Arkansas

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL 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 09/01/2015 12.46.05 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	119841336
Expiration Date	

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

Agency Name	Arkansas Department of Human Services
Organizational Unit	Division of Behavioral Health Services
Mailing Address	305 South Palm Street
City	Little Rock
Zip Code	72205

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

First Name	Charlie
Last Name	Green
Agency Name	Arkansas Department of Human Services, Division of Behavioral Health Services
Mailing Address	305 South Palm Street
City	Little Rock
Zip Code	72205
Telephone	501-686-9164
Fax	501-686-9182
Email Address	charlie.green@dhs.arkansas.gov

State CMHS DUNS Number

Number	1119988441
Expiration Date	

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

Agency Name	Department of Human Services
Organizational Unit	Division of Behavioral Health Services
Mailing Address	305 S Palm St
City	Little Rock
Zip Code	72205

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

First Name	Charlie
Last Name	Green
Agency Name	Department of Human Services
Mailing Address	305 S Palm St

City	Little Rock
Zip Code	72205
Telephone	501-686-9164
Fax	501-686-9182
Email Address	charlie.green@dhs.arkansas.gov

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

From	
To	

IV. Date Submitted

Submission Date	9/1/2015 12:44:52 PM
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Julie
Last Name	Meyer
Telephone	501-683-0551
Fax	501-686-9182
Email Address	julie.meyer@dhs.arkansas.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		
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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 OPMâ€™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 childrenâ€™s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to childrenâ€™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 childrenâ€™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: James C. Green

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: _____

mm/dd/yyyy

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

State Information

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Fiscal Year 2016

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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: James C. Green

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: 7/1/30

mm/dd/yyyy

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

CC: Jeff Jerry
Letha Dial
Kharyssa Bro.
Pam Ordsen
Paula Stone
Julie Meyer
File

STATE OF ARKANSAS
ASA HUTCHINSON
GOVERNOR

July 6, 2015

James C. Green, Ph.D.
Director
Division of Behavioral Health Services
Arkansas Department of Human Services
305 South Palm Street
Little Rock, AR 72205

RE: Designation of Authority

Dear Dr. Green:

As Governor of the State of Arkansas, I affirm that the Division of Behavioral Health Services of the Department of Human Services is, by statute, the state authority for mental health and substance abuse services.

I hereby delegate authority of the Single State Agency Representative within the Division of Behavioral Health Services as the Arkansas Approving Authority on all grant applications and cooperative agreements developed and submitted on behalf of the Division. This authority includes authorization to sign funding agreements and certifications, to provide assurances of compliance, and to perform similar acts relevant to the administration of grants and cooperative agreements deemed to fulfill the mission of the Arkansas Department of Human Services. This delegation of authority is effective until such time as it is rescinded.

I further certify that the responsibility for management of grants will be vested in the Division of Behavioral Health Services of the Department of Human Services. The Division will be responsible to the federal government, the legislature of the State of Arkansas, and to my office for carrying out grant provisions. Thank you for your attention to this matter.

Sincerely,

Asa Hutchinson

Cc: John Selig, DHS Director

STATE CAPITOL, SUITE 250 • LITTLE ROCK, AR 72201
TELEPHONE (501) 682-2345 • FAX (501) 682-1382
INTERNET WEBSITE • www.governor.arkansas.gov

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17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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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.

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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: James C. Green

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: 7/1/30

mm/dd/yyyy

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

CC: Jeff Jerry
Letha Dial
Kharyssa Bro.
Pam Odsen
Paula Stone
Julie Meyer
File

STATE OF ARKANSAS
ASA HUTCHINSON
GOVERNOR

July 6, 2015

James C. Green, Ph.D.
Director
Division of Behavioral Health Services
Arkansas Department of Human Services
305 South Palm Street
Little Rock, AR 72205

RE: Designation of Authority

Dear Dr. Green:

As Governor of the State of Arkansas, I affirm that the Division of Behavioral Health Services of the Department of Human Services is, by statute, the state authority for mental health and substance abuse services.

I hereby delegate authority of the Single State Agency Representative within the Division of Behavioral Health Services as the Arkansas Approving Authority on all grant applications and cooperative agreements developed and submitted on behalf of the Division. This authority includes authorization to sign funding agreements and certifications, to provide assurances of compliance, and to perform similar acts relevant to the administration of grants and cooperative agreements deemed to fulfill the mission of the Arkansas Department of Human Services. This delegation of authority is effective until such time as it is rescinded.

I further certify that the responsibility for management of grants will be vested in the Division of Behavioral Health Services of the Department of Human Services. The Division will be responsible to the federal government, the legislature of the State of Arkansas, and to my office for carrying out grant provisions. Thank you for your attention to this matter.

Sincerely,

Asa Hutchinson

Cc: John Selig, DHS Director

STATE CAPITOL, SUITE 250 • LITTLE ROCK, AR 72201
TELEPHONE (501) 682-2345 • FAX (501) 682-1382
INTERNET WEBSITE • www.governor.arkansas.gov

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
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Signature of CEO or Designee[1]: _____

Title: Director

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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: James C. Green

Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: 07/02/15
mm/dd/yyyy

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

CC: Jeff Jerry
Letha Dial
Kharyssa Bro.
Pam Ordsen
Paula Stone
Julie Meyer
File

STATE OF ARKANSAS
ASA HUTCHINSON
GOVERNOR

July 6, 2015

James C. Green, Ph.D.
Director
Division of Behavioral Health Services
Arkansas Department of Human Services
305 South Palm Street
Little Rock, AR 72205

RE: Designation of Authority

Dear Dr. Green:

As Governor of the State of Arkansas, I affirm that the Division of Behavioral Health Services of the Department of Human Services is, by statute, the state authority for mental health and substance abuse services.

I hereby delegate authority of the Single State Agency Representative within the Division of Behavioral Health Services as the Arkansas Approving Authority on all grant applications and cooperative agreements developed and submitted on behalf of the Division. This authority includes authorization to sign funding agreements and certifications, to provide assurances of compliance, and to perform similar acts relevant to the administration of grants and cooperative agreements deemed to fulfill the mission of the Arkansas Department of Human Services. This delegation of authority is effective until such time as it is rescinded.

I further certify that the responsibility for management of grants will be vested in the Division of Behavioral Health Services of the Department of Human Services. The Division will be responsible to the federal government, the legislature of the State of Arkansas, and to my office for carrying out grant provisions. Thank you for your attention to this matter.

Sincerely,

Asa Hutchinson

Cc: John Selig, DHS Director

STATE CAPITOL, SUITE 250 • LITTLE ROCK, AR 72201
TELEPHONE (501) 682-2345 • FAX (501) 682-1382
INTERNET WEBSITE • www.governor.arkansas.gov

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
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 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).
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.

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Signature of CEO or Designee[1]: _____

Title: Director

Date Signed: 07/02/15
mm/dd/yyyy

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

CC: Jeff Jerry
Letha Dial
Kharyssa Bro.
Pam Ordsen
Paula Stone
Julie Meyer
File

STATE OF ARKANSAS
ASA HUTCHINSON
GOVERNOR

July 6, 2015

James C. Green, Ph.D.
Director
Division of Behavioral Health Services
Arkansas Department of Human Services
305 South Palm Street
Little Rock, AR 72205

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Sincerely,

Asa Hutchinson

Cc: John Selig, DHS Director

STATE CAPITOL, SUITE 250 • LITTLE ROCK, AR 72201
TELEPHONE (501) 682-2345 • FAX (501) 682-1382
INTERNET WEBSITE • www.governor.arkansas.gov

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	James C. Green
Title	Director
Organization	Department of Human Services, Division of Behavioral Heal

Signature: _____ Date: _____

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:

Division of Behavioral Health Services
FUNDED SUBSTANCE ABUSE TREATMENT PROVIDERS

Catchment Area 1

Preferred Family Healthcare, Inc. DBA Decision Point
602 N. Walton Blvd.
Bentonville AR 72712
479-464-1060
www.aoinc.org

Counties Served
Benton, Carroll, Washington, Madison

Catchment Area 2

Preferred Family Healthcare, Inc. DBA Health Resources of Arkansas
#25 Gap Road
Batesville AR 72503
870-793-8900
www.aoinc.org

Counties Served
Boone, Marion, Baxter, Newton, Searcy, Fulton, Izard, Stone, Cleburne, Van Buren, Sharp, Independence, Jackson, White, Woodruff

Catchment Area 3

Northeast Arkansas Community Mental Health Center DBA Mid South Health Systems
2707 Browns Lane
Jonesboro AR 72401
870-972-4000
www.mshs.org

Counties Served
Randolph, Clay, Greene, Lawrence, Craighead, Poinsett, Mississippi, Cross, Crittenden, St. Francis, Lee, Phillips, Monroe

Catchment Area 4

Western Arkansas Counseling and Guidance Center
3111 South 70th Street
Fort Smith AR 72908
479-452-6650
www.wacgc.org

Counties Served
Crawford, Franklin, Sebastian, Logan, Scott, Polk

Catchment Area 5

Quapaw House, Inc.
812 Mountain Pine Road
Hot Springs AR 71913
501-767-4456
www.quapawhouseinc.org

Counties Served
Johnson, Pope, Yell, Conway, Faulkner, Perry, Montgomery, Garland, Pike, Clark, Hot Spring

Catchment Area 6

10th District Substance Abuse Program dba New Beginnings C.A.S.A
412 York Street
Warren AR 71671
870-226-9970
newbeginningscasa@sbcglobal.net

Counties Served
Jefferson, Arkansas, Grant, Cleveland, Lincoln, Desha, Drew, Bradley, Ashley, Chicot

Catchment Area 7

Southwest Arkansas Counseling and Mental Health Center
2904 Arkansas Blvd.
Texarkana AR 71854
870-773-4655
www.swacmhc.com

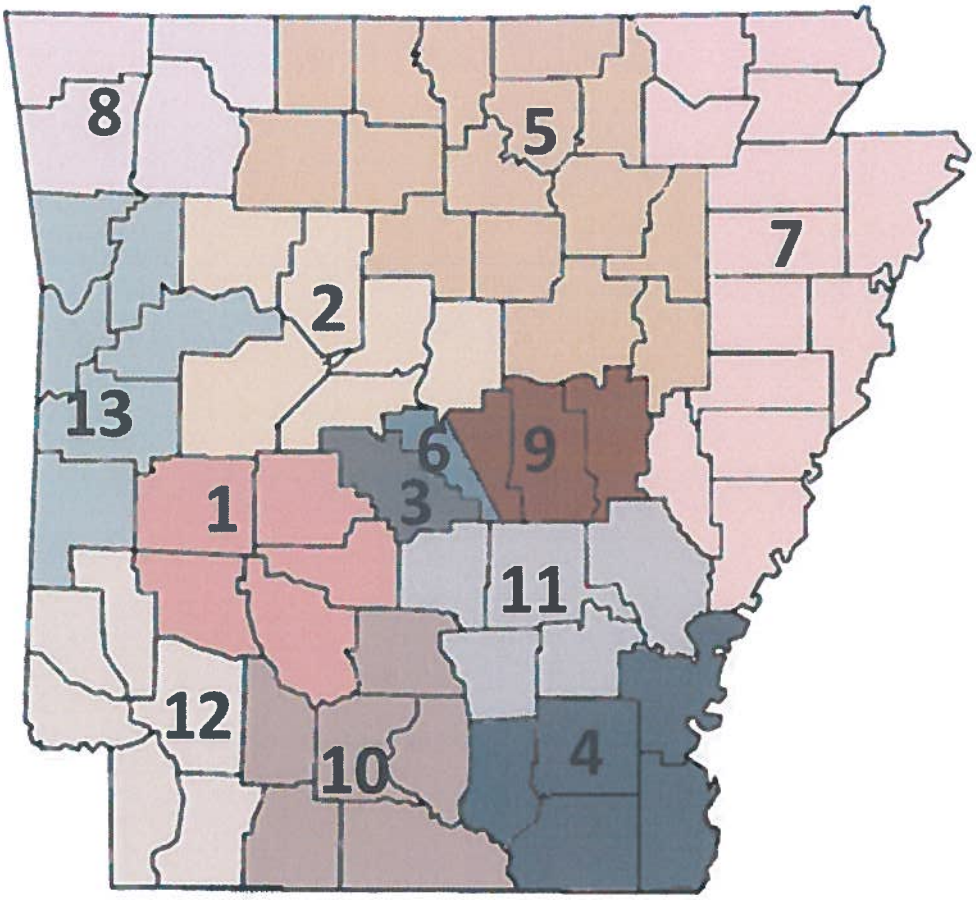
Counties Served
Sevier, Howard, Hempstead, Lafayette, Miller, Little River, Dallas, Nevada, Ouachita, Calhoun, Union, Columbia

Catchment Area 8

Recovery Centers of Arkansas
1201 River Road
North Little Rock AR 72114
501-372-4611
www.rcofa.org

Counties Served
Saline, Pulaski, Lonoke, Prairie

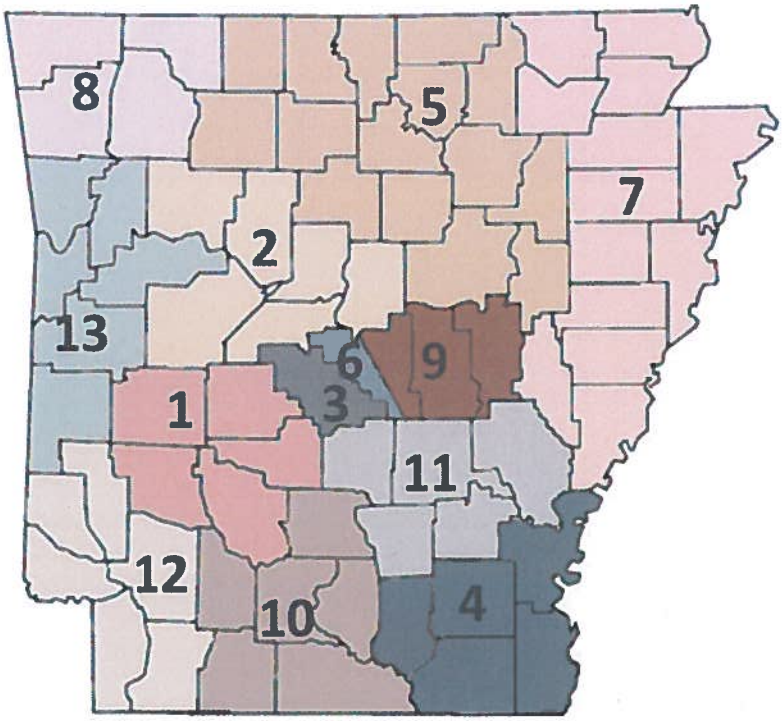
Arkansas Community Mental Health Center Directory



Arkansas Department of Human Services
Division of Behavioral Health Service
Central Administration Office
Physical Address: 4800 West 7th Street
Mailing Address: 305 South Palm Street
Little Rock, AR 72205

Telephone: 501.686-9164
Fax: 501.686.9182
Teletypewriter (TTY): 501.683.6972
humanservices.arkansas.gov/dbhs

Arkansas Community Mental Health Center Directory



Area	Provider	Telephone
1	Community Counseling Services, Inc.	501-624-7111
2	Counseling Associates, Inc.	501-327-4889
3	Counseling Clinic, Inc.	501-315-4224
4	Delta Counseling Associates	870-367-9732
5	Health Resources of Arkansas, Inc.	870-793-8900
6	Little Rock Community Mental Health Center, Inc.	501-686-9300
7	Mid-South Health Systems, Inc.	870-972-4000
8	Ozark Guidance Center, Inc.	479-750-2020
9	Professional Counseling Associates	501-221-1843
10	South Arkansas Regional Health Center	870-862-7921
11	Southeast Arkansas Behavioral Healthcare System, Inc.	870-534-1834
12	Southwest Arkansas Counseling & Mental Health Center, Inc.	870-773-4655
13	Western Arkansas Counseling & Guidance Center	479-452-6650

Arkansas Community Mental Health Center Directory

Area 1

Community Counseling Services

Contact Information:
125 Dons Way
Hot springs, AR 71913

501-624-7111
communitycounselingservices.org

Counties Served:
Clark
Garland
Hot Spring
Montgomery
Pike

Area 2

Counseling Associates, Inc.

Contact Information:
350 Salem Road, Suite 9
Conway, AR 72034

501-327-4889
caiinc.org

Counties Served:
Conway
Faulkner
Johnson
Perry
Pope
Yell

Area 3

Counseling Clinic, Inc.

Contact Information:
307 East Sevier Street
Benton, AR 72015

501-315-4224
counselingclinicinc.org

Counties Served:
Saline

Area 4

Delta Counseling Associates

Contact Information:
790 Roberts Drive
Monticello, AR 71655

870-367-9732
deltacounseling.org

Counties Served:
Ashley
Bradley
Chicot
Desha
Drew

Arkansas Community Mental Health Center Directory

Area 5

Health Resources of Arkansas

Contact Information:
25 Gap Road
Batesville, AR 72503

870-793-8900
healthresourcesofarkansas.com

Counties Served:
Baxter
Boone
Cleburne
Fulton
Izard
Independence
Jackson
Marion
Newton
Searcy
Sharp
Stone
Van Buren
White

Area 6

Little Rock Community Mental Health Center

Contact Information:
1100 North University, Suite 200
Little Rock, AR 72205

501-686-9300

Counties Served:
Pulaski (South of the Arkansas River)

Area 7

Mid-South Health Systems, Inc.

Contact Information:
2707 Browns Lane
Jonesboro, AR 72401

870-972-4000
mshs.org

Counties Served:
Clay
Craighead
Crittenden
Cross
Greene
Lawrence
Lee
Mississippi
Monroe
Phillips
Poinsett
Randolph
St. Francis

Area 8

Ozark Guidance Center

Contact Information:
2400 South 48th Street
Springdale, AR 72762

479-750-2020
ozarkguidance.org

Counties Served:
Benton
Carroll
Madison
Washington

Arkansas Community Mental Health Center Directory

Area 9

Professional Counseling Associates

Contact Information:
3601 Richards Road
North Little Rock, AR 72231

501-221-1843
pca-ar.org

Counties Served:
Lonoke
Prairie
Pulaski (North of the Arkansas River)

Area 10

South Arkansas Regional Health Center

Contact Information:
715 North College
El Dorado, AR 71730

870-862-7921
sarhc.org

Counties Served:
Calhoun
Columbia
Dallas
Ouachita
Nevada
Union

Area 11

Southeast Arkansas Behavioral Healthcare System, Inc.

Contact Information:
2500 Rike Drive
Pine Bluff, AR 71613

870-534-1834
sabhs.org

Counties Served:
Arkansas
Cleveland
Grant
Jefferson
Lincoln

Area 12

Southwest Arkansas Counseling and Mental Health Center, Inc.

Contact Information:
2904 Arkansas Boulevard
Texarkana, AR 71854

870-773-4655
swacmhc.com

Counties Served:
Hempstead
Howard
Lafayette
Little River
Miller
Sevier

Arkansas Community Mental Health Center Directory

Area 13

Western Arkansas Counseling and Guidance Center

Contact Information:
3111 South 70th Street
Fort Smith, AR 72903

479-452-6650
swacmhc.com

Counties Served:
Crawford
Franklin
Logan
Polk
Sebastian
Scott

Specialty Clinics

Birch Tree Communities

Contact Information:
1718 Old Hot Springs Hwy
Benton, AR 72015

501-315-3344
birchtree.org

Centers for Youth and Families

Contact Information:
6601 W 12th Street
Little Rock, AR 72204

501-666-8686
centersforyouthandfamilies.org

GAIN, Inc.

