and adapt to change. Together, DCS, behavioral health, and other involved agencies should identify resources to support the needs of both family and child.

Families – whether the child's family of origin, a foster family, a relative, a friend providing kinship care, or an adoptive family giving legal guardian -- can be supported through the individual service plan of the child with services and/or interventions such as respite, family support, peer support, living skills training, or family counseling to address the child's treatment needs. The CFT may recommend behavioral health services that can help to stabilize the child's family situation and address mental health and substance abuse needs of family members without removing the child from the home. Parents and others in the home, including siblings, may also need specific individualized treatment, and it may be necessary to refer those family members for enrollment in the behavioral health system. Service plans for family members should be coordinated with those of the child to make them compatible and mutually reinforcing. Without diminishing the needs that may exist for

individual interventions, the CFT should participate in an overall plan that makes sense to the family and is consistent with the goals of DCS and the juvenile court.

Service Expectations: The behavioral health service provider facilitates the CFT development of a behavioral health service plan that is consistent with the goals of DCS and the juvenile court and incorporates the family's preferences, strengths and culture in alignment with their vision for the future. The Service Plan identifies formal services and natural supports that address the identified needs.

3. When the Child Remains with His/Her Own Family

Children involved with DCS often live in family homes where DCS is actively monitoring identified concerns relating to safety, security, or basic needs. In these situations, adults and siblings living in the home may be the primary focus of behavioral health system involvement through provision of treatment and support services to parents that also reduce risks to the children. Service providers working with families who are involved with DCS must remain alert to common emotional responses of children that may indicate a need for further assessment or referral to the behavioral health system. If a CFT has convened, such considerations should be factored into developing the service plan. Common responses can include:

- disturbed parent-child and child-sibling relationships,
- disrupted capacity for trust and attachments,
- anxiety,
- developmental delays or compromised learning,
- dysfunctional coping skills,
- behavioral disturbances,
- post traumatic stress disorder (PTSD),⁷
- mood disturbances, and/or
- physical complaints or symptoms like headaches, abdominal pain, or bedwetting.

Some of these responses might be associated with – or indicate potential need for -- involvement in primary health care, juvenile justice, special education, and/or developmental disabilities systems. Behavioral health treatment can be most effective when provided prior to a child's removal to protective foster care. The behavioral health system must furnish behavioral health services to address critical behavioral health needs, ideally as part of a collaborative intervention with DCS, the juvenile court, and other child-serving systems.

A child remaining at home with a family involved with DCS may need to develop or strengthen supportive relationships with family and others – both peers and adults. To meet these unique needs, behavioral health services with most families will need to be intensive, comprehensive, and delivered quickly in order to maximize engagement with the family and to strengthen their existing support systems. When DCS services are also in place, behavioral health professionals and other providers should work in concert with those services.

⁷ Saltzman, W.R., Pynoos, R.S., Layne, C.M. et al. (2001), *Trauma- and grief-focused intervention for adolescents exposed to community violence: Results of a school-based screening and group treatment tool. Group Dynamics: Theory, Research and Practice, 5(4):291-303*: When failing adolescent students with severe PTSD symptoms were recognized and treated for trauma, their symptoms were markedly reduced, they required no further discipline, and their grade point averages went up significantly.

Parents should be helped to learn/know how to manage their child's unique needs, and to anticipate and respond to those needs as they change. A key challenge for many parents and family members in this situation is the need to advance their own recovery from behavioral health conditions or substance use disorder while remaining responsive and attentive to the needs of their child. Behavioral health services provided to such families must be designed to impart skills and confidence to the parents – both in their role as caregivers and their role as a person entering recovery. Siblings and other family members should be incorporated in service planning and delivery, and advised of choices they may exercise in the process.

The Clinical Liaison must ensure the provision of covered behavioral health services identified and recommended by the CFT that address the child's treatment needs, including coordination with services for parents and promotion of the child's ability to live and thrive in his/her own family home, with safety and stability.

Service Expectations: The behavioral health service provider must furnish behavioral health services to address critical behavioral health needs of children, youth, and/or adult family members. The CFT must identify any unmet behavioral health service needs. The Regional Behavioral Health Authority (RBHA) must ensure that needed behavioral health services are promptly provided and barriers to service are rapidly removed.

4. When the Child Is Removed to Protective Foster Care

The presence of serious safety concerns may require DCS to remove children from their family home to a protective placement (shelters, receiving homes, relative ["kinship"] placements, family foster homes, or group homes). A child who may already have been seriously neglected or abused (physically, sexually, and/or emotionally) within the family home will very likely be affected not only by the neglect or abuse that precipitated removal, but also by the removal itself. The child may experience trauma, disorientation, and uncertainty related to such a drastic change in his/her life circumstances^{8,9}. A Team Decision Meeting (TDM) can be scheduled when DCS is considering removal of a child or has removed a child from their home. The meeting is typically held within a very short time frame to address the potential removal. Behavioral health staff may be invited to participate in these meetings in order to provide insight into the behavioral health system and the services that may be provided to the child, family or relatives.

⁸ Landsverk, Garland & Leslie (2002), *Mental health services for children reported to Child Protective Services*, APSAC Handbook on Child Maltreatment (Sage Publications), 487-507. In Great Smoky Mountain Study, 80% of children in contact with child welfare (n = 234) met criteria for DSM-IV diagnosis, functional impairment or both; as well as 78% of children (n = 132) who had ever been in foster care.

⁹ Landsverk, J, *National Study of Child and Adolescent Well-Being*, 2003 (Washington, DC: U.S. DHHS Administration for Children and Families): In San Diego Children's Hospital study, 40-50% of children in out-of-home care ages 4-17 demonstrate significant behavioral problems; and 42% (n = 426) of children in out-of-home care ages 6-17 met criteria for DSM-IV disorders with moderate impairment (POC).

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) considers the removal of a child from his/her family home to the protective custody of DCS to be an urgent behavioral health situation. In these situations, the RBHA must respond within 24 hours of a referral from DCS surrounding a child's removal from his/her home unless an alternative timeframe has been agreed upon as detailed below under the Urgent Response process.

The behavioral health service provider is expected to consider an extended assessment period (e.g., over 30 to 45 days) to more accurately identify any emerging/developing behavioral health treatment needs that are not immediately apparent following the child's removal. Children in foster care who do not initially demonstrate behavioral health symptoms may still require active therapeutic intervention, including family-focused services and continued close observation to address any potential effects of their removal and to support placement stability. The behavioral health service provider identifies areas which may require further assessment during the period of time the child is enrolled. While identifying and arranging the behavioral health services needed for a child, the CFT is also expected to support familial relationships, such as visitations with their siblings and other members of their birth families as arranged by DCS. When there is multi-agency involvement, every effort is made by the CFT to collectively develop a single, unified service plan that addresses the needs and mandates of all the parties involved. A child who is adjusting well and is not exhibiting signs and symptoms of behavioral health concerns over the course of the assessment may be disenrolled after an appropriate period of time, but can still be referred for future services, including re-assessment, should a need arise. The behavioral health service provider must work collaboratively with DCS caseworkers to establish a process for a subsequent referral to the behavioral health system should clinical symptoms manifest in the future.

Each RBHA and DCS district in Arizona has established joint local tools to implement the urgent response requirement. The Urgent Behavioral Health Response for Children Entering Foster Care is intended to:

1. **Identify immediate behavioral health needs and presenting problems** of children removed from their homes, to stabilize crises, enroll the child in the behavioral health system and offer the immediate services and supports each given child may need;
2. **Provide direct (therapeutic) support to each child** removed from their home as appropriate, intending to reduce stress or anxiety the child may be experiencing;
3. **Provide direct support to each child's new caregiver** as appropriate, including guidance about how to respond to the child's immediate behavioral health needs;
4. **Identify a point of contact within the behavioral health system;**
5. **Initiate the development of a Child and Family Team;** and
6. **Provide the DCS Specialist with findings and recommendations,** related to the behavioral health needs of each child, within five to seven days of the referral or prior to the Preliminary Protective Hearing, whichever is the latter

Foster parents and other protective caregivers must be recognized as significant, knowledgeable members of the CFT. They should experience well-integrated coordination among, and clear communication from, all involved systems, beginning immediately upon placement of the child. Foster parents and other protective caregivers will need guidance

and support to raise children experiencing the trauma of neglect/abuse and subsequent removal from their family homes. The caregivers will need guidance to better understand each child's adjustment, how to respond to the coping mechanisms the child may demonstrate in his/her new situation, and how to seek outside assistance and/or recommendations to support any treatment.

When children are removed to protective foster care, their parents may also benefit from behavioral health services, either as included in the treatment plan for the child or through separate enrollment in the adult behavioral health system. Parents may need assistance in order to:

- learn how to better analyze and solve problems in relation to the safety needs of the child and other family members, and
- be engaged (or possibly re-engaged) to participate in assessment, service planning, and delivery processes for their children and themselves.

The behavioral health system is expected to assist DCS Specialists, judges, attorneys, court-appointed special advocates (CASAs), and others to understand how behavioral health services, as well as their own respective relationships with the child, impact the child's overall treatment progress and functional outcomes.

Children who have been removed by DCS from their family homes because of neglect or abuse might experience the following emotional responses:

- disrupted parent-child and child-sibling relationships,
- disrupted capacity for trust and attachments,
- anxiety,
- developmental delays or compromised learning,
- dysfunctional coping skills,
- behavioral disturbances,
- running away,¹⁰
- post traumatic stress disorder,
- mood disturbances,
- substance abuse,¹¹ and/or
- physical complaints or symptoms like headaches, abdominal pain, or bedwetting.

In addition, some children may need specially informed treatment to address their victimization by sexual abuse, including specific interventions for such children who act out in a sexually aggressive manner.

Any child who has experienced a removal by DCS is at risk for negative emotional consequences and future behavioral health disorders. Under the Urgent Response process, the procedure outlined below must be followed.

Upon notification from DCS that a child has been, or will imminently be physically removed from his/her home and taken into the custody of DCS, RBHAs or their

¹⁰ Deborah Bass, "Study of Runaway Youths Finds One-Third Were In Foster Care," *St. Louis Post-Dispatch*, (January 19, 1992). [results of a survey of 170 runaway shelters.]

¹¹ Clark, H.W., McClanahan, T.M. & Sees, L.K. (Spring 1997), *Cultural aspects of adolescent addiction and treatment. Valparaiso University Law Review, Vol.31(2)*. Adolescents with alcohol dependence are six to 12 times more likely to have a childhood history of physical abuse, and 18 to 21 times more likely to have a history of sexual abuse than those without substance abuse problems.

subcontractors shall respond within a timeframe indicated by clinical need, but no later than 24 hours from initial contact by DCS, unless the RBHA or subcontracted provider and DCS have mutually arranged an alternative timeframe for coordinating a response based on the best interests of the child. This requirement applies regardless of the child's Title XIX/XXI eligibility status at the time of referral.

More specifically, once the notification is received from DCS, the RBHA or subcontracted provider will;

- Contact the DCS Specialist to gather relevant information such as the outcome of the DCS Safety Assessment, the reason for the removal, how-when-where the removal occurred, any known special needs of the child, any known supports for the child, where siblings are, any known needs of the new caregiver, etc.
- Contact the caregiver to schedule the face-to-face, in-placement response to occur within 24 hours of referral, unless there is a mutually agreed upon and arranged alternative timeframe (as mentioned above), in order to achieve the six goals of the Urgent Response Process.
- Complete an initial assessment focused on immediate presenting concerns, to include a determination of the immediate behavioral health needs of the child and family. At this time, trauma issues such as grief and loss should be addressed. If the child is not currently enrolled with the RBHA, the intake process should be initiated at this time as well.
- Provide the DCS worker with a copy of the initial assessment and behavioral health recommendations within five to seven days of the referral or prior to the Preliminary Protective Hearing, whichever is the latter.

In the event that a child enrolled in one RBHA is removed from his/her home and placed in another RBHA catchment area, the Urgent Response Process should follow the guidelines outlined in [ADHS/DBHS Policy and Procedures Manual Policy 901, Inter-RBHA Coordination of Care](#). This policy calls for the RBHA of origin or subcontracted provider to make arrangements and pay for the services provided by the receiving RBHA.

Since one of the main goals of this process is to help identify the immediate behavioral health needs of children and address the trauma of the removal itself, the timeliness of the referral from DCS is crucial. The RBHA receiving the referral is responsible for providing the urgent response if the notification is received within 5 calendar days of the physical removal of the child from his/her home. If a referral is made after the 5th day of removal, the RBHA has the discretion to follow the Urgent Response Process or schedule the child for a regular intake appointment, depending on the specific circumstances surrounding the referral.

Service Expectations: The behavioral health assessment process must detect both initial and delayed effects of trauma. Unless otherwise agreed upon, an urgent behavioral health response must be provided within 24 hours to every child removed and referred by DCS. An extended assessment period of 30-45 days is recommended best practice in order to detect possible delayed reactions to the traumatic experience. During this early assessment period the behavioral health service provider must extend clinically indicated services to the children who have been removed from their homes to address their immediate and

ongoing behavioral health needs in addition to foster families and other protective caregivers; must support the child through CFT practice; and must serve as educational resources for staff from other child-serving agencies. The RBHA has the discretion to implement the Urgent Response Process or other Intake timelines as outlined in [ADHS/DBHS Policy and Procedures Manual Policy 102, Appointment Standards and Timeliness of Service](#), for referrals submitted after the 5th day of a child's removal by DCS.

5. When the Child Returns to His/Her Family of Origin from Foster Care

Children who have been living apart from their families of origin have had time to adapt to new expectations, interactions, roles, and experiences. Coping skills and behavioral response patterns have likely been adapted to the dynamics of the protective caregivers, and these may be distinct from those of their own families. At the same time, their families of origin will likely have adapted to new daily realities that have not included the child.

Consequently, visitation and contact must be promoted with family members and other anchoring relationships (e.g., friends, extended family, and teachers) to the greatest extent possible. The CFT must work collaboratively with DCS caseworkers to identify opportunities for therapeutic support during episodes of visitation and other family contact and to promote practicing the new skills and behaviors that successful reunification requires. All involved parties will need to understand how to optimize the transition process according to the child's age, developmental level, and specific circumstances, including how to support productive transition strategies.

Each CFT member/partner agency should contribute knowledge, skills, appropriate services, and resources to the reunification plan. In spite of the planning and work undertaken to prepare for the child's return home, reunification will likely be stressful and difficult.¹² Issues relating to neglect, abuse, abandonment, fear, and mistrust may resurface. Negative feelings, memories, and traumatic stress symptoms can be triggered by re-exposure to the home environment. Familiar but dysfunctional family coping patterns may return and threaten to replace recently learned adaptive patterns. The CFT must focus on preparing both the child and the family for reunification by ensuring that appropriate service plans (including crisis plans) are in place as needed.

Children and family members may require additional assessment and individualized behavioral health services during the period of reunification based on new or recurrent behavioral health needs. Behavioral health providers and child welfare professionals on the CFT must work collaboratively to promote:

- A strong recovery environment for the family,
- The child being embraced, re-accepted, and not blamed (e.g., for the initial removal) by his or her reunified families,
- The child being wanted, permanently,
- Evidence that the family will put the child's needs first, and
- Confidence that the child's stay with the family will last.

¹² National Child Welfare Resource Center for Family-Centered Practice, 2003. "The problems of these children are not likely to disappear once they are adopted or reunified with their families. Therefore children and parents need post-adoptive or post-reunification services to help them deal with lifelong effects of abuse, neglect and separation."

Service Expectations: The behavioral health service provider must coordinate with staff from other child-serving agencies involved in the child’s reunification process and provide clinically indicated behavioral health services. Integrated service planning and provision will include transition strategies and be implemented through CFT practice.

6. When the Child Achieves Permanency through Adoption or Guardianship

Children who leave foster care for other permanent situations (adoption, guardianship) may experience significant feelings of loss at the same time their permanency is viewed as a success by DCS, the juvenile court, their new families, and even by themselves. Many adopted children experience feelings of isolation and being different. They may feel irreversibly abandoned by their families of origin, engendering anger, feelings of guilt, and even self-blame. The adopted child may experience the loss of not only both natural parents, but also of extended family, cultural and genealogical heritage, a sense of connectedness, former social status, and personal identity. Such losses are rarely recognized in the context of adoption, and few supports have been made available to children experiencing them. The CFT must draw upon the expertise and resources of participating agencies to identify supports for children in this stage of transition.

The same children may strive for, and be integrating, new feelings of gratitude, inclusion, and acceptance. Children entering new ties through adoption or guardianship are likely to strive to gain a new sense of identity and belonging – a feeling of “fitting in” – in their new home and community. Given their prior losses, they are likely to need reassurance that “I am wanted, no matter what I do or how I act.” Many will choose to test limits repeatedly to try the strength of their new ties as they adjust. Children in adoptive or guardianship situations need to know that their past will be considered by others and included in their futures.

These emotional responses may occur on top of existing issues such as abuse and neglect, the trauma of separation, the adaptation challenge posed to the child by his/her removal from family to foster care, and the additional transitions the child most likely endured within foster care. (All children eligible for the Adoption Subsidy program remain categorically eligible for Title XIX behavioral health services for the duration of their childhoods.)

The CFT must organize to meet the many needs of the child in their new home. Adoptive parents, child welfare, and behavioral health professionals must work together to help the child understand what adoption/guardianship means, and to name and manage confusing feelings. The team may identify the need for such feelings to be addressed in the context of individual, family, or group therapy or identify behavioral health services that prepare the child for success in the new family situation. Minimally, the family should receive information on how to access additional assistance if problems occur.

The CFT must recognize that the child’s new family may also need adequate preparation and support to successfully welcome and incorporate a new family member. Every member of the child’s new family will be affected by the changing relationships within the family system. They may need to be prepared for complex emotional and behavioral issues often presented by children leaving foster care, and to anticipate that the older the child, and the

longer he/she has been in foster care, the more challenges and limit-testing will be likely.¹³ Supportive services provided by the child welfare system, behavioral health services, and other individualized services must be readily available, consistently provided, and sufficiently tailored to meet the unique needs of the child and the adoptive family. Adoptive parents will feel the need to be fully recognized as the child's parent, and reassured that they will know what to do when faced with the child's adjustment issues over time.

Safe people from the child's family of origin or past support system, who are important to the child, should remain involved in the child's life as much as possible. This dimension may also require assistance by the behavioral health provider to ensure that the child and his/her new family can have positive connections to the child's past. The CFT should continue involving those safe people in the ongoing planning and treatment process.

Service Expectations: Behavioral health service plans developed by the CFT must consider the behavioral health needs of the child and family by specifically addressing the transitional area of permanency when adoption or guardianship processes are involved.

7. Special Considerations for Infants, Toddlers, and Preschool-Aged Children

The CFT can contribute to the well-being of infants, toddlers, and young children by helping other involved partners to view the child holistically. Clinical Liaisons are expected to facilitate the special assessment approach prescribed by ADHS/DBHS in the [Instruction Guide for the Assessment Birth to 5, Service Plan and Annual Update](#), which supports this holistic perspective. The behavioral health expertise they bring to the CFT must:

- help family members to appreciate the impact of their interactions on young children (most therapeutic work at this age is likely to focus on those dyadic interactions and relationships, as individual interventions with such young children are rarely indicated),
- recognize signs, symptoms, and indicators of other needs (e.g., speech delays, sensory challenges, secondary effects of maternal substance abuse) that may impact children's social and emotional development (and, for children below age 3, initiate referrals for early intervention services [Arizona Early Intervention Program (AzEIP)] when indicated by developmental screenings), and
- work closely with family members, pediatricians, and other early intervention partners to recognize and address such needs.

Parents, foster parents, and other protective caregivers must be given guidance and support to understand the strong sensory base to an infant's experience of interactions with people

¹³ A recent survey of 375 Maine families who had adopted children from foster care an average of six years earlier [John Levesque and Michael Lahti, *Maine Adoption Guides Project*, "Maine Post-Adoption Legalization Survey: Child and Family Needs and Services," DHHS IV-E Demonstration Project, January 2002] reported the following problems persisting in at least half of those children: Sudden changes in mood or feelings (82%); argues too much (75%); difficulty concentrating (75%); impulsive, acts without thinking (75%); disobedient at home (74%), stubborn, sullen (71%); cheats or tells lies (70%); high-strung, tense or nervous (61%); has trouble getting along with other children (60%); very strong temper, loses it easily (60%); restless, overly active (59%); does not seem to feel sorry after misbehaving (57%); fearful or anxious (55%); disobedient at school (53%); not liked by other children (52%); has obsessions (52%); and easily confused (51%). These problems were identified within stable adoptive families of relatively long standing. Yet even after an average of six years since finalization of the adoptions, 38% of parents rated the child's current adjustment as "somewhat difficult," and 12% as "very difficult."

and the world in general. Pediatricians, parent aides, behavioral health clinicians, or early interventionists must educate caregivers to recognize indicators of the young child's adjustment through observable behavior (e.g., an infant's eating, sleeping, and other bodily functions). They must be helped to understand that, as children make gains with receptive and expressive language and with cognitive development,¹⁴ they will have increasing capacity to identify and describe how they are reacting to or coping with new situations, how it feels, and perhaps what might help them to feel better.

Service Expectations: When serving infants, toddlers and pre-school age children the behavioral health provider must utilize the ADHS/DBHS Assessment and Service Planning process specific to children age birth to five. Assessment, treatment and service planning processes will include the child's primary caregiver and other involved family members.

8. Preparing the Adolescent for Independent Living

Behavioral health service needs of children reaching the age of majority while in protective state custody can be multi-dimensional. Some individuals may continue to have behavioral health needs that can be addressed through enrollment in services for adult General Mental Health, Substance Abuse, and/or Serious Mental Illness.¹⁵ Studies demonstrate that problems that tend to surface in adolescence (e.g., alcohol and drug use, truancy) will be more common among adolescents in the child welfare system. In addition, in order to become stable and productive adults, they may require transitional financial assistance (including but not limited to DCS independent living subsidy) and budget management skills. Added challenges of moving to adulthood include assistance in locating and securing housing, connecting to a first job, and/or beginning pursuit of higher education. Employment, higher education, and housing issues will pose significant challenges for many young people.

Some young adults continue their involvement with DCS on a voluntary basis during this period. DCS independent living and young adult programs offer opportunities to gradually develop skills necessary for stable, productive adult living. Many young adults, understanding they are now fully responsible for making their own decisions, opt to forego such opportunities and cut ties with the system that may have, in their view, been "controlling my life" before now. Because former foster care youth frequently experience

¹⁴ Lederman, C., Osofsky, J & Youcha, V, *Meeting the unique needs of infants and toddlers in juvenile and family court*, (2005), Zero to Three, "Almost 80% of young children (below age 5) in foster care have been prenatally exposed to maternal drugs. Developmental delay among these children is four to five times greater than for children in the general population. More than half suffer from serious physical health problems." See also, Landsverk, op. cit., "50-65% of children in out-of-home placements ages 0-6.4 years screen positive for developmental problems."

¹⁵ Chapin Hall Center for Children (2004), "Midwest sample of youth transitioning out of foster care to adulthood found: 12.9% with major depression, 25.1% PTSD, 21.1% substance use disorders. *Northwest Foster Care Alumni Study* (2005) of 479 young adults in Oregon and Washington, "PTSD incidence among former foster children is twice as high as for U.S. war veterans. Foster care alumni experienced over seven times the rate of drug dependence and nearly two times the rate of alcohol dependence experienced in the general population."

poor outcomes,¹⁶ behavioral health counseling may assist them in realizing their decision-making power without “proving it” by cutting ties with this important lifeline.

Many young people who have been in the foster care system have expressed the recurring theme of stigma, of an overwhelming desire to be free of it, and to be seen in the world as competent, self-sufficient, and independent. Many young adults will still have – or will strive to re-establish -- close connections with others from their past, such as siblings, family, friends, educators, and faith communities. The behavioral health provider, in collaboration with DCS personnel, must:

- respond quickly to meet any identified behavioral health needs,
- solicit input from the young adult to determine their needs
- involve the young adult’s own support system,
- plan adequately to address their needs,
- stay involved in their lives, and
- help them transition to adulthood by teaching them the skills they need to thrive and to meet their ongoing needs, including behavioral health issues that may continue into adulthood, or which may emerge over time.

The CFT must anticipate the need to help a young person prepare for the transition to adulthood beginning at age 16. The [ADHS Practice Tool, Transition to Adulthood](#) provides specific guidance and required service expectations to support the CFT in thorough planning and preparatory activities.

Service Expectations: Behavioral health service plans developed by the CFT/Adult clinical team must include services, and resources that promote the continuation of supportive relationships and successful transitions to adulthood, consistent with the ADHS/DBHS policy and the [Practice Tool, Transition to Adulthood](#).

Summary: While this tool describes many likely emotional responses of children and adolescents, it is not exhaustive. Children and youth may manifest a wide variety of psychological, social and even medical problems in combination. The RBHAs and their service providers are expected to recognize and appropriately address the unique behavioral health needs of children involved with DCS, their families, and caregivers through the CFT process. In addition, in order to ensure coordination of care with the child’s primary care physician, the RBHAs and their service providers must follow the guidelines described in [ADHS/DBHS Policy and Procedure 902, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers](#).

Service Expectations: The RBHAs and behavioral health service providers must develop and furnish sufficient behavioral health services consistent with this tool that will meet the needs of the child with special attention to the timeliness, frequency, intensity, duration, and level of expertise of services provided. RBHAs

¹⁶ *Northwest Foster Care Alumni Study*, op.cit., “Between age 20 and 33, 1/3 of the study group lived below the poverty level, 1/3 lacked health insurance, and ¼ had experienced periods of homelessness.” A survey of 113 former foster care youth (Wisconsin, 1998) found that, 12-18 months after leaving foster care, 39% were unemployed, 32% were on public assistance, and 27% of men and 10% of women had been incarcerated at least once.

and their service providers must follow the guidelines described in [ADHS/DBHS Policy and Procedure 902, Coordination of Care with AHCCCS Health Plans, Primary Care Providers and Medicare Providers.](#)

Training and Supervision Expectations

This Practice Tool applies to T/RBHAs and their subcontracted network and provider agencies for all behavioral health service providers who have direct contact with or provide services to children, adolescents and their families. Each RBHA shall establish their own process for ensuring all agency clinical and support services staff working with children and adolescents understands the required service expectations and implements the practice elements as outlined in this document. To support the training surrounding this Tool, the behavioral health staff noted above will be required to attend “Unique Needs of Children Involved with DCS” training offered by each RBHA on a regular basis (see [Policy and Procedures Manual Policy 403, Training Requirements, subsection 9.1.6-E, Training Expectations for ADHS/DBHS Clinical and Recovery Practice tools](#)).

Each RBHA is required to provide documentation, upon request from ADHS, demonstrating that all required network and provider agency staff has been trained on the service expectations and guidance contained in this Tool. Whenever this Practice Tool is updated or revised, RBHAs must ensure their subcontracted network and provider agencies are notified and required staff is retrained as necessary on the changes. In alignment with [A.A.C. R9-20-205, Clinical Supervision](#) requirements, the supervision for implementation of this Tool is to be incorporated into other supervision processes which the RBHA and their subcontracted network and provider agencies have in place for direct care clinical staff.

Anticipated Outcomes and How they will be Measured

- Improved engagement and collaboration in service planning between children, families, community providers and Department of Child Safety.
- Improved functional outcomes for children involved with Division of Child Safety
- Improved identification and incorporation of strengths and cultural preferences into the planning processes
- Increased statewide practice in accordance with the 12 Arizona Principles;
- Coordinated planning between behavioral health and Department of Child Safety to ensure seamless transitions for children involved with DCS

How will Fidelity be Monitored?

- Consumer/family satisfaction surveys
- RBHA reviews of CFT practice
- Random audits completed by ADHS/DBHS
 - Administrative Reviews (chart reviews)
 - Monitoring and Oversight Department audits (chart reviews)
 - Morbidity/Mortality reviews

The Unique Behavioral Health Service Needs of Children, Youth and Families
Involved with DCS
Desktop Guide

Service Expectations:

- **Behavioral health service plans must be developed by the Child and Family Team (CFT) to address the behavioral health treatment needs of the child, and should strive to be consistent with service goals established by other agencies serving the child and/or family. The team should seek the active participation of other involved agencies in the planning process.**
- **The behavioral health service provider facilitates the CFT development of a behavioral health service plan that is consistent with the goals of DCS and the juvenile court and incorporates the family's preferences, strengths and culture in alignment with their vision for the future. The Service Plan identifies formal services and natural supports that address the identified needs.**
- **The behavioral health service provider must furnish behavioral health services to address critical behavioral health needs of children, youth, and/or adult family members. The CFT must identify any unmet behavioral health service needs. The Regional Behavioral Health Authority (RBHA) must ensure that needed behavioral health services are promptly provided and barriers to service are rapidly removed.**
- **The behavioral health assessment process must detect both initial and delayed effects of trauma. Unless otherwise agreed upon, an urgent behavioral health assessment must be provided within 24 hours to every child removed and referred by DCS. An extended assessment period of 30-45 days is recommended best practice in order to detect possible delayed reactions to the traumatic experience. During this early assessment period the behavioral health service provider must extend clinically indicated services to foster families and other protective caregivers; must support the child through CFT practice; and must serve as educational resources for staff from other child-serving agencies. The RBHA has the discretion to implement the Urgent Response Process or other Intake timelines as outlined in ADHS/DBHS PM3.2 Appointment Standards and Timeliness of Service Policy for referrals submitted after the 5th day of a child's removal by DCS.**
- **The behavioral health service provider must coordinate with staff from other child-serving agencies involved in the child's reunification process and provide clinically indicated behavioral health services. Integrated service planning and provision will include transition strategies and be implemented through CFT practice.**
- **Behavioral health service plans developed by the CFT must consider the behavioral health needs of the child and family by specifically addressing the transitional area of permanency when adoption or guardianship processes are involved.**
- **Behavioral health service plans developed by the CFT/Adult clinical team must include services, and resources that promote the continuation of supportive relationships and successful transitions to adulthood, consistent with the ADHS/DBHS PM 3.17, Transition of Persons policy and the Practice Tool, Transitioning to Adulthood.**

- **The RBHAs and behavioral health service providers must develop and furnish sufficient behavioral health services consistent with this tool that will meet the needs of the child with special attention to the timeliness, frequency, intensity, duration, and level of expertise of services provided. RBHAs and their service providers must follow the guidelines described in ADHS/DBHS Policy and Procedures Manual Section 902 “Coordination of Care with AHCCCS Health Plans, Primary Care Providers, and Medicare Providers”**

- ❖ **Key elements to remember about this best practice:**
 - Actively identify and remain vigilant about potential emergence of behavioral health needs of children and family members, as significant risk factors are known to be associated with involvement with the child welfare system.
 - Support enrollment of family members who have behavioral health needs.
 - Integrate/coordinate behavioral health service planning and service provision for all enrolled family members.
 - Ensure appropriate alignment of Behavioral Health (BH) service plan with DCS case plan and any other pertinent plans of other involved systems.
 - Offer specific options and alternatives when out-of-home placement is being considered. The goal is to avoid congregate care settings whenever possible.
 - Plan and provide necessary BH services with respect for timeframes governing DCS case planning.
 - Consider any individual needs for an extended assessment period to detect emerging BH needs following the removal of children into protective foster care
 - Involve any protective caregivers (e.g., foster families, relatives) in service planning and provision, and address their needs related to the BH needs of children in their care.
 - Help DCS know how to quickly re-refer children for BH services when clinical symptoms may manifest in the future.
 - Support appropriate family contact for children in foster care.
 - Provide BH services necessary to support reunification.
 - Help to prepare children and caregivers for permanency (e.g., adoption, guardianship).
 - Ensure specialized BH service is provided when needed for infants and toddlers.
 - Help to prepare youth for transitions and be aware of the multi-dimensional needs of youth preparing for adulthood.

- ❖ **Benefits of using this best practice:**
 - Timely BH service can mitigate harmful effects of trauma and other adverse experiences in children and family members.
 - Service coordination/integration increases likelihood of positive outcomes for children and families and uses limited resources most efficiently.
 - Optimal BH service provision can minimize harmful instability in lives of children and families.
 - Effective BH service can prevent deeper penetration of children/families into “the system.”



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





Guiding Principles: Guiding Principles Accomplishments

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

Additional Guiding Principles





Guiding Principles: Guiding Principles Accomplishments

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



Children and Families Served by ADHS

<p>Title XIX</p>	<p>AHCCCS for Families with Children (AFC) provides medical coverage, such as doctor's office visits, hospitalization, prescriptions, lab work, and behavioral health services to families. To qualify, there must be a child in the household under the age of 18 years (or 19 years if a full-time student). The monthly income limit for this program is 100% of the Federal poverty level (FPL) or \$1,767 for a family of four. There is no limit on the resources or property that may be owned.</p> <p>AHCCCS offers several low or no cost medical coverage programs to Arizona families and children. To participate in these programs, all individuals must be U.S. citizens or qualified immigrants http://www.ahcccs.state.az.us/Services/Programs/AFC.asp</p>
<p>Title XXI</p>	<p>The Arizona State Legislature passed legislation in May 1998 implementing the Title XXI Arizona Children's Health Insurance Program (KidsCare). The KidsCare program was approved by the Health Care Financing Administration (HCFA) in September 1998 and became effective November 1, 1998. The program was designed to decrease the number of children in Arizona who are uninsured. Applications are processed by the AHCCCS Administration and are screened for Medicaid eligibility in addition to KidsCare eligibility. The program is for children under the age of 19 with household income under the appropriate limit, and resources are not considered http://www.ahcccs.state.az.us/Members</p>
<p>Non-Title XIX Children and Youth ages</p>	<p>Non-Title XIX/XXI funds are available but limited and the behavioral health services offered through this fund source are not considered entitlements. As such, each Regional and Tribal Behavioral Health Authority (T/RBHA) must implement priorities for Non-Title XIX/XXI funded service delivery. Non-Title XIX/XXI funds include, but are not limited to:</p> <ul style="list-style-type: none"> • Center for Mental Health Services (CMHS) and Substance Abuse Prevention and Treatment Performance Partnership • (SAPT) block grants; • State appropriations; and • County funds. <p>http://www.azdhs.gov/bhs/provider/sec3_1.pdf</p>

Additional Information

<p>Enrollment Penetration Report</p>	<p>http://www.azdhs.gov/bhs/Enrollment_Penetraton_2007_2009SFY_200807.pdf</p>
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Child & Family Team Practice:

Child and Family Team Practice is the method used by the Arizona Behavioral Health System to plan and provide services for children and families. It involves nine primary activities including:

1. engaging with the child and family,
2. determining if the child or family has any immediate crises or concerns that need to be addressed and stabilized,
3. getting to know the family and reflecting that knowledge through the development of a Strengths, Needs and Culture Discovery that can be used to guide planning and service delivery,
4. determining, with the family, who could be helpful to have on the Child and Family Team to help the child and family reach their goal(s),
5. developing an individualized service plan to address the needs and utilize the child's and family's strengths while being observant of the family's culture,
6. developing a crisis plan when needed to assist the child and/or family,
7. effectively implementing the service plan in a timely manner,
8. making changes in the service plan or in providers to effectively reach the desired outcomes, and
9. anticipating transitions that may affect the child and family in their progress toward their goals.

It is important that no one element of Child and Family Team Practice be seen as the total practice. It is the combination of all the above activities that make Child and Family Team practice effective.

Teams, in the context of Child and Family Team Practice, are made up of individuals the family believes can help them develop and implement a service plan that will assist the child and family in realizing their vision of the future. The team may be small or large, having as few as two or as many as ten or more members, but the number is not nearly as important as the composition. Regardless of the number, an effective Child and Family Team should be comprised of individuals chosen by the child and family as necessary to help them achieve their vision.

There are many definitions of **team** and some of them include:

"People working together in a committed way to achieve a common goal or mission. The work is interdependent and team members share responsibility and hold themselves accountable for attaining the results." ([MIT Information Services and Technology](#))

"A group in which members work together intensively to achieve a common group goal." (Lewis-McClea & Taylor 1998)

Additional Activities





Child & Family Team Practice:

Engagement	Ongoing Crisis, Safety and Wellness Planning
Immediate Crisis Stabilization	Behavioral Health Service Plan -Implementation
Strengths, Needs and Culture Discovery (SNCD)	Tracking and Adapting
CFT Formation	Transition
Behavioral Health Service Plan – Development	



Child & Family Team Practice:

<p>Engagement</p>	<p>Engagement is the centerpiece of CFT practice. Engagement begins during the first contact between the child/family and the behavioral health system and continues throughout the family's involvement with the behavioral health system. Engagement is not a one time event. The success of CFT practice depends upon a foundation of trust between the child/family and other team members. CFT practice is a partnership, and engagement is both the beginning and the sustaining characteristic of that partnership. These initial communications with the child and family provide opportunities for the behavioral health service provider to learn and understand the family's concerns. The behavioral health service provider is also expected to introduce the child and family to the behavioral health system and provide them with a clear explanation of CFT practice through <u>conversation</u> and <u>active listening</u> rather than a <u>structured interview</u>.</p>
<p>Immediate Crisis Stabilization</p>	<p>The behavioral health service provider, with the child and family, identifies any risks that require immediate intervention. Examples include immediate safety risks such as suicidal or homicidal behaviors/intentions or the imminent risk of a child's removal from his/her home. For a child or family experiencing a critical crisis situation, immediate stabilization takes precedence over all other assessment and planning activities. When the development of a crisis stabilization plan is indicated, crisis intervention services which work in conjunction with a child/family's strengths are identified and secured. Also additional supports, such as family support, respite, or in-home services that may assist in crisis stabilization must be identified and secured as quickly as possible.</p>

Additional Activities



Child & Family Team Practice:

Strengths, Needs, and Culture Discovery

The Strengths, Needs and Culture Discovery (SNCD) provides essential information used to develop a strengths-based, individualized service plan that respects the unique culture of the child and family. It allows the CFT to develop a highly individualized plan which fits with this child and family in a way that encourages their commitment to success. By identifying strengths, assets and sources of natural support, the SNCD can facilitate an expansion of the array and volume of resources available to the CFT beyond formal, categorical services. Strengths, when understood in a functional context, serve as practical resources and service-substitutes in the planning process. Having a written document will reflect back to the child and family their strengths, needs and culture. The SNCD shifts the focus of the CFT to allow team members, including the family, to obtain a balanced perspective of the family's strengths, needs and history of solution finding. This process acknowledges family voice which builds engagement and trust. Family members are central participants in the development of the SNCD.

The elements of the Strengths, Needs and Culture Discovery include:

1. Identification of strengths, assets and resources that can be mobilized to address family needs for support.
2. Exploration and understanding of the unique culture of the family, so the service plan will be a plan the child and family will support and utilize. The family's culture is influenced by family relationships, rituals, social relationships, living environment, work environment, spiritual focus, health, financial situation and other factors.
3. Recording of the child and family's vision of a desired future.
4. Identifying the needs and areas of focus that must be addressed to move toward this desired future.

Additional Activities



Child & Family Team Practice:

CFT Formation

In conjunction with the family, the behavioral health service provider facilitates the identification, engagement and participation of additional family members, close family friends, appropriate clinical expertise, and other potential CFT members including partner agencies such as Child Protective Services (CPS), Division of Developmental Disabilities (DDD), juvenile justice, and education. One of the goals is to strengthen or help to build a natural and community based social support network for the family.

The size, scope and intensity of the involvement of CFT members is driven by the needs and desires of the child and family. The CFT may consist of only the child, a parent and the identified behavioral health service provider or may be larger if the child and family are involved with other systems, have complex needs or have an extensive natural support system. When Child Welfare is the identified guardian, inclusion of the child's family members in the CFT is critical especially, but not limited to, when reunification is an identified goal. Members of the CFT may be added or removed as the needs and strengths of the child and family change over time. The CFT is only one piece of Child and Family Team practice.

Additional Activities





Child & Family Team Practice:

<p>Behavioral Health Service Plan – Development</p>	<p>The foundation for plan development begins when the child and family participate in the assessment process. The Behavioral Health Service Plan describes the family’s vision for the future (stated in their own language) and identifies the short-term objectives, interventions, supports and services that will address their identified and prioritized needs. The CFT members engage in brainstorming options and identify creative and nontraditional approaches, including formal and natural supports, for meeting the needs of the child and family. During this activity the CFT is to give careful consideration and weight to the child and family’s preferences, strengths, culture and the parent’s expert knowledge of their own child. Objectives that can be readily accomplished and celebrated within a short timeframe are identified to encourage early success and continued involvement and achievement.</p>
<p>Ongoing Crisis, Safety, and Wellness Planning</p>	<p>CFT practice includes planning for crisis situations and addressing ongoing safety issues. Crisis planning includes specific objectives and strategies to ensure timely availability of necessary supports and interventions in a crisis situation. Crisis situations refer to situations which pose a significant safety risk to the child, family, or community, including violent behaviors, self-injurious behaviors, running away, setting fires, etc. Crisis plans provide for 24 hour-a-day responsiveness and address the question, “What might go wrong that would divert the CFT from successfully implementing the activities in the Service Plan?” Through using creative thinking the CFT members identify the most likely crisis situations for a particular child and/or family. The CFT members then develop a plan to prevent these potential crisis situations from occurring, as well as an approach for responding most effectively should one of these situations occur. Crisis planning includes recognizing when a situation is escalating and how to best defuse the situation or obtain assistance to prevent further escalation.</p> <p>Safety planning is addressed by the CFT when there is solid evidence of prior unsafe behavior toward others that threatens the chance the child/youth can remain/return to living in his/her community. Effective safety planning includes preventive approaches for potential unsafe behaviors or situations. Effective safety planning also identifies interventions to be implemented and the persons responsible for each intervention when the unwanted behavior is attempted or occurs.</p>

Additional Activities

CFT Practice





Child & Family Team Practice:

Behavioral Health Service Plan – Implementation

Based upon the recommendations and decisions of the CFT, the behavioral health service provider is responsible for overseeing and facilitating the effective implementation of the Service Plan. Effective implementation includes the provision of covered behavioral health services, and initiating action for those services requiring prior authorization in accordance with ADHS/DBHS' policy.

Behavioral health service planning includes tasks or activities assigned to specific CFT members for completion outside of planning meetings. Some assignments may consist of specific activities or ways for interacting with the child to reinforce a particular behavior. CFT members are expected to make reasonable efforts to carry out their assigned responsibilities within the agreed timeframes. In a situation where a particular CFT member fails to complete an assigned task, the behavioral health service provider is responsible for taking two actions. First, to determine if there is a barrier or a change in priorities/needs that is preventing completion. And second, to explore and implement options for resolution with the team, supervisors or other resources. When an activity, support or service cannot be secured in a timely manner, even with such assistance, or the barrier is a system's issue, the behavioral health service provider elevates the issue within the T/RBHA system for additional assistance and resolution. Alternative or interim strategies may be presented to the CFT for consideration.

Additional Activities



Child & Family Team Practice:

Tracking and Adapting

Child and Family Teams require ongoing follow-up between meetings. The behavioral health service provider ensures: that engagement continues with the child, family and other team members; services are being implemented and are achieving expected results; and assignments are completed. The frequency of ongoing meetings are scheduled in relation to the child/family's situation, preferences, severity of need, level of progress or barriers to progress, and the plan's target dates.

The Service Plan includes short-term, observable/measurable goals with indicators to objectively track progress made over time.

The CFT is responsible for tracking and monitoring outcomes related to goals/objectives in the Service Plan. A lack of progress and/or incomplete follow-through on assignments can indicate that certain strategies or interventions are not working. The behavioral health service provider facilitates the CFT in refining existing strategies or developing new interventions.

The behavioral health service provider is also responsible for tracking the effectiveness of the crisis and safety planning interventions. After these actions or interventions have been implemented and "tested," the CFT reviews their effectiveness and when indicated incorporates modifications to increase their effectiveness. This review of effectiveness should occur shortly after the crisis situation has stabilized.