Contact Information:
712 W 3rd Street Suite 100
Little Rock, AR 72201

501-379-4246

Arkansas Department of Human Services
Division of Behavioral Health Service
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Physical Address: 4800 West 7th Street
Mailing Address: 305 South Palm Street
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Telephone: 501.686-9164
Fax: 501.686.9182
Teletypewriter (TTY): 501.683.6972
humanservices.arkansas.gov/dbhs

Arkansas Community Mental Health Center Directory

AREA KEY	COUNTY	COMMUNITY MENTAL HEALTH CENTER	LOCATION	CONTACT INFORMATION
11	Arkansas	Southeast Arkansas Behavioral Healthcare System, Inc.	2500 Rike Drive Pine Bluff, AR 71613	870-534-1834 sabhs.org
4	Ashley	Delta Counseling Associates	790 Roberts Drive Monticello, AR 71655	870-367-9732 deltacounseling.org
5	Baxter	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
8	Benton	Ozark Guidance Center	2400 South 48th Street Springdale, AR 72762	479-750-2020 ozarkguidance.org
5	Boone	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
4	Bradley	Delta Counseling Associates	790 Roberts Drive Monticello, AR 71655	870-367-9732 deltacounseling.org
10	Calhoun	South Arkansas Regional Health Center	715 North College El Dorado, AR 71730	870-862-7921 sarhc.org
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7	Clay	Mid-South Health Systems, Inc.	2707 Browns Lane Jonesboro, AR 72401	870-972-4000 mshs.org
5	Cleburne	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
11	Cleveland	Southeast Arkansas Behavioral Healthcare System, Inc.	2500 Rike Drive Pine Bluff, AR 71613	870-534-1834 sabhs.org
10	Columbia	South Arkansas Regional Health Center	715 North College El Dorado, AR 71730	870-862-7921 sarhc.org
2	Conway	Counseling Associates, Inc.	350 Salem Road Suite 9 Conway, AR 72034	501-327-4889 caiinc.org

Arkansas Community Mental Health Center Directory

7	Craighead	Mid-South Health Systems, Inc.	2707 Browns Lane Jonesboro, AR 72401	870-972-4000 mshs.org
13	Crawford	Western Arkansas Counseling and Guidance Center	3111 South 70th Street Fort Smith, AR 72903	479-452-6650 swacmhc.com
7	Crittenden	Mid-South Health Systems, Inc.	2707 Browns Lane Jonesboro, AR 72401	870-972-4000 mshs.org
7	Cross	Mid-South Health Systems, Inc.	2707 Browns Lane Jonesboro, AR 72401	870-972-4000 mshs.org
10	Dallas	South Arkansas Regional Health Center	715 North College El Dorado, AR 71730	870-862-7921 sarhc.org
4	Desha	Delta Counseling Associates	790 Roberts Drive Monticello, AR 71655	870-367-9732 deltacounseling.org
4	Drew	Delta Counseling Associates	790 Roberts Drive Monticello, AR 71655	870-367-9732 deltacounseling.org
2	Faulkner	Counseling Associates, Inc.	350 Salem Road Suite 9 Conway, AR 72034	501-327-4889 caiinc.org
13	Franklin	Western Arkansas Counseling and Guidance Center	3111 South 70th Street Fort Smith, AR 72903	479-452-6650 swacmhc.com
5	Fulton	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
1	Garland	Community Counseling Services	125 Dons Way Hot springs, AR 71913	501-624-7111 communitycounselingservices.org
11	Grant	Southeast Arkansas Behavioral Healthcare System, Inc.	2500 Rike Drive Pine Bluff, AR 71613	870-534-1834 sabhs.org
7	Greene	Mid-South Health Systems, Inc.	2707 Browns Lane Jonesboro, AR 72401	870-972-4000 mshs.org
12	Hempstead	Southwest Arkansas Counseling and Mental Health Center, Inc.	2904 Arkansas Boulevard Texarkana, AR 71854	870-773-4655 swacmhc.com
1	Hot Spring	Community Counseling Services	125 Dons Way Hot springs, AR 71913	501-624-7111 communitycounselingservices.org
12	Howard	Southwest Arkansas Counseling and Mental Health Center, Inc.	2904 Arkansas Boulevard Texarkana, AR 71854	870-773-4655 swacmhc.com

Arkansas Community Mental Health Center Directory

5	Independence	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
5	Izard	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
5	Jackson	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
11	Jefferson	Southeast Arkansas Behavioral Healthcare System, Inc.	2500 Rike Drive Pine Bluff, AR 71613	870-534-1834 sabhs.org
2	Johnson	Counseling Associates, Inc.	350 Salem Road Suite 9 Conway, AR 72034	501-327-4889 caiinc.org
12	Lafayette	Southwest Arkansas Counseling and Mental Health Center, Inc.	2904 Arkansas Boulevard Texarkana, AR 71854	870-773-4655 swacmhc.com
7	Lawrence	Mid-South Health Systems, Inc.	2707 Browns Lane Jonesboro, AR 72401	870-972-4000 mshs.org
7	Lee	Mid-South Health Systems, Inc.	2707 Browns Lane Jonesboro, AR 72401	870-972-4000 mshs.org
11	Lincoln	Southeast Arkansas Behavioral Healthcare System, Inc.	2500 Rike Drive Pine Bluff, AR 71613	870-534-1834 sabhs.org
12	Little River	Southwest Arkansas Counseling and Mental Health Center, Inc.	2904 Arkansas Boulevard Texarkana, AR 71854	870-773-4655 swacmhc.com
13	Logan	Western Arkansas Counseling and Guidance Center	3111 South 70th Street Fort Smith, AR 72903	479-452-6650 swacmhc.com
9	Lonoke	Professional Counseling Associates	3601 Richards Road North Little Rock, AR 72231	501-221-1843 pca-ar.org
8	Madison	Ozark Guidance Center	2400 South 48th Street Springdale, AR 72762	479-750-2020 ozarkguidance.org
5	Marion	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
12	Miller	Southwest Arkansas Counseling and Mental Health Center, Inc.	2904 Arkansas Boulevard Texarkana, AR 71854	870-773-4655 swacmhc.com
7	Mississippi	Mid-South Health Systems, Inc.	2707 Browns Lane Jonesboro, AR 72401	870-972-4000 mshs.org

Arkansas Community Mental Health Center Directory

7	Monroe	Mid-South Health Systems, Inc.	2707 Browns Lane Jonesboro, AR 72401	870-972-4000 mshs.org
1	Montgomery	Community Counseling Services	125 Dons Way Hot springs, AR 71913	501-624-7111 communitycounselingservices.org
10	Nevada	South Arkansas Regional Health Center	715 North College El Dorado, AR 71730	870-862-7921 sarhc.org
5	Newton	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
10	Ouachita	South Arkansas Regional Health Center	715 North College El Dorado, AR 71730	870-862-7921 sarhc.org
2	Perry	Counseling Associates, Inc.	350 Salem Road Suite 9 Conway, AR 72034	501-327-4889 caiinc.org
7	Phillips	Mid-South Health Systems, Inc.	2707 Browns Lane Jonesboro, AR 72401	870-972-4000 mshs.org
1	Pike	Community Counseling Services	125 Dons Way Hot springs, AR 71913	501-624-7111 communitycounselingservices.org
7	Poinsett	Mid-South Health Systems, Inc.	2707 Browns Lane Jonesboro, AR 72401	870-972-4000 mshs.org
13	Polk	Western Arkansas Counseling and Guidance Center	3111 South 70th Street Fort Smith, AR 72903	479-452-6650 swacmhc.com
2	Pope	Counseling Associates, Inc.	350 Salem Road Suite 9 Conway, AR 72034	501-327-4889 caiinc.org
9	Prairie	Professional Counseling Associates	3601 Richards Road North Little Rock, AR 72231	501-221-1843 pca-ar.org
6	Pulaski (South of the Arkansas River)	Little Rock Community Mental Health Center	1100 North University Suite 200 Little Rock, AR 72205	501-686-9300
9	Pulaski (North of the Arkansas River)	Professional Counseling Associates	3601 Richards Road North Little Rock, AR 72231	501-221-1843 pca-ar.org
7	Randolph	Mid-South Health Systems, Inc.	2707 Browns Lane Jonesboro, AR 72401	870-972-4000 mshs.org
3	Saline	Counseling Clinic, Inc.	307 East Sevier Street Benton, AR 72015	501-315-4224 counselingclinicinc.org

Arkansas Community Mental Health Center Directory

13	Scott	Western Arkansas Counseling and Guidance Center	3111 South 70th Street Fort Smith, AR 72903	479-452-6650 swacmhc.com
5	Searcy	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
13	Sebastian	Western Arkansas Counseling and Guidance Center	3111 South 70th Street Fort Smith, AR 72903	479-452-6650 swacmhc.com
12	Sevier	Southwest Arkansas Counseling and Mental Health Center, Inc.	2904 Arkansas Boulevard Texarkana, AR 71854	870-773-4655 swacmhc.com
5	Sharp	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
7	St. Francis	Mid-South Health Systems, Inc.	2707 Browns Lane Jonesboro, AR 72401	870-972-4000 mshs.org
5	Stone	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
10	Union	South Arkansas Regional Health Center	715 North College El Dorado, AR 71730	870-862-7921 sarhc.org
5	Van Buren	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
8	Washington	Ozark Guidance Center	2400 South 48th Street Springdale, AR 72762	479-750-2020 ozarkguidance.org
5	White	Health Resources of Arkansas	25 Gap Road Batesville, AR 72503	870-793-8900 healthresourcesofarkansas.com
2	Yell	Counseling Associates, Inc.	350 Salem Road Suite 9 Conway, AR 72034	501-327-4889 caiinc.org

DASEP DWI Services Directory

Please call the number in the county of your residence. If you live outside of Arkansas please call the number in the county of your arrest. These DWI Court Staff will assist you in obtaining and/or documenting the DWI rehabilitation required prior to driver's license reinstatement.

Arkansas County		870-541-9200	Main Office: Office Hours:	Jefferson County 8 a.m. – 4:30 .p.m. M-F
Ashley County		870-367-1701	Main Office: Office Hours:	Desha County 8 a.m. - 5 p.m. M-F
Baxter County		866-308-9923 Ext. 1915	Main Office: Office Hours:	Independence County 8 a.m. - 5 p.m. M-F
Benton County		479-271-6137	Main Office Office Hours:	Benton County 8:00 a.m. – 4:00 p.m. M-F
Boone County		866-308-9925 Ext. 1616	Main Office: Office Hours:	Independence County 8 a.m. - 5 p.m. M-F
Bradley County		870-367-1701	Main Office: Office Hours:	Desha County 8:00 a.m. - 5 p.m. M-F
Calhoun County		870-234-7242	Main Office: Office Hours	Columbia County 8 a.m. - 5 p.m. M-F
Carroll County		479-271-6137	Main Office Office Hours:	Benton County 8:00 a.m. – 4:00 p.m. M-F
Chicot County		870-367-1701	Main Office: Office Hours:	Desha County 8:00 a.m. - 5 p.m. M-F
Clark County		870-318-0398	Main Office: Office Hours:	Garland County 8 a.m. - 4:30 p.m. M-TH 8 a.m.- 3:30 F
Clay County		870-892-7111	Main Office: Office Hours:	Craighead County 8 a.m. - 4:30 p.m. M-F
Cleburne County		501-250-1104	Main Office: Office Hours:	Independence County 8 a.m. - 5 p.m. M-F
Cleveland County		870-541-9200	Main Office: Office Hours:	Jefferson County 8 a.m. – 4:30 p.m. M-F

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Columbia County		870-234-7242	Main Office: Office Hours:	Columbia County 8 a.m. - 5 p.m. M-F
Conway County		479-968-7667	Main Office: Office Hours:	Pope County 8:00 a.m. - 4:30 p.m. M-F
Craighead County		870-972-4078	Main Office: Office Hours:	Craighead County 8 a.m. - 4:30 p.m. M-F
Crawford County		479-474-4584	Main Office: Office Hours:	Sebastian County 8:30 a.m. - 5 p.m. M-F
Crittenden County		870-702-5913	Main Office: Office Hours:	Crittenden County 8:00 a.m. - 5:00 p.m. M-F
Cross County		870-588-3752	Main Office: Office Hours:	Crittenden County 8 a.m. - 5:00 p. m. M-F
Dallas County		870-234-7242	Main Office: Office Hours:	Columbia County 8 a.m. - 5 p.m. M-F
Desha County		870-367-1701	Main Office: Office Hours:	Desha County 8:00 a.m. - 5 p.m. M-F
Drew County		870-367-1701	Main Office: Office Hours:	Desha County 8:00 a.m. - 5 p.m. M-F
Faulkner County		479-968-7667	Main Office: Office Hours:	Pope County 8:00 a.m.-4:30 p.m. M-F
Franklin County		479-667-2497	Main Office: Office Hours:	Sebastian County 8:30 a.m.-5 p.m. M-F
Fulton County		866-533-1762 Ext. 1846	Main Office: Office Hours:	Independence County 8 a.m. - 5pm M-F
Garland County		501-318-0398	Main Office: Office Hours:	Garland County 8 a.m. - 4:30 p.m. M-TH 8 a.m.- 3:30 F
Grant County		870-541-9200	Main Office Office Hours:	Jefferson County 8 a.m. – 4:30 p.m. M-F
Greene County		870-892-7111	Main Office: Office Hours:	Craighead County 8 a.m. - 4:30 p. m. M-F
Hempstead County		870-777-3850	Main Office: Office Hours:	Hempstead County 8:00 a.m.-4 p.m. M-F
Hot Springs County		501-318-0398	Main Office: Office Hours:	Garland County 8 a.m. - 4:30 pm M-TH 8 a.m.- 3:30 F

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Howard County		870-777-3850	Main Office: Office Hours:	Hempstead County 8:00 a.m.-4 p.m. M-F
Independence County		866-533-1760 Ext. 1059	Main Office: Office Hours:	Independence County 8 a.m.-5 p.m. M-F
Izard County		866-533-1760 Ext. 1059	Main Office: Office Hours:	Independence County 8 a.m.-5 p.m. M-F
Jackson County		866-533-1757 Ext. 1712	Main Office: Office Hours:	Independence County 8 a.m.-5 p.m. M-F
Jefferson County		870-541-9200	Main Office Office Hours:	Jefferson County 8 a.m. – 4:30 p.m. M-F
Johnson County		479-968-7667	Main Office: Office Hours:	Pope County 8:00 a.m.-4:30 p.m. M-F
Lafayette County		870-234-7242	Main Office: Office Hours:	Columbia County 8 a.m. - 5 p.m. M-F
Lawrence County		870-892-7111	Main Office: Office Hours:	Craighead County 8 a.m. - 4:30 p. m. M-F
Lee County		870-338-3900	Main Office: Office Hours:	Crittenden County 8 a.m. - 5 p.m. M-F
Lincoln County		870-541-9200	Main Office Office Hours:	Jefferson County 8 a.m. – 4:30 p.m. M-F
Little River County		870-772-0773	Main Office: Office Hours:	Miller County 8 a.m. – 4:30 p.m. M-F
Logan County		479-963-2140	Main Office: Office Hours:	Sebastian County 8:30 a.m. - 5 p.m. M-F
Lonoke County		501-372-4242	Main Office: Office Hours:	Pulaski County 8 a.m. - 5 p.m. M-F
Madison County		479-271-6137	Main Office Office Hours:	Benton County 8:00 a.m. – 4:00 p.m. M-F
Marion County		866-308-9923 Ext. 1915	Main Office: Office Hours:	Independence 8 a.m.-5 p.m. M-F
Miller County		870-772-0773	Main Office: Office Hours:	Miller County 8:00 a.m.-4 p.m. M-F
Mississippi County		870-763-2139	Main Office: Office Hours:	Craighead County 8 a.m. - 4:30 p. m. M-F
Monroe County		870-630-3808	Main Office: Office Hours:	Crittenden County 8 a.m. - 5 p.m. M-F

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Montgomery County		501-318-0398	Main Office: Office Hours:	Garland County 8 a.m. - 4:30 p.m. M-TH 8 a.m.- 3:30 F
Nevada County		870-777-3850	Main Office: Office Hours:	Hempstead County 8:00 a.m. - 4 p.m. M-F
Newton County		866-308-9925 Ext. 1616	Main Office: Office Hours:	Boone County 8 a.m. - 5 p.m. M-F
Ouachita County		870-234-7242	Main Office: Office Hours:	Columbia County 8 a.m. - 5 p.m. M-F
Perry County		479-968-7667	Main Office: Office Hours:	Pope County 8:00 a.m. - 4:30 p.m. M-F
Phillips County		870-338-3900	Main Office: Office Hours:	Crittenden County 8 a.m. - 5 p. m. M-F
Pike County		501-318-0398	Main Office: Office Hours:	Garland County 8:00 a.m. - 4:30 M-TH 8 a.m.- 3:30 F
Poinsett County		870-972-4031	Main Office: Office Hours:	Craighead County 8 a.m. - 4:30 p. m. M-F
Polk County		479-394-5277	Main Office: Office Hours:	Sebastian County 8:30 a.m. - 5 p.m. M-F
Pope County		479-968-7667	Main Office: Office Hours:	Pope County 8:00 a.m. - 4:30 p.m. M-F
Prairie County		501-372-4242	Main Office: Office Hours:	Pulaski County 8 a.m. - 5 p.m. M-F
Pulaski County		501-372-4242	Main Office: Office Hours:	Pulaski County 8 a.m. - 5 p.m. M-F
Randolph County		870-892-7111	Main Office: Office Hours:	Craighead County 8 a.m.-4:30 p.m. M-F
Saline County		501-372-4242	Main Office: Office Hours:	Pulaski County 8 a.m. -5 p.m. M-F
Scott County		479-637-2468	Main Office: Office Hours:	Sebastian County 8:30 a.m-5 p.m. M-F
Searcy County		866-308-9925 Ext. 1616	Main Office: Office Hours:	Independence 8 a.m.-5 p.m. M-F

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Sebastian County		479-452-6650	Main Office: Sebastian County Office Hours: 8:30 a.m. – 5 p.m. M-F
Sevier County		870-772-0773	Main Office: Miller County Office Hours: 8:00 a.m.-4 p.m. M-F
Sharp County		866-533-1762 Ext. 1846	Main Office: Independence County Office Hours: 8 a.m.-5p.m. M-F
St. Francis County		870-588-3752	Main Office: Crittenden County Office Hours: 8 a.m.-4:30 p.m. M-F
Stone County		501-250-1104	Main Office: Independence County Office Hours: 8 a.m. - 5 p.m. M-F
Union County		870-234-7242	Main Office: Columbia County Office Hours: 8 a.m. - 5 p.m. M-F
Van Buren County		501-250-1104	Main Office: Independence County Office Hours: 8 a.m. - 5 p.m. M-F
Washington County		479-271-6137	Main Office: Benton County Office Hours: 8:00 a.m. – 4:00 p.m. M-F
White County		501-278-5104	Main Office: Independence County Office Hours: 8 a.m.-5 p.m. M-F
Woodruff County		866-533-1757 Ext. 1712	Main Office: Independence County Office Hours: 8 a.m.-5 p.m. M-F
Yell County		479-968-7667	Main Office: Pope County Office Hours: 8:00 a.m.-4:30 p.m. M-F

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DASEP Court Staff Directors

AREA 1

DECISION POINT BATES CAMPUS
602 N Walton Blvd
Bentonville, AR 72712
Web-Site: http://www.decision-point.org

Counties: Benton, Carroll, Washington, Madison

Bud Boman, DASEP Project Director
Telephone: (479) 271-6137
Fax: (479) 271-6234
bboman@decision-point.org

AREA 2

HEALTH RESOURCES OF ARKANSAS, INC.
P.O. Box 2578
#25 Gap Road (Physical)
Batesville, AR 72503
Website: www.healthresourcesofarkansas.com

Counties: Boone, Marion, Baxter, Fulton, Newton, Searcy, Stone, Izard, Sharp, Van Buren, Cleburne, Independence, White, Jackson, Woodruff

Sue Lamons, DASEP Project Director
Telephone: (870) 793-8900 Ext. 1126
Fax: (870) 793-4258
E-Mail: Slamons@hra-health.org

AREA 3

MID SOUTH HEALTH SYSTEMS
905 N. 7TH Street
West Memphis, AR 72301

Counties: Randolph, Clay, Lawrence, Greene, Craighead, Mississippi, Poinsett, Cross, Crittenden, St. Francis, Lee, Monroe, Phillips

Laketha Brown, DASEP Project Director
Telephone: 870-702-5913
Fax: 870-735-5260
E-Mail: lbrown@mshs.org

AREA 4

WESTERN ARKANSAS COUNSELING AND GUIDANCE CENTER INC.
P. O. Box 11818
3111 South, 70th
Fort Smith, AR 72917-1818
Web-site: http://www.wacgc.org/

Counties: Crawford, Franklin, Sebastian, Logan, Scott, Polk

Stuart Byford, DASEP Project Director
Phone: (479) 484-8189
Fax: (479) 637-2492
E-Mail: stuart.byford@wacgc.org

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AREA 5

QUAPAW HOUSE, INC.
500 Quapaw Avenue
Hot Springs, AR 71914
www.quapawhouse.org

Counties: Johnson, Pope, Conway, Faulkner, Yell, Perry, Montgomery, Garland, Pike, Hot Spring, Clark

BJ Brady, DASEP Project Director
Phone: (501) 318-0398
Fax: (501) 318-0496
E-Mail: bjbrady@quapawhouseinc.org

AREA 6

DELTA COUNSELING
102B North Main street
Monticello, AR 71655

Counties: Grant, Jefferson, Arkansas, Cleveland, Lincoln, Desha, Bradley, Drew, Ashley, Chicot

Paul Dottley, DASEP Project Director
Phone: (870) 367-1701

E-Mail: p.dottley@deltacounseling.org

AREA 7

SOUTHWEST ARKANSAS COUNSELING AND MENTAL HEALTH CENTER, INC.
601 Hazel Street
Texarkana, AR 71854

Counties: Sevier, Howard, Little River, Hempstead, Miller, Nevada, Lafayette, Columbia, Dallas, Ouachita, Calhoun, Union

Doris Stanley, DASEP Project Director
Phone: (870) 772-0773 (870) 779-1501
Fax: (870) 772-6042
E-Mail: doris1247@yahoo.com

AREA 8

FAMILY SERVICE AGENCY
628 West Broadway, Suite 300
North Little Rock, AR 72114
Website: http://www.helpingfamilies.org/

Counties: Saline, Pulaski, Lonoke, Prairie

Michelle Coleman, DASEP Project Director
Phone (501) 372-4242
Fax: (501) 372-1582
E-Mail: mcoleman@fsainc.org

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ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES

SUBSTANCE ABUSE TREATMENT SERVICES PROGRAM (SATS)

CATCHMENT AREA 1	COUNTIES SERVED
Preferred Family Healthcare, Inc. DBA –Decision Point 602 N. Walton Blvd (Physical) Bentonville, AR 72712 (O): 479-464-1060	Benton, Carroll, Washington, Madison
Youth Bridge, Inc. 2153 E. Joyce Blvd. Suite 201 Fayetteville, AR 72703 (O): 479-575-9471	Benton, Carroll, Washington, Madison
CATCHMENT AREA 2	**COUNTIES SERVED**
Ozark Mountain Alcohol Residential Treatment, Inc. 116 Snowball Drive Gassville, AR 72653 (O): 870-435-6200	Boone, Marion, Baxter, Newton, Searcy, Fulton, Izard, Stone, Cleburne, Van Buren, Sharp, Independence, Jackson, White, Woodruff
CATCHMENT AREA 3	**COUNTIES SERVED**
Northeast Arkansas Community Mental Health Center dba Mid-South Health Systems 2707 Browns Lane Jonesboro, AR 72401 (O): 870-972-4000	Randolph, Clay, Greene, Lawrence, Craighead, Poinsett, Mississippi, Cross, Crittenden, St. Francis, Lee, Phillips, Monroe
CATCHMENT AREA 4	**COUNTIES SERVED**
Western Arkansas Counseling and Guidance Center 3111 South 70th Street Fort Smith, AR 72908 (O): 479-452-6650	Crawford, Franklin, Sebastian, Logan, Scott, Polk
Harbor House, Inc. 615 North 19th Street Fort Smith, AR 72914 (O): 479-785-4083	Crawford, Franklin, Sebastian, Logan, Scott, Polk
CATCHMENT AREA 5	**COUNTIES SERVED**
Quapaw House, Inc. 812 Mountain Pine Road Hot Springs, AR 71914 (O): 501-767-4456	Johnson, Pope, Yell, Conway, Faulkner, Perry, Montgomery, Garland, Pike, Clark, Hot Spring
ARVAC, Inc. Freedom House, ADTC 400 Lake Front Drive Russellville, AR 72802 (O): 479-968-7086	Johnson, Pope, Yell, Conway, Faulkner, Perry, Montgomery, Garland, Pike, Clark, Hot Spring
CATCHMENT AREA 6	**COUNTIES SERVED**
10th District Substance Abuse Program dba New Beginnings C.A.S.A 412 York Street Warren, AR 71671 (O): 870-226-9970	Jefferson, Arkansas, Grant, Cleveland, Lincoln, Desha, Drew, Bradley, Ashley, Chicot
Southeast Arkansas Behavioral Health Care System, Inc. 2500 Rike Drive Pine Bluff, AR 71613 (O): 870-534-1834	Jefferson, Arkansas, Grant, Cleveland, Lincoln, Desha, Drew, Bradley, Ashley, Chicot

United Family Services, Inc. 616 S. Linden Street Pine Bluff, AR 71601 (O): 870-534-3386	Jefferson, Arkansas, Grant, Cleveland, Lincoln, Desha, Drew, Bradley, Ashley, Chicot
Jefferson Comprehensive Counseling Associates PO Box 21203 White Hall, Arkansas 71612 (O):870-247-5222	Jefferson, Arkansas, Grant, Cleveland, Lincoln, Desha, Drew, Bradley, Ashley, Chicot
CATCHMENT AREA 7	**COUNTIES SERVED**
Southwest Arkansas Counseling and Mental Health Center 2904 Arkansas Blvd Texarkana, AR 71854 (O): 870-773-4655	Sevier, Howard, Hempstead, Lafayette, Miller, Little River, Dallas, Nevada, Ouachita, Calhoun
South Arkansas Youth Services 128 North Washington Magnolia, AR 717130 (O): 870-234-6550	Sevier, Howard, Hempstead, Lafayette, Miller, Little River, Dallas, Nevada, Ouachita, Calhoun
CATCHMENT AREA 8	**COUNTIES SERVED**
Family Service Agency, Inc. 628 West Broadway, Suite 300 North Little Rock, AR 72114 (O): 501-372-4242	Saline, Pulaski, Lonoke, Prairie
Recovery Centers of Arkansas 1201 River Road North Little Rock, AR 72114 (O): 501-372-4611	Saline, Pulaski, Lonoke, Prairie

Arkansas County

Southeast Arkansas Behavioral Health Care System, Inc.
Site Name: Southeast Arkansas Behavioral Health Care System, Inc.
121 Commercial Drive B
Stuttgart AR 72160
870-673-1633
www.sabhs.org

Non-Funded, Adult & Adolescent Outpatient, Community Mental Health Center, Mental Health Services, Drug Court Referrals Accepted

United Family Services, Inc.
Site Name: United Family Services, Inc.
1600 S. Main Street
Stuttgart AR 72160
870-534-3386
www.ufamservices.com

Non-Funded, Adolescent Outpatient

Baxter County

Ozark Mountain Alcohol Residential Treatment, Inc.
Site Name: OMART, Inc.
116 Snowball Drive
Gassville AR 72635
870-435-6200
www.omartinc.com

Non-Funded, Adult Residential, Adult Outpatient, Mental Health Services, Specialized Women's Services, Adult Observational Detox, Adult Partial Day, Drug Court Referrals Accepted

Youth Bridge, Inc.
Site Name: Mountain Outpatient Clinic
707 N. Cardinal Drive Suite 7
Mountain Home AR 72653
870-425-5644
www.youthbridge.com

Non-Funded, Adolescent Outpatient, Juvenile Drug Court Referrals Accepted

Benton County

Fresh Roots Family Counseling
Site Name: Fresh Roots Family Counseling
411 W. Poplar
Rogers AR 72756
479-986-8655

Non-Funded, Adult & Adolescent Outpatient,, Drug Court & Juvenile Drug Court Referrals Accepted, Mental Health Services

Ozark Guidance Center, Inc.
Site Name: Ozark Guidance Center, Inc.
710 Holly Street
Siloam Springs AR 72761
479-524-8618
www.ozarkguidance.org

Non-Funded, Adult Outpatient, Community Mental Health Center, Mental Health Services

Ozark Guidance Center, Inc.
Site Name: Ozark Guidance Center, Inc.
2508 Southeast 20th Street
Bentonville AR 72712
479-273-9088
www.ozarkguidance.org

Non-Funded, Adult Outpatient, Community Mental Health Center, Mental Health Services

Texarkana Behavioral Associates, LLC DBA Vantage Point of Northwest Arkansas
Site Name: DBA Vantage Point of NWA/Bentonville Therapeutic Day Treatment
2005 SE Walton Blvd.
Bentonville AR 72712
479-464-5925
www.vantagepointnwa.com

Non-Funded, Adolescent Outpatient, Mental Health Services

Texarkana Behavioral Health Associates LLC DBA Vantage Point of Northwest Arkansas
Site Name: DBA Vantage Point of NW AR: Bentonville Counseling Center
2003 SW Walton Blvd.
Bentonville AR 72712
479-464-8081
www.vantagepointnwa.com

Non-Funded, Adult & Adolescent Outpatient, Mental Health Services

Youth Bridge, Inc.
Site Name: Rogers Outpatient Clinic
1200 W. Walnut, Suite 1500
Rogers AR 72756
479-636-0083
www.youthbridge.com

Non-Funded, Adolescent Outpatient, Juvenile Drug Court Referrals Accepted

Boone County

Ozark Mountain Alcohol Residential Treatment, Inc.
Site Name: OMART, Inc.
801 South Pine, Suite 4
Harrison AR 72601
870-365-7251
www.omartinc.com

Non-Funded, Adult Outpatient

Right Move Counseling

Site Name: Right Move Counseling
600 East Stephenson
Harrison AR 72601
870-688-8352

Non Funded, Adult Outpatient, Drug Court Referrals Accepted

Texarkana Behavioral Associates, LLC DBA Vantage Point of Northwest Arkansas

Site Name: DBA Vantage Point of NWA/Harrison Therapeutic Day Treatment
121 Sawgrass Point
Harrison AR 72601
870-391-3871
www.vantagepointnwa.com

Non-Funded, Adolescent Outpatient, Mental Health Services

Texarkana Behavioral Health Associates LLC DBA Vantage Point of Northwest Arkansas

Site Name: DBA Vantage Point of NW AR: Harrison Counseling Center
117 Sawgrass Point
Harrison AR 72601
870-741-2658
www.vantagepointnwa.com

Non Funded, Adult & Adolescent Outpatient, Mental Health Services

Youth Bridge, Inc.

Site Name: Harrison Outpatient Clinic
107 East Crandall Avenue, Suite B
Harrison AR 72601
870-741-8484
www.youthbridge.com

Non-Funded, Adolescent Outpatient, Juvenile Drug Court Referrals Accepted

Carroll County

Fresh Roots Family Counseling
Site Name: Recovery Services
104 E. 8th Street
Green Forrest AR 72638
479-986-8655
www.freshrootsfamilycounseling.com

Non-Funded, Adult & Adolescent Outpatient,, Drug Court & Juvenile Drug Court Referrals Accepted

Ozark Guidance Center, Inc.
Site Name: Ozark Guidance Center, Inc.
208 Hwy 62 West
Berryville AR 72616
870-423-2758
www.ozarkguidance.org

Non-Funded, Adult Outpatient, Community Mental Health Center, Mental Health Services

Youth Bridge, Inc.
Site Name: Berryville Outpatient Clinic
1004 S. Main Street, Suite A
Berryville AR 72616
870-423-1077
www.youthbridge.com

Non-Funded, Adolescent Outpatient, Juvenile Drug Court Referrals Accepted

Columbia County

South Arkansas Youth Services, Inc.
Site Name: Columbia County Behavioral Health and Outreach Clinic
301 Boundary Street
Magnolia AR 71753
870-234-2600
www.saysyouth.org

Non-Funded, Adolescent Outpatient, Mental Health Services, Community Mental Health Center, Juvenile Drug Court Referrals Accepted

Conway County

Conway County Community Service, Inc.
Site Name: Community Service, Inc.
100 South Cherokee Street
Morrilton AR 72110
501-354-4589
www.communityserviceinc.com

Non-Funded, Adolescent Outpatient, Juvenile Drug Court Referrals Accepted

Counseling Associates, Inc.
Site Name: Counseling Associates, Inc.
8 Hospital Drive
Morrilton AR 72110
501-354-1561
www.caiinc.org

Non-Funded, Community Mental Health Center, Adult & Adolescent Outpatient, Mental Health Services

Craighead County

Crowley's Ridge Development Council, Inc.
Site Name: Northeast Arkansas Regional Recovery Center
6009 C.W. Post Road
Jonesboro AR 72401
870-932-0228
www.crdcnea.com

Non-Funded, Adult Residential, Adult & Adolescent Outpatient, Adult & Adolescent Partial Day, Drug Court Referrals Accepted, Adult Observational Detox

Northeast Arkansas Treatment Services, LLC
Site Name: Northeast Arkansas Treatment Services, LLC
912 Osler Drive, Suite B
Jonesboro AR 72401
870-336-0549

Non Funded, Adult Outpatient, Opioid Program

St. Benards, Inc.

Site Name: St. Benards Counseling Center
615 E. Matthews
Jonesboro AR 72401
870-931-5184
www.stbenards.info/

Non-Funded, Adult Outpatient, Mental Health Services

Crawford County

Credit Counseling Advocates, Inc. DBA Serenity Counseling Advocates, Inc.

Site Name: Serenity Counseling Advocates, Inc.
3103 Alma Highway
Van Buren AR 72956
479-410-1700

Non-Funded, Adult & Adolescent Outpatient, Mental Health Services

Drew County

Alternative Opportunities DBA Dayspring Behavioral Health

Site Name: Alternative Opportunities DBA Dayspring Behavioral Health
583 West Gaines
Monticello AR 71655
870-367-2143
www.aoinc.org

Non-funded, Community Mental Health Center, Adult & Adolescent Outpatient, Drug Court & Juvenile Drug Court Referrals Accepted

Faulkner County

Conway County Community Service, Inc.
Site Name: Community Service, Inc.
818 N. Creek Drive
Conway AR 72032
501-327-9788
www.communityserviceinc.com

Non-Funded, Adolescent Outpatient, Juvenile Drug Court Referrals Accepted

Counseling Associates, Inc.
Site Name: Counseling Associates, Inc.
350 Salem Road, Suite 1
Conway AR 72034
501-366-8300
www.caiinc.org

Non-Funded, Community Mental Health Center, Adult & Adolescent Outpatient, Mental Health Services, Juvenile Drug Court Referrals Accepted

Franklin County

Conway County Community Service, Inc.
Site Name: Community Service, Inc.
203 North 4th Street
Ozark AR 72949
479-967-3370
www.communityserviceinc.com

Non-Funded, Adolescent Outpatient, Juvenile Drug Court Referrals Accepted

Garland County

CATAR Ltd
Site Name: CATAR Clinic of Hot Springs
1 Mercy Lane Suite 403
Hot Springs AR 71913
501-463-9565
www.catarclinic.com

Non-Funded, Opioid Program, Adult Outpatient

Grant County

Southeast Arkansas Behavioral Health Care System, Inc.
Site Name: Southeast Arkansas Behavioral Health Care System, Inc.
301 North Oak Street
Sheridan AR 72150
870-942-5101
www.sabhs.org

Non-Funded, Adult & Adolescent Outpatient, Community Mental Health Center, Mental Health Services

Independence County

North Central Arkansas Development Council, Inc.
Site Name: NADC, Inc.
550 9th Street
Batesville AR 72501
870-793-2561

Non Funded, Adult & Adolescent Outpatient

Jefferson County

Cares Behavioral Services

Site Name: Cares Behavioral Services
9116 State Street
Pine Bluff AR 71601
870-293-4478

Non-Funded, Adult Outpatient, Drug Court & Juvenile Drug Court Referrals Accepted

Jefferson Comprehensive Counseling Associates

Site Name: Jefferson Comprehensive Counseling Associates
2304 West 29th Avenue
Pine Bluff AR 71603
870-247-5222

Non Funded, Adult & Adolescent Outpatient, Mental Health Services, Drug Court & Juvenile Drug Court Referrals Accepted

Southeast Arkansas Behavioral Health Care System, Inc.

Site Name: Southeast Arkansas Behavioral Health Care System, Inc.
2500 Rike Drive
Pine Bluff AR 71613
870-534-1834
www.sabhs.org

Non-Funded, Adult & Adolescent Outpatient, Community Mental Health Center, Mental Health Services, Juvenile Drug Court Referrals Accepted

United Family Services, Inc.