Additional Activities



Child & Family Team Practice:

Transition

Child and Family Teams develop plans that support the child and family by maintaining positive outcomes throughout periods of transition. Transition planning activities can include some of the following situations:

1. Changes in living environment, relationships and school settings
2. Admission/discharge to and from higher levels of care
3. Shifting from the children's service delivery system into the adult service system
4. Transforming Child and Family Teams into functioning Adult Clinical Teams
5. Successful completion of goals and disenrollment from behavioral health services

Planning for transition when a youth has been receiving long-term or intensive behavioral health services begins at the age of 16. When planning for transition into the adult behavioral health system a request to determine SMI eligibility can occur at age 17. The youth and legal guardian, if involved, may request to retain his/her current Child and Family Team until the youth turns 21. Adult Clinical Team membership may change based on the needs of the youth as she/he matures out of the children's system. If a new provider will be involved with a youth in the adult behavioral health system, key professionals from the adult service system are invited to join the CFT to facilitate a smooth transition and support the continuity of team practice.

[Additional Activities](#)



Goals

Children's System of Care Network Development Plan: Under the Jason K. (JK) Settlement Agreement the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and the Arizona Health Care Cost Containment System (AHCCCS) have agreed to prepare an Annual Action Plan that (1) describes progress made during the past year (e.g., 11/1/07 to 06/30/08) as it relates to each obligation and the 12 Principles laid out in the Settlement Agreement; and (2) sets forth major strategies and activities that will be employed over the coming year to meet the State's obligation under the Settlement Agreement.

http://www.azdhs.gov/bhs/childrenplan_0806.pdf

Goal 1	Develop a statewide quality management system for children's services that strengthens practice according to the Arizona 12 Principles.
Goal 2	Implement a children's statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.
Goal 3	Develop strong technical assistance initiatives to strengthen Child and Family Team Practice in accordance with the Arizona 12 Principles
Goal 4	Involve youth and families in improving the behavioral health system.



Goal 1 – Develop a statewide quality management system for children’s services that strengthens practice according to the Arizona 12 Principles.

Objective 1.1	Implement an in-depth, statewide tool and process that reviews practice and adherence to the Child and Family Team Practice and 12 Principles.
Objective 1.2	Promote adherence to the Arizona 12 Principles and Child and Family Team practice through the use of Quality Management measures at the ADHS, T/RBHA, and Provider levels.
Objective 1.3	Publish and disseminate practice review findings and quality management information.

Arizona's System of Care for Children/Adolescents



Goal 1 – Develop a statewide quality management system for children’s services that strengthens practice according to the Arizona 12 Principles.

Objective 1.1 – Implement an in-depth, statewide tool and process that reviews practice and adherence to the Child and Family Team Practice and 12 Principles.

Task 1.1.1	Fully implement the “gold standard” reviewer qualification process to qualify all existing and new reviewers to administer the Document Review Measure Process.
Task 1.1.2	Continue to maintain a list of qualified reviewers for the Wraparound Fidelity Assessment System (WFAS) including the Wraparound Fidelity Index (WFI) and Document Review Measure (DRM).
Task 1.1.3	Oversee completion of Wraparound Fidelity Index (interviews) for each child-serving agency using family organizations.
Task 1.1.4	Oversee T/RBHA completion of Document Review Measure (chart reviews) for child-serving agencies.
Task 1.1.5	Conduct data verification activities and inter-rater reliability checks.
Task 1.1.6	Arrange for additional reviewer training, as needed.
Task 1.1.7	Develop process for reviewing practice for low/moderate needs children.
Task 1.1.8	Develop sampling methodology for practice review of low/moderate needs children.

Additional Objective 1.1

Arizona's System of Care for Children/Adolescents



Goal 1 – Develop a statewide quality management system for children’s services that strengthens practice according to the Arizona 12 Principles.

Objective 1.1 – Implement an in-depth, statewide tool and process that reviews practice and adherence to the Child and Family Team Practice and 12 Principles.

Task 1.1.9	Conduct pilot of practice review process for low /moderate needs children.
Task 1.1.10	Begin review process for low/moderate needs children.
Task 1.1.11	Oversee completion of practice review process for low/moderate needs children.
Task 1.1.12	Develop work plan for transitioning management of the WFI, DRM, and low/moderate needs process to the T/RBHAs.
Task 1.1.13	Implement transition of the WFI, DRM, and low/moderate needs process to the T/RBHAs.
Task 1.1.14	Monitor T/RBHA process for completion of Wraparound Fidelity Index (interviews) for each child-serving agency using family organizations.
Task 1.1.15	Monitor T/RBHA process for completion of Document Review Measure (chart reviews) for child-serving agencies.
Task 1.1.16	Monitor T/RBHA process for completion of low/moderate needs review process.
Task 1.1.17	Conduct data verification activities and inter-rater reliability checks.

Arizona's System of Care for Children/Adolescents



Goal 1 – Develop a statewide quality management system for children’s services that strengthens practice according to the Arizona 12 Principles.

Objective 1.2 – Promote adherence to the Arizona 12 Principles and Child and Family Team practice through the use of Quality Management measures at the ADHS, T/RBHA, and Provider levels.

Task 1.2.1	Evaluate T/RBHA performance on Children's System performance measures.
Task 1.2.2	Review T/RBHA Quality Management Plans to ensure incorporation of Wraparound Fidelity Assessment System (WFAS) measures and other children’s system performance measures.
Task 1.2.3	Assess practice review findings and other children’s system performance measures in Quality Management Committee and make recommendations, as appropriate.
Task 1.2.4	Require T/RBHAs and providers to develop performance improvement plans based on practice review results and other children’s system performance measures, as applicable.
Task 1.2.5	ADHS will monitor the implementation of T/RBHA performance improvement plans.
Task 1.2.6	ADHS will monitor the implementation of the Child and Family Team Practice Improvement.

Arizona's System of Care for Children/Adolescents



Goal 1 – Develop a statewide quality management system for children’s services that strengthens practice according to the Arizona 12 Principles.

Objective 1.3 – Publish and disseminate practice review findings and quality management information.

Task 1.3.1	Post Wraparound Fidelity Index (WFI) and Document Review Measure (DRM) findings to the ADHS website.
Task 1.3.2	Provide reports to T/RBHAs and providers based on findings from review process for low/moderate needs children.
Task 1.3.3	Post findings from practice reviews for low/moderate needs children to the ADHS website.

Arizona's System of Care for Children/Adolescents



Goal 2 – Implement a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.

Objective 2.1	Conduct ongoing network analysis of case manager capacity in order to provide case managers for all children with complex behavioral health needs.
Objective 2.2	Expand the capacity and quality of Support and Rehabilitation Services, and of specialty Clinical Services.
Objective 2.3	Expand capacity in Substance Abuse Services and incorporate goals into the System of Care development planning process.
Objective 2.4	Implement the revised intake, assessment, and service planning process and adjust current policy and practice related to this process.
Objective 2.5	Implement T/RBHA Child and Family Team expansion plans to serve all enrolled children and families through the Child and Family Team practice.
Objective 2.6	Promote the use of Functional Behavioral Assessment/Analysis and Positive Behavioral Support strategies using existing covered behavioral health services.
Objective 2.7	Enhance service delivery, for young adults ages 18-21, in accordance with the Arizona 12 Principles
Objective 2.8	Enhance Home Care Training to Home Care Client (HCTC) services for children, adolescents and young adults.
Objective 2.9	Enhance behavioral health services for children, birth to five.
Objective 2.10	Implement the Child and Adolescent Service Intensity Instrument (CASII).



Goals



Arizona's System of Care for Children/Adolescents



Goal 2 – Implement a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.

Objective 2.1 – Conduct ongoing network analysis of case manager capacity in order to provide case managers for all children with complex behavioral health needs.

Task 2.1.1	Modify the Client Information System (CIS) to identify and track case manager assignment information.
Task 2.1.2	Require each T/RBHA to incorporate Case Manager expansion goals, as part of their Annual System of Care goals.
Task 2.1.3	Monitor T/RBHA Case Manager expansion goals.
Task 2.1.4	Maintain quarterly monitoring of the percent of children with complex behavioral health needs who have an assigned case manager using Client Information System (CIS) demographics.

Arizona's System of Care for Children/Adolescents



Goal 2 – Implement a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.

Objective 2.2 – Expand the capacity and quality of Support and Rehabilitation Services, and of specialty Clinical Services.

Task 2.2.1	ADHS will set expansion expectations to continue the development of Support and Rehabilitation Services, where indicated in the T/RBHA System of Care Plans.
Task 2.2.2	ADHS will monitor the T/RBHA’s growth in Support and Rehabilitation Services.
Task 2.2.3	ADHS will provide ongoing technical assistance to T/RBHAs and providers in developing increased capacity to provide Support and Rehabilitation Services or agencies interested in becoming new Support and Rehabilitation Services providers.
Task 2.2.4	The Support and Rehabilitation Steering Committee will guide and monitor implementation of the “Meet Me Where I Am” campaign with input from local design teams which include family and stakeholder agency representation.
Task 2.2.5	ADHS will provide ongoing coaching to T/RBHAs and providers aimed at supporting continued skill development around incorporating Support and Rehabilitation Services in Child and Family Team practice.
Task 2.2.6	Address how to best incorporate E-learning Modules at T/RBHA and Provider level in the MMWIA Steering Committee.
Task 2.2.7	ADHS will monitor T/RBHA Support and Rehabilitation expansion to apply future incentives based on inventory information, network indicators and other available quantitative and qualitative data.

Arizona's System of Care for Children/Adolescents



Goal 2 – Implement a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.

Objective 2.3 – Expand capacity in Substance Abuse Services and incorporate goals into the System of Care development planning process.

Task 2.3.1	ADHS will establish a baseline of T/RBHA Substance Abuse Programs or Service providers and specialty clinicians delivering adolescent substance abuse services.
Task 2.3.2	ADHS will monitor T/RBHA System of Care Plans for adequacy in number and quality of Substance Abuse programs and/or providers and specialty clinicians identified in the plan.
Task 2.3.3	ADHS will support the implementation of Evidence Based and culturally appropriate practice using Substance Abuse Coordination (SAC) and Child/Adolescent State Infrastructure Grant (SIG) funds. These evidence based practices may include: Motivational Interviewing; Motivational Enhancement Therapy/Cognitive Behavioral Therapy; Brief Strategic Family Therapy; Adolescent Community Reinforcement Approach and Adolescent Matrix.
Task 2.3.4	ADHS will revise Practice Improvement Protocol #10, “Substance Abuse Treatment in Children” which includes a description of the elements or framework for a clinically sound substance abuse program.
Task 2.3.5	ADHS will evaluate the T/RBHAs Substance Abuse Treatment Services utilizing developed audit tool and provide the data to T/RBHAs.
Task 2.3.6	ADHS will require T/RBHAs to work with existing substance abuse programs, providers, and specialty clinicians to ensure substance abuse service conform to the elements identified in the Substance Abuse Treatment in Children Protocol.

Additional Objective 2.3

Arizona's System of Care for Children/Adolescents



Goal 2 – Implement a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.

Objective 2.3 – Expand capacity in Substance Abuse Services and incorporate goals into the System of Care development planning process.

Task 2.3.7	ADHS will require each T/RBHA to identify the Substance Abuse services needed for each Tribal Nation within their GSA and incorporate the needed services into their System of Care Plans.
Task 2.3.8	ADHS will require the T/RBHAs to set expansion goals based on baseline data, and the status of existing programs as measured by the elements of a sound program and incorporate these goals in their Children’s System of Care Plans.
Task 2.3.9	ADHS will monitor T/RBHA System of Care Plans for adequacy in number and quality of Substance Abuse programs and/or providers and specialty clinicians identified in the plan.
Task 2.3.10	ADHS will sponsor training, through the Substance Abuse Coordination (SAC) and State Infrastructure Grant (SIG) grants, in substance abuse treatment practices that are culturally sensitive for clinicians who work with Native American youth.
Task 2.3.11	ADHS will sponsor a Conference around Substance Abuse Treatment supported with the SAC and SIG grants.
Task 2.3.12	ADHS will host bi-monthly meetings with T/RBHA substance abuse leaders to develop a forum for sharing ideas and identify and solve potential barriers.
Task 2.3.13	Conduct substance abuse prevention coalition training and development in: growth management & sustainability, prevention theory, and environmental strategies for substance abuse prevention.



Goal 2 – Implement a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.

Objective 2.4 – Implement the revised intake, assessment, and service planning process and adjust current policy and practice related to this process.

Task 2.4.1	ADHS will publish a Behavioral Health Assessment and Service Planning Practice Protocol that outlines required service expectations including essential elements for the Birth to Five assessment and service planning processes.
Task 2.4.2	ADHS will modify policies and procedures to communicate revisions to the intake, assessment, and service planning processes to the system.
Task 2.4.3	Provide training to T/RBHA and provider staff regarding changes to the intake, assessment, and service planning process.
Task 2.4.4	ADHS will provide ongoing technical assistance, as needed, to T/RBHA and providers to support the implementation of the revised process.

Arizona's System of Care for Children/Adolescents



Goal 2 – Implement a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.

Objective 2.5 – Implement T/RBHA Child and Family Team expansion plans to serve all enrolled children and families through the Child and Family Team practice.

Task 2.5.1	Monitor Child and Family Team expansion using Client Information System (CIS) data and other reports to assess adequacy of progress.
Task 2.5.2	Based on progress toward goals the Quality Management Committee will recommend an appropriate course of action (Corrective Action Plan, Notice to Cure or Sanction.) to keep the expansion on track.



Goal 2 – Implement a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.

Objective 2.6 – Promote the use of Functional Behavioral Assessment/Analysis and Positive Behavioral Support strategies using existing covered behavioral health services.

Task 2.6.1	Provide training in Positive Behavioral Support through Module 3 of the “Meet Me Where I Am” Campaign, or the e-learning version of that training, as well as other training regarding positive behavior support.
Task 2.6.2	ADHS will provide, directly or through contract, ongoing technical assistance to T/RBHAs and providers aimed at supporting continued skill development around Functional Behavioral Analysis and Positive Behavioral Support.
Task 2.6.3	Develop a Practice Protocol on the role of Functional Behavioral Analysis and Positive Behavioral Support in the behavioral health system, including how to promote its effective use.
Task 2.6.4	ADHS will monitor availability of staff trained in Functional Behavioral Analysis and Positive Behavior Support strategies through T/RBHA System of Care Plans.

Arizona's System of Care for Children/Adolescents



Goal 2 – Implement a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.

Objective 2.7 – Enhance service delivery, for young adults ages 18-21, in accordance with the Arizona 12 Principles

Task 2.7.1	Provide technical assistance to T/RBHAs to ensure adherence to service delivery and service planning to the Arizona 12 Principles and Practice Protocol <u>Transitioning to Adulthood</u> .
Task 2.7.2	Require each T/RBHA to develop System of Care plan objectives focused on coordination strategies that support a seamless transition of young adults from the Child and Adolescent to the Adult behavioral health system.
Task 2.7.3	ADHS will require T/RBHAs to develop transition planning guidance which includes strategies to increase planning meetings through a joint child and adult team process which starts at least 6 months prior to the young adult turning 18. The transition planning guidance will incorporate the elements of the ADHS Transition to Adulthood Practice Protocol.
Task 2.7.4	Each T/RBHA will identify a group of young adults (ideally 20% of transition aged youth) transferring to the adult system that will have a joint child and adult teams working on the transition for at least 6 months prior to the young adult turning 18 years of age and will send a quarterly report to DBHS.
Task 2.7.5	ADHS will require each T/RBHA to incorporate, into their System of Care Plans, incremental increases in the number of joint transition planning processes until all young adults, of transitioning age, have joint planning by July 2009.
Task 2.7.6	Identify and publish best practice models for youth/transition age young adult’s employment/pre-job training services.

Additional Objective 2.7

Arizona's System of Care for Children/Adolescents



Goal 2 – Implement a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.

Objective 2.7 – Enhance service delivery, for young adults ages 18-21, in accordance with the Arizona 12 Principles

Task 2.7.7	Provide technical assistance to T/RBHA Business/Vocational and Housing Coordinators on best practice models.
Task 2.7.8	Inventory current employment services for eligible young adults to develop a baseline of available services.
Task 2.7.9	Incorporate expansion and utilization goals for employment services for Title Nineteen (TXIX) eligible young adults in T/RBHA System of Care Plans.
Task 2.7.10	Inventory the currently available housing services for young adults 18 – 21 years to develop a baseline on available services or units.
Task 2.7.11	As funds are available, develop new housing units for independent living.
Task 2.7.12	ADHS will host a quarterly Transition to Adulthood forum with T/RBHA Children and Adult staff, system partner identified transition leads from CPS/DES, RSA, DDD, ADE, and ADJC to share ideas, brainstorm and problem solve to improve the process of transitioning to adulthood young adults.

Arizona's System of Care for Children/Adolescents



Goal 2 – Implement a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.

Objective 2.8 – Enhance Home Care Training to Home Care Client (HCTC) services for children, adolescents and young adults.

Task 2.8.1	ADHS will require the T/RBHAs to set HCTC expansion goals based on baseline data and incorporate these goals in their System of Care Plans.
Task 2.8.2	ADHS will monitor T/RBHAs to ensure that training requirements for the HCTC Curriculum have been met.



Goal 2 – Implement a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.

Objective 2.9 – Enhance behavioral health services for children, birth to five.

Task 2.9.1	ADHS will publish a Birth to Five Practice Protocol and provide training and technical assistance on the protocol.
Task 2.9.2	Develop an infant behavioral health state plan to identify approaches to better serve children birth to 5 years.
Task 2.9.3	Survey workforce that has received training around serving children 0-5 to determine additional training needs.
Task 2.9.4	Identify additional workforce development strategies through the use of State Infrastructure Grant funds to continue improving services for children Birth to 5 Years of age.
Task 2.9.5	Monitor T/RBHA workforce development to serve children 0-5.



Goal 2 – Implement a children’s statewide service delivery system in accordance with the Arizona 12 Principles and Child and Family Team Practice.

Objective 2.10 – Implement the Child and Adolescent Service Intensity Instrument (CASII).

Task 2.10.1	Provide training on the CASII Protocol to T/RBHA Training Coordinators and Provider Agency Clinical Directors.
Task 2.10.2	Monitor fidelity of CASII training at T/RBHA level.
Task 2.10.3	Develop a data collection system that can track Child and Adolescent Services Intensity Instrument (CASII) data and make reports available at the ADHS, T/RBHA and Provider levels.
Task 2.10.4	Develop method to monitor fidelity to CASII tool.
Task 2.10.5	Provide and continue follow-up technical assistance for the Child and Adolescent Services Intensity Instrument (CASII) training of trainers.



Goal 3 – Develop strong technical assistance initiatives to strengthen Child and Family Team Practice in accordance with the Arizona 12 Principles

Objective 3.1	Enhance clinical supervision and coaching to promote the development of practice improvement strategies
Objective 3.2	Enhance training to develop and strengthen the behavioral health workforce.
Objective 3.3	Enhance monitoring to ensure appropriate implementation and utilization of ADHS practice protocols, technical assistance, training, and supervision requirements.
Objective 3.4	Improve access of quality behavioral health services to diverse populations by promoting, developing, and maintaining a culturally and linguistically competent children's behavioral health system.





Goal 3 – Develop strong technical assistance initiatives to strengthen Child and Family Team Practice in accordance with the Arizona 12 Principles

Objective 3.1 – Enhance clinical supervision and coaching to promote the development of practice improvement strategies

Task 3.1.1	ADHS will continue hosting statewide quarterly Child and Family Team Coaches meetings to discuss training, mentoring, and technical assistance needs and approaches as identified by the Coaches and ADHS.
Task 3.1.2	ADHS will develop recommendations for core clinical supervision standards, practices and competencies as these apply to Child and Family Team Practice.
Task 3.1.3	The Monitoring and Oversight Office of QM Operations will conduct ongoing monitoring reviews of implementation and adherence to ADHS initiatives and required Practice Protocol elements.



Goal 3 – Develop strong technical assistance initiatives to strengthen Child and Family Team Practice in accordance with the Arizona 12 Principles

Objective 3.2 – Expand the capacity and quality of Support and Rehabilitation Services, and of specialty Clinical Services.

Task 3.2.1	Provide training on the Child and Family Team Practice Protocol to T/RBHA Training Coordinators and Provider Agency Clinical Directors and continue technical assistance to T/RBHAs and providers.
Task 3.2.2	Provide training and technical assistance as indicated by Wraparound Fidelity Assessment System (WFAS) results.
Task 3.2.3	Provide training to T/RBHAs and providers via Module # 6 (Supervising and Enhancing the Quality of Support Service Provision) of the Meet Me Where I Am training curriculum.
Task 3.2.4	Research and identify best practices in Trauma Focused Care for statewide training opportunities.
Task 3.2.5	Provide Training in Trauma Focused Care through the State Infrastructure Grant (SIG).
Task 3.2.6	As Practice Protocols are developed or revised, plan and schedule training and technical assistance for the T/RBHAs and providers.
Task 3.2.7	Design training curriculum for educators and behavioral health staff targeted at educating the school system about CFTs, the BH system about educational processes and the role of educators on Child and Family Teams.
Task 3.2.8	Roll-out the training curriculum for educators and behavioral health staff to support collaboration between the education and behavioral health systems through CFT practice.



Goal 3 – Develop strong technical assistance initiatives to strengthen Child and Family Team Practice in accordance with the Arizona 12 Principles

Objective 3.3 – Enhance monitoring to ensure appropriate implementation and utilization of ADHS practice protocols, technical assistance, training, and supervision requirements.

Task 3.3.1	ADHS will conduct ongoing monitoring reviews of implementation and adherence to ADHS initiatives and required Practice Protocol elements.
Task 3.3.2	Utilizing the Monitoring and Oversight reports, ADHS will provide technical assistance for personnel who facilitate or participate in Child and Family Teams.
Task 3.3.3	ADHS will monitor the roll-out of the Unique BH Service Needs of Children, Youth and Families involved with CPS training.



Goal 3 – Develop strong technical assistance initiatives to strengthen Child and Family Team Practice in accordance with the Arizona 12 Principles

Objective 3.4 – Improve access of quality behavioral health services to diverse populations by promoting, developing, and maintaining a culturally and linguistically competent children’s behavioral health system.

Task 3.4.1	ADHS will develop a Cultural Competency Plan that meets the requirements of AHCCCS Cultural Competency Policy.
Task 3.4.2	Work with T/RBHA Cultural Consultants to develop contractor Cultural Competency Plans that meets the requirements of the ADHS Policy CO 1.2 Cultural Competency
Task 3.4.3	Continue to facilitate monthly Cultural Competency Advisory Committee with T/RBHA representatives to monitor the effectiveness of Annual Cultural Competency Plans.
Task 3.4.4	ADHS will develop a Cultural Competency Plan that meets the requirements of AHCCCS Cultural Competency Policy.