Site Name: United Family Services, Inc.
1314 W. 6th Street
Pine Bluff AR 71601
870-534-8826
www.ufamservices.com

Non-Funded, Adolescent Outpatient

Johnson County

Conway County Community Service, Inc.
Site Name: Community Service, Inc.
106 Cherokee Street
Clarksville AR 72830
479-754-7296
www.communityserviceinc.com

Non-Funded, Adolescent Outpatient, Juvenile Drug Court Referrals Accepted

Counseling Associates, Inc.
Site Name: Counseling Associates, Inc.
1021 Poplar Street
Clarksville AR 72830
479-754-8610
www.caiinc.org

Non-Funded, Community Mental Health Center, Adult & Adolescent Outpatient, Mental Health Services

Lincoln County

Southeast Arkansas Behavioral Health Care System, Inc.
Site Name: Southeast Arkansas Behavioral Health Care System, Inc.
612 East Arkansas Street
Star City AR 71667
870-628-4181
www.sabhs.org

Non-Funded, Adult & Adolescent Outpatient, Community Mental Health Center, Mental Health Services, Drug Court Referrals Accepted

Madison County

Ozark Guidance Center, Inc.
Site Name: Ozark Guidance Center, Inc.
1104 N. College
Huntsville AR 72740
479-738-2878
www.ozarkguidance.org

Non-Funded, Adult Outpatient, Community Mental Health Center, Mental Health Services

Miller County

Arkansas Treatment Services, PA
Site Name: Arkansas Treatment Services, PA
408 Hazel Street
Texarkana AR 71854
870-744-0421
www.methadone4me.com

Non-Funded, Opioid Program

South Arkansas Youth Services, Inc.
Site Name: Miller County Behavioral Health and Outreach Clinic
1202 State Line Avenue
Texarkana AR 71854
870-774-0920
www.saysyouth.org

Non-Funded, Adolescent Outpatient, Mental Health Services, Community Mental Health Center. Juvenile Drug Court Referrals Accepted

Ouachita County

South Arkansas Youth Services, Inc.
Site Name: Ouachita Behavioral Health and Outreach Clinic
301 Washington SW
Camden AR 71701
870-836-2321
www.saysyouth.org

Non-Funded, Adolescent Outpatient, Community Mental Health Center, Juvenile Drug Court Referrals Accepted, Mental Health Services

Pope County

Arkansas River Valley Area Council, Inc.
Site Name: Freedom House
400 Lake Front Drive
Russellville AR 72802
479-968-7086
www.arvacinc.org

Non-Funded, Adult Residential, Adult Outpatient, Adult Partial Day, Adult Observational Detox, Drug Court Referrals Accepted, Mental Health Services

Conway County Community Service, Inc.
Site Name: Community Service, Inc.
1415 S. Oswego Avenue
Russellville AR 72802
479-967-3370
www.communityserviceinc.com

Non-Funded, Adolescent Outpatient, Juvenile Drug Court Referrals Accepted

Conway County Community Service, Inc.
Site Name: Community Service, Inc.
1505 S. Oswego Avenue
Russellville AR 72802
479-967-3370
www.communityserviceinc.com

Non-Funded, Adolescent Outpatient, Juvenile Drug Court Referrals Accepted

Counseling Associates, Inc.

Site Name: Counseling Associates, Inc.
110 Skyline Drive
Russellville AR 72801
479-968-1298
www.caiinc.org

Non-Funded, Community Mental Health Center, Adult & Adolescent Outpatient, Juvenile Drug Court Referral Accepted, Mental Health Services

Pulaski County

Baptist Health Medical Center

Site Name: Baptist Health Recover Program
9601 Interstate 630, Exit 7
Little Rock AR 72205
501-202-2893
www.baptist-health.com

Non-Funded, Adult Outpatient, Adult Medical Detox, Mental Health Services, Hospital, Faith Based Organization

Better Community Development, Inc.

Site Name: Hoover Treatment Center
3604 West 12th Street
Little Rock AR 72204
501-663-4774
www.bcdinc.org

Non-Funded, Adult Residential, Adult Outpatient, Adult Partial Day, Drug Court Referrals Accepted

CATAR Ltd

Site Name: CATAR Clinic of North Little Rock
4260 Stockton Drive
North Little Rock AR 72117
501-664-7833
www.catarclinic.com

Non-Funded, Opioid Program, Adult Outpatient

Family Service Agency, Inc.

Site Name: Family Service Agency, Inc.
628 West Broadway Suite 300
North Little Rock AR 72114
501-372-4242
www.helpingfamiliesfirst.org

Non-Funded, Adult Outpatient, Adolescent Outpatient

Gyst House, Inc.

Site Name: Gyst House, Inc.
8101 Frenchman's Lane
Little Rock AR 72209
501-568-1682
www.gysthouseinc.com

Non-Funded, Adult Outpatient, Drug Court Referrals Accepted

Quality Living Center, Inc.

Site Name: Quality Living Center, Inc.
3925 Asher Avenue
Little Rock AR 72204
501-663-3490
www.qualitylivingcenter.org

Non-Funded, Adult Residential, Drug Court Referrals Accepted

Step Up Support Center

Site Name: Step Up Support Center
8501 Geyer Springs Road
Little Rock AR 72209
501-313-2486
www.thestepupsupportcenter.com

Non-Funded, Adult Outpatient, Adult Partial Day, Drug Court Referrals Accepted

UAMS - Center for Addiction Services and Treatment (CAST)

Site Name: UAMS - Center for Addiction Services and Treatment (CAST)
4224 Shuffield Drive
Little Rock AR 72205
501-526-8100
www.uams.edu

Non-Funded, Adult Outpatient, Opioid Treatment, Mental Health Services, Drug Court Referrals Accepted

UAMS Center for Addiction Services & Treatment - Substance Abuse Treatment Clinic (SATC)

Site Name: UAMS Center for Addiction Services & Treatment -Substance Abuse Treatment Clinic
4224 Shuffield Drive
Little Rock AR 72205
501-526-8100
www.uams.edu

Non-Funded, Opioid Program, Mental Health Services, Drug Court Referrals Accepted

United Family Services, Inc.

Site Name: United Family Services, Inc.
1202 W. 6th Street
Little Rock AR 72201
501-244-0062
www.ufamservices.com

Non-Funded, Adolescent Outpatient, Mental Health Services

United Methodist Children's Home

Site Name: Arkansas CARES
2002 South Fillmore
Little Rock AR 72204
501-906-4928
www.methodistfamily.org

Non-Funded, Specialized Women's Services, Female Only, Adult Residential, Adult Outpatient, Mental Health Services, Drug Court Referrals Accepted

Wards of Serenity, Inc.

Non-Funded, Outpatient

Site Name: Wards of Serenity, Inc.
2020 W. 3rd Street, Suite 213
Little Rock AR 72205
501-372-1370

Saline County

Counseling Clinic, Inc.

Non-Funded, Community Mental Health Center, Adult & Adolescent Outpatient

Site Name: Counseling Clinic, Inc.
307 East Sevier Street
Benton AR 72015
501-315-4224
www.cc-inc.org

Sebastian County

Christ for the World - The Bridge

Non-Funded, Adult & Adolescent Outpatient, Drug Court & Juvenile Drug Court Referrals Accepted, Faith Based

Site Name: Christ for the World - The Bridge
4401 Windsor Drive
Fort Smith AR 72904
479-434-4681

Fort Smith Behavioral Health, Inc.

Non-Funded, Adult Outpatient, Mental Health Services

Site Name: Fort Smith Behavioral Health, Inc.
1620 South 46th Street
Fort Smith AR 72903
479-494-7889

Harbor House, Inc.
Site Name: Gateway Recovery Center
3900 Armour Avenue
Fort Smith AR 72904
479-785-4083
www.recoveryhhi.org

Non-Funded, Female Only, Adult Residential & Adult Outpatient, Mental Health Services, Adult Observational Detox, Specialized Women's Services, Adult Partial Day, Drug Court Referrals Accepted

Harbor House, Inc.
Site Name: Harbor Recovery Center
615 North 19th Street
Fort Smith AR 72914
479-785-4083
www.recoveryhhi.org

Non-Funded, Male Only, Adult Residential & Adult Outpatient, Adult Partial Day, Adult Observational Detox, Mental Health Services, Drug Court Referrals Accepted

Northwest Arkansas Psychological Group
Site Name: Northwest Arkansas Psychological Group
211 Greenwood Avenue
Fort Smith AR 72901
479-409-1400
www.nwapg.com

Non-Funded, Outpatient

Recovery Solutions, Inc.
Site Name: Recovery Solutions, Inc.
501 South 18th Street
Fort Smith AR 72901
479-434-5566

Non-Funded, Adolescent & Adult Outpatient

Texarkana Behavioral Health Associates, LLC DBA Valley Behavioral Health System
Site Name: Valley Behavioral Health System
10301 Mayo Drive
Barling AR 72923
479-494-5700

Non-Funded, Hospital, Adult & Adolescent Outpatient, Mental Health Services

Texarkana Behavioral Health Associates, LLC DBA Valley Behavioral Health System
Site Name: Valley Behavioral Health System
815 Fort Street, Suite A
Barling AR 72923
479-494-5700

Non-Funded, Adult & Adolescent Outpatient, Mental Health Services

Union County

South Arkansas Substance Abuse
Site Name: South Arkansas Substance Abuse
100 Hargett Drive
El Dorado AR 71730
870-881-9301
www.southarkansassubstanceabuse.org

Non-Funded, Adult Residential, Adult Outpatient, Drug Court Referrals Accepted

South Arkansas Youth Services, Inc.
Site Name: Union County Behavioral Health and Outreach Clinic
514 West Faulkner
El Dorado AR 71730
870-863-5153
www.saysyouth.org

Non-Funded, Adolescent Outpatient

Van Buren County

Conway County Community Service, Inc.
Site Name: Community Service, Inc.
451 Ingram Street
Clinton AR 72031
501-745-2956
www.communityserviceinc.com

Non-Funded, Adolescent Outpatient, Juvenile Drug Court Referrals Accepted

Washington

Texarkana Behavioral Associates, LLC DBA Vantage Point of Northwest Arkansas
Site Name: DBA Vantage Point of NWA/Fayetteville Therapeutic Day Treatment
4171 N. Crossover Road
Fayetteville AR 72703
479-443-6496
www.vantagepointnwa.com

Non-Funded, Adolescent Outpatient, Mental Health Services

Washington County

Northwest Arkansas Psychological Group
Site Name: Northwest Arkansas Psychological Group
1706 Joyce, Suite 3
Fayetteville AR 72703
479-442-9381
www.nwapg.com

Non-Funded, Adult Outpatient, Mental Health Services

Ozark Guidance Center, Inc.

Site Name: Ozark Guidance Center, Inc.
2400 S. 48th Street
Springdale AR 72762
479-750-2020
www.ozarkguidance.org

Non-Funded, Adult Outpatient, Community Mental Health Center, Mental Health Services

Ozark Guidance Center, Inc.

Site Name: Ozark Guidance Center, Inc.
60 W. Sunbridge
Fayetteville AR 72703
479-695-1240
www.ozarkguidance.org

Non-Funded, Adult Outpatient, Mental Health Services, Community Mental Health Center

Springdale Treatment Center

Site Name: Springdale Treatment Center
1353 East Henri De Tonti Blvd, Suite A
Springdale AR 72762
479-306-4480
www.methadonetreatmentcenter.com

Non-Funded, Opioid Program, Drug Court Referrals Accepted

Texarkana Behavioral Health Associates LLC DBA Vantage Point of Northwest Arkansas

Site Name: DBA Vantage Point of NW AR: Hospital Site
4253 Crossover Road
Fayetteville AR 71703
479-521-5731
www.vantagepointnwa.com

Non-Funded, Opioid Program, Adult Medical Detox, Mental Health Services, Hospital

Texarkana Behavioral Health Associates LLC DBA Vantage Point of Northwest Arkansas
Site Name: DBA Vantage Point of NW AR: Fayetteville Counseling Center
4253 Crossover Road
Fayetteville AR 72703
479-442-8577
www.vantagepointnwa.com

Non-Funded, Adult & Adolescent Outpatient, Mental Health Services

Youth Bridge, Inc.
Site Name: Residential Treatment Facility
3895 George Anderson Road
Springdale AR 72764
479-770-8000
www.youthbridge.com

Non-Funded, Adolescent Residential, Male Only, Juvenile Drug Court Referrals Accepted

Youth Bridge, Inc.
Site Name: Fayetteville Outpatient Clinic
3715 N. Business Drive Suite 104
Fayetteville AR 72703
479-521-1532
www.youthbridge.com

Non-Funded, Adolescent Outpatient, Juvenile Drug Court Referrals Accepted

White County

Capstone Treatment Center, LLC
Site Name: Capstone Treatment Center, LLC
120 Meghan Lane
Judsonia AR 72081
501-729-4479
www.capstonetreatmentcenter.com

Non-Funded, Male Only, Adult Residential, Adult Outpatient, Faith Based, Mental Health Services, Drug Court & Juvenile Drug Court Referrals Accepted

Conway County Community Service, Inc.

Site Name: Community Service, Inc.
730 Boston Street
Danville AR 72833
479-495-5177
www.communityserviceinc.com

Non-Funded,
Adolescent Outpatient,
Juvenile Drug Court
Referrals Accepted

ARKANSAS DEPARTMENT OF HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES

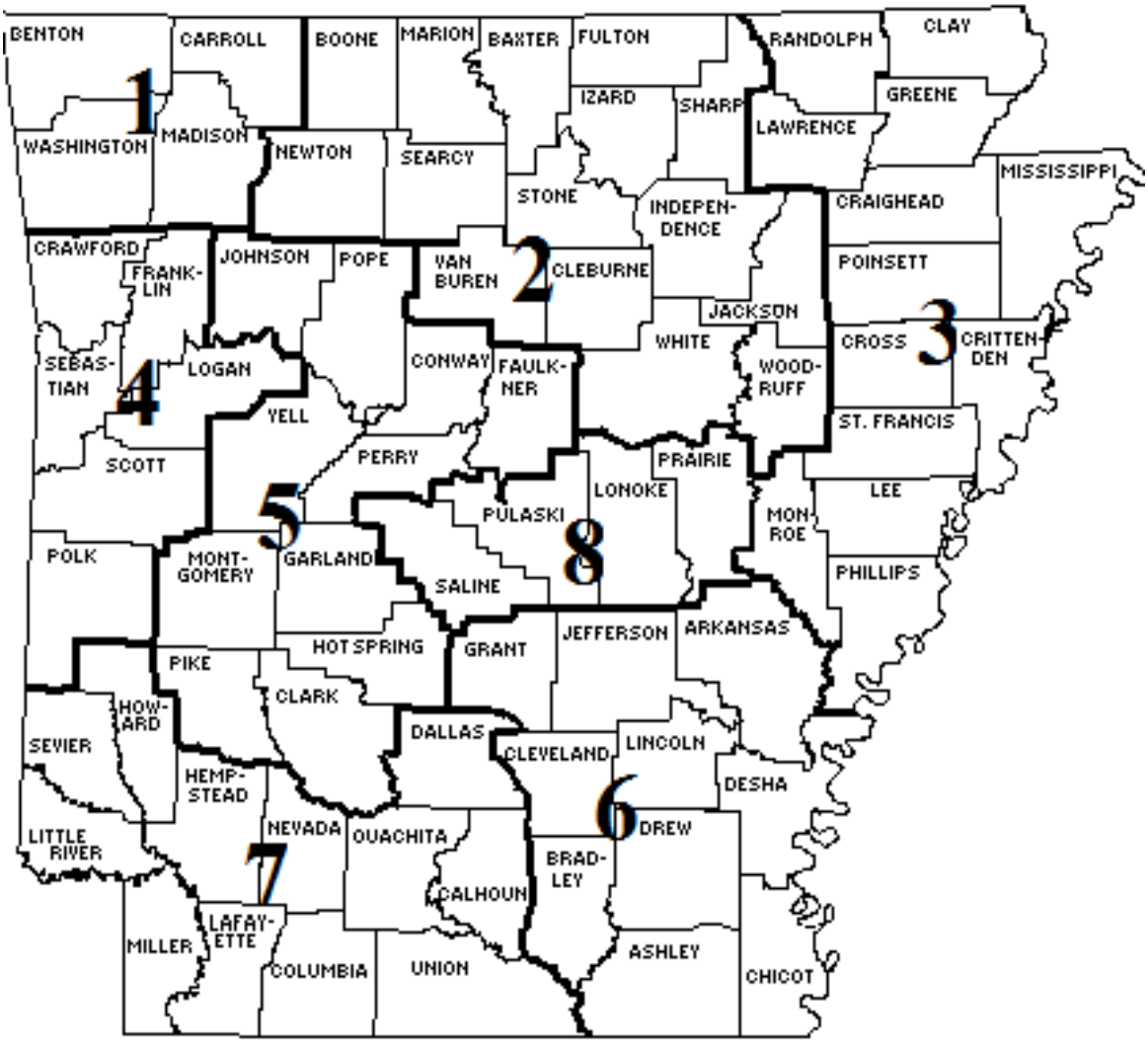
Prevention Services Providers Directory

SFY 2015

Revised 6/10/15

REGIONAL PREVENTION PROVIDERS

REGIONAL MAP



Revised 6/10/15

KEY

ACDEC-AR Collegiate Drug Education Committee
APCB- Arkansas Prevention Certification Board
APNA-AR Prevention Needs Assessment
ARF-Archival Risk Factors
DTS-Data Technical Support
RPP-Regional Prevention Provider
SEOW-State Epidemiological Outcome Workgroup
MSCPT-MidSOUTH Center for Prevention and Training
SPF PFS-Partnership for Success
SPF PSP-Prevention Service Providers
WFD-Workforce Development

REGION 1

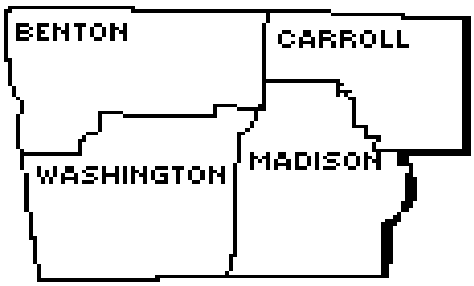
Benton, Carroll, Madison, & Washington Counties

PREFERRED FAMILY HEALTHCARE, INC. dba DECISION PT (RPP)

ADDRESS: 602 North Walton Boulevard
Bentonville, AR 72712

EXECUTIVE DIRECTOR: Helen Balding
PHONE: (479) 464-1060 **CELL:** (479) 856-8459
EMAIL: hbalding@dayspringbhs.com

FINANCE: Sharon Taylor
PHONE: (479) 464-1060 ext. 6176
EMAIL: staylor@dayspringbhs.com



REPRESENTATIVE: Laurie Reh
ASSISTANT REPRESENTATIVE: Codi McCuistion
614 East Emma Avenue, Suite M426
Springdale, AR 72764
(479) 927-2655
FAX: (479) 927-2752
EMAIL: lreh@decision-point.org
EMAIL: cmccuistion@decision-point.org

Revised 6/10/15

REGION 2

Baxter, Boone, Cleburne, Fulton, Independence, Izard, Jackson, Marion, Newton, Searcy, Sharp, Stone, Van Buren, White, & Woodruff Counties

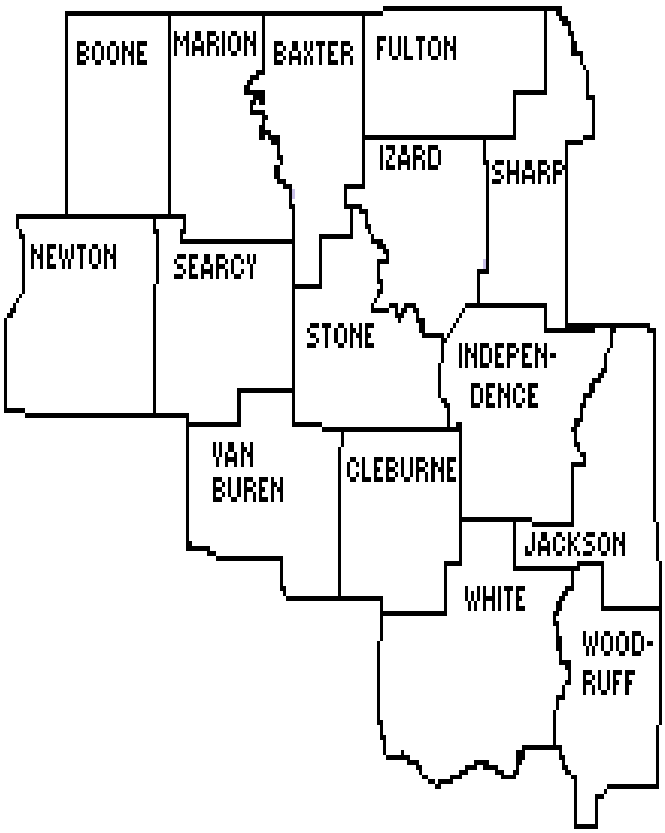
PREFERRED FAMILY HEALTHCARE, INC. dba HEALTH RESOURCES OF ARKANSAS (RPP)

ADDRESS: Physical
25 Gap Road
Batesville, AR 72501

Mailing
P O Box 2578
Batesville, AR 72501

CEO: Current Everett
PHONE: (870) 793-8900 ext. 1135 **CELL:** 870-834-5107
EMAIL: ceverett@hra-ao.org

FINANCE: Sue Lamons
PHONE: (870) 793-8900 ext. 1126
EMAIL: slamons@hra-ao.org



REPRESENTATIVE: Margaret Morrison
ADMIN. ASSISTANT: Tarrah Powell
(Mailing Address)
P O Box 492
Mountain View, AR 72560

(Physical Address)
106 Mountain Place Sq.
Mountain View, AR 72560

(870) 269-6770
(866) 533-1759 ext. 1408 (Margaret)
(866) 533-1759 ext. 1406 (Tarrah)
FAX: (870) 269-2196
EMAIL: mmorrison@hra-ao.org
EMAIL: tpowell@hra-ao.org
Counties: Izard, Newton, Searcy, Stone & Van Buren

REPRESENTATIVE: Marcy Wright
(Physical Address)
1800 Myers St.,
Batesville, AR 72501
(866) 793-8925 ext.1009
FAX: (870) 793-8929
EMAIL: mwright@hra-ao.org
Counties: Cleburne, Jackson, Independence, White & Woodruff

REPRESENTATIVE: Vacant
(Mailing Address)
P O Box 2698
Mountain Home, AR 72654

(Physical Address)
8 Medical Plaza
Mountain Home, AR 72654

(866) 308-9923 ext. 1913
FAX: (870) 424-0903
EMAIL: Vacant
Counties: Baxter, Boone, Fulton, Marion & Sharp

Revised 6/10/15

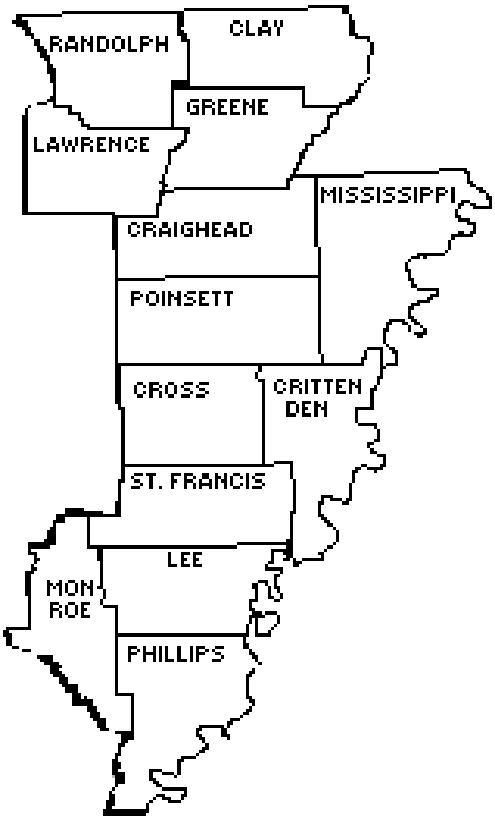
REGION 3

Clay, Craighead, Crittenden, Cross, Greene, Lawrence, Lee, Mississippi, Monroe, Phillips, Poinsett, Randolph, & St. Francis Counties

CROWLEY'S RIDGE DEV. COUNCIL (RPP)

DIRECTOR: Cindy Smith
PHONE: (870) 932-0228 ext. 115
EMAIL: csmith@crdcnea.com

FINANCE : Rhonda Gillis
PHONE: (870) 802-7100 ext. 115
EMAIL: rgillis@crdcnea.com



REPRESENTATIVE: Dorothy "Dot" Newsom
ADMIN. ASSISTANT: Cora Goodson

(Mailing Address)	(Physical Address)
P O Box 16720	2401 Fox Meadow Lane
Jonesboro, AR 72403	Jonesboro, AR 72404

(870) 933-0033
FAX: (870) 933-0048
CELL: (870) 926-9663
EMAIL: dnewsomrpp@yahoo.com
dnewsom@crdcnea.com

EMAIL: goodcora2000@yahoo.com
coragoodson@crdcnea.com

Counties: Clay, Craighead, Lawrence, Mississippi, & Randolph

REPRESENTATIVE: Sandra Drennin
EMAIL: sdrennin@crdcnea.com
CELL: (870) 273-2921

Counties: Crittenden, Cross, Greene, and Poinsett

REPRESENTATIVE: Kendon Gray
ADMIN. ASSISTANT: Pearlie Bogan
593 Highway 243
Marianna Civic Center
Marianna, AR 72360

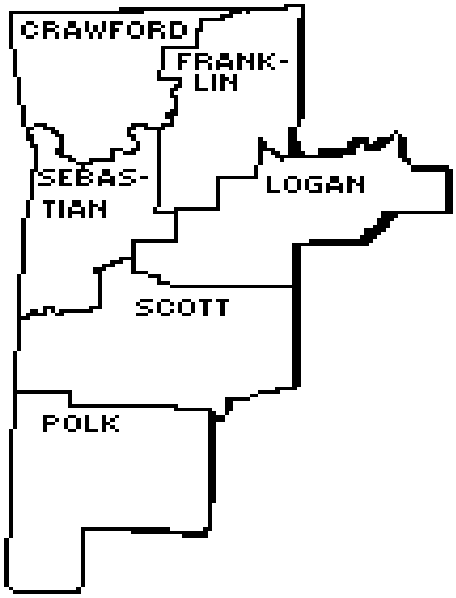
(870) 298-2250
FAX: (870) 298-2249
CELL: (870) 298-2249
EMAIL: kendongray@yahoo.com

Counties: Lee, Monroe, Phillips, and St. Francis

Revised 6/10/15

REGION 4
Crawford, Franklin, Logan, Polk, Scott, & Sebastian Counties

HARBOR HOUSE, INC. (RPP)

DIR. OF OPERATIONS: Cindy Stokes **PHONE:** (479) 785-4083 **EMAIL:** cstokes@recoveryhhi.org	**FINANCE:** Vickie McDaniel **PHONE:** (479) 785-4083 ext. 111 **EMAIL:** vmcdaniel@recoveryhhi.org
	**REPRESENTATIVE:** Emily Starr **REPRESENTATIVE:** Tabitha Fondrem (Mailing Address) (Physical Address) P O Box 4207 3900 Armour Avenue Fort Smith, AR 72914 Fort Smith, AR 72904 (479) 785-4083 ext. 204 (Emily) (479) 785-4083 ext. 212 (Tabitha) CELL: (479) 926-6636 (Emily) (479) 652-5072 (Tabitha) FAX: (479) 783-1914 **EMAIL:** estarr@recoveryhhi.org tfondren@recoveryhhi.org

Revised 6/10/15

REGION 5

Clark, Conway, Faulkner, Garland, Hot Spring, Johnson, Montgomery, Perry, Pike, Pope, & Yell Counties

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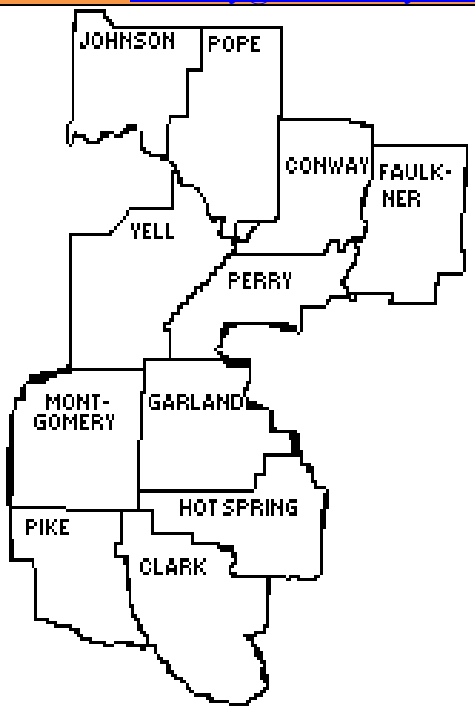

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REGION 6

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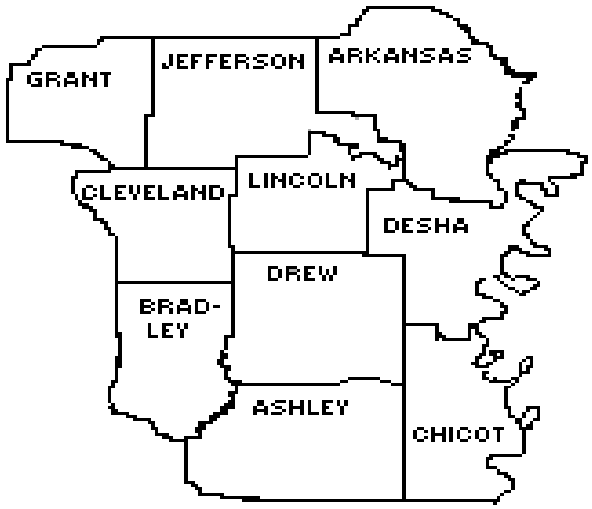

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Revised 6/10/15

REGION 7

Calhoun, Columbia, Dallas, Hempstead, Howard, Lafayette, Little River, Miller, Nevada, Ouachita, Sevier & Union Counties

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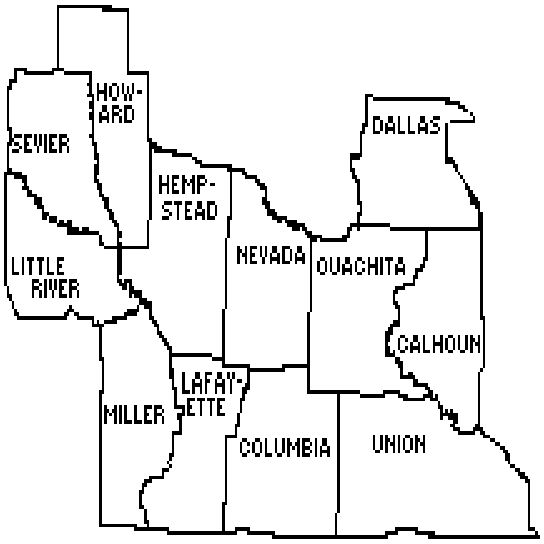

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Revised 6/10/15

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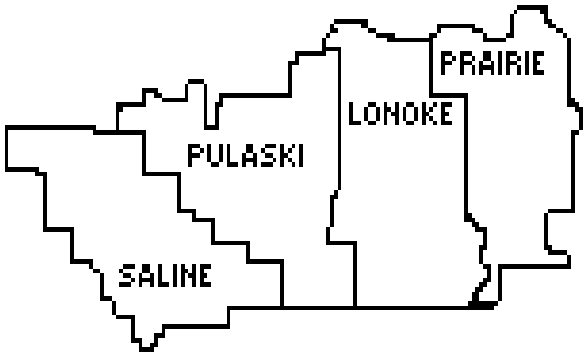	**REPRESENTATIVE: Hayse Miller** **ASSISTANT REPRESENTATIVE: **VACANT**** 628 West Broadway Street, Suite 300 North Little Rock, AR 72114 (501) 372-4242 ext. 752 & 753 FAX: (501) 372-4758 EMAIL: hmiller@fsainc.org

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Revised 6/10/15

Step One: Assess the strengths and needs of the services system to address specific populations

Overview

The Division of Behavioral Health Services (DBHS) is Arkansas' Single State Agency for Behavioral Health Treatment including both public mental health services and public alcohol and drug abuse prevention and treatment services. DBHS is part of the Department of Human Services (DHS), an umbrella agency that includes ten Divisions responsible for providing social, health, and human services, including those for the developmentally disabled, the elderly, adjudicated youth, and at-risk children and families. Also within DHS is the state's Medicaid Authority agency, the Division of Medical Services (DMS). The Director of DHS is appointed by the Governor and sits on the Governor's cabinet. The Director of DHS, with staff and stakeholder input, appoints the Director of DBHS.

The provision of block grant funded substance abuse services is facilitated through eight contracts with treatment providers and eight prevention providers covering the state. The Division of Behavioral Health Services fulfills its responsibility for the provision of public mental health services by operating the 230 bed Arkansas State Hospital (ASH) and the 310 bed Arkansas Health Center (AHC) skilled nursing facility, by contracting with thirteen local, private, nonprofit Community Mental Health Centers (CMHCs), and certifying two private, nonprofit specialty Community Mental Health Clinics.

Each provider of behavioral health services are expected to assess the diversity of their region and population served. Based on this assessment, providers are expected to assure that staff are trained on the specific treatment needs, cultural and ethnic differences, and disparities.

Substance Abuse Treatment

DBHS is responsible for administering a comprehensive and coordinated program for the prevention and treatment of alcohol and drug abuse in Arkansas. As the Single State Authority, DBHS distributes federal funds from the Substance Abuse Prevention and Treatment (SAPT) Block Grant. DBHS provides oversight for 58 treatment providers, with eight of those funded by DBHS to provide substance use disorder prevention, treatment, and recovery services throughout the State. Substance abuse treatment services span a continuum that includes detoxification, residential treatment, outpatient treatment, and education. Current specialized programs include those for methadone maintenance and treatment for women with children.

DBHS operates with a policy and philosophy that the most effective services are community-based and community-supported. In support of that, DBHS contracts with local programs to provide services for residents in all 75 counties in Arkansas.

The current substance abuse treatment catchment areas are as follows:

1. Benton, Carroll, Washington, Madison counties
2. Boone, Marion, Baxter, Newton, Searcy, Fulton, Izard, Sharp, Stone, Independence, Van Buren, Cleburne, Jackson, White, Woodruff counties
3. Randolph, Clay, Lawrence, Greene, Craighead, Mississippi, Poinsett, Cross, Crittenden, St. Francis, Lee, Monroe, Phillips counties

4. Crawford, Franklin, Sebastian, Logan, Scott, Polk counties
5. Johnson, Pope, Conway, Yell, Perry, Faulkner, Montgomery, Garland, Hot Spring, Pike, Clark counties
6. Arkanss, Jefferson, Grant, Lincoln, Cleveland, Desha, Drew, Bradley, Ashley, Chicot counties
7. Howard, Sevier, Hempstead, Little River, Lafayette, Miller, Dallas, Nevada, Ouachita, Calhoun, Columbia, Union counties
8. Prairie, Lonoke, Pulaski, Saline counties

DBHS also funds and oversees the Drug and Alcohol Safety Education Program (DASEP), which regulates the screening, assessment, and treatment of those who have received a Driving While Intoxicated (DWI) charge. A total of eight providers conduct assessment and treatment referral services within the 75 counties in Arkansas. Approximately 23,000 individuals are screened each year, with 4,000 receiving education or placed into treatment programs.

There are 11 funded juvenile drug courts across the state have historically been funded through Tobacco Settlement Funds. Moving forward, the treatment provided in these specialty courts will be funded by a mix of State General Revenue and Medicaid funding. Drug courts refer clients to local substance abuse providers to provide outpatient services, tobacco cessation, and drug screens.

Substance Abuse Prevention

The Arkansas Prevention System currently consists of eight Regional Prevention Providers (RPP). The system serves as a statewide infrastructure for providing resource support necessary to promote capacity development at the local level. The RPP represents the Division of Behavioral Health Services (DBHS) in forming a statewide infrastructure to develop knowledge, skills and abilities within communities to address behavioral health prevention needs. The RPP representatives must make progress towards the accomplishment of the state prevention plan and support the requirements of the federal funding source. The primary focus for the RPP will be to build substance abuse prevention capacity within the region and communities to address their own issues and to address the National Outcome Measure (NOMS). The secondary focus will be to assist with the statewide prevention infrastructure for promoting and increasing behavioral health prevention across the lifespan. The capacity will be built through raising community awareness and promoting media campaigns, conducting public presentations, information dissemination, prevention education/training, alternative activities, community-based process, environmental approaches, problem identification and referral, and the use of the Strategic Prevention Framework 5 step planning process.

Mental Health Treatment

There are thirteen Community Mental Health Centers (CMHCs) covering the state of Arkansas. The CMHCs are responsible for providing behavioral health services to indigent individuals in their respective catchment area.

The CMHCs also serve as the Single Point of Entry (SPOE) for adults in to the public mental health system. Created by Act 861 of 1989, each CMHC has a contractual obligation to perform

initial SPOE screenings for individuals who live in their respective catchment areas to determine if the individual meets the criteria for admission to inpatient programs of the State Mental Health System , to determine if appropriate alternatives to inpatient treatment are clinically appropriate and available, and arrange for the provision of alternative outpatient services if inpatient or crisis residential services are not recommended.

DBHS provides funding for the purchase of local acute care (psychiatric) beds for Arkansas adults who have no other funding source to pay for a psychiatric crisis situation. The funds are distributed through the community mental health centers and are based on population data. Community mental health centers utilize clinical criteria to determine the least restrictive safe alternative available and refer to inpatient psychiatric hospitals when needed. This funding allows individuals to be treated in local communities rather than in a centralized location.

The Projects for Assistance in Transition from Homelessness (PATH) program is a grant created under the McKinney Act. It provides funding for Community Mental Health Centers to deliver services to individuals that are Seriously Mental Ill or Seriously mentally ill with co-occurring substance abuse disorders, and who are homeless or at imminent risk of becoming homeless. There are currently three CMHCs providing PATH services.

DBHS maintains the current Rehabilitative Services for Persons with Mental Illness (RSPMI) Certification Policy which includes compliance and outcome monitoring of providers. To be an eligible RSPMI provider, the agency must offer a full array of outpatient treatment services, and is eligible to bill the Arkansas Medical Assistance Program (Medicaid) for reimbursable services. The agency must follow an application process and become certified as an RSPMI provider by the DBHS prior to applying for Medicaid provider enrollment. DBHS manages the application process and compliance standards for all RSPMI and LMHP providers. This is to assure that care and services comply with applicable laws, which require, among other things, that all care reimbursed by the Arkansas Medical Assistance Program (Medicaid) must be provided efficiently, economically, only when medically necessary, and is of a quality that meets professionally recognized standards of health care.

Individual mental health professionals in private practice in Arkansas may apply to become a Licensed Mental Health Practitioner (LMHP). A DBHS certified LMHP provides outpatient mental health services for the Arkansas Medicaid population under the age of 21, and is eligible to bill the Arkansas Medical Assistance Program (Medicaid) for reimbursable services. The applicant must apply and become certified as an LMHP provider by the DBHS prior to applying for Medicaid provider enrollment.

DBHS also ensures mental and behavioral health care is available to children and youth throughout the state. Outpatient mental health services are available through certified community providers and as such, must comply with State requirements that meet nationally accepted standards for delivering services. DBHS recognizes that in order to successfully treat children and youth, family and community involvement is key. To support this belief, the Department of Human Services (DHS) has increased department wide efforts to create and build a System of Care (SOC) that is a coordinated network providing an array of services, of which mental health is a part. To improve the mental health service delivery system for children with severe to moderate behavioral health care needs and their families, DHS SOC Wraparound Demonstration

Projects sites are developing methods that are becoming standards of practices based on Wraparound principles. Financial support for the behavioral health system comes from a variety of funding sources including Arkansas state general revenue, federal grants, Medicaid, and private insurance.