Goal 4 – Involve youth and families in improving the behavioral health system.

Objective 4.1	The Family Committee, consisting of family representatives from across the state, will continue to review quality management data, gather feedback from their local communities, and make recommendations to ADHS for system improvement.
Objective 4.2	Strengthen family involvement in an effort to enhance positive outcomes for children and families.
Objective 4.3	Strengthen youth involvement to enhance positive outcomes for children and families.



Goal 4 – Involve youth and families in improving the behavioral health system.

Objective 4.1 – Enhance clinical supervision and coaching to promote the development of practice improvement strategies

Task 4.1.1	ADHS will incorporate “Roles of Families in the Children’s Behavioral Health System”, developed by the Family Committee, into Practice Protocol and/or other guidance documents.
Task 4.1.2	The Family Committee will recommend strategies to strengthen the role of family support in the behavioral health system, including how family support can be included in service planning.
Task 4.1.3	The Family Committee will identify quality management issues or concerns that are brought back by the Geographical Service Area’s respective communities.
Task 4.1.4	The Family Committee will participate in the Children’s System practice improvement review process and monitor the data which comes from that process.
Task 4.1.5	The Family Committee will review and provide feedback on various Quality Management reports and other system information.
Task 4.1.6	ADHS will utilize recommendations from the Family Committee in the oversight of the children’s system.



Goal 4 – Involve youth and families in improving the behavioral health system.

Objective 4.2 – Expand the capacity and quality of Support and Rehabilitation Services, and of specialty Clinical Services.

Task 4.2.1	ADHS will continue to host the Statewide Support and Rehabilitation Steering Committee, maintaining 25% family member participation, to guide expansion of support and rehabilitation services.
Task 4.2.2	ADHS will include family participation in its annual Quality Management Plan.
Task 4.2.3	ADHS will review T/RBHA Quality Management Plans to ensure incorporation of family involvement.
Task 4.2.4	ADHS will monitor T/RBHAs to assure minimum of 25% family members are sitting on the local Support and Rehabilitation Design Teams and the local Wraparound Fidelity Assessment System (WFAS) Task Forces.
Task 4.2.5	The ADHS led Arizona Children's Executive Committee (ACEC) will solicit input from its Family Involvement Subcommittee which is comprised of family members from across the state.
Task 4.2.6	ADHS will support family involvement, at all levels, by providing stipends for family/youth participation in meetings and other events.
Task 4.2.7	ADHS will utilize the recommendations of the Family Committee to develop a common definition of Family Support Partner and a description of the functions that make up a Family Support Partner position within the behavioral health system.



Goal 4 – Involve youth and families in improving the behavioral health system.

Objective 4.3 – Strengthen youth involvement to enhance positive outcomes for children and families.

Task 4.3.1	Explore opportunities for youth involvement in developing a web page for youth that is linked to the ADHS web home page.
Task 4.3.2	Utilize web page to seek youth input on ADHS initiatives.
Task 4.3.3	Continue to support the ADHS Youth Advisory Council.
Task 4.3.4	Require T/RBHAs to develop and/or maintain Youth Advisory Councils in their System of Care plan.



ADHS System's Change Process—Mechanisms to communicate how the system should practice according to Arizona's 12 Principles

<p>ADHS Provider Manual</p>	<p>ADHS/DBHS has developed the statewide Provider Manual to articulate the requirements of the Arizona public behavioral health system. The ADHS/DBHS Provider Manual contains requirements applicable to direct providers of Arizona's publicly funded behavioral health services. Each Tribal and Regional Behavioral Health Authority (T/RBHA) adds geographic specific area information and creates a T/RBHA specific version of the document. http://www.azdhs.gov/bhs/provider/provider_main.htm</p>
<p>ADHS Policy and Procedure Manual</p>	<p>ADHS/DBHS has developed policies and procedures designed to communicate behavioral health system requirements to Tribal and Regional Behavioral Health Authorities (T/RBHAs) and T/RBHA subcontracted providers. http://www.azdhs.gov/bhs/policy.htm</p>
<p>T/RBHA contract provisions</p>	<p>ADHS/DBHS, either directly or through subcontractors, shall be responsible for the provision of all medically necessary covered behavioral health services to AHCCCS Title XIX, Title XXI and SSDI-TMC acute care members in accordance with applicable federal, state and local laws, rules, regulations and policies, including services described in the contract and those incorporated by reference throughout the contract and AHCCCS policies referenced in the contract. http://www.azdhs.gov/bhs/contracts/contracts.htm</p>
<p>Covered Services Guide</p>	<p>The Arizona Department of Health Services – Division of Behavioral Health Services (ADHS/DBHS) has developed a comprehensive array of covered behavioral health services that will assist, support and encourage each eligible person to achieve and maintain the highest possible level of health and self-sufficiency. http://www.azdhs.gov/bhs/bhs_guide.pdf</p>
<p>Practice Protocols</p>	<p>Under the direction of the Medical Director and Assistant Medical Director, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) has researched and published several best practices documents (also referred to as clinical guidance documents) to assist behavioral health providers in Arizona's public behavioral health system. These documents are known as Clinical and Recovery Practice Protocols. http://www.azdhs.gov/bhs/guidance/guidance.htm</p>

Additional Processes





ADHS System's Change Process—Mechanisms to communicate how the system should practice according to Arizona's 12 Principles

<p>Children's SOC Network Development Plan</p>	<p>Under the Jason K. (JK) Settlement Agreement the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) and the Arizona Health Care Cost Containment System (AHCCCS) have agreed to prepare an Annual Action Plan that (1) describes progress made during the past year (e.g., 11/1/07 to 06/30/08) as it relates to each obligation and the 12 Principles laid out in the Settlement Agreement; and (2) sets forth major strategies and activities that will be employed over the coming year to meet the State's obligation under the Settlement Agreement. http://www.azdhs.gov/bhs/childrenplan_0806.pdf</p>
<p>Interagency agreements with system partners</p>	<p>ADHS/DBHS has developed interagency agreements with the Arizona Department of Economic Security/Division of Developmental Disabilities, Arizona Administrative Office of the Courts, Arizona Department of Corrections, and the Arizona Department of Housing. The interagency agreements are for the purpose of ensuring coordinated efforts, for children and their families between the various state agencies. http://www.azdhs.gov/bhs/interagcyagrmts.htm</p>
<p>Administrative review standards</p>	<p>The purpose of the administrative review is to evaluate T/RBHA clinical, quality management, administrative, and financial performance as required by AHCCCS; assess additional areas of contractual performance; assess RBHA compliance with the BBA; validate T/RBHA strengths; establish baseline for system improvement; and identify training and technical assistance needs. The following areas are reviewed: Clinical Services, Cultural Competence, Grievance and Appeals, Financial Management, Financial Operations, Member Information, Network Services, Program Integrity, Provider Selection, Quality Management, Utilization Management. http://www.azdhs.gov/bhs/contracts/contracts.htm</p>
<p>Quality Management Plan standards</p>	<p>The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) Quality Management and Utilization Management Plan is designed to be a comprehensive document that incorporates and supports principles and strategic goals as they relate to the unique needs of the individuals served by the behavioral health delivery system. http://www.azdhs.gov/bhs/qm_plan.pdf</p>



Quality Management and Practice Improvement Processes

<p>Practice Improvement Review Process</p>	<p>According to the Jason K Settlement Agreement, Defendants shall change their quality management and improvement system so that it measures whether services to class members are consistent with and designed to achieve the Principles. The measurement process will include as an integral component, an in depth case review of a sample of individual children's cases that includes interviews of relevant individuals in the child's life. In changing their quality management and improvement system, Defendants will use lessons from the training program (see Section VI.A. above) and the 300 Kids Project (see Section VI.G. above). If Defendants choose to retain one or more consultants to help them design the measurement process, Defendants shall first notify Plaintiffs' counsel of the identity of the proposed consultant(s) and shall give serious consideration to Plaintiffs' counsel's input, if any, regarding the competency and qualifications of the proposed consultant(s).</p> <p>http://www.azdhs.gov/bhs/jkfinaleng.pdf</p>
<p>Practice Improvement Plan Development and Monitoring</p>	<p>The RBHAs monitor their providers on an ongoing basis utilizing a number of tools and data. If it is found that a provider agency is not practicing within the parameters established by ADHS/DBHS a practice improvement plan is developed to focus on coaching and training.</p>
<p>Assessment and CFT Chart Review Process</p>	<p>Office of Monitoring & Oversight completes a quarterly provider on-site review to assess the quality of services delivered and to perform data validation activities related to performance measures. ADHS/DBHS establishes a minimum compliance/performance threshold for each standard and Contractors are required to develop performance improvement activities when their performance is rated below the established minimum threshold. Chart review findings and corrective action plans for each Contractor are reviewed in the Quality Management Committee to ensure performance improves and compliance is achieved. The universal chart review tool is found in Plan Attachment 8, Audit Tools. In addition, ad hoc reviews are conducted when needed.</p> <p>http://www.azdhs.gov/bhs/qm_plan.pdf</p> <p>For further details, see the Covered Services guide at http://www.azdhs.gov/bhs/bhs_guide.pdf</p>

Additional Processes





Quality Management and Practice Improvement Processes

Practice Protocol and Program Area Monitoring

ADHS/DBHS assures that clinical guidance documents (Practice Protocols), including national accepted evidence-based Practice Guidelines are developed and disseminated for use by Contractors in providing care. Practice Protocols are reviewed every two years to determine adherence to national best practices, and are modified and/or updated as necessary.

ADHS/DBHS develops Practice Protocols as needed per Policy MI 5.1, *Division Document Development, Maintenance and Dissemination*. These documents are used to direct practice across the state, educate recipients and providers, provide the basis for utilization management decisions, and enhance service delivery. Practice Protocols with required implementation elements are incorporated by reference into applicable sections of the ADHS/DBHS Provider Manual. All practice protocols are available on the ADHS/DBHS website and to potential recipients upon request.

PRACTICE PROTOCOLS

Contractors are required to monitor the implementation of practice protocols and particularly protocols that contain required elements, which include but are not limited to

- Child and Family Team Practice
- Child and Adolescent Service Intensity Instrument (CASII)
- Support and Rehabilitation Services for Children, Adolescents and Young Adults
- Transition to Adulthood
- The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with CPS
- Out of Home Services
- Home Care Training
- Psychotropic Medication Use in Children, Adolescents & Young Adults
- Substance Abuse Treatment in Children, Adolescents & Young Adults

[More](#)

Additional Processes



Quality Management and Practice Improvement Processes

Practice Protocol and Program Area Monitoring (cont'd)

PROGRAM AREAS

Periodically ADHS/DBHS develops a program area that needs specific development to assure that the System of Care Network includes all of the services that are needed to provide comprehensive and up to date behavioral health services. These program areas must be monitored by the Contractor to assure that they meet the guidelines and expectations of ADHS/DBHS. These program areas include but are not limited to:

- Support and Rehabilitation Generalist Services
- Case Manager Expansion
- Substance Abuse Services
- Planning for, transitioning to, and receiving individualized services in the Adult System (Focused on those individuals 17 ½ to 21)

Note: Some Practice Protocols and Program Areas overlap and the monitoring of the Protocol and Program Area Requirements should be done at the same time.

MONITORING EXPECTATIONS/GUIDELINES

It is the expectation of ADHS/DBHS that contractors utilize and implement the following guidelines in their monitoring approach.

- Regular periodic reviews (approximately every 6 months) by staff of the Contractor with family recipient participation when possible.
- Data used as evidence of implementation must be observable and verifiable.
- Programs and providers must be monitored on site and not rely solely on self report or record reviews processes.
- DBHS must be able to accompany the Contractor staff in doing the monitoring review periodically as the means by which DBHS will monitor the Contractor to avoid duplication.
- The Contractor shall talk with both management and line staff as part of the monitoring process.
- Reports of the monitoring visit must be developed and maintained for use in providing feedback and for DBHS periodic review.
- Improvement expectations must be provided to address any areas where a protocol is not being followed and enforcement actions (including sanctions) must be implemented when necessary.

Additional Processes



Quality Management and Practice Improvement Processes

<p>Performance Measures</p>	<p>The <i>Quarterly Children's System of Care Performance Outcome Measure Report</i> highlights the Children's System of Care performance by presenting quarter 4 FY2008 data from the Functional Outcome Measures and Child and Family Team evaluation method. Further, it highlights progress made in regards to the Jason K Settlement. http://www.azdhs.gov/bhs/csocq4_08.pdf</p> <p><i>ADHS/DBHS Quarterly Contractor Performance Improvement Activity Report</i>: This quarterly report identifies contractor(s) performance and improvement activities related to AHCCCS prescribed Performance Measures. http://www.azdhs.gov/bhs/cpiq4_08.pdf</p>
<p>Structural Elements Report</p>	<p>The Structural Elements are a series of quality management reports that are utilized to measure growth within the children's behavioral health system. The reports cover a 12 month period in quarterly time intervals, to compare change over time. The structural elements data is collected from the T/RBHAs monthly and the reports are created and published quarterly; in January, April, July, and October. The structural elements information is displayed by T/RBHA and on a statewide basis including all T/RBHAs. http://www.azdhs.gov/bhs/measures/jkmeasures.htm</p>
<p>Administrative Review Process</p>	<p>Staff from all functional areas within ADHS/DBHS completes an annual on-site review to assess Contractor compliance with contractual requirements and standards and to perform data validation activities related to performance measures. ADHS/DBHS establishes a minimum compliance/performance threshold for each standard and Contractors are required to develop performance improvement activities when their performance is rated below the established minimum threshold. Administrative review findings and corrective action plans for each Contractor are reviewed through the Contractor Compliance Teams to ensure performance improves and compliance is achieved. http://www.azdhs.gov/bhs/qm_plan.pdf</p>

Additional Processes



Quality Management and Practice Improvement Processes

<p>Member Satisfaction Survey</p>	<p>The statewide consumer survey was conducted April through May 2007 jointly by the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS), Tribal/Regional Behavioral Health Authorities (T/RBHAs) and their contracted service providers. Two distinct surveys are administered based on the Substance Abuse and Mental Health Services Administration's Mental Health Statistics Improvement Program (MHSIP) consumer surveys: The Adult Consumer Survey The Youth Services Survey for Families (YSS-F). http://www.azdhs.gov/bhs/annual_report/consumer.pdf</p>
<p>Mystery Shopper</p>	<p>ADHS/DBHS works with the National Alliance for the Mentally Ill (NAMI) contractually to complete proxy calls to a sample of providers in each GSA to assess the accessibility of service and appointment availability. Results are trended and reviewed through the QM Committee with recommendations for follow-up activities given to the Contractor Compliance teams. http://www.azdhs.gov/bhs/qm_plan.pdf</p>
<p>Quality of Care Reviews</p>	<p>The DBHS Office of Medical Management receives, and is responsible for ensuring timely and appropriate resolution of, potential Quality of Care (QOC) issues involving Tribal or Regional Behavioral Health Authority (T/RBHA) consumers. These QOC issues can be received from behavioral health recipients, their families, providers, AHCCCS, the ADHS/DBHS Director, the Governor's Office, and other agencies. The DBHS (OMM) is staffed with individuals who have the necessary clinical, administrative, and quality assurance knowledge and expertise to facilitate the investigation, evaluation, analysis, resolution, closure, and trending of QOC issues and work in concert with the DBHS Medical Director to address QOC concerns. http://www.azdhs.gov/bhs/qm_plan.pdf</p>

Additional Processes





Success Stories

Cenpatico	<p>A young man was expelled from school for inappropriate behaviors and breach of his behavior contract. His CFT has been built up to help he and his family navigate through the school system requirements. Services have been put into place to aid with his behavior management by helping him learn techniques to reduce his anger outbursts and inappropriate behaviors. The young man has successfully been able to decrease his inappropriate behaviors and has shown an increase in respect for authority figures and peers. A recent meeting with school district officials demonstrated the new skills he has acquired. He was able to answer questions appropriately and respectfully. In addition, he wrote a letter to the school district superintendent explaining his desire to return to school.</p>
CPSA	<p>A young man initially entered the system due to legal involvement and abandonment issues by his family, he was close to being sent to detention. The CFT persuaded the judge to give him another chance in the community at a foster home placement. He was able to see that he needed more intensive structure in his life in order to succeed, and asked to participate in the Barber education program at Canyon State. The youth has now received his Barber's license, is excelling at school and has completed probation requirements. He will be returning to his hometown very soon, moving towards independent living with support from the Young Adult Team, has plans to graduate from high school within the next year, attend college and find a job.</p>



Success Stories

<p>CPSA</p>	<p>A child and his siblings were removed from their home and placed in an out of home setting. A CFT was formed and was able to work with the child's before/after school program, CPS and an Home Care Training to the Home Care Client (HCTC) service provider to keep him stable within the home. Services were put into place to help the child improve behaviors and social skills to maintain in current school and before/after school program. The CFT worked with school staff to develop and implement a behavior support plan. Services were also provided to teach coping and intervention skills for him and to teach the HCTC provider to use to prevent escalation of disruptive behaviors.</p>
<p>Magellan</p>	<p>A young boy was referred, by the CFT, to a support and rehabilitation agency for poor anger management (which included property damage and physical aggression towards self and others) and poor social interactions. He initially had been diagnosed with ADHD and a mood disorder but through the course of treatment the possibility of reactive attachment disorder was also discussed. The maladaptive behaviors exhibited were significant enough that at intake he was at risk of losing his current placement. The support and rehabilitation agency actively collaborated with the rest of the CFT team, which included CPS, East Valley Crisis Team, ASU equine therapy program, Black Family and Child Services, and the child's school. As a result of support and rehabilitation agency's services and those of the CFT Team, the child was able to successfully transition from the shelter to a therapeutic foster placement and be reunited with siblings. At graduation from services, the child had met all of their treatment objectives.</p>
<p>Magellan</p>	<p>The CFT referred a young man for behavioral health services due to a long history of assault behavior, including hitting and threatening peers at school, destroying school property, throwing objects at teachers, threatening his family, punching holes in walls at home. The child has an extensive history in Out of Home placements. Child Protective Services (CPS) placed him in a Therapeutic Group Home with CPS funding. The direct support staff worked with Mom while client was in placement to help her prepare for the child's transition back home. Upon his return home the behavior coaches worked with the entire family and the child. Since he has return home there have been no incidents of aggressive or violent behaviors and explosive episodes have diminished. Improved communication skills are preventing conflicts. Mom feels more secure in her new parenting techniques. The family is doing wonderful! Quotes from Mom, "We love the behavior coaches!" "We feel like they are part of our family." "They have helped our son to improve his behaviors; they really care about our son."</p>



Success Stories

<p>NARBHA</p>	<p>A child was referred, by their CFT, for services through a support and rehabilitation agency due to a recent disrupted adoptive placement and to help prevent future disruptions. The services were developed to focus on living Skills, Personal Care and Family Support. Specifically these services focused on developing improved social skills, age appropriate activities, self-control and interactions with others. The services have been a good fit and disruption to a higher level of care has been diverted. Reports of improvements include increased frequency of the child being able to approach siblings to request participation in games, less frequent, less severe, and shorter outbursts especially when in group activities, regular dining and conversation with family during evening hours and completion of daily homework with little redirection needed. The child's hygiene skills have also improved. The child's previous extreme behaviors have ceased and although the days vary, the child appears to be maximizing benefit from the services.</p>
<p>NARBHA</p>	<p>A child's CFT referred him for support in an attempt to keep him with his family and avoid placement in a Residential Treatment Center or a Detention Center due to ongoing contact with the Sheriff's Department as a result of being a danger to himself and others. Services were created to focus on personal care, life skills, social skills, and peer and family relationships in order to support this young man in remaining in the community. Supports have been utilized to provide this young man an opportunity to participate in family activities and community events which he was not able to do previously due to aggressive behaviors and safety concerns. This young man has also been able to attend social functions, trips to the community pool and barbeques at friend's homes. In addition, this young man has been able to improve his ability to read social cues, appropriate tone when speaking and recognize personal boundaries.</p>



Family Involvement

Office of Individual and Family Affairs:
within
ADHS/DBHS

The Office focuses on building partnerships with individuals, families, youth, communities, organizations and key stakeholders to promote recovery, resiliency and wellness. Activities of the office are conducted in collaboration with these partners, and include the following:

Developing and enhancing a variety of statewide initiatives to increase adult, youth and family voice and participation at all levels.

- Advocating for the development of environments that are supportive and welcoming to individuals, youth and families.
- Working with individuals, families and youth to identify concerns and remove barriers to inclusion and resolving issues impacting statewide behavioral health service delivery.
- Establishing structure and mechanisms necessary to increase the youth, adult and family voice in areas of leadership and service delivery throughout Arizona.
- Developing training, technical assistance and related instructional materials for persons served through the behavioral health system and their families in such areas as leadership and advocacy skills, program development, resource identification and coordination.
- Ensuring parent and peer support programs (self-help initiatives) are available to all persons receiving services and their families through T/RBHAs in Arizona.
- Establishing mechanisms, standards, and activities to monitor contractor and T/RBHA compliance.

[Plan Objective](#)

Continue



Family Involvement

<p>Family Involvement Center (FIC)</p>	<p>The Family Involvement Center is a not-for-profit family-directed organization that was founded in 2001. The majority of our employees and Board of Directors have personal life experience raising children with emotional, behavioral, and/or mental health challenges. www.familyinvolvementcenter.org</p> <p>Mission - Our mission is to assist and support families/caregivers, and help policy makers, agencies and providers transform systems, to ensure that children and youth with an emotional, behavioral, or mental health disorder succeed in school, live with their families, avoid delinquency, and become productive adults and youth.</p>
<p>Mentally Ill Kids in Distress (MIKID)</p>	<p>MIKID's history stemmed from one individual's overwhelming concern for the lack of services provided for children in the mental health field and the many serious issues that were not being properly addressed.</p> <p>MIKID was incorporated in Arizona in 1991. From 1990 until 1996, MIKID was a board-operated organization with an Office Manager and/or a Program Director on staff full time or part time as funds would allow. With continued growth, MIKID hired its first Executive Director in 1996. Governor Fife Symington signed a proclamation declaring March 11, 1997 as "MIKID Day" in recognition of its 10th birthday. http://www.mikid.org/</p> <p>Mission - To provide support and assistance to families in Arizona with behaviorally challenged children and young adults.</p>



System Partner Involvement

The Arizona Children's Executive Committee (ACEC)

The Arizona Children's Executive Committee (ACEC) was formed in 2002 in response to the Jason K. Settlement Agreement. The committee brings together multiple state agencies, government entities, community advocacy organizations, and parents 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. ACEC representatives work together to support the development and strengthening of local systems of care. To ensure the voice of the committee is heard at multiple levels, ACEC representatives are asked to share committee recommendations and updates with the senior leadership at each of their respective agencies.
<http://www.azdhs.gov/bhs/ACEC.htm>

Continue



System Partner Involvement

<p>Office of Individual and Family Affairs: within ADHS/DBHS</p>	<p>The Office focuses on building partnerships with individuals, families, youth, communities, organizations and key stakeholders to promote recovery, resiliency and wellness. Activities of the office are conducted in collaboration with these partners, and include the following:</p> <p>Developing and enhancing a variety of statewide initiatives to increase adult, youth and family voice and participation at all levels.</p> <ul style="list-style-type: none"> • Advocating for the development of environments that are supportive and welcoming to individuals, youth and families. • Working with individuals, families and youth to identify concerns and remove barriers to inclusion and resolving issues impacting statewide behavioral health service delivery. • Establishing structure and mechanisms necessary to increase the youth, adult and family voice in areas of leadership and service delivery throughout Arizona. • Developing training, technical assistance and related instructional materials for persons served through the behavioral health system and their families in such areas as leadership and advocacy skills, program development, resource identification and coordination. • Ensuring parent and peer support programs (self-help initiatives) are available to all persons receiving services and their families through T/RBHAs in Arizona. • Establishing mechanisms, standards, and activities to monitor contractor and T/RBHA compliance.
<p>System Partners</p>	<p>Arizona Department of Economic Security/Division of Developmental Disabilities: https://www.azdes.gov/ddd/</p> <p>Arizona Administrative Office of the Courts: http://www.supreme.state.az.us/nav2/aoc.htm</p> <p>Arizona Department of Corrections: http://www.adc.state.az.us/</p> <p>Arizona Department of Housing: http://www.housingaz.com/</p>



Community Involvement

Office of Individual and Family Affairs: within ADHS/DBHS

The Office focuses on building partnerships with individuals, families, youth, communities, organizations and key stakeholders to promote recovery, resiliency and wellness. Activities of the office are conducted in collaboration with these partners, and include the following:

Developing and enhancing a variety of statewide initiatives to increase adult, youth and family voice and participation at all levels.

- Advocating for the development of environments that are supportive and welcoming to individuals, youth and families.
- Working with individuals, families and youth to identify concerns and remove barriers to inclusion and resolving issues impacting statewide behavioral health service delivery.
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- Ensuring parent and peer support programs (self-help initiatives) are available to all persons receiving services and their families through T/RBHAs in Arizona.
- Establishing mechanisms, standards, and activities to monitor contractor and T/RBHA compliance.



Youth Involvement

Office of Individual and Family Affairs:
within
ADHS/DBHS

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Developing and enhancing a variety of statewide initiatives to increase adult, youth and family voice and participation at all levels.

- Advocating for the development of environments that are supportive and welcoming to individuals, youth and families.
- Working with individuals, families and youth to identify concerns and remove barriers to inclusion and resolving issues impacting statewide behavioral health service delivery.
- Establishing structure and mechanisms necessary to increase the youth, adult and family voice in areas of leadership and service delivery throughout Arizona.
- Developing training, technical assistance and related instructional materials for persons served through the behavioral health system and their families in such areas as leadership and advocacy skills, program development, resource identification and coordination.
- Ensuring parent and peer support programs (self-help initiatives) are available to all persons receiving services and their families through T/RBHAs in Arizona.
- Establishing mechanisms, standards, and activities to monitor contractor and T/RBHA compliance.



Youth Involvement

ADHS/DBHS
Youth Advisory
Council

Mission - To organize a united voice for Arizona's youth around substance abuse prevention, treatment and recovery and mental health rehabilitation through peer-to-peer messages of hope and empowerment via multi-media, education and community efforts developed and driven by Arizona's youth.

The Arizona Department of Health Services, Division of Behavioral Health Service (ADHS/DBHS) is looking for 12 people between the ages of 14 and 24 to join the Arizona Youth Advisory Council (AZ YAC).

The AZ YAC's activities will focus on skill building and incorporate the following opportunities: Leadership, Influence, Decision-Making, Voice, Sharing and Friendship.

WHO - Male and female youth aged 14-24 residing in Arizona who are enrolled in the Title XIX/XXI funded ADHS/DHBS Tribal/Regional Behavioral Health Authority (T/RBHA) system, former enrollees, youth advocates in support of our efforts, youth family members of enrollees and youth interested in influencing the way the community looks at Substance and Behavioral health issues affecting adolescents.

WHY - To promote the development of a strong and positive youth voice on Substance and Behavioral health issues affecting Arizona youth in order to improve and develop programs that are responsive to their needs.

[Plan Objective](#)



Youth Involvement

<p>CPSA</p>	<p>Welcome to YES, an initiative designed to help young people in elementary, middle, and high school better connect with their schools (and families) by building on their strengths and partnerships with adults to create healthier conditions in their school communities. Connectedness to school increases academic achievement and acts as a buffer against a myriad of negative outcomes such as academic failure; alcohol, tobacco, and other drug use; violence; teen pregnancy; suicide; depression; and delinquency.</p> <p>http://www.arizonayes.com/</p>
<p>Magellan</p>	<p>Magellan of Arizona is dedicated to improving the lives of youth who have experience living with mental illness and/or substance abuse.</p> <p>http://www.magellanofaz.com/azmem-en/getinvolved/youthinvolvement.aspx</p>
<p>Family Involvement Center</p>	<p>Mission - Through friendship we will find strength to overcome adversity, hope for a better future, advocate for ourselves and others, power to push forward and education to make it happen.</p> <p>http://familyinvolvementcenter.org/index.php?option=com_content&task=blogcategory&id=27&Itemid=193</p>
<p>MIKID – Youth Council</p>	<p>The Youth Advisory Council is a team of youth ages 13-21, who provide a valuable youth perspective to the community. The council will provide service projects and education. The council is a positive force for change.</p> <p>http://www.mikid.org/support_groups/support_groups.htm</p>



Provider Monitoring by T/RBHA

ADHS/DBHS requires its Contractors to conduct on-site provider monitoring no less than twice annually, for all subcontractor(s)/provider(s), and more frequently for providers who demonstrate poor performance. The Contractor must include a detailed provider-monitoring plan in their Annual Quality Management Plan, indicating the frequency and schedule of provider monitoring activities. Contractors are required to develop a mechanism for a focused visit to provider sites as a result of concerns identified. As part of its provider monitoring, Contractor(s) are required to implement processes for verifying the accuracy and timeliness of reported data; screen the data for completeness, logic, and consistency, and collect service information in standardized data quality formats as part of their provider monitoring programs.

<p>Provider Profiling</p>	<p>ADHS/DBHS requires its Contractors to complete 'Provider Profiles' at a minimum of quarterly, for all providers in their contracted network. Minimum provider profiling data elements are referenced in Plan Attachment 6, Provider Profiles, and include utilization management, cost effectiveness review, meeting access standards, patient satisfaction, outcomes assessment, population health, etc. This information must be used by Contractors to improve outcomes, make their practices more efficient, and for ongoing quality improvement. Contractor(s) must develop a 'Provider Profile' for each of its sites and subcontractors and take immediate action to address deficiencies and improve provider performance when problems or areas in need of improvement are identified. The performance improvement plans must include action(s) to be taken which may include education; follow-up monitoring/evaluation of improvement; sanctions, and/or terminating affiliation with the provider. The Contractor(s) must provide technical assistance as needed, as well as tracking and monitoring subcontractor(s) improvement activities. The information from this process must be utilized in the next monitoring cycle. The purpose of the provider monitoring process is to monitor and evaluate the service delivery system to promote improvement in the quality of care provided to Behavioral Health Recipients.</p>
<p>Prevention Providers</p>	<p>Contractors are required to assess the quality of each prevention program in its network annually. This evaluation must include an analysis of process and outcome data and on site visit(s). Contractors may choose not to conduct the onsite visit, and instead gather information through interviews with program staff. Contractors must provide written feedback to prevention programs at least once annually, which notes program successes and provides recommendations for improvement.</p> <p>http://www.azdhs.gov/bhs/qm_plan.pdf</p>





Practice Protocol Monitoring

ADHS/DBHS develops Practice Protocols as needed per Policy MI 5.1, Division Document Development, Maintenance and Dissemination. These documents are used to direct practice across the state, educate recipients and providers, provide the basis for utilization management decisions, and enhance service delivery. Practice Protocols with required implementation elements are incorporated by reference into applicable sections of the ADHS/DBHS Provider Manual. All practice protocols are available on the ADHS/DBHS website and to potential recipients upon request. <http://www.azdhs.gov/bhs/guidance/guidance.htm>

Practice Protocols

Contractors are required to monitor the implementation of practice protocols and particularly protocols that contain required elements, which include but are not limited to

- Child and Family Team Practice
- Child and Adolescent Service Intensity Instrument (CASII)
- Support and Rehabilitation Services for Children, Adolescents and Young Adults
- Transition to Adulthood
- The Unique Behavioral Health Service Needs of Children, Youth, and Families Involved with CPS
- Out of Home Services
- Home Care Training
- Psychotropic Medication Use in Children, Adolescents & Young Adults
- Substance Abuse Treatment in Children, Adolescents & Young Adults

http://www.azdhs.gov/bhs/qm_plan.pdf



Service Area Monitoring

<p>Program Areas</p>	<p>Periodically ADHS/DBHS develops a program area that needs specific development to assure that the System of Care Network includes all of the services that are needed to provide comprehensive and up to date behavioral health services. These program areas must be monitored by the Contractor to assure that they meet the guidelines and expectations of ADHS/DBHS. These program areas include but are not limited to:</p> <ul style="list-style-type: none"> • Support and Rehabilitation Generalist Services • Case Manager Expansion • Substance Abuse Services • Planning for, transitioning to, and receiving individualized services in the Adult System (Focused on those individuals 17 ½ to 21) <p>Note: Some Practice Protocols and Program Areas overlap and the monitoring of the Protocol and Program Area Requirements should be done at the same time.</p>
<p>Monitoring Expectations/ Guidelines</p>	<p>It is the expectation of ADHS/DBHS that contractors utilize and implement the following guidelines in their monitoring approach.</p> <ul style="list-style-type: none"> • Regular periodic reviews (approximately every 6 months) by staff of the Contractor with family recipient participation when possible. • Data used as evidence of implementation must be observable and verifiable. • Programs and providers must be monitored on site and not rely solely on self report or record reviews processes. • DBHS must be able to accompany the Contractor staff in doing the monitoring review periodically as the means by which DBHS will monitor the Contractor to avoid duplication. • The Contractor shall talk with both management and line staff as part of the monitoring process. • Reports of the monitoring visit must be developed and maintained for use in providing feedback and for DBHS periodic review. • Improvement expectations must be provided to address any areas where a protocol is not being followed and enforcement actions (including sanctions) must be implemented when necessary. <p>http://www.azdhs.gov/bhs/qm_plan.pdf</p>



Coaching and Training

According to the Jason K Settlement Agreement the Defendants will take the following specific actions (a) develop and implement a statewide training program, as described in paragraphs 32-39 below:

Paragraph 32	Defendants shall develop and implement a statewide training program focusing on collaboration, assessment, service planning and implementation, and on maximizing the use of monies for Title XIX services in the context of managed care.
Paragraph 33	Defendants shall identify persons to be trained and a training schedule. Initial priority shall be given to the training of people designated to “train the trainers” and to agencies and personnel involved in planning or delivery of behavioral health services for the 300 Kids Project and other multi-agency children.
Paragraph 34	ADHS/DBHS will designate up to \$2 million to be allocated over a three-year period as necessary to design and implement the statewide training program. 35. The training program will be designed to provide front-line staff and supervisors sufficient knowledge and skills to enable them to plan and provide services consistent with the Principles.
Paragraph 36	The training program will have an on-the-job “hands-on” component for front-line staff and supervisors, in addition to a classroom component. In the on-the-job component, trainers will coach and mentor front-line staff and supervisors in effective techniques and approaches
Paragraph 37	Defendants will develop and implement a pilot training program for the 300 Kids Project. Using lessons learned from the pilot program and other information, Defendants will develop and implement a comprehensive training plan.



Coaching and Training

<p>Paragraph 38</p>	<p>The comprehensive training plan will include the following:</p> <p>A. Learning opportunities that teach, at a minimum:</p> <ol style="list-style-type: none">1. A family-centered and strengths-based approach;2. Comprehensive, unified assessment that involves the family;3. Single, unified service planning and implementation including the involvement of parents as partners;4. Facilitation of child-centered team meetings including team-building and involvement of parents as partners;5. How to access and use wraparound supports. <p>B. Tools to evaluate the ongoing effectiveness of the training program and enhance areas demonstrating need for improvement.</p> <p>C. A methodology for measuring core competencies for front-line staff.</p>
<p>Paragraph 39</p>	<p>The behavioral health system will have qualified trainers in sufficient numbers to train front-line staff and supervisors.</p> <p>http://www.azdhs.gov/bhs/jkfinaleng.pdf</p>



Provider Monitoring by T/RBHA

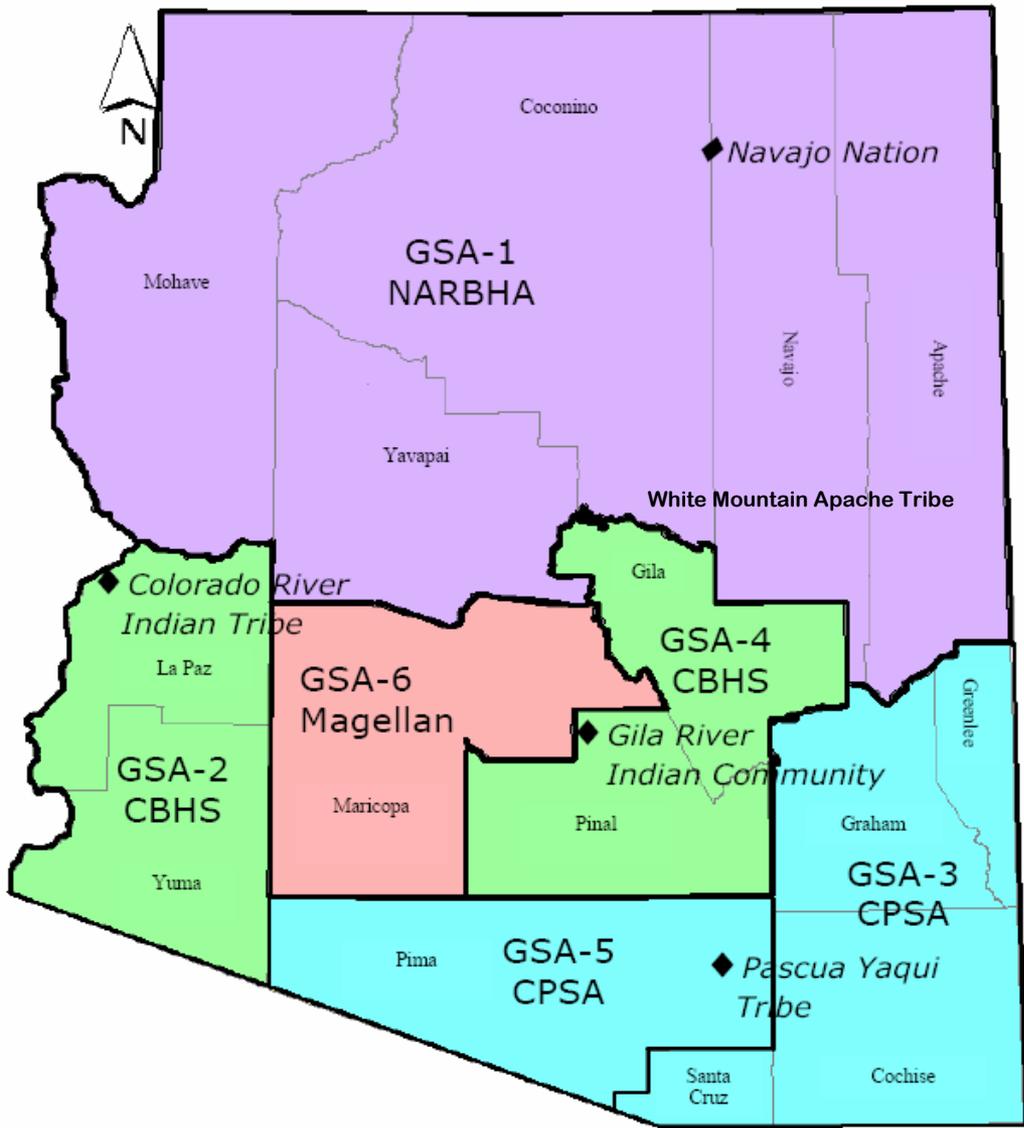
<p>NARBHA</p>	<p>Our goal is to provide relevant and up-to-date training opportunities to assist all individuals in reaching their career objectives and requirements. Furthermore, we hope to support one's passion for learning and exploring new concepts and ideas.</p> <p>https://www.narbha.org/NARBHACD/CDEngine.aspx?loc=0,83</p>
<p>Magellan</p>	<p>Service recipients, family members and other interested people in the community now have access to a variety of health and wellness trainings. Learn at your own pace. It's a no-pressure way to begin making improvements in your life!</p> <p>http://www.magellanofaz.com/azmem-en/azprogserv/training-en/index.aspx</p>
<p>Cenpatico</p>	<p>Welcome to the Cenpatico Behavioral Health of Arizona's Training and Technical Assistance Page. There are several avenues that you can take to obtain training and technical assistance.</p> <p>https://www.cenpaticoaz.com/portal/public/cbh_az/kcxml/04_Sj9SPykssy0xPLMnMz0vM0Y_QjzKLd4o3NbYASYG_ZRt76kWhiJmFuWMRcEWJBqXn63vq-Hvm5qfoB-gW5oaER5Y6KAKmFR0o!/delta/base64xml/L3dJdyEvd0ZNQUFzQUMmNEIVRS82X0JfNTNR</p>
<p>CPSA</p>	<p>CPSA is proud to offer training to behavioral health staff, members, families and to the community. Training sessions listed in the Community Training Calendar are free and open to the general public unless otherwise indicated.</p> <p>http://w3.cpsa-rbha.org/static/index.cfm?contentID=6</p>



Provider Monitoring by T/RBHA

Contracting	<ul style="list-style-type: none">• ADHS/AHCCCS• Magellan of Arizona• NARBHA• Cenpatico• CPSA
Tribal Intergovernmental Agreements	<ul style="list-style-type: none">• Gila River• Navajo Nation• Pascua Yaqui• White Mountain Apache Tribe
Practice Improvement Feedback	Information will be added to this link once the process is finalized

Arizona's System of Care for Children/Adolescents



T/RBHA Websites

- GSA-1 [NARBHA](#)
- GSA-2 & 4 [Cenpatico](#)
- GSA-3&5 [CBHS](#)
- GSA 6 [Magellan](#)
- [White Mountain Apache](#)
- [Gila River Indian Community](#)
- [Pascua Yaqui Tribe](#)

NARBHA-1 = Northern Arizona Behavioral Health Authority
CBHS-2 & CBHS-4 = Cenpatico Behavioral Health Services
CPSA-3 & CPSA-5 = Community Partnership of Southern Arizona



Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
 - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
 - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-19 PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) serves as the single state authority to provide coordination, planning, administration, regulation and monitoring of all facets of the state public behavioral health system. ADHS/DBHS contracts with community-based organizations, known as Regional Behavioral Health Authorities (RBHAs), to administer behavioral health services. Then, each RBHA contracts with a network of service providers similar to health plans to deliver comprehensive array of services outlined in Arizona's covered service guide geared toward prevention, treatment, and recovery for both adults and children.

The overall goal of the State is to ensure appropriate access to treatment services for pregnant women and women with dependent children. It also ensures that sufficient outreach, specialized treatment, and recovery supports are available to this population. The contracts between the State and RBHAs continue to include language for preferential access to care and provision of interim services. The State monitors the RBHAs for compliance with preferential access standards, including review of data reporting mechanisms and corrective action as appropriate. Language continues to be located within the contracts between the State and RBHAs and referenced in the Policy and Procedure Manual.

Dialogue with Tribes and Regional Behavioral Health Authorities (T/RBHA) and Provider Agencies were incorporated into standing meetings: Internal Substance Use Disorder and T/RBHA Substance Use Disorder Meeting. In return the RBHAs have a standing meeting with their Providers about Substance Use.

The State added a SABG training requirement into the Provider Manual in July 2010, which is referenced in all contracts with the RBHAs. The requirement includes an overview of Substance Abuse Block Grant: Priority placement criteria, interim service provision, consumer wait list reporting, and expenditure restrictions of the SABG in accordance with requirements in the Policy and Procedure Manual and 45 CFR Part 96.

Per the recommendation of CSAT during the SABG Core Review in FY 2010, Arizona elected to develop a web-based "real time" waitlist system for tracking priority population (Pregnant Intravenous Drug Users, Pregnant or Parenting Women with a Substance Use Disorder, all Intravenous Drug Users) members awaiting placement in a Residential Treatment Facility. Effective 4/1/2011, users at provider organizations, RBHAs, and ADHS/DBHS were able to log into the system using a unique username and password, and enter basic information for priority population members unable to begin treatment within the timeframes specified in the States policy and procedure manual.

The State receives an e-mail notification when a member is added onto the waitlist in "real time". A designated member of the System of Care Team reviews the information and coordinates with the RBHA if needed. Also, the State reviews the data entered into the waitlist to

C-19 PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN

monitor preferential access standards, the provision of interim services and to monitor sufficiency in capacity to treat this population.