The Child and Adolescent Service System Program (CASSP) was established in Arkansas by Act 964 of 1991 and in 2001 through Act 1517. CASSP is based on the concept developed by the National Institute of Mental Health that focuses on the need for interagency collaboration and coordination across systems in delivering multiple services to seriously emotionally disturbed children. CASSP service teams are available throughout the state to develop multi-agency plans and wraparound plans of care for individual children and adolescents with serious emotional disturbance when the current system is not adequately meeting their needs.

Identified Strengths

Through a SWOT analysis the following areas of strength were identified:

- DBHS has recently hired a new director, Joy Figarsky. Ms. Figarsky comes to the division with years of experience in the mental health system from the providers perspective. The hiring process for Ms. Figarsky included the involvement of individuals with lived experience.
- DBHS was recently awarded a Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) grant to "promote the wide-scale adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental health conditions." Arkansas' 2013 Policy Academy Action Plan proposed leveraging support for sustainable development and implementation of Peer-, Youth- and Family-Support Partners in the context of the Affordable Care Act. The planned activities include development and implementation of Learning Communities to promote understanding and practice of Peer/Consumer (and Family Member) Voice to drive Arkansas' concepts and practices of Behavioral Health Recovery.
- The Arkansas Insurance Department (AID) is the lead in the development and implementation of the Arkansas Health Insurance Marketplace. Jay Bradford, who was the Director of DBHS years ago, is now the Director of AID. It is an asset to the behavioral health system to have an individual with experience in the behavioral health system leading the charge in this initiative.
- DBHS is currently receiving intensive technical assistance services to assist the Arkansas Planning Council continue the transition from a Mental Health Planning Council (MHPC) to a Behavioral Health Planning Council (BHPC) through the Technical Assistance Center at Advocates for Human Potential, Inc..
- Youth M.O.V.E. Arkansas is a statewide youth-led organization devoted to improving services and supports provided to children and youth in the State of Arkansas. This organization partners with youth, adults, professionals and other partners to help transform Arkansas' youth-serving systems. They share their experiences as consumers of youth services from various systems (child welfare, mental health, juvenile justice) and agencies (public and private) in Arkansas and by actively participating in the redevelopment of those systems designed to serve young Arkansans.
- All contracted substance abuse providers in Arkansas are nationally accredited. This is a requirement of the contract and of the licensure standards.
- All mental health providers certified to provide mental health services through the RSPMI program in Medicaid are nationally accredited.
- The State of Arkansas has a unique opportunity to plan the implementation of a state-wide System of Care (SOC). This project will take a multi-pronged approach to plan for a family-driven and youth-guided SOC across the entire state of Arkansas, emphasizing (1) training and certification for service providers, (2) outcome measurement to ensure efficacy, and (3) infrastructure for financial sustainability. This initiative is supported by grant funds and includes technical assistance from Georgetown University to assist in this initiative.
- All of the Community Mental Health Centers have Consumer Councils which are in place to allow consumers to develop a strong and unified voice to influence and improve

State policy decisions, further develop the consumer-led initiatives, impact local service development, and forge productive alliances with community resources.

- During 2012, eight Family Support Partners (FSPs) served and supported 142 families within nine service areas encompassing 50 counties in the state. FSPs are peer counselors who model recovery and resiliency in overcoming obstacles common to those who live with children or youth with behavioral health care needs. Legacy Families, those that have had multiple experiences with the mental health and broader social service system, are recruited to serve as FSPs. In this role, FSPs are charged to work alongside Community Care Directors (CCDs) and Wraparound Specialists (WAS) to help engage and support local families in the Wraparound process.

Identified Needs

Through a SWOT analysis the following areas of need were identified:

- Behavioral health support within the criminal justice system
- Services for individuals with a behavioral health condition and intellectual disability
- Transitional services
- Supported housing
- Employment education
- Over reliance on inpatient and residential services
- Focus on special populations, such as LGBTQIA, aging, and military
- Linkage between primary care and behavioral health
- Crisis services
- Access to services in rural areas

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:

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

Through the Payment Improvement Initiative, the Division of Behavioral Health Services (DBHS) has worked with the State Medicaid Authority and consultants to conduct extensive analyses of Medicaid claims data. The extensive data analysis has led to an extensive proposal to alter the Medicaid State Plan in regards to the reimbursement for behavioral health services. These efforts have been supported by a State Innovation Model (SIM) grant through the Center for Medicaid and Medicare (CMS). The analysis shows service gaps and the proposal features new services to address these gaps and rebalance funding. These gaps are highlighted below:

- Medicaid does not currently fund care coordination for individuals with serious mental illness or children with serious emotional disturbances.
- The current Medicaid program supporting substance abuse treatments services (SATS) is severely underutilized. This is due to the limited population eligible for the services, the professional requirements for providing services, and other procedural complications.
- The Medicaid programs supporting individuals with serious mental illness or children with serious emotional disturbances are not recovery oriented. Recovery oriented services are not available. For example, peer support is not included in the State Plan. Additionally, policies and procedures are not oriented towards recovery and do not utilize recovery language.

The Division is currently spearheading an initiative to select an outcomes instrument for children receiving Medicaid services. The implementation of a new outcome measurement tool will allow DBHS to collect and analyze richer data regarding the served population and make data based policy decisions.

Addressing the gaps within the Medicaid system is essential to moving the entire behavioral health system. This is due to the discrepancy in funding in Medicaid versus contracted services. For example, annually Medicaid reimburses for approximately $550 million for mental health services, while the Community Mental Health Centers received approximately $27 million for contracted services.

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:

DBHS would like to move to an integrated data platform for all data collection purposes. Technical assistance from SAMHSA to achieve this would be appreciated.

Footnotes:

Quality and Data Collection Readiness

The Division of Behavioral Health Services (DBHS) collects client level data for all clients treated for substance abuse by providers receiving federal block grant monies. The Division also receives similar data from non-funded substance abuse treatment providers. In State Fiscal Year 2014, DBHS received client level substance abuse data, which indicated providers treated 16,750 unique clients. Individual level data elements include most of the measures under SAMHSA's National Outcomes Measures (NOMs) domains.

DBHS is the recipient of SAMHSA's three year Data Infrastructure Grant (DIG) designed to assist states develop their data infrastructure system for collecting mental health data. Arkansas is using the fund to collect encounter data on more than 70,000 adult and children receiving mental health services from the 13 Community Mental Health Centers receiving SAMHSA Block Grant funding.

- The Alcohol Drug Management Information System (ADMIS) is a web enabled database system maintained by the Department of Human Services (DHS) Office of Systems Technology and operated by staff of DBHS. The system is utilized to collect client level data from admission to discharge using the National Outcome Measures (NOMS) and payment by fee-for-service, and budget based participants. The ADMIS data is used to report to SAMHSA's substance abuse treatment admission data set called Treatment Episode Data Set (TEDS).

- Minimum Data Set (MDS) is a Web-based, Group Level Evaluation Tool operated under the direction of the Center for Substance Abuse Prevention (CSAP). The system was developed to enable states, substance abuse agencies, community-based service providers, and others to quantify and compare the numbers and types of primary substance abuse prevention and early intervention services delivered across the United States. MDS was maintained by Kit Solutions and SSA employees. The stakeholders for prevention entered their services that were provided in the communities; however, this system was taken down and the states were asked to provide their own data capturing system. We have selected Web Infrastructure for Treatment Services (WITS), a system maintained by FEi Systems. We will continue to capture community level data using this system as of July 2015.

- The DBHS Service Process Quality Management Data Mart (SPQM) serves a number of purposes including, 1) assist with required Federal Reporting to include Client Level Data to support National Outcomes Measures; 2) assist with Required State Level Reporting to support reports to the state legislature; and 3) produce Individual Provider Level Reporting to support quality initiatives and benchmarking across the statewide provider network. The data mart derives from 28 source transaction fields across 18 service provider entities to include the Arkansas State Hospital. Raw transaction data is transformed to produce specialty reporting cubes as well as a raw transaction data mart available for ad hoc reporting. The data mart features advanced security protocols to include

next generation web application firewalls, industry leading intrusion prevention and detection, and multifactor/out-of-band telephone authentication for all users.

- The Arkansas Prevention Needs Assessment Student Survey (APNA) is an annual survey of grades 6, 8, 10 and 12 school students in Arkansas. Almost all the school districts participate in this needs assessment survey. The needs assessment survey instrument consists of more than 120 questions measuring current students' use of alcohol, tobacco, and other drugs, anti-social behaviors and the prevalence of 22 risk and 4 protective factors. Results are reported in an aggregate form-state, county, school districts and schools. This survey has been conducted since 2002. In 2014 88,912 students from 576 schools in 206 school districts responded to the survey. DBHS maintains the survey data sets.

- The Mental Health Statistics Improvement Project (MHSIP) is an adult and child/adolescent consumer satisfaction survey conducted on a sample of more than 3,000 adult and child/adolescents receiving services from the 15 Community Mental Health Centers. The survey covers the following domains: overall satisfaction, access to services, treatment outcomes, consumer participation in treatment planning, quality and appropriateness of services, cultural sensitivity of staff, social connectedness, and improved functioning.

- System of Care (SOC) is a web enabled database system maintained by the Department of Human Services (DHS) Office of Systems Technology and operated by the staff of DBHS and its 17 providers. This program serves children and youth receiving SOC services and supports across the state. Through state funding, the Intensive Family Services, Multi-Systemic Therapy, substance abuse treatment, and non-traditional services and supports are being expanded. The application collects demographic and treatment data from individual clients.

- The Arkansas Department of Human Services (DHS) Enterprise Data Warehouse (EDW) is a centralized data repository consisting of disparate contributing source systems from both within and external to DHS. In existence since 2010 and continually growing, the EDW strives to provide access to cross divisional and agency information for analysis and decision support. DHS EDW provides both historical and current views of contributing data. Business processes are denoted for grouping similar actions across DHS in an effort for data cleansing, consistency and presentation. Security for access to the contained data within the EDW is governed by the contributing source data owner. DBHS is one of the contributors of data to the EDW system. Historically, the Youth Outcomes Questionnaire (Y-OQ®) data was migrated to the system. Currently, the substance abuse treatment data from ADMIS is migrated into the EDW system.

DBHS has upgraded its data analysis system by acquiring new computers and data analysis statistical software (SAS and SPSS). DBHS continues to work with the substance abuse and

mental health providers by providing various service utilization and client satisfaction reports and technical assistance on various related topics on a regular and as needed basis.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Substance Abuse Treatment

Priority Type: SAT

Population(s):

Goal of the priority area:

Maintain and expand access to substance abuse services for the indigent and/or court involved population with an emphasis on individuals who are intravenous drug users, women who are pregnant and/or parenting, military, and adolescents.

Objective:

Strategies to attain the objective:

- Contract with community based providers to provide services to the indigent populations. These contracts prioritize individuals who are intravenous drug users, women who are pregnant and/or parenting, military, and adolescents.

- Provide detoxification, outpatient services, partial day treatment, residential services, and Specialized Women Services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of unduplicated individuals served

Baseline Measurement: 11306

First-year target/outcome measurement: 11476

Second-year target/outcome measurement: 11645

Data Source:

ADMIS

Description of Data:

First year target represents a 1.5% increase from baseline.

Second year target represents a 3% increase from baseline.

Data issues/caveats that affect outcome measures::

The Baseline Measurement is the number of unduplicated individuals served from July 1, 2014 to June 30, 2015.

Indicator #: 2

Indicator: Units of services provided

Baseline Measurement: Total Units for Residential Treatment = 98,690 / Total Units for Outpatient Treatment = 2,859 / Total Detoxification Units = 3,222

First-year target/outcome measurement: otal Units for Residential Treatment = 100,170 / Total Units for Outpatient Treatment = 2,901 / Total Detoxification Units = 3,270

Second-year target/outcome measurement: otal Units for Residential Treatment = 101,651 / Total Units for Outpatient Treatment = 2,945 / Total Detoxification Units = 3,318

Data Source:

ADMIS

Description of Data:

First year target represents a 1.5% increase from baseline.

Second year target represents a 3% increase from baseline.

Data issues/caveats that affect outcome measures::

The outpatient treatment unit = 1 hour

The residential and detoxification unit = 1 day

Priority #: 2

Priority Area: Mental Health Treatment

Priority Type: MHS

Population(s): SMI, SED

Goal of the priority area:

Maintain or expand access to quality mental health services for the population of adults with serious mental illness and children with serious emotional disturbance.

Objective:

Support the statewide implementation of Forensics Outpatient Restoration Program

Implement the First Episode of Psychosis requirement

Strategies to attain the objective:

Continue to contract with community based providers to provide mental health treatment to adults with serious mental illness and children with severe emotional disturbance.

Priority #: 3

Priority Area: Medicaid Transformation

Priority Type: SAT, MHS

Population(s): SMI, SED, Other (Adolescents w/SA and/or MH, Criminal/Juvenile Justice, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Promote and improve integrated care approaches, evidence based practices, recovery-oriented services, and delivery and access to services for underserved communities within the Medicaid system.

Objective:

- Partner with the Division of Medical Services (DMS), the Medicaid agency in Arkansas and a sister division within the Arkansas Department of Human Services (DHS), to continue working to transform the Medicaid funded behavioral health system through the implementation of support services and care coordination. The transformation involves DBHS staff participation at the front end and will affect the Division's business practices, contracts, and populations in the coming year. DBHS staff will work closely with Medicaid to develop and implement population-based and episode-based care delivery standards and to implement recovery oriented services in a community setting through a State Plan Amendment to introduce new services and care management.

- Develop, standardize, and implement youth, peer, and family support services. Provide support and training to newly introduced Peer and Youth Support Specialist, Family Support Partners, and providers.

- Include Recovery Support Services as a Medicaid funded service, which includes Supported Housing, Life Skills Development, and Supported Employment

- Fund Wraparound and Care Coordination through Medicaid

Strategies to attain the objective:

Continue to meet with stakeholders to garner feedback and support.

Work with the

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of evidence based practices funded through Medicaid

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Medicaid claims

Description of Data:

Data issues/caveats that affect outcome measures::

Implementation is dependent on legislative approval

Indicator #: 2

Indicator: Number of individuals receiving care coordination

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Medicaid claims

Description of Data:

Data issues/caveats that affect outcome measures::

Implementation is dependent on legislative approval

Indicator #: 3

Indicator: Number of individuals received supportive services

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Medicaid claims

Description of Data:

Data issues/caveats that affect outcome measures::

Implementation is dependent on legislative approval

Priority #: 4

Priority Area: Children's System of Care

Priority Type:

Population(s): SED

Goal of the priority area:

Build a family and youth involvement and leadership structure that will facilitate the family and youth voice and choice at every level of service planning, development, delivery, and evaluation

Objective:

Enhance family and youth involvement and capacity building activities, amplifying the voice of families and youth, creating a position of presence and leadership for youth and families, increasing the number and capacity of Family and Youth Affiliate Liaisons and expanding the number and capacity of community based, family and youth run organizations.

Strategies to attain the objective:

Partner with NAMI AR to develop youth and family capacity and hire Liaisons

Partner with UALR/MidSOUTH Center for Prevention and Training/University of Arkansas at Little Rock School of Social Work To provide funding to build capacity in workforce development, continuing education, resource development, and technical assistance to professionals and family members.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of support groups held

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

NAMI AR

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number of individuals trained by UALR/MidSouth

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

UALR/MidSouth

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Number of Youth and Family Affiliate Liaisons hired

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

NAMI AR

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: Consumer Affairs

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, PP, IVDUs, Other (Adolescents w/SA and/or MH, LGBTQ, Rural, Criminal/Juvenile Justice, Persons with Disablities, Homeless)

Goal of the priority area:

Develop and build Division of Behavioral Health Service's Office of Consumer Affairs to meet the needs of the identified populations throughout the state of Arkansas.

Objective:

Strategies to attain the objective:

DBHS and the Office of Consumer Affairs will develop policies sensitive to peer operated, person-centered, evidenced based, and trauma informed services.

DBHS will track and compile data regarding complaints made to DBHS and the Office of Consumer Affairs regarding services and lack of services.

DBHS and the Office of Consumer Affairs will identify types of consumer issues and design advocacy traits to address those issues involving stakeholders.

Priority #: 6

Priority Area: Lower alcohol usage

Priority Type: SAP

Population(s):

Goal of the priority area:

Lower the reported 30 day alcohol usage rate

Objective:

Strategies to attain the objective:

Training and Technical Assistance:
1. Increase public awareness of FASD, its consequences and that it is preventable along with increase educator understanding of the signs and symptoms of FASD and the required accommodations.
2. Expand youth efforts for leadership and advocacy by increasing the knowledge and skills involved in prevention and community mobilization so that youth will become recognized advocates for themselves and their peers.
3. Develop curriculums and provide Training of Trainers (TOTs) on topics centering on collaboration, community mobilization, and community requested topics.

Coordination of Services:
1. Expand Arkansas Collegiate Drug Education Consortium's role in order to increase services to college age youth by increasing involvement of colleges in local coalitions and increasing coalitions' involvement with students.
2. Coordinate services for veterans, families, and other impacted by war to determine and fill gaps based on issues, geography, age, and gender.

Data:
1. Develop survey about ATOD use among LGBTQ to be analyzed by DBHS Outcome and Performance section which can be administered through the LGBTQ consortium.
2. Enhance or expand data being collected by veteran serving organization for ATOD usage.
- Evaluation:
3. Implement standardized collection processes and expected measures for process and outcome data.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	% of youth reporting alcohol usage
Baseline Measurement:	16.3% (reported in 2011)
First-year target/outcome measurement:	13.00%
Second-year target/outcome measurement:	

Data Source:

Arkansas Prevention Needs Assessment

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #:	7
Priority Area:	Lower Tobacco Usage
Priority Type:	SAP

Population(s):

Goal of the priority area:

Lower the reported 30 day smokeless tobacco usage rate

Objective:

Strategies to attain the objective:

Data:
1. Enhance or expand data being collected by veteran serving organization for ATOD usage.

Evaluation Objective:
1. Implement standardized collection processes and expected measures for process and outcome data.

Coordination of Services:
1. Enhance coordination with Arkansas Dept. of Health Tobacco Prevention and Arkansas Tobacco Control Board to coordinate trainings to create more community responsiveness.
2. Initiate coordination with Arkansas Chapter of American Lung Association and the American Cancer Society to solidify coordinated efforts to reduce tobacco use.
3. Expand youth efforts for leadership and advocacy by increasing the knowledge and skills involved in prevention and community mobilization so that youth will become recognized advocates for themselves and their peers.
4. Restructure current regional technical assistance system to focus on local community training and parent education. Incorporate integrated services and cross-training in workforce development. Provide local funding for leveraged direct services to the community.

Training and Technical Assistance:
1. Coordinate efforts between Arkansas Tobacco Control Board, Arkansas Beverage Control, and DBHS for joint merchant education.
2. Develop curriculums and provide Training of Trainers (TOTs) on topics centering on collaboration, community mobilization, and community requested topics.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Smokeless Tobacco Rate

Baseline Measurement: 16.3% (2011)

First-year target/outcome measurement: 3.6%

Second-year target/outcome measurement:

Data Source:

Arkansas Prevention Needs Assessment

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Cigarette Usage Rate

Baseline Measurement: 8.8% (2011)

First-year target/outcome measurement: 6.8%

Second-year target/outcome measurement:

Data Source:

Arkansas Prevention Needs Assessment

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 8

Priority Area: Lower the Usage Rate for Prescription Drug Usage

Priority Type: SAP

Population(s):

Goal of the priority area:

Lower the reported 30 day usage rate for prescription drugs

Objective:

Strategies to attain the objective:

Coordination of Services:
1. Continue and enhance efforts by State Drug Director's office, Rotary, and law enforcement to raise community awareness through Monitor, Secure and Dispose campaign and biennial drug take-backs.
2. Coordinate services for veterans, families, and other impacted by war to determine and fill gaps based on issues, geography, age, and gender.
3. Restructure current regional technical assistance system to focus on local community training and parent education. Incorporate integrated services and cross-training in workforce development. Provide local funding for leveraged direct services to the community.