The T/RBHAs monitor all contractors who provide residential services under SABG Grant Funds. Providers of residential services report data to the RBHA, in accordance with ADHS/DBHS requirements, on a monthly basis. This report tracks all priority recipients who completed intake assessment and are willing to enter treatment. T/RBHAs use this data to identify provider specific and/or system wide trends and provide technical assistance to providers as needed.

In Maricopa County, collaboration between Maricopa County Adult Probation, Estrella Jail, residential substance abuse providers that serve women and the Maricopa RBHA comprise of the Women’s Treatment Network. The work plan for this collaboration is to minimize barriers to receiving behavioral health care for women who can qualify for an early release program if they agree to go directly to residential services to address their substance use issues.

Also, is working with a Contractor to conduct a comprehensive needs assessment that will ultimately lead to effective and enduring improvements in community services and support pregnant women and women with dependent children with substance abuse and mental health conditions. One component of this project, which leads to improving outcomes in accessing treatment services, is to update ADHS’ Treatment Resource Guide for pregnant women and women with dependent children. In addition, we will be collecting state and national data related to this population to direct future programming. A comprehensive literature report will inform key stakeholders of best practices in delivering effective treatment services to this population.

Specialized Programs for Women			
Type of Service	Women Only	Women with Children	Pregnant Women
Outpatient	22	16	22
Intensive Outpatient	8	5	7
Behavioral Health Residential	9	9	10
Detoxification Ambulatory	0	0	1
Halfway/Transitional Housing	3	2	3
Opioid Replacement Therapy	4	2	26

The outpatient and residential programs coordinate with Opiate Treatment Programs and other providers to coordinate care for pregnant women and women with dependent children.

C-19 PREGNANT WOMEN AND WOMEN WITH DEPENDENT CHILDREN

Lastly, ADHS/DBHS has coordinating with the Division of Public Health Services (PHS) the Bureau of Women and Children's Health to reach a larger group of pregnant and parenting women. PHS conducted a Research Brief *Neonatal Abstinence Syndrome: 2008-2013 Overview* in 2014 (<http://www.azdhs.gov/phs/phstats/documents/neonatal-abstinence-syndrom-research.pdf>) and one of the major findings was the increase of Neonatal Abstinence Syndrome (NAS) cases. They are also working on the following:

- Arizona Opioid Prescribing Guidelines
- Controlled Substances Prescription Monitoring Program (CSPMP)
- Policies for Licensed Healthcare Facilities
- Home Visiting – Substance Abuse Screening
- Providing CME Credits to help prescribers incorporate the 2014 Arizona Opioid Prescribing Guidelines

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).⁹⁶

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

⁹⁶ http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-20 SUICIDE PREVENTION

The *2015 Arizona State Plan to End Suicide* (see attachment) was specifically created with the Zero Suicide model in mind and targets six priority populations for outreach during the calendar year: Native Americans, elders, veterans, medical examiners, emergency service workers and gun vendors.

With approximately 1050 completed suicides per year; the Arizona Department of Health Services, Division of Behavioral Health Services continues to partner with new community stakeholders, representatives from many of the state's 22 tribal populations and other government entities to review available suicide prevention resources and to reaffirm our commitment to bringing suicides to zero.

An End to Suicide in Arizona 2015 State Plan

“Never never never give up.” – Winston Churchill

EXECUTIVE SUMMARY

According to officials at the World Health Organization (WHO), more than 800,000 people die due to suicide annually; many more make an attempt. Suicide was the second leading cause of death among 15-29 year olds globally in 2012. It is a global phenomenon in all regions of the world and accounted for 1.4% of all deaths worldwide, making it the 15th leading cause of death in 2012. In Arizona, the latest data shows some 1100 Arizonans committed suicide in 2012. From 2009-2013, Arizona had more than 5,500 suicides, 2,000 homicides, and another almost 900 undetermined deaths. Many of those undetermined deaths were ruled unintentional poisonings. Some 750 Arizonans died by taking too much of one medication in 2012.

Suicide is not just a behavioral health concern. Suicide may be linked to depression and other mental illnesses, but the majority of those who have a behavioral health illness do not commit suicide. Suicide touches every family and community in Arizona, regardless of diagnoses, zip codes, ethnicities, or faith.

Suicide is the second leading cause of “years of potential life lost” in our state for American Indians, at 8.7%. Also of grave concern are suicides among our increasing populations of retirees and veterans. Data from the American Foundation for Suicide Prevention shows Arizona’s suicide rate is 39% higher than the national average, at 17.1 suicides per 100,000 people.

The 2015 state plan is a guideline for activities to prevent suicide in Arizona. This plan has been created with guidance and using the framework from the Substance Abuse and Mental Health Administration (SAMHSA) and the National Action Alliance’s plan for Zero Suicide.

Also, special thanks to the authors of the Texas State Plan for Suicide Prevention 2014. Its comprehensive plan served as the framework to create a similar strategy for Arizona.

HISTORY

The last state plan in Arizona (2009) addressed various behavioral health concerns, including suicide, from 2010-2015. The plan heavily emphasized efforts toward preventing and limiting substance abuse.

Following research and new national models on ending suicide, leadership at the Arizona Department of Health Services (ADHS) decided to separate the state suicide strategic plan into its own document and to create a yearly plan – rather than one per five years.

The motivation behind these changes is to focus this plan wholly on suicide prevention (which may include substance abuse prevention initiatives.) Also, by making this plan yearly, a constant communication and collaboration between ADHS, regional behavioral health authorities (RBHAs), American Indian tribal leadership, universities, and community members must occur. The plan cannot be shelved. It is a living document, with regularly updated activities and notes from community meetings and events.

Additionally, the *2015 An End to Suicide in Arizona State Plan* is the first plan in the state to follow the changes incorporated in the recommendations from the 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action, a joint report from the U.S. Surgeon General and the National Action Alliance for Suicide Prevention, surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/.

2015 STATE PLAN

The *2015 An End to Suicide in Arizona State Plan* provides recommendations including strategic directions, objectives and strategies specific to our state. The four strategic directions are the same as those given in the National Strategy with the goals, objectives, and strategies closely following the national plan. The statewide strategies identified in the plan are those that can be directly supported by the Arizona Suicide Prevention Coalition and ADHS.

ADHS reached out to communities statewide for their input in this plan; meetings took place during a three month period, and included tribal members, community-based organizations, universities, clergy, behavioral health practitioners, researchers, and other concerned citizens. All were asked to review the previous 2010-2015 plan and add ideas and regionalized activities already occurring. More than 200 people attended these regional meetings and provided feedback.

This plan is different from previous state plans; substance abuse and suicide prevention have been separated into their own plans. While ADHS leadership recognizes there is overlap, a plan specifically dedicated to each gives the weight both substance abuse and suicide merit.

Additionally, 2015 plan is different in that it does not specifically target teens, but instead looks to reach all those in need – including the largest population of those committing suicide in our state: senior citizens. As such, we are working closely with the Area Agency on Aging on effective and appropriate suicide prevention messaging.

Also, ADHS is outreaching Garrett Lee Smith Memorial Act for suicide prevention. This federal funding to campuses can fund education and outreach activities related to mental health and substance abuse prevention, while funding to states and tribes can develop and implement youth suicide prevention and early intervention strategies. This federal suicide funding can be used toward government, university, and tribal projects. Those in Arizona with 2015 funding include:

- Arizona State University
- Gila River Health Care Corporation
- Havasupai Tribal Government Office
- Native Americans for Community Action, Inc.
- Navajo Nation Dept. of Behavioral Health Services
- Tohono O'odham Nation
- University of Arizona
- White Mountain Apache/Johns Hopkins University

ADHS leadership will also be assessing other community resources for partnership, especially in rural communities. When appropriate, faith organizations and libraries may be excellent partners to disseminate suicide prevention education materials and hold trainings.

This plan was submitted to the Arizona Coalition for Suicide Prevention and other community partners for final review. As such, this plan is presented in collaboration with the Coalition, on behalf of the citizens of Arizona.

Together, our mission is to improve the health and wellbeing of all Arizonans by eliminating suicide.

KEY COMPONENTS

Suicide prevention should be community-based; the effort to reduce stigma associated with suicide, and/or asking for help to address mental illness needs to be communal. Key mental health and suicide prevention terms used in this document follow definitions in the National Strategy for Suicide Prevention,

surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/

STRATEGIC DIRECTIONS:

- Healthy individuals and communities
- Ready access to prevention resources for clinicians and communities
- Treatment and support services available to clinicians, communities, survivors
- Continued evaluation and monitoring of prevention programming

A 2015 calendar is included in the index with a preliminary list of activities related to the following goals, objectives, and immediate points of action.

GOALS:

- Reduce the number of suicides in Arizona to zero through coordinated prevention activities and messaging in multiple sectors
- Develop broad-base support for the Zero Suicide model
- Reduce stigma related to suicide
- Promote responsible media reporting of suicide
- Develop, implement, and monitor best practice-based programs promoting zero suicide
- Promote efforts to reduce access to lethal means of suicide among those with identified suicide risk
- Provide training to schools, community, clinical, and behavioral health service providers on the prevention of suicide and related behaviors
- Promote suicide prevention as a core component of health care services
- Promote suicide prevention best practices among Arizona's largest health care providers for patients and staff
- Promote and implement effective clinical and professional practices for assessing and treating those identified as being at risk for suicidal behaviors
- Provide care and support to individuals affected by suicide deaths or suicide attempts and implement community best practice-based postvention strategies to help prevent further suicides
- Increase the timeliness and usefulness of national, state, tribal, and local surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action
- Improve timeliness of data collection regarding suicide deaths
- Communicate suicide death trends appropriately to the public using ADHS blogs, website, and news releases
- Communicate ADHS activities related to addressing suicide clusters via ADHS blogs
- Promote and support research on suicide prevention
- Evaluate the impact and effectiveness of suicide prevention interventions and systems, and synthesize and disseminate findings
- Coordinate statewide of suicide prevention activities, fostering a collaborative community of support
- Coordinate conversations among Arizona grantees of federal suicide prevention funding
- Foster communities of loss survivors who can provide insight and comfort to others and help prevent further suicide deaths in their communities

Strategic Direction 1: Healthy Individuals and Communities

GOAL 1. Reduce the number of suicides in Arizona to zero through coordinated prevention activities and messaging in multiple sectors

OBJECTIVE 1.1: Integrate zero suicide prevention into the core values, culture, leadership, conversation and work of a broad range of organizations and programs with a role to support suicide prevention activities.

STRATEGY 1.1.1: Implement programs and policies to build social connectedness and promote positive mental and emotional health.

STRATEGY 1.1.2: Implement organizational changes to promote mental and emotional health in the workforce.

STRATEGY 1.1.3: Increase the number of local, state, tribal, professional, and faith-based groups that integrate suicide prevention activities into their programs.

OBJECTIVE 1.2: Establish effective, sustainable, and collaborative suicide prevention programming at the state, county, tribal, and local levels.

STRATEGY 1.2.1: ADHS, in collaboration with the Arizona Coalition for Suicide Prevention, will coordinate and convene public and private stakeholders, assess needs and resources, and update and implement a comprehensive strategic state suicide prevention plan annually.

STRATEGY 1.2.2: Through the support of the ADHS, in collaboration with the Arizona Coalition for Suicide Prevention, county health departments and representatives from each RBHA will participate in local coalitions of stakeholders to promote and implement comprehensive suicide prevention efforts at the community level.

STRATEGY 1.2.3: ADHS will support the annual conference organized by the Arizona Coalition for Suicide Prevention.

OBJECTIVE 1.3: Sustain and strengthen collaborations across agencies and organizations to advance suicide prevention.

STRATEGY 1.3.1: Strengthen partnerships with agencies that serve individuals at higher risk of suicide, such as military, veterans, substance abuse, foster care, juvenile justice, youth, elderly, American Indian, middle-aged white males, mental health consumers, suicide attempt survivors, those bereaved by suicide, GLBTQ2S (gay/lesbian/bisexual/transgender/questioning/two-spirited people), and other higher risk groups.

STRATEGY 1.3.2: Educate local, state, professional, volunteer and faith-based organizations about the importance of integrating suicide prevention activities into their programs, and distribute specific suggestions and examples of integration.

STRATEGY 1.3.4: Collaborate with ADHS' injury and violence prevention committee

OBJECTIVE 1.4: Integrate Zero Suicide into all relevant health care policy efforts.

STRATEGY 1.4.1: Encourage businesses and employers to ensure that mental health services are included as a benefit in health plans and encourage employees to use these services as needed.

STRATEGY 1.4.2: Encourage businesses and employers to ensure that mental health services are included in employee assistance programs, and encourage employees to use these services as needed.

ADHS 2015 actions: ADHS will organize regional meetings of suicide prevention stakeholders statewide to discuss the zero suicide model and successful prevention activities. This will include coordination of Zero Suicide prevention plans by the regional behavioral health authorities, 22 American Indian tribes in Arizona, state universities, hospital systems, faith organizations, and major employers. ADHS will work with each of these entities to create and manage such plans.

GOAL 2. Develop broad-base support for the Zero Suicide model

OBJECTIVE 2.1: Develop, implement, and evaluate communication efforts designed to reach defined segments of the population.

STRATEGY 2.1.1: Develop and implement an effective communications strategy for defined higher risk audiences and school personnel promoting suicide prevention, mental health, and emotional well-being, incorporating traditional and new media.

OBJECTIVE 2.2: Reach policymakers with dedicated communication efforts.

STRATEGY 2.2.1: Increase policymakers' understanding of suicide, its impact on constituents and stakeholders, and effective suicide prevention efforts.

OBJECTIVE 2.3: Increase communication efforts in mass and social media that promote positive messages and support safe crisis intervention strategies.

STRATEGY 2.3.1: Incorporate emerging technologies in suicide prevention programs and communication strategies, using best practices guidelines, and link to Teen LifeLine.

STRATEGY 2.3.2: Incorporate positive messages and safe crisis intervention information in suicide prevention communication programs.

OBJECTIVE 2.4: Increase knowledge of risk factors and warning signs for suicide and how to connect individuals in crisis with assistance and care.

STRATEGY 2.4.1: Increase public awareness of the role of the national and local crisis lines in providing services and support to individuals in crisis.

STRATEGY 2.4.2: Increase the use of new and emerging technologies such as tele-health, chat, text services, websites, mobile applications, the ADHS blog, and online support groups for suicide prevention communications.

ADHS 2015 actions: ADHS will regularly report on state zero suicide prevention efforts using the DBHS blog and will report activities from partners statewide.

GOAL 3. Reduce stigma related to suicide

OBJECTIVE 3.1: Promote effective programs and practices that increase protection from suicide risk.

STRATEGY 3.1.1: Provide opportunities for social participation and inclusion for those who may be isolated or at risk.

STRATEGY 3.1.2: Implement programs and policies to prevent abuse, bullying, violence, and social marginalization or exclusion.

STRATEGY 3.1.3: Encourage individuals and families to build strong, positive relationships with family and friends.

STRATEGY 3.1.4: Encourage individuals and families to become involved in their community's volunteer efforts (e.g. mentor or tutor youth, join a faith or spiritual community, reach out to older adults in the community.)

OBJECTIVE 3.2: Reduce prejudice, discrimination or stigma associated with suicidal behaviors, and mental health and substance use disorders.

STRATEGY 3.2.1: Promote mental health, increase understanding of mental and substance abuse disorders and eliminate barriers to accessing help through broad communications, public education, and public policy efforts.

STRATEGY 3.2.2: Increase funding and access to mental health services in an effort to reduce suicide attempts, hospitalizations, or incarcerations due to mental health related behaviors.

OBJECTIVE 3.3: Promote the understanding that recovery from mental health illness and substance use disorders is possible for all.

STRATEGY 3.3.1: Communicate messages of resilience, hope, and recovery to communities, patients, clients, and their families with mental health and substance use disorders.

<http://suicidepreventionmessaging.actionallianceforsuicideprevention.org/>

ADHS 2015 actions: ADHS will coordinate suicide stigma reduction activities during the month of September – suicide prevention month. ADHS will also reach out to media to discuss suicide in our community and share effective prevention mechanisms. ADHS staff will be counseled in using the word “suicide” in lieu of softer language.

GOAL 4. Promote responsible media reporting of suicide

OBJECTIVE 4.1: Encourage and recognize news and online organizations that develop and implement policies and practices addressing the safe and responsible reporting of suicide and other related behaviors.

STRATEGY 4.1.1: Disseminate *Recommendations for Reporting on Suicide* to news and online organizations. <http://reportingonsuicide.org>

STRATEGY 4.1.2: Encourage communication and feedback to news and online organizations in response to stories related to suicide, noting when they are appropriate and/or inappropriate, utilizing a variety of communications such as letters to the editor, op-eds, articles, online article comments, personal contacts, and phone calls.

STRATEGY 4.1.3: Develop a sample response template for recommendations to media and a procedure for dissemination of the recommendations.

STRATEGY 4.1.4: Recognize selected members of the news media industry who follow safe messaging guidelines at suicide prevention symposiums and regional meetings/summits.

OBJECTIVE 4.2: Encourage and recognize members of the entertainment industry who follow recommendations regarding the appropriate representation of suicide and other related behaviors.

STRATEGY 4.2.1: Develop a sample response template for recommendations to the entertainment industry and a procedure for dissemination of the recommendations.

OBJECTIVE 4.3: Promote and disseminate national guidelines on the safety of online content for new and emerging communication technologies and applications.

STRATEGY 4.3.1: Encourage statewide groups, local coalitions, and gatekeepers to monitor and respond to the safety of online content and encourage the use of national guidelines on safe messaging and suicide prevention.

OBJECTIVE 4.4: Disseminate national guidelines for journalism and mass communication schools regarding how to address consistent and safe messaging on suicide and related behaviors in their curricula.

STRATEGY 4.4.1: Develop a distribution list of journalism and mass communications schools in Arizona and disseminate the national guidelines.

ADHS 2015 actions: ADHS will develop stronger relationships with local and national media to discuss suicide prevention efforts in an appropriate way. ADHS will also foster these relationships to ensure suicide reporting is conducted effectively.

Strategic Direction 2: Ready Access to Prevention Resources for Clinicians and Communities

GOAL 5. Develop, implement, and monitor best practice-based programs promoting zero suicide

Objective 5.1: Strengthen the coordination, implementation, and evaluation of comprehensive state, county, tribal, and local suicide prevention programming.

STRATEGY 5.1.1: Support the implementation of suicide prevention, interventions and policies as recommended in places such as the Suicide Prevention Resource Center’s best practice registry, and the Substance Abuse and Mental Health Services (SAMHSA) national registry of evidence-based programs and practices. nrepp.samhsa.gov

STRATEGY 5.1.2: ADHS will annually update a list of state and local suicide prevention council membership groups and contact information on the DBHS website: azhealth.gov/bhs

OBJECTIVE 5.2: Encourage community-based settings to implement effective programs and provide education that promote wellness, reduce risk factors and prevent suicide and related behaviors.

STRATEGY 5.2.1: Target groups at risk of suicide in Arizona such as military, veterans, substance abuse, foster care, juvenile justice, youth, elderly, American Indians, middle-aged white males, mental health consumers, suicide attempt survivors, gay/lesbian/bisexual/transgender/questioning/two-spirited people, those bereaved by suicide, and other higher risk groups.

STRATEGY 5.2.2: Work with various stakeholders to implement suicide prevention policies and programs that address the needs of these at risk groups.

STRATEGY 5.2.3: Train employees and supervisors to recognize co-workers in distress and respond appropriately using information such as *Clinical Workplace Preparedness* and *Comprehensive Blueprint for Workplace Suicide Prevention* developed by the National Action Alliance for Suicide Prevention, and other best practice materials.

actionallianceforsuicideprevention.org/task-force/workplace/cspp/training

STRATEGY 5.2.4: Work with educational groups and related programs and agencies.

STRATEGY 5.2.5: Identify opportunities to promote wellness messaging, information and education.

OBJECTIVE 5.3: Intervene to reduce suicidal thoughts and behaviors in individuals and populations with suicide risk.

STRATEGY 5.3.1: Screen for mental health needs, including suicidal thoughts and behaviors, and make referrals to treatment and community resources, as needed.

STRATEGY 5.3.2: Implement suicide prevention programs in nonprofit, community, workplace, and faith-based programs that address the needs of groups at risk for suicide and that are culturally, linguistically, and age appropriate.

STRATEGY 5.3.3: Encourage individuals and families to learn the risk factors and warning signs of suicide and suicidal behaviors. Programs should include how to reach out to those who may be at risk and connect them with appropriate resources.

STRATEGY 5.3.4: Encourage businesses and corporations to implement education and prevention programs for the workforce to learn the risk factors and warning signs of suicide and suicidal behaviors. Programs should include how to reach out to those who may be at risk and connect them with appropriate resources.

STRATEGY 5.3.5: Encourage sharing of information and referral sources for suicide prevention across multiple sectors.

OBJECTIVE 5.4: Strengthen efforts to increase access to, and delivery of, best practice-based effective programs and services for mental health and substance use disorders.

STRATEGY 5.4.1: Provide suicide safe care best practices and standards of care for providers of health, mental health, and substance abuse treatment, such as the National Action Alliance's *Zero Suicide in Health and Behavioral Health Care* toolkit, beginning with local behavioral health and mental health authorities. zerosuicide.actionallianceforsuicideprevention.org

STRATEGY 5.4.2: Educate the general public and policy makers about the need for adequate funding and leveraging of resources to increase access to and delivery of best practice-based programs.

ADHS 2015 actions: ADHS will work with community partners statewide to develop and implement specific zero suicide prevention plans for their area. ADHS will provide technical assistance as necessary to interested community partners to see these plans are created, implemented and monitored.

GOAL 6. Promote efforts to reduce access to lethal means of suicide among those with identified suicide risk

OBJECTIVE 6.1: Encourage providers who interact with individuals and groups at risk for suicide to routinely assess for access to lethal means.

STRATEGY 6.1.1: Sponsor trainings and disseminate information on means restriction to mental health and healthcare providers, professional associations, patients, and their families.

STRATEGY 6.1.2: Incorporate lethal means counseling into suicide risk assessment protocols and address means restriction in safety plans.

STRATEGY 6.1.3: Sponsor medication take-back days and ongoing methods for the disposal of unwanted medications (e.g. secure collection kiosks at police departments or pharmacies)

STRATEGY 6.1.4: Encourage individuals and families to dispose of unused medications, particularly those that are toxic or abuse-prone, and take additional measures (e.g. medication lock box) if a member of the household is at high risk for suicide.