Training and Technical Assistance:
1. Provide training about prevention to physicians and other healthcare providers for a greater understanding of science of addiction and prescription drug issues related to over prescribing.
2. Provide training about prevention to law enforcement, especially school resource officers, for better understanding of youth drug trends, behaviors, and appropriate environmental prevention strategies.
3. Provide training about prevention to PE and health teachers who are primarily responsible for substance abuse prevention in classroom so that students will receive consistent messages statewide.
4. Develop curriculums and provide Training of Trainers (TOTs) on topics centering on collaboration, community mobilization, and community requested

topics. Obtain parenting curriculums and provide TOTs for Regional Prevention Representatives who will provide training in communities.

Data:
1. Enhance or expand data being collected by veteran serving organization for ATOD usage.
2. Coordinate with the Arkansas Health Department to review data collected about prescribing trends through the Prescription Drug Monitoring Program.

Evaluation:
1. Implement standardized collection processes and expected measures for process and outcome data.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	30 day usage rate for prescription drugs
Baseline Measurement:	4.4% (2011)
First-year target/outcome measurement:	3.4%
Second-year target/outcome measurement:	

Data Source:

Arkansas Prevention Needs Assessment

Description of Data:

Data issues/caveats that affect outcome measures::

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	$20,156,240		$0	$0	$4,550,046	$0	$10,343,850
a. Pregnant Women and Women with Dependent Children*	$2,338,724		$0	$0	$0	$0	$0
b. All Other	$17,817,516		$0	$0	$4,550,046	$0	$10,343,850
2. Substance Abuse Primary Prevention	$5,374,998		$0	$0	$0	$0	$0
3. Tuberculosis Services	$0		$0	$0	$0	$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)	$1,343,750		$0	$0	$0	$0	$0
13. Total	$26,874,988	$0	$0	$0	$4,550,046	$0	$10,343,850

* 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 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			$0	$0	$0	$0	$0
6. Other 24 Hour Care		$0	$0	$0	$12,370,932	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$7,519,384	$0	$3,035,362	$35,930,136	$0	$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)		$406,283	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$200,000	$0	$0	$0	$0	$0
13. Total	$0	$8,125,667	$0	$3,035,362	$48,301,068	$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:

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:

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	$10,078,119
2 . Substance Abuse Primary Prevention	$2,687,499
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	$671,875
6. Total	$13,437,493

* 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	
	Selective	$311,731
	Indicated	
	Unspecified	
	Total	$311,731
Education	Universal	$195,492
	Selective	$20,000
	Indicated	
	Unspecified	
	Total	$215,492
Alternatives	Universal	$137,373
	Selective	
	Indicated	
	Unspecified	
	Total	$137,373
Problem Identification and Referral	Universal	$36,985
	Selective	
	Indicated	
	Unspecified	
	Total	$36,985

Community-Based Process	Universal	$553,456
	Selective	$20,000
	Indicated	
	Unspecified	
	Total	$573,456
Environmental	Universal	$99,067
	Selective	
	Indicated	
	Unspecified	
	Total	$99,067
Section 1926 Tobacco	Universal	$32,302
	Selective	
	Indicated	
	Unspecified	
	Total	$32,302
Other	Universal	$1,281,093
	Selective	
	Indicated	
	Unspecified	
	Total	$1,281,093
Total Prevention Expenditures		$2,687,499
Total SABG Award*		$13,437,493
Planned Primary Prevention Percentage		20.00 %

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

Footnotes:

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	$1,406,406	
Universal Indirect	$1,281,093	
Selective		
Indicated		
Column Total	$2,687,499	
Total SABG Award*	$13,437,493	
Planned Primary Prevention Percentage	20.00 %	

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

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

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

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

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	$266,823	$0	$0	$266,823
2. Quality Assurance	$9,486	$0	$0	$9,486
3. Training (Post-Employment)	$468,481	$145,000	$0	$613,481
4. Education (Pre-Employment)	$0	$0	$0	
5. Program Development	$337,466	$0	$0	$337,466
6. Research and Evaluation	$28,837	$0	$0	$28,837
7. Information Systems	$170,000	$0	$0	$170,000
8. Total	$1,281,093	$145,000		$1,426,093

Footnotes:

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	$80,000
MHA Administration	$50,000
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	$168,910
Total Non-Direct Services	$298910
Comments on Data:	

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 homes[39] and ACOs[40] 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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Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

State of Arkansas *As Engrossed: S1/26/15 S1/27/15 H2/4/15*
90th General Assembly

A Bill

Regular Session, 2015 SENATE BILL 96

By: Senators J. Hendren, *Bledsoe, Caldwell, E. Cheatham, A. Clark, J. Dismang, Files, S. Flowers, Hester, Hickey, J. Hutchinson, B. Pierce, B. Sample, D. Sanders, E. Williams*
By: Representatives Farrer, Linck, Baine, Baltz, Bell, Boyd, Bragg, Branscum, Della Rosa, L. Fite, Gillam, Hammer, K. Hendren, Jett, Johnson, Lemons, Love, Lowery, Lundstrum, G. McGill, D. Meeks, Scott, Womack

For An Act To Be Entitled

AN ACT TO ADDRESS THE HEALTHCARE NEEDS OF INDIVIDUALS SERVED BY THE HEALTH CARE INDEPENDENCE PROGRAM TO BE KNOWN AS THE ARKANSAS HEALTH REFORM ACT OF 2015; TO CREATE THE ARKANSAS HEALTH REFORM LEGISLATIVE TASK FORCE; TO TRANSFORM THE ARKANSAS MEDICAID PROGRAM WITH INNOVATIVE AND COST-EFFECTIVE SOLUTIONS FOR THE PROVISION OF HEALTHCARE SERVICES; TO DECLARE AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO CREATE THE ARKANSAS HEALTH REFORM ACT OF 2015; AND TO DECLARE AN EMERGENCY.

WHEREAS, the federal Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, requires that Arkansas citizens obtain credible health insurance coverage either through employer mandates or individual action, or face threat of tax penalties; and

WHEREAS, the federal Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, further jeopardized the Arkansas healthcare system and its clinical providers' ability to meet healthcare needs of citizens by excising new taxes, cutting existing Medicare payments, and imposing new

penalties on clinical providers; and

WHEREAS, the federal Emergency Medical Treatment & Labor Act requires Arkansas hospitals to provide direct health care for Arkansas citizens, including those citizens eligible for the Arkansas Health Care Independence Program, regardless of ability to pay; and

WHEREAS, the Arkansas Health Care Independence Program was the State of Arkansas's initial response to the disruptive challenges of the federal healthcare legislation and regulation in an effort to safeguard Arkansas employers and citizens and healthcare systems; and

WHEREAS, the Arkansas Health Care Independence Program and the federal waiver under which the state operates the Arkansas Health Care Independence Program will terminate on December 31, *2016, which will have the effect of ending eligibility for Medicaid expansion populations in the absence of legislative action by the General Assembly; and*

WHEREAS, the State of Arkansas has historically sought state-specific strategies to provide health care for low-income and other vulnerable populations while reducing state and federal obligations to entitlement spending; and

WHEREAS, the State of Arkansas continues to seek out strategies to provide health care for low-income and other vulnerable populations in a manner that will promote accountability, personal responsibility, and transparency; remove disincentives for work and social mobility; encourage and reward healthy outcomes and responsible choices; and promote efficiencies that will deliver value to the taxpayers; and

WHEREAS, the State of Arkansas is recognized as a leader in healthcare finance and delivery system innovation; and

WHEREAS, the State of Arkansas seeks to assert its responsibility for local control and to protect Arkansas consumers and businesses from federal mandates,

NOW THEREFORE,
BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. DO NOT CODIFY. Title.

This act shall be known and may be cited as the "Arkansas Health Reform Act of 2015".

SECTION 2. TEMPORARY LANGUAGE. DO NOT CODIFY. Arkansas Health Reform Legislative Task Force — Creation — Membership — Duties.

(a) There is created the Arkansas Health Reform Legislative Task Force.

(b)(1) The task force shall consist of the following sixteen (16) members of the General Assembly:

(A) The President Pro Tempore of the Senate, or his or her designee who is a member of the Senate;

(B) Five (5) members of the Senate appointed by the President Pro Tempore of the Senate;

(C) The Senate Majority Leader, or his or her designee who is a member of the Senate;

(D) The Senate Minority Leader, or his or her designee who is a member of the Senate;

(E) The Speaker of the House of Representatives, or his or her designee who is a member of the House of Representatives;

(F) Five (5) members of House of Representatives appointed by the Speaker of the House of Representatives;

(G) The House Majority Leader, or his or her designee who is a member of the House of Representatives; and

(H) The House Minority Leader, or his or her designee who is a member of the House of Representatives.

(2) The Surgeon General shall serve as a nonvoting member of the task force.

(3) If a vacancy occurs on the task force, the vacancy shall be filled by the same process as the original appointment.

(4) Legislative members of the task force shall be paid per diem and mileage as authorized by law for attendance at meetings of interim

1 committees of the General Assembly.
2 (c)(1) The President Pro Tempore of the Senate shall designate one (1)
3 member of the task force to call the first meeting of the task force within
4 thirty (30) days of the effective date of this act and serve as chair of the
5 task force at the first meeting.
6 (2) At the first meeting of the task force, the members of the
7 task force shall elect from its membership a chair and other officers as
8 needed for the transaction of its business.
9 (3)(A) The task force shall conduct its meetings in Pulaski
10 County at the State Capitol or another site with teleconferencing
11 capabilities.
12 (B) Meetings of the task force shall be held at least one
13 (1) time every two (2) months but may occur more often at the call of the
14 chair.
15 (4) The task force shall establish rules and procedures for
16 conducting its business.
17 (5)(A) A majority of the voting members of the task force shall
18 constitute a quorum for transacting business of the task force.
19 (B) An affirmative vote of a majority of a quorum present
20 shall be required for the passage of a motion or other task force action.
21 (6) The Bureau of Legislative Research shall provide staff for
22 the task force.
23 (d)(1) The purpose of the task force is to:
24 (A) Recommend an alternative healthcare coverage model and
25 legislative framework to ensure the continued availability of healthcare
26 services for vulnerable populations covered by the Health Care Independence
27 Program established by the Health Care Independence Act of 2013, §§ 20-77-
28 2401 et seq., upon program termination; and
29 (B) Explore and recommend options to modernize Medicaid
30 programs serving the indigent, aged, and disabled.
31 (2) To achieve this purpose, the task force shall:
32 (A) Identify resources and funding necessary to ensure an
33 effective and efficient transition from the Health Care Independence Program,
34 while minimizing or eliminating any need for the General Assembly to raise
35 additional state general revenue;
36 (B) Identify the populations eligible for and

participating in the Health Care Independence Program, including both:

(i) Individuals newly eligible for health coverage under the program; and

(ii) Individuals previously eligible for Medicaid before the effective date of the program, whether under a Medicaid waiver or some other eligibility criteria;

(C) Study the healthcare needs and other relevant characteristics of those populations served by the Health Care Independence Program;

(D) Recommend measures and options to preserve access to quality health care for those populations served by the Health Care Independence Program;

(E) Structure any recommended measures and options in a manner that achieves the following:

(i) Protection of Arkansas workers and employers from federal mandates and regulations by limiting the role of the federal government in defining the healthcare choices and coverage available in the Arkansas health insurance market;

(ii) Maximum flexibility for the state and limitations on federal restrictions on the state's ability to efficiently and effectively manage the Arkansas Medicaid Program;

(iii) Opportunities to limit the size of the traditional Medicaid program by serving healthier beneficiaries in the private market;

(iv) Strengthening of the employer-sponsored health insurance market;

(v) Increased employment of able-bodied recipients of taxpayer-funded healthcare services;

(vi) Healthier behaviors, increased accountability, and personal responsibility for beneficiaries;

(vii) Enlistment of enough providers so that care and services are available at least to the extent that such care and services are available under the Health Care Independence Program;

(viii) Access to health services in rural areas of the state;

(ix) Continuity of coverage for eligible individuals

as their income or life circumstances change; and

(x)(a) Continued payment innovation, delivery system reform, and market driven improvement, including without limitation the Arkansas Health Care Payment Improvement Initiative, for which current federal grant support will expire on or before December 31, 2016.

(b) The task force shall review the Arkansas Health Care Payment Improvement Initiative and recommend continuation, suspension, termination, or other actions the task force deems appropriate to the Governor.

(F) Estimate the impact of the Health Care Independence Program and of its termination on the state's economy as a whole and on the state's general revenue budget;

(G) Recommend procedures to optimize and streamline the legislative review and approval process for state plan amendments and other Medicaid rules, so as to promote efficiency, ensure agency responsiveness to changing market conditions, encourage transparency, and protect against undue *influence by special interests; and*

(H) If the task force determines necessary, contract with the consultants to assist the task force with the study.

(3)(A) On or before December 31, 2015, the task force shall file with the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate a written report of the task force's activities, findings, and recommendations.

(B) The task force may file with the Governor, the Speaker of the House of Representatives, and the President Pro Tempore of the Senate a final written report on or before December 30, 2016.

(e) The task force expires December 31, 2016.

SECTION 3. TEMPORARY LANGUAGE. DO NOT CODIFY. Efforts to transform the Arkansas Medicaid Program — Federal waivers or authorities.

(a)(1) Notwithstanding any other rule, regulation, or law to the contrary, the Department of Human Services may submit and apply for any federal waivers or authority necessary to transform the Arkansas Medicaid Program into a program with maximum state flexibility in the use of the funds for innovative and cost-effective solutions for the provision of healthcare services.

(2) Under no circumstances may Medicaid eligibility be extended past December 31, 2016, for the current Medicaid expansion population under the Health Care Independence Program, commonly referred to as the "Private Option," including the current Medicaid expansion population in the eligibility category created by Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. § 1396a, without express legislative approval through a proper enactment of law by the General Assembly.

(3) The options pursued as part of this effort may include without limitation:

(A) A block grant or global budget cap program in which the federal government provides the state with a defined annual lump sum, calculated on the basis of past and existing Medicaid funding levels, adjusted annually for healthcare inflation; and

(B) Innovative measures and options such as capitated payment models, including without limitation managed care programs for specific high-need populations such as people with serious mental illness or elders with frailty.

(b) The solutions pursued through this effort shall aim to sustain and improve the following:

(1) Appropriate care and improved outcomes through early intervention, prevention, and wellness programs, including the reduction of rates of obesity and tobacco use;

(2) Services in the most cost-effective settings;

(3) Enhanced injury prevention;

(4) Optimized use of telemedicine;

(5) Transparency in healthcare price, quality, and utilization for consumers, taxpayers, and policymakers;

(6) Discouraged over-utilization and reduced waste, fraud, and abuse; and

(7) Other efficiencies that will deliver value to the taxpayers.

(c) The programs and populations in this effort may include without limitation:

(1) The traditional Medicaid program;

(2) Existing Medicaid waiver programs, including without limitation those waivers authorized or required by *Arkansas law*; and

(3) Individuals eligible for the Health Care Independence

Program authorized under § 20-77-2401 et seq.

(d) The department, in consultation with the Arkansas Health Reform Legislative Task Force, shall submit the necessary waiver requests to the Centers for Medicare and Medicaid Services no later than July 1, 2016, for a waiver term of up to five (5) years.

(e) The department may promulgate rules to administer and implement this section.

SECTION 4. TEMPORARY LANGUAGE. DO NOT CODIFY. Suspension of certain changes to the Health Care Independence Program.

(a) The Department of Human Services shall suspend, as of the effective date of this act and notwithstanding any other rules, regulations, or provisions of law to the contrary, any further inclusion or transition of Medicaid-eligible recipient populations to the Arkansas Health Insurance Marketplace, including without limitation:

(1) Children eligible for the ARKids First Program Act, § 20-77-1101 et seq., commonly known as the "ARKids B program"; and

(2) Populations under Medicaid from zero percent (0%) of the federal poverty level to seventeen percent (17%) of the federal poverty level.

(b) Notwithstanding any other rule, regulation, or law to the contrary, the department shall suspend, as of the effective date of this act, the application of any additional cost sharing requirements *to go into effect on or after* January 31, 2015, under the Health Care Independence Program to Medicaid beneficiaries with incomes below one hundred percent (100%) of the federal poverty level.

(c) The purpose of this section is to:

(1) Ensure a focus on future improvements; and

(2) Limit the state's exposure to additional costs.

(d) This section shall expire at the earliest of:

(1) The effective date of the termination of the Health Care Independence Program; or

(2) December 31, 2016.

SECTION 5. TEMPORARY LANGUAGE. DO NOT CODIFY. Modification of Medicaid State Plan.

(a) The Department of Human Services shall amend the Medicaid State Plan to eliminate all eligibility categories authorized by Section 1902(a)(10)(i)(VIII) of the Social Security Act, 42 U.S.C. § 1396a, by December 31, 2016.

(b) The department shall submit and make effective the Medicaid State Plan amendments required by this section prior to the date on which the federal waivers actually terminate.

(c) This section does not require modification of any Medicaid *eligibility categories that were in effect on or before December 31, 2013.*

(d) The purpose of this section is to ensure that Medicaid eligibility does not continue past December 31, 2016, for the current Medicaid expansion population under the Health Care Independence Program, commonly referred to as the "Private Option," including the current Medicaid expansion population in the eligibility category created by Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. § 1396a, without express approval through a proper enactment of law by the General Assembly.

SECTION 6. DO NOT CODIFY. Expiration of Health Care Independence Program.

Eligibility, enrollment and participation in Medicaid for the current Medicaid expansion population under the Health Care Independence Program authorized under § 20-77-2401 et seq., including the current Medicaid expansion population in the eligibility category created by Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. § 1396a, shall cease and terminate effective January 1, 2017, in the absence of legislative action by the General Assembly.

SECTION *7*. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that without legislative action, the Health Care Independence Program will terminate before reductions in federal medical assistance percentages require the expenditure of additional state general revenues; that an urgent need exists to develop contingency plans for the termination of the Health Care Independence Program and to ensure continued healthcare access for eligible individuals; that to ensure efficient use of taxpayer dollars and continued healthcare coverage for the state's most vulnerable citizens, it is immediately necessary to transform

the Arkansas Medicaid Program; and that this act is immediately necessary to initiate reforms of the state's healthcare system. Therefore, an emergency is declared to exist, and this act is immediately necessary for the preservation of the public peace, health, and safety, and shall become effective on:

(1) The date of this act's approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

/s/J. Hendren

APPROVED: 02/11/2015

PRELIMINARY DRAFT

Building a healthier future for all Arkansans

Behavioral Health Transformation

October 2013

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

Agenda

- Introduction
- Health home model
- New behavioral health services

Today, we face major health care challenges in Arkansas

- **The health status of Arkansans is poor**: the state is ranked at or near the bottom of all states on national health indicators
- **The health care system is hard for patients to navigate**, and it does not reward providers who work as a team to coordinate care for patients
- **Health care spending is growing unsustainably:**
  - Insurance premiums doubled for employers and families in past 10 years (adding to uninsured population)
  - Often unnecessary costs are created in Medicaid due to duplication of services and lack of care coordination

We have worked closely with providers, clients, and family members across Arkansas to shape an approach to transforming the behavioral health system

85	▪ **Meetings with providers, consumers, family members**, and other stakeholders to help shape the new model
10	▪ **Public workgroup meetings** connected to 6-8 sites across the state through videoconference
4	▪ **Webinars** open to the public to review model design and answer questions
Monthly	▪ **Updates with many Arkansas provider associations**
Ongoing	▪ **Efforts to enhance the quality and access to services in the child and adult systems of care** (e.g., Behavioral Health Care Commission, Recovery Oriented SOC)

There are many challenges specifically within the current behavioral health system

	Current challenges
Prevention	▪ Awareness of available services can be improved ▪ Gaps in services for behavioral health needs (mental health and substance abuse) ▪ Need for additional training programs
Early intervention	▪ Gaps in early intervention services, including crisis intervention ▪ Existing early intervention can be enhanced ▪ Areas for improvement in current referral and awareness programs
Treatment	▪ Gaps in current treatment delivery system (inc. provider training and workforce limitations) ▪ Treatment is not always delivered in a guideline concordant manner ▪ Care integration and coordination is limited ▪ Outcomes are not tracked effectively
Recovery / resilience	▪ There are gaps in the ways providers address recovery and resilience today ▪ Opportunity to improve consistency in existing recovery / resilience efforts ▪ Consumer, peer, family, and community supports are not always leveraged most effectively
Screenings and assessments	▪ Inconsistent screening and assessment process ▪ Need to improve the use of data ▪ Arkansas has a high prevalence of SED/SMI designations

Key facts in behavioral health for the Medicaid population

Early facts in Arkansas

Total Medicaid behavioral health beneficiaries	~110,000 recipients
"Core" behavioral health spend (38% IP, 62% OP)	~$550 M
"Halo" spend	~$380 M
Pharmacy spend of behavioral health clients (BH and halo)[2]	~$150 M

Definitions of key terms

"Core" behavioral health spend[1]:

- Includes behavioral health services delivered to the client, (e.g., services for ADHD or depression)
- Does not include direct dementia or DD costs, but does includes BH spend from these populations

Halo:

- Includes non-behavioral health services (e.g., medical, support services) delivered to people who also use BH services

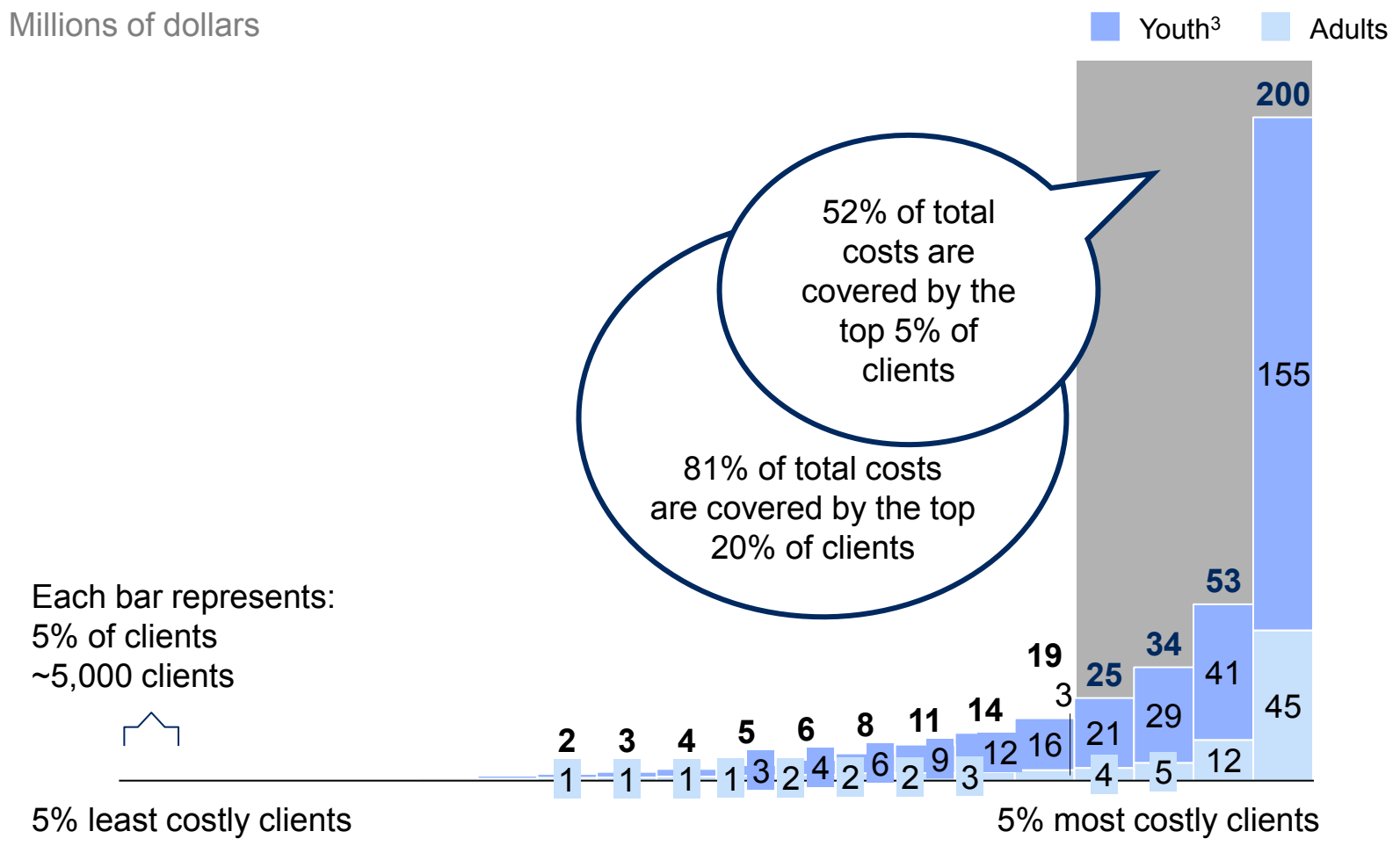
NOTE: Does not include those funded solely from state general revenue. Analysis underway to incorporate broader behavioral health programs

1 Details of BH spend: ICD9 291 – 314 excluding autism (299) and dementia codes in 294, excludes pharmacy

2 Pharmacy includes some spend from some DD and dementia clients that has not yet been excluded

Behavioral health core spend is concentrated amongst the highest need clients

Distribution of clients[1,2] by cost of core care for behavioral health

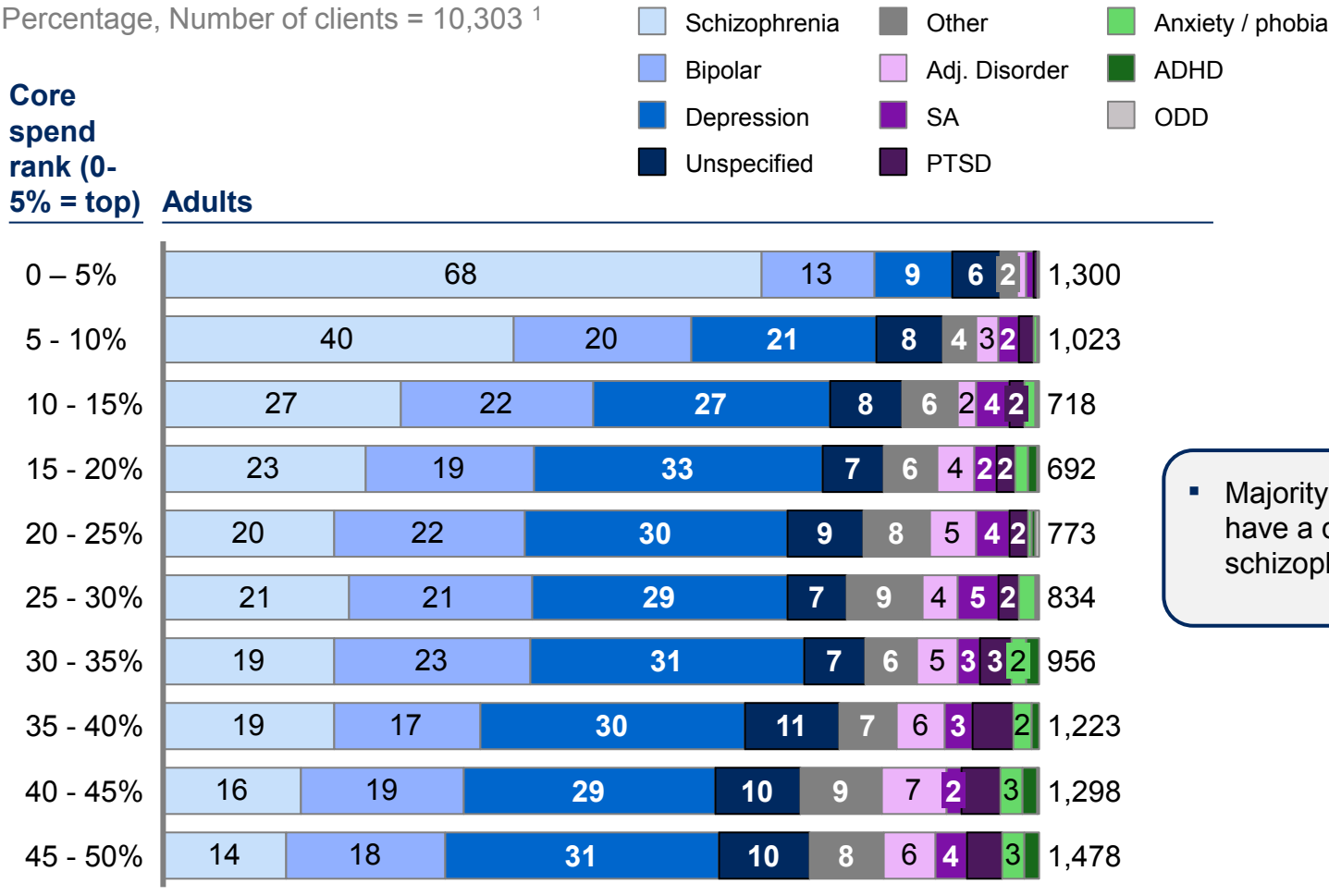


1 Includes all clients with at least one core related claim
2 Excludes clients with DD and LTSS because this group is likely to have multiple health home options
3 Youths are clients<21 years of age; Adults are clients ≥ 21 years of age

Diagnostic profiles for adult BH clients by level of core spend

Breakdown of diagnoses by behavioral health spend rank for adults in top 50% of core spend

Percentage, Number of clients = 10,303 [1]



- Majority of top 5% adults have a diagnoses of schizophrenia

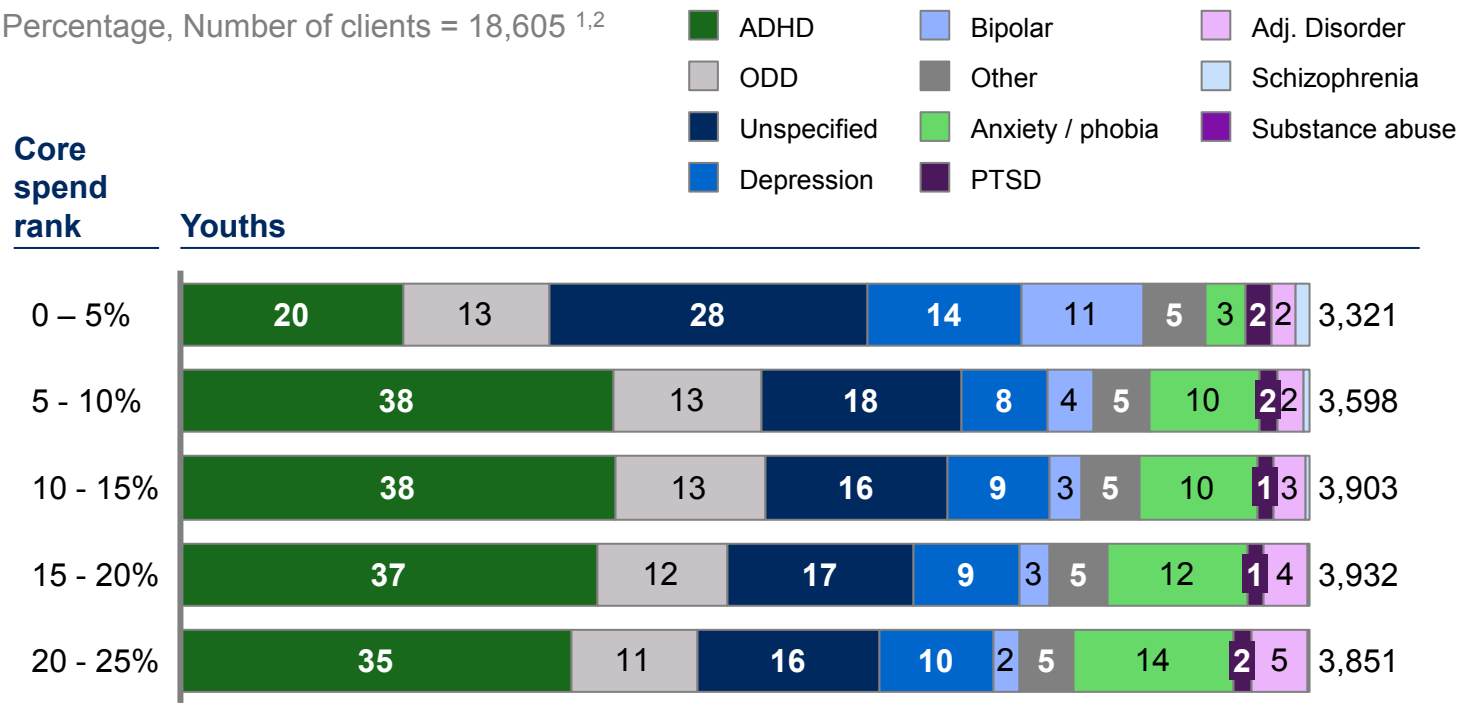
1 Excludes clients with DD and LTSS because this group is likely to have multiple health home options

SOURCE: 2011 Medicaid BH claims (ICD-9 291 – 314 excluding 299 and dementia codes in 294), excludes pharmacy and

Diagnostic profiles for youth BH clients by level of core spend

Breakdown of diagnoses by behavioral health spend rank for youth in top 25% of core spend

Percentage, Number of clients = 18,605 [1,2]



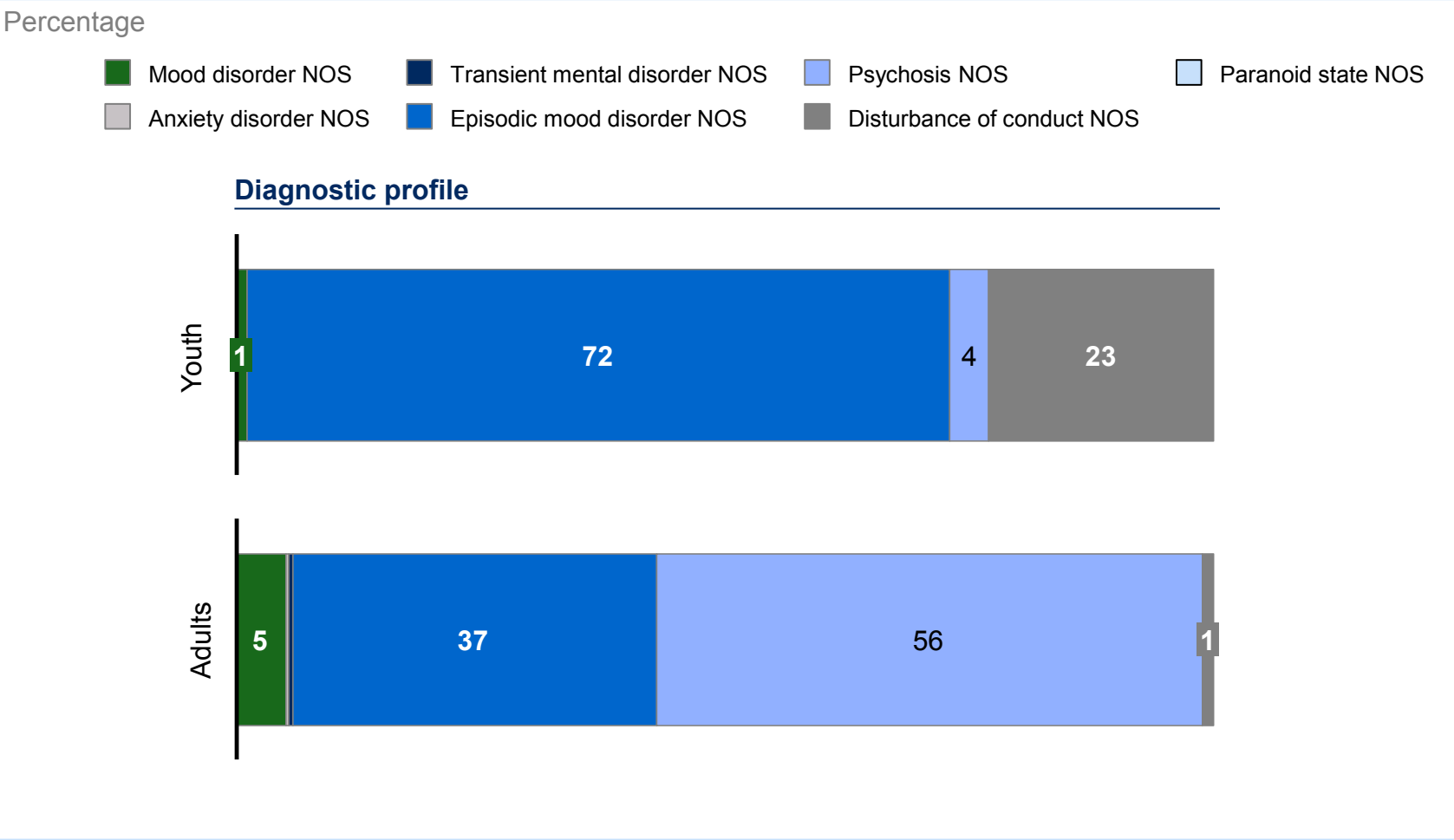
- Both ADHD and ODD will be covered by episodes
- Over 1,000 clients in top 5% of spend are diagnosed with ADHD or ODD

1 Excludes clients with DD and LTSS because this group is likely to have multiple health home options
2 Youths are clients<21 years of age; Adults are clients ≥ 21 years of age

SOURCE: 2011 Medicaid BH claims (ICD-9 291 – 314 excluding 299 and dementia codes in 294), excludes pharmacy and

Unspecified diagnosis deep dive for adult and youth BH clients

Deep dive into Unspecified diagnosis for youth and adult clients[1,2]



1 Excludes clients with DD and LTSS because this group is likely to have multiple health home options
2 Includes diagnoses that are "not elsewhere specified" or "classified elsewhere"
SOURCE: 2011 Medicaid BH claims (ICD-9 291 – 314 excluding 299 and dementia codes in 294), excludes pharmacy and

Our vision to improve care for Arkansas is a comprehensive, patient-centered delivery system

Focus today

Objectives

For patients

- Improve the health of the population
- Enhance the patient experience of care
- Enable patients to take an active role in their care

For providers

- Reward providers for high quality, efficient care
- Reduce or control the cost of care

How care is delivered

Population-based care
- Medical homes
- Health homes

Episode-based care
- Acute, post-acute, or select chronic conditions

Five aspects of broader program