STRATEGY 6.1.5: Educate clergy, parent groups, schools, juvenile justice personnel, rehabilitation centers, defense and divorce attorneys, healthcare providers, and others about the importance of promoting efforts to reduce access to lethal means among individuals at risk for suicide.

STRATEGY 6.1.6: Encourage all individuals and families to store household firearms locked and unloaded with ammunition locked separately.

STRATEGY 6.1.7: For households with a member at high risk for suicide, take additional measures such as recommendations in the Means Matter website

hsph.harvard.edu/means-matter/

OBJECTIVE 6.2: Partner with firearm dealers, gun owners, concealed handgun trainers and law enforcement to incorporate suicide awareness as a basic tenet of firearm safety and responsible firearm ownership.

STRATEGY 6.2.1: Develop a list of potential firearm suicide safe advocacy groups in Arizona, such as gun retailers, shooting clubs and ranges, manufacturers, firearm retail insurers, concealed handgun instructors, law enforcement, farm and ranch associations, and veterans groups.

STRATEGY 6.2.2: Initiate partnerships with firearm advocacy groups (e.g. retailers, shooting clubs, manufacturers, firearm retail insurers, concealed handgun instructors, law enforcement, farm and ranch associations and veterans groups) to increase suicide prevention awareness.

STRATEGY 6.2.3: Develop and implement pilot community projects to promote gun safety and suicide safe homes, incorporating the National Action Alliance's Zero Suicide recommendations.

<http://zerosuicide.actionallianceforsuicideprevention.org>

OBJECTIVE 6.3: Encourage the implementation of safety technologies to reduce access to lethal means.

STRATEGY 6.3.1: Promote safety technologies to reduce access to lethal means (e.g. reducing carbon monoxide, restricting medication pack sizes, pill dispensing lockboxes, barriers to bridges.)

ADHS 2015 actions: ADHS will work with community partners to advertise medication take-back days and the dangers of prescription medications left unattended. Additionally, ADHS will work with firearm vendors and advocacy groups to provide suicide prevention materials and education.

GOAL 7. Provide training to schools, community, clinical, and behavioral health service providers on the prevention of suicide and related behaviors

OBJECTIVE 7.1: Provide training to community groups in the prevention of suicide and related behaviors.

STRATEGY 7.1.1: ADHS will promote the use of best practice programs and the Zero Suicide model.

STRATEGY 7.1.2: ADHS will support the Arizona Coalition for Suicide Prevention and Teen Lifeline on their work with schools in Arizona concerning suicide prevention, including helping to provide technical assistance to interested school districts in the creation of suicide prevention plans. store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669

OBJECTIVE 7.2: Provide training to all health care providers, including mental health, substance abuse and behavioral health, on the recognition, assessment, and management of risk factors, warning signs, and the delivery of effective clinical care for people with suicide risk.

STRATEGY 7.2.1: Increase the capacity of health care providers to deliver suicide prevention services in a linguistically and culturally appropriate way.

STRATEGY 7.2.2: Increase the capacity of healthcare providers to deliver routine suicide prevention screening and services using best practice guidelines.

OBJECTIVE 7.3: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education.

STRATEGY 7.3.1: Integrate core suicide prevention competencies into relevant curricula and continuing education programs (e.g. nursing, medicine, allied health, pharmacy, social work, education, counseling, therapists.)

OBJECTIVE 7.4: Promote the adoption of core education and training guidelines on the prevention of suicide and related behaviors by credentialing and accreditation bodies.

STRATEGY 7.4.1: Review current core requirements for credentialing and accreditation bodies and make recommendations regarding suicide prevention and intervention guidelines to their curricula.

OBJECTIVE 7.5: Develop and implement protocols, programs, and policies for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk.

STRATEGY 7.5.1: Add suicide risk-specific protocols to programs and policies for mental health clinicians, supervisors, first responders, and their support staff.

STRATEGY 7.5.2: Enhance effective communication and coordination among mental health clinicians, supervisors, first responders, their support staff, and others on responding to clients at imminent risk.

ADHS 2015 actions: ADHS will provide in service to behavioral health providers concerning recognizing suicide behaviors in members and how to prevent suicide.

Strategic Direction 3: Treatment and Support

GOAL 8. Promote suicide prevention as a core component of health care services

OBJECTIVE 8.1: Promote the adoption of Zero Suicide as an aspirational goal by health care and community support systems that provide services and support to defined patient populations.

STRATEGY 8.1.1: ADHS will develop a pilot program and Zero Suicide Toolkit on how to implement suicide safe care centers in communities.

STRATEGY 8.1.2: Promote zerosuicide.com website in publications and communications about treatment and support services.

STRATEGY 8.1.3: Educate providers of health care and community support systems about adopting zero suicide as an aspirational goal, and promote the organizational readiness survey of the National Action Alliance for Suicide Prevention.

OBJECTIVE 8.2: Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings.

OBJECTIVE 8.3: Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide.

STRATEGY 8.3.1: Advocate for funding for prevention and postvention for clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.

OBJECTIVE 8.4: Promote continuity of care and the safety and well-being of all patients treated for suicide risk in emergency departments or hospital inpatient units.

STRATEGY 8.4.1: Promote the use of safety planning and other best practices for emergency department care as highlighted in the Suicide Prevention Resource Center’s Best Practices Registry sprc.org/bpr

OBJECTIVE 8.5: Encourage healthcare delivery systems to incorporate suicide prevention and appropriate responses to suicide attempts as indicators of continuous quality improvement efforts.

OBJECTIVE 8.6: Establish linkages among providers of primary care, mental health and substance abuse services and community-based programs, including peer support programs.

STRATEGY 8.6.1: The Arizona Department Health Services and the Arizona Coalition for Suicide Prevention will promote suicide prevention regional summits to enhance linkages among providers of primary care, mental health and substance abuse services and community-based programs, including peer support programs.

OBJECTIVE 8.7: Coordinate services among suicide prevention and intervention programs, health care systems, and accredited local crisis centers.

OBJECTIVE 8.8: Develop collaborations between emergency departments and other health care providers to provide safe alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up and ongoing care after discharge.

STRATEGY 8.8.1: Promote rapid enhanced programs for immediate care after discharge, such as caring letters, postcards, texts, and letters.

ADHS 2015 actions: ADHS will work with healthcare entities statewide to provide training for staff concerning suicide prevention among patients and staff. ADHS will also help to develop suicide prevention materials for healthcare settings and materials for loss survivors upon a suicide death.

GOAL 9. Promote suicide prevention best practices among Arizona’s largest health care providers for patients and staff

OBJECTIVE 9.1: Promote national guidelines for the assessment of suicide risk among persons receiving care in all settings.

STRATEGY 9.1.1: Educate providers about best practice-based toolkits and ways to implement the national guidelines for the assessment of suicide risk among persons receiving care in all settings, which can be found on the Suicide Prevention Resource Center’s Best Practices Registry, sprc.org/bpr

OBJECTIVE 9.2: Disseminate and implement best practice-based guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk, such as guidelines posted on the best practices registry at sprc.org/bpr

STRATEGY 9.2.1: Educate providers about the best practice-based national guidelines for clinical practice and continuity of care for providers who treat persons with suicide risk, which can be found on the Suicide Prevention Resource Center’s Best Practices Registry, sprc.org/bpr.

OBJECTIVE 9.3: Promote the safe disclosure of suicidal thoughts and behaviors by all patients.

STRATEGY 9.3.1: The Arizona Coalition for Suicide Prevention will advocate to eliminate penalties for suicide attempts from insurance providers.

STRATEGY 9.3.2: ADHS and community partners will educate providers about safe and effective guidelines for conducting safe suicide risk assessments such as the Chronological Assessment of Suicide Events (CASE approach - suicideassessment.com), Columbia Suicide Severity Rating Scale (CSSRS - cssrs.columbia.edu/), Assessing and Managing Suicide Risk (AMSR - sprc.org/training-institute/amsr), Collaborative Assessment and Management of Suicidality (CAMS - psychology.cua.edu/faculty/jobes.cfm), and other programs identified on the Suicide Prevention Resource Center's best practice registry, <http://www.sprc.org/bpr>, beginning with local mental health authorities, by 2016.

OBJECTIVE 9.4: Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for persons with suicide risk.

STRATEGY 9.4.1: Engage families and those at risk of suicide about the importance of including families and concerned others in the safety planning process.

OBJECTIVE 9.5: Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among patients receiving care for mental health and/or substance use disorders.

STRATEGY 9.5.1: Promote best practice risk stratification systems and pathways of clinical care.

OBJECTIVE 9.6: Promote standardized protocols for use within emergency departments based on common clinical presentation to allow for more differentiated responses based on risk profiles and assessed clinical needs.

OBJECTIVE 9.7: Promote guidelines on the documentation of assessment and treatment of suicide risk and establish a training and technical assistance capacity to assist providers with implementation.

STRATEGY 9.7.1: Promote best practice-based recommendations such as those identified in suicide prevention and resources for primary care by the Suicide Prevention Resource Center (sprc.org) and SAMHSA (samhsa.gov) related to assessment and treatment of those identified with suicidal thoughts and behaviors. Example: Recognizing and Responding to Suicide Risk in Primary Care, sprc.org/bpr/section-III/recognizing-and-responding-suicide-risk-primary-care-rrsr-pc.

ADHS 2015 actions: ADHS will reach out to Arizona's largest employers to determine what policies are currently in place for helping suicidal employees and help create an appropriate plan for referring employees for further care.

GOAL 10. Provide care and support to individuals affected by suicide deaths or suicide attempts and implement community best practice-based postvention strategies to help prevent further suicides

OBJECTIVE 10.1: Promote guidelines for effective comprehensive support programs for individuals with lived experience, including those bereaved by suicide and survivors of suicide attempts, and promote the full implementation of these guidelines at the state, county, tribal, and community levels.

actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-Way-Forward-Final-2014-07-01.pdf

STRATEGY 10.1.1: ADHS will add links and/or information on best-practice support programs or guidelines for postvention strategies to the state website.

OBJECTIVE 10.2: Provide appropriate clinical care to individuals affected by a suicide attempt or bereaved by suicide, including trauma treatment and care for complicated grief.

STRATEGY 10.2.1: Disseminate guidelines on trauma informed care to clinicians, agencies, and first responders. samhsa.gov/traumajustice/traumadefinition/guidelines.aspx

STRATEGY 10.2.2: ADHS will collaborate with state initiatives on trauma informed care and systems of care to include suicide prevention and postvention.

OBJECTIVE 10.3: Engage suicide attempt survivors and those bereaved by suicide in suicide prevention planning, including support services, treatment, community suicide prevention education, and promote guidelines and protocols for support groups for suicide attempt survivors and those bereaved by suicide.

STRATEGY 10.3.1: ADHS will promote the development of follow-up services for attempt survivors, and those bereaved by suicide, in emergency departments and other community providers after a suicide attempt or death by suicide. Follow-up may include phone calls, post cards, email, or texts at intervals with caring messages and contact information for help.

STRATEGY 10.3.2: ADHS will promote inclusion of people with lived experience, including suicide attempt survivors and those bereaved by suicide, in local, regional, and state initiatives.

OBJECTIVE 10.4: Promote community postvention best practice-based policies and programs to help prevent suicide clusters and contagion.

STRATEGY 10.4.1: Inform communities and school districts about support for postvention including how to address suicide clusters and contagion through the local mental health authority suicide prevention coordinator, local suicide prevention coalitions, and the state suicide prevention coordinator.

OBJECTIVE 10.5: Adopt, disseminate, implement, and evaluate guidelines for communities to respond effectively to suicide clusters and contagion within their cultural context, and support implementation with education, training, and consultation.

STRATEGY 10.5.1: Support and encourage communities to develop a LOSS Team (Local Outreach to Suicide Survivors), trainings, support groups, and offer best practice-based bibliotherapy and other resources. lossteam.com/About-LOSSteam-2010.shtml

STRATEGY 10.5.2: Provide support for open and direct talk about suicide postvention through best practice-based presentations, debriefing, and counseling.

STRATEGY 10.5.3: Provide support to schools and school districts for training and facilitated discussions with teachers, administrators, support staff, and parents after a suicide loss.

STRATEGY 10.5.4: Provide support to students after a suicide loss in one-to-one or small group discussions only.

STRATEGY 10.5.5: Provide awareness about the need for best practice supports to medical examiner officers, victim services groups, first responders, funeral homes and faith-based organizations for those bereaved by suicide deaths or affected by suicide attempts.

STRATEGY 10.5.6: Disseminate guidelines about best practices for online and social media after suicide attempt or loss.

STRATEGY 10.5.7: Develop or disseminate best practice based support materials targeted to youth after a suicide loss.

STRATEGY 10.5.8: Encourage safe messaging training for all individuals and organizations involved in prevention, intervention and postvention activities. SuicidePreventionMessaging.org

OBJECTIVE 10.6: Provide health care providers, first responders, and others with best practice-based care and support when a patient under their care, or a colleague, dies by suicide.

STRATEGY 10.6.1: Provide support (including training, facilitated discussions, and counseling support) to professional caregivers in communities and schools after a patient or a colleague dies by suicide.

STRATEGY 10.6.2: Consider utilizing hospital or health care organizations' regular communications to inform other providers about increased suicide risk and potential clusters.

ADHS 2015 actions: ADHS will reach out to healthcare providers to see what information is being provided to loss and attempt survivors. ADHS will partner with Arizona Coalition for Suicide Prevention to develop appropriate resources and materials. ADHS will encourage healthcare providers to reach out to both groups within 24 hours after the event. ADHS will encourage loss and attempt survivor participation in suicide prevention policy creation and at the quarterly suicide prevention meetings statewide.

STRATEGIC DIRECTION 4: Continued Evaluation and Monitoring of Prevention Programming

GOAL 11. Increase the timeliness and usefulness of national, state, tribal, and local surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action

OBJECTIVE 11.1: Improve the timeliness of reporting vital records data at state, county, local, school, and higher education levels.

STRATEGY 11.1.1: Improve capacity for state epidemiologists and the state suicide prevention coordinator to review and report suicide data

OBJECTIVE 11.2: Improve the usefulness and quality of suicide related data, including death, attempt, ideation, and exposure to suicide.

STRATEGY 11.2.1: Promote a mechanism in Arizona to collect and disseminate suicide attempt data.

OBJECTIVE 11.3: Improve and expand state, county, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions.

STRATEGY 11.3.1: As allowed by law, encourage government entities to enter into memorandums of understanding to share suicide data that does not name a deceased person.

OBJECTIVE 11.4: Increase the number of national and state representative surveys and other data collection instruments that include questions on suicidal behaviors, related risk factors, and exposure to suicide.

STRATEGY 11.4.1: ADHS will review and make recommendations for the addition of questions to the Arizona Behavioral Risk Factor Surveillance System Survey related to suicide prevention and gay/lesbian/bisexual/transgender/two-spirited adults.

STRATEGY 11.4.2: ADHS will collaborate with Arizona State University on the state’s data included in the National Violent Death Reporting System.

ADHS 2015 actions: ADHS will encourage the White River Apache Reservation to provide technical assistance to other Arizona American Indian tribes concerning suicide surveillance.

GOAL 12. Improve timeliness of data collection regarding suicide deaths

OBJECTIVE 12.1: Develop an Arizona suicide prevention research agenda with comprehensive input from multiple stakeholders.

STRATEGY 12.1.1: Form partnerships with higher education to promote and support suicide prevention research.

STRATEGY 12.1.2: Consult with the research prioritization task force of the National Action Alliance for Suicide Prevention on how Arizona can develop a mechanism to prioritize state research.

OBJECTIVE 12.2: Disseminate national and Arizona-based suicide prevention research agenda.

STRATEGY 12.2.1: Encourage Arizona researchers to apply for national grants and research opportunities on suicide prevention, intervention, and postvention.

STRATEGY 12.2.2: Encourage suicide prevention researchers to inform the ADHS about their articles and research projects so that their results can be shared statewide.

Objective 12.3: Promote the timely dissemination of suicide prevention research findings.

STRATEGY 12.3.1: Provide timely dissemination of suicide research findings through links on bhsblog.azhealth.gov, Facebook, newsletters, Twitter, and other social media.

OBJECTIVE 12.4: Support a repository of research resources to help increase the amount and quality of research on suicide prevention and care in the aftermath of suicidal behaviors.

STRATEGY 12.4.1: Provide links to repositories of national suicide prevention, intervention and postvention toolkits and websites.

OBJECTIVE 12.5: Encourage Arizona foundations to support suicide prevention research.

ADHS 2015 actions: ADHS will foster relationships with state and private universities in Arizona to promote the research of suicide prevention.

GOAL 13. Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

OBJECTIVE 13.1: Evaluate the effectiveness of suicide prevention interventions in Arizona.

STRATEGY 13.1.1: ADHS publicize evaluation results of best practice-based suicide prevention projects, including the Zero Suicide pilot project.

OBJECTIVE 13.2: Assess, synthesize, and disseminate the evidence in support of suicide prevention interventions in Arizona.

OBJECTIVE 13.3: Examine how suicide prevention efforts are implemented in different states/counties and communities to identify the types of delivery structures that may be most efficient and effective.

ADHS 2015 actions: ADHS will work with other SAMHSA region 9 state suicide prevention coordinators to share information about state plans, successful programming and noted trends. Additionally, ADHS will work with the National Action Alliance for Suicide Prevention for continued mentorship concerning suicide prevention policy and planning.

STRATEGIC DIRECTION 1 – HEALTHY AND EMPOWERED INDIVIDUALS, FAMILIES AND COMMUNITIES

- Participate in local coalitions of stakeholders to promote and implement comprehensive suicide prevention efforts at the community level. For more information, email: kelli.donley@azdhs.gov
- Develop and implement communication strategies that convey messages of help, hope, and resiliency. suicidepreventionmessaging.org/
- Provide opportunities for social participation and inclusion for those who may be isolated or at risk.
- Include those with lived experience such as attempt survivors and those bereaved by suicide for planning and implementation of programs.
- Consider sharing recommendations for reporting on suicide and safe messaging to media and encourage communication and feedback to news and online communities in response to local stories related to suicide. suicidepreventionmessaging.org/

STRATEGIC DIRECTION 2 – CLINICAL AND COMMUNITY PREVENTIVE SERVICES

- Implement suicide prevention programs that address the needs of groups at risk for suicide and that are culturally, linguistically, and age appropriate.
- Initiate partnership with firearm advocacy groups (e.g. retailers, shooting and hunting clubs, manufacturers, firearm retail insurers) to increase suicide awareness. hsph.harvard.edu/means-matter/examples-of-means-restriction-programs/
- Educate first responders, clergy, parent groups, schools, juvenile justice personnel, rehabilitation centers, defense and divorce attorneys, and others about the importance of promoting efforts to reduce access to lethal means among individuals at risk for suicide. hsph.harvard.edu/means-matter/ and sprc.org/search/apachesolr_search/means%20matters?filters=
- Advocate with your local hospital, emergency departments and other health care providers to provide follow up connections through rapid enhanced programs for immediate care after discharge, such as caring letters, postcards, texts and letters. bjp.rcpsych.org/content/197/1/5.full

STRATEGIC DIRECTION 3 – TREATMENT AND SUPPORT SERVICES

- Coordinate the services of community-based and peer-support programs with the support available from local providers of mental health and substance abuse services to better serve individuals at risk for suicide.
- Consider providing support services for those with lived experience such as suicide attempt survivors and those bereaved by suicide.

STRATEGIC DIRECTION 4 – SURVEILLANCE RESEARCH, AND EVALUATION

- Work with a local university to evaluate your suicide prevention program

RESOURCES REFERENCED

2015 AN END TO SUICIDE IN ARIZONA STATE PLAN

2012 National Strategy for Suicide Prevention -
<http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/>.

After a Suicide: A Toolkit for Schools
<https://www.afsp.org/coping-with-suicide-loss/education-training/after-a-suicide-a-toolkit-for-schools>

Assessing and Managing Suicide Risk (AMSR)
<http://www.sprc.org/training-institute/amr>

Best Practices Registry, Suicide Prevention Resource Center
<http://www.sprc.org/bpr>

Counseling on Access to Lethal Means Project (CALM)
<http://www.hsph.harvard.edu/means-matter/examples-of-means-restriction-programs/>

Center for Elimination of Disproportionality and Disparities
http://www.hhsc.state.tx.us/hhsc_projects/cedd/

Chronological Assessment of Suicide Events (CASE approach - www.suicideassessment.com),
Clinical Workplace Preparedness and Comprehensive Blueprint for Workplace Suicide Prevention
<http://actionallianceforsuicideprevention.org/task-force/workplace/cspp/training>

Collaborative Assessment and Management of Suicidality (CAMS)
<http://psychology.cua.edu/faculty/jobes.cfm>

Columbia Suicide Severity Rating Scale (CSSRS)
<http://www.cssrs.columbia.edu/>)

Framework for Successful Messaging
www.SuicidePreventionMessaging.org

LOSS Team Postvention Workshops and Trainings
<http://www.lossteam.com/About-LOSSTeam-2010.shtml>

Means Matters, Harvard School of Public Health
<http://www.hsph.harvard.edu/means-matter/examples-of-means-restriction-programs/>

National Registry of Evidence-Based Prevention Programs
<http://nrepp.samhsa.gov>

National Suicide Prevention Lifeline, 1-800-273-8255
<http://www.suicidepreventionlifeline.org>

Preventing Suicide: A Toolkit for Schools
<http://store.samhsa.gov/product/Preventing-Suicide-A-Toolkit-for-High-Schools/SMA12-4669>

Recommendations for Reporting on Suicide
<http://reportingonsuicide.org>

Self-Directed Violence Surveillance Uniform Definition and Recommended Data Elements
<http://www.cdc.gov/violenceprevention/pdf/self-directed-violence-a.pdf>

Suggested Guidelines for Implementation of a Trauma-informed Approach
<http://www.samhsa.gov/traumajustice/traumadefinition/guidelines.aspx>

The Way Forward - Pathways to hope, recovery, and wellness with insights from lived experience
<http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/The-Way-Forward-Final-2014-07-01.pdf>

Zero Suicide in Health and Behavioral Health Care
<http://zerosuicide.actionallianceforsuicideprevention.org>

ADHS PARTNERS IN ZERO SUICIDE

- Area Agency on Aging
- Arizona Coalition to End Sexual and Domestic Violence
- Arizona Coalition for Military Families
- Arizona Criminal Justice Commission
- Arizona Coalition for Suicide Prevention
- ASU – Center for Applied Behavioral Health Policy
- ADHS Bureau of Public Health Statistics
- ADHS Office of Injury Prevention
- First Things First
- Gila River Indian Community Police Department
- Glendale Police Department
- Goodyear Police Department
- Pasadera Behavioral Health Network
- Phoenix Police Department
- Pima County Administrator’s Office
- Pima County Medical Society
- St. Joseph’s Hospital and Medical Center
- Teen Lifeline
- Tucson Police Department
- Maricopa County Justice System Planning and Information
- Mercy Maricopa Integrated Care
- Northern Arizona Regional Behavioral Health Authority
- Cenpatco Integrated Care
- University of Arizona Medical Center

2015 Suicide Prevention Calendar

ADHS Regional Suicide Prevention Community Conversations

Tucson, Phoenix, Flagstaff

February

May

August

November

Locations to be determined

Arizona Suicide Prevention Coalition:

Second Tuesday of the month

January 13

March 10

May 12

July 14

September 8

November 10

1:30-3:30 pm

JFCS

2033 N. 7th St. Phoenix, AZ

Dial in: 1-619-326-2772 #5131264

Verde Valley Suicide Prevention Coalition

Second Wednesday of the Month

3:30-4:30 pm

Location varies

Arizona Commission of Indian Affairs

February 12th

9:30-11:30 am

TBD

May 2:

Survivors of Suicide Conference

Black Canyon Conference Center

Phoenix, AZ

September:

Suicide Prevention Month

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working 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, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

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

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-21 SUPPORT OF STATE PARTNERS

The Arizona Department of Health Services, Division of Behavioral Health Service's (ADHS/DBHS) commitment to collaborative efforts begins at its administrative level, where mental health and substance abuse services are administered out of one office. Both the Single State Authority and State Mental Health Authority designation is held by the Director of ADHS/DBHS. The Division partners with numerous State agencies, including the Department of Economic Security (DES), Juvenile and Adult Corrections, Department of Education, the Administrative Office of the Courts, the Governor's Office, and Arizona Health Care Cost Containment System (Medicaid), to provide a comprehensive array of publicly funded services to children and adults through memorandums of understanding, intergovernmental service agreements and/or informal relationships. Formal partnerships include:

- An Intergovernmental Agreement between ADHS/DBHS and the Department of Economic Security, Rehabilitation Services Administration (DES/RSA) exists to increase coordination and facilitate the expansion of vocational rehabilitation services between the agencies.
- In an Intergovernmental Agreement between ADHS/DBHS and Pima County Board of Supervisors, ADHS/DBHS is tasked with providing a comprehensive, community-based system of mental health care for persons with a serious mental illness who are residing in Pima County.
- In an 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 continues to provide education and technical assistance to the T/RBHAs around the protocol, as needed.
- The Interagency Services Agreement between the ADHS/DBHS and the Arizona Department of Housing (ADOH) 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.
- An Intergovernmental Agreement also exists between ADHS and Maricopa County Board of Supervisors. This agreement ensures service provision for remanded juveniles as well as for the Seriously Mentally Ill, the Non-Seriously Mentally Ill and those needing Local Alcohol Reception Services. While Maricopa County is obligated to provide certain services, this agreement ensures individuals are entered into the larger public behavioral health system at the earliest point.

C-21 SUPPORT OF STATE PARTNERS

- The Arizona Substance Abuse Partnership (ASAP) 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.
- T/RBHAs, contracted providers, and ADHS/DBHS are all active participants in the Arizona Suicide Prevention Coalition. This group conducts research, gathers data, creates publicity, and works to make policy changes; areas of focus include the media, Native Americans, older adults, and youth.
- The Arizona Children's Executive Committee (ACEC) brings together multiple state and government agencies, community advocacy organizations, and family members of children/youth with behavioral health needs to 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.

ADHS/DBHS has focused on developing collaborations that both drive system initiatives and leverage funding. By working with the community partners as well as internal and external stakeholders, the Division is able to implement policies and programs that extend beyond the behavioral health system. With cross system collaboration, ADHS/DBHS has had the opportunity to positively impact areas such as the foster care system, the prescription drug epidemic, mental health first aid, and homeless outreach.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).⁹⁷

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, 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 block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*⁹⁸

⁹⁷<http://beta.samhsa.gov/grants/block-grants/resources>

⁹⁸There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) 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 (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

C-22 BEHVIORAL HEALTH PLANNING COUNCIL

The Arizona Behavioral Health Planning Council maintains a positive relationship with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS). 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. The Council meets across Arizona to consult with local area community members and behavioral health service providers to implement projects and learn of local accomplishments and challenges. The Council meets with the ADHS/DBHS to discuss the barriers and arrive at a mutually agreeable course of action.

The Planning Council has had integrated representation between mental health and substance abuse since 1999, with the participation of several substance abuse providers. 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 June 2015 demonstrated that 93 percent of respondents work in the substance abuse field, were persons in substance abuse recovery, or have a family member with substance abuse challenges. The Council has strong representation of persons experienced in substance abuse treatment, and continually strives to improve representation among its members.

The Council strives to ensure 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 serious mental illness (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), Yuma, Bullhead City, Kingman, and Northern Arizona (Lake Havasu City). Still, the Council understands the importance of its membership being representative of the State and has prioritized recruitment for members residing in rural and remote locations. Conducting meetings in various locations around the state allows for membership that is mixed between urban and rural participants. The Executive Committee has marked 2015 as being the year it further diversifies by actively recruiting a transition-age youth/young adult to serve on the Council.

As part of its discussion on membership recruitment, the Executive Committee identified the need to develop a training manual and orientation process that provides candidates with basic information on the Council and committees' functions, as well as a high level overview of what the Council and each committee has been working on for the past six (6) months. The Executive Team has completed the training manual and it will be issued to all new candidates who express an interest in joining the Council and/or its supporting committees. To further ensure the orientation process is a smooth one, candidates will also be partnered with an existing member/mentor to help navigate the membership process.

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

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encompass planning for not only adults with a SMI and seriously emotionally disturbed children (SED), but also for individuals with substance abuse and mental health 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; and
- 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 members, 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. Regional Behavioral Health Authorities (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 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 are 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 Planning 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 ADHS/DBHS (Phoenix) as well as various locations around the State. Meetings held in local communities allow the Council to meet with the agencies providing 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.

Through its supporting Legislative Committee, the Council is active in reviewing and tracking state and federal legislation pertaining to mental health services. Should an issue of concern be

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presented, the Committee works to develop and disseminate position papers, provides testimony at legislative hearings, and advocates 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 discussed by the Planning and Evaluation Committee and are included in the full Council agendas for discussion and feedback to the State.

The Community Advisory Committee has been particularly active in the past two years. This Committee developed and implemented the “Bracelet Project” in Southern Arizona. Similar to a medical alert bracelet, these bracelets alert first responders that the individual wearing the bracelet has mental health needs. The project has had a positive impact with how first responders approach and engage with this population, and has decreased adverse police encounters. The police department has found the bracelets helpful and now provides a copy of the training video for new recruits. Having successfully implemented the project in Southern Arizona, the Community Advisory Committee Co-Chairs are committed to expanding program implementation to other geographical areas.

The Community Advisory Committee also met with Peer and Family Coalitions throughout Arizona to discuss the potential outcome measurement of the 9 Adult Principles. The outcome of these discussions resulted in the Committee’s understanding that the Peer and Family Coalitions are satisfied with the 9 Adult Principles. This feedback allowed the Community Advisory Committee to refocus its efforts on developing criteria to measure the Coalitions’ fidelity to the principles. The Committee plans to formally submit the measurement to the ADHS/DBHS for consideration by the end of 2015.

The Community Advisory Committee is currently working with the ADHS/DBHS to identify issues with the transition of adolescents to the adult behavioral health system. The Committee met with several children’s services providers and the Maricopa County Regional Behavioral Health Authority (RBHA) to discuss their process for ensuring children transition without an interruption in services. The Committee is awaiting encounter data for this population and if negative trends are identified, the Committee will work with the ADHS/DBHS to develop and implement a resolution.

The Council meets with the 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 (MHBG) and Substance Abuse Prevention and Treatment (SABG) 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 facing 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.

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In prior years, adult and children's issues were addressed in two (2) separate forums- the Community Advisory Committee and the Children's Committee. In 2010, these committees merged and the Community Advisory Committee now focuses on both adults and children.

System of Care Plans provide a mechanism for planning and implementation of mental health and substance abuse services within the state. Annual plans are developed and updates are submitted to the ADHS/DBHS staff quarterly. The Planning Council is included in this process with the ADHS/DBHS System of Care Plan being disseminated for review and feedback. The process allows the Council, the 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 the ADHS/DBHS.

The ADHS/DBHS staff meet with the Council's Planning and Evaluation Committee to discuss programs and activities related to the Block Grants. The ADHS/DBHS staff received feedback from the Committee regarding new priorities and data needed to respond to them. During 2015, the ADHS/DBHS staff also worked with the Council regarding a proposed change in the funding allocation methodology for the SABG/MHBG Block Grant. The ADHS/DBHS Assistant Director of Quality Management and Utilization Management met with the Planning and Evaluation Committee to discuss data specific to grievance, appeals and complaints. The Committee communicated its trepidations that not all issues are reaching the ADHS/DBHS because recipients do not know how to express their concerns beyond the Regional Behavioral Health Authority's level. The Chief Financial Officer also met with the Planning and Evaluation Committee to discuss financial allocations for Block Grant dollars. Finally, the Office Chief of the Office of Individual and Family Affairs (OIFA), or a representative from OIFA, also attends the committees and the Planning Council.

Arizona Governor Ducey has implemented "Administrative Simplification." As part of this process, duties performed by the Division of Behavioral Health Services (DBHS) will move under the Arizona Health Care Cost Containment System (AHCCCS). The Council, its supporting committees and functions will also transition to AHCCCS. AHCCCS and DBHS have been partners in the provision behavioral health services for decades and the "Administrative Simplification" will further promote what has always been known, "The mind cannot be separated from the body." The change will simplify the system of care for over 30,000 behavioral health recipients who are living with a serious mental illness. The transition is being carefully monitored to ensure the "Administrative Simplification" results in no disruption to behavioral health recipients, the Council or its supporting committees.

The Planning Council has already identified areas of focus for the 2016-2017 grant years. One of these areas pertains to grant fund oversight. The Council intends to become more involved with the expenditure of the grant funds. Communication proved to be challenging in 2015 because the Planning Council and Committee coordinator passed away suddenly. Shortly thereafter, the Council and Committees' were assumed by new staff, some of which were not clear on the Council's role. As a result of a breakdown of communication, Block Grant dollars

C-22 BEHVIORAL HEALTH PLANNING COUNCIL

were used to fund a program without the Council's knowledge, and the Council was not notified of the allocation until after it had occurred.

The Council has also discussed requesting presentations from local Prevention programs funded by SABG. Since the council travels around the state, this would be a way to learn about these programs from these small organizations that are not in a position to sacrifice time to travel away from their home communities. The Council is interested in how the use of Block Grant funds will change as a result of more individuals having health insurance due to the Affordable Care Act.

The Council is interested in exploring ways to address underutilization of block grant funds – especially for the portion intended for SED children.

ARIZONA BEHAVIORAL HEALTH PLANNING COUNCIL
150 North 18th Avenue, 2nd Floor
Phoenix, AZ 85007

August 25, 2015

Virginia Simmons
Office of Financial Resources
SAMHSA
1 Choke Cherry Road, Room 8-1083
Rockville, MD 20857

Dear Ms. Simmons,

The Arizona Behavioral Health Planning Council is required by Public Law 103-321 to review Arizona's Mental Health and SABG Services Plan for Children and Adults for Fiscal Year 2016. 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 SABG for 2016. 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.

The Planning Council has had integrated representation between mental health and substance abuse since 1999, with the participation of several substance abuse providers. 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 June 2015 demonstrated that 93 percent of respondents 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 strong representation of persons experienced in substance abuse treatment, and continually strives to improve representation among its members.

The Council ensures 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, Kingman, Bullhead City). One of the Council members is currently serving as the chair of the Office of Individual and Family Affairs Advisory Council. Still, the Council understands the importance of its membership being representative of the state and has prioritized recruitment for members residing in rural and remote locations. Conducting meetings in various locations around the state allows for membership that is mixed between urban and rural participants. The Executive

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(Public Laws 99-660, 100-639, and 102-321)

Committee has marked 2015 as being the year it further diversifies by actively recruiting a transition-age youth/ young adult to serve on the Council.

As part of its discussion on membership recruitment, the Executive Committee identified the need to develop a training manual and orientation process that provides candidates with basic information on the Council and committees' functions, as well as a high level overview of what the Council and each committee has been working on for the past six (6) months. The Executive Team has completed the training manual and it will be issued to all new candidates who express an interest in joining the Council and/or its supporting committees. To further ensure the orientation process is a smooth one, candidates will also be partnered with an existing member/mentor to help navigate the membership process. The current Council members will be given a training manual to use as a reference and refresher.

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.

Through its supporting Legislative Committee, the Council is active in reviewing and tracking state and federal legislation pertaining to mental health services. Should an issue of concern be presented, the Committee works to develop and disseminate position papers, provides testimony at legislative hearings, and advocates 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 discussed by the Planning and Evaluation Committee, as well as included in the full Council agendas for discussion and feedback to the State.

The Community Advisory Committee has been particularly active in the past two years. This Committee developed and implemented the "Bracelet Project" in Southern Arizona. Similar to a medical alert bracelet, these bracelets alert first responders that the individual wearing it has mental health needs. The project has had a positive impact with how first responders approach and engage with this population, and has decreased adverse police encounters. The police department has found the bracelets helpful and now provides a copy of the training video for new recruits.

Having successfully implemented the project in Southern Arizona, the Community Advisory Committee Co-Chairs are committed to expanding program implementation to other geographical areas.

The Community Advisory Committee also met with Peer and Family Coalitions throughout Arizona to discuss the meaningfulness of the 9 Adult Principles. The outcome of these

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discussions resulted in the Committee's understanding that the Peer and Family Coalitions are satisfied with the 9 Adult Principles. This feedback allowed the Community Advisory Committee to refocus its efforts on developing criteria to measure the Coalitions' fidelity to the principles. The Committee plans to formally submit the measurement to ADHS/DBHS for consideration by the end of this year.

The Community Advisory Committee is currently working with the ADHS/DBHS to identify issues with the transition of adolescents to the adult mental health system. The Committee met with several children's services providers and the Maricopa County Regional Behavioral Health Authority (RBHA) to discuss their process for ensuring children transition without an interruption in services. The Committee is awaiting encounter data for this population and if negative trends are identified, the Committee will work with ADHS/DBHS to develop and implement a resolution.

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 (MHBG) and Substance Abuse Prevention and Treatment (SABG) Block Grant. These meetings provide an opportunity to share updates and feedback on priorities, issues, and other relevant topics related to the Block Grant.

System of Care Plans provide a mechanism for planning and implementation of mental health and substance abuse services within the state. Annual plans are developed and updates are submitted to ADHS/DBHS staff quarterly. The Planning Council is included in this process with the ADHS/DBHS System of Care Plan 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 meet with the Council's Planning and Evaluation Committee to discuss programs and activities related to the Block Grants. ADHS/DBHS staff received feedback from the Committee regarding new priorities and data needed to respond to them. During 2015, ADHS/DBHS staff also worked with the Council regarding a proposed change in the funding allocation methodology for the SABG/MHBG Block Grant. The ADHS/DBHS Assistant Director of Quality Management and Utilization Management met with the Planning and Evaluation Committee to discuss data specific to grievance, appeals and complaints. The Committee communicated its trepidations that not all issues are reaching ADHS/DBHS because recipients do not know how to express their concerns beyond the Regional Behavioral Health Authority's level. The Chief Financial Officer also met with the Planning and Evaluation Committee to discuss financial allocations for Block Grant dollars. Finally, the Office Chief of the Office of Individual and Family Affairs (OIFA), or a representative from OIFA, also attends the committees and the Planning Council.

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Arizona Governor Ducey has implemented “Administrative Simplification.” As part of this process, duties performed by the Division of Behavioral Health Services (DBHS) will move under the Arizona Health Care Cost Containment System (AHCCCS). The Council, its supporting committees and functions will also transition to AHCCCS. AHCCCS and DBHS have been partners in the provision of mental and behavioral health services for decades and the “Administrative Simplification” will further promote what has always been known, “The mind cannot be separated from the body.” The change will simplify the system of care for over 30,000 behavioral health recipients who are living with a serious mental illness. The transition is being carefully monitored to ensure the “Administrative Simplification” results in no disruption to behavioral health recipients, the Council or its supporting committees

The Planning Council has identified areas of focus for the 2016-2017 grant years. The Council:

- Become more involved with the expenditure of the grant funds. In 2015 dollars were used to fund a program without the Council’s knowledge. The Council was not notified of the allocation until after it had occurred although the Council was aware of the set-aside monies for an evidence-based program addressing first episode psychosis.
- Plans to recruit representatives from programs that are awarded block grant funds. Although the Council is well represented in the number of members who are impacted by, or provide services related to substance use and abuse, the Council is not well represented in providers who are receiving the block grant dollars for the provision of the services. Recruiting a provider that receives block grant funds will allow the Council to better understand how the dollars are used.
- Will evaluate the impact the Affordable Care Act has on the block grants expenditure.
- Will focus on training and educating the RBHAs on how to maximize the use of SED dollars.
- Will seek information to understand how the Mental Health Parity and Addiction Equality Act and the Affordable Care Act are working in Arizona.

Thank you for the opportunity to provide comment on the State Mental Health and SABG Plan. The Council continues to review, monitor and evaluate all aspects of the development of this plan.

Sincerely,



Michael Carr
Chair Planning Council

**“...to advise, review, monitor, and evaluate all aspects of the development of the State Plan”
(Public Laws 99-660, 100-639, and 102-321)**

Environmental Factors and 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)
Michael Carr	State Employees		400 N. Central Avenue Phoenix, AZ 85012 PH: 602-771-3631	MCarr@azdes.gov
Daniel Haley	Family Members of Individuals in Recovery (to include family members of adults with SMI)		H.O.P.E. Inc., 1200 N. Country Club Road Tucson, AZ 85716 PH: 520-869-6263	danielhaley@hopetucson.org
Vicki Johnson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		5409 W. Siesta Way Laveen, AZ 85339 PH: 480-236-2552	Vlj30@cox.net
Margery Ault	State Employees		150 N 18th Avenue Phoenix, AZ 85007 PH: 602-364-4566	Margery.Ault@azdhs.gov
Nanci Stone	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		791 S. 4th Avenue, Ste. A Yuma, AZ 85364 PH: 928-783-3986	nstone@horizonhumanservices.org
Alida Montiel	Federally Recognized Tribe Representatives		2214 N. Cnetral Avenue Phoenix, AZ 85004 PH: 602-258-4822	Alida.Montiel@itcaonline.com
Barbara Lang	State Employees		701 E. Jefferson, MD 6100 Phoenix, AZ 85034 PH: 602-417-4493	Barbara.Lang@azahcccs.gov
Joy Johnson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1110 W. Washington st., Ste. 310 Phoenix, AZ 85007 PH: 602-771-1026	joy.johnson@azhousing.gov
Alicia Ruiz	State Employees		1789 W. Jefferson St., 2NW Phoenix, AZ 85007 PH: 602-542-3792	AliciaRuiz@azdes.gov
John Baird	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1036 W. 3rd Avenue San Manuel, AZ 85631 PH: 520-385-2667	johnbaird1@hotmail.com
Aaron Brown	State Employees		2500 E. Van Buren St Pheonix, AZ 85008 PH: 602-220-6000	Aaron.Bowen@azdhs.gov
Phyllis Grant	Providers		H.O.P.E. Inc., 1200 N. Country Club Road Tucson, AZ 85716 PH: 520-427-9052	phyllisgrant@hopetucson.org
Akia Compton	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		2642 E. Thomas Rd Phoenix, AZ 85016 PH: 480-414-4879	akiac@mikid.org

5333 N. 7th Street, A

Jane Kallal	Providers	-100 Phoenix, AZ 85014 PH: 602-412-4070	Jane@Familyinvolvementcenter.org
Asim Varma	State Employees	5025 E. Washington St., Ste.202 Phoenix, AZ 85034 PH: 602-274-6287	avarma@azdisabilitylaw.org
Deanna Bellinger	Family Members of Individuals in Recovery (to include family members of adults with SMI)	1201 E. Fry Blvd. Sierra Vista, AZ 85635 PH: 520-452-0080	bellinger@wellness- connections.org
Dawn Abbott	Providers	1743 Sycamore Avenue Kingman, AZ 86409 PH: 928-681-5990	dabbott@mmhc-inc.org

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	21	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	3	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	4	
Parents of children with SED*	0	
Vacancies (Individuals and Family Members)	<input type="text" value="2"/>	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	9	42.86%
State Employees	6	
Providers	3	
Federally Recognized Tribe Representatives	1	
Vacancies	<input type="text" value="2"/>	
Total State Employees & Providers	12	57.14%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="7"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="1"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	8	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="3"/>	

* 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?

Footnotes:

JUL 6 2015

Dr. Cara M. Christ
Arizona Department of
Health Services
150 N. 18th Ave. Suite 500
Phoenix, AZ 85007

Dear Dr. Christ:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Page – 2 Dr. Christ

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the “Application Complete” function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA’s block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, “Management’s Responsibility for Internal Controls,” and one of the controls involves a review of how SAMHSA ensures states’ and jurisdictions’ compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

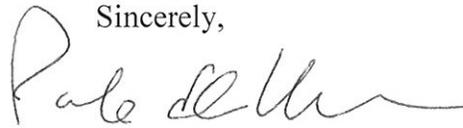
Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state’s chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state’s chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS’s Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

A handwritten signature in black ink, appearing to read "Paolo del Vecchio". The signature is fluid and cursive, with a large initial "P" and a long, sweeping underline.

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Kelly Charbonneau
Michael Carr

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory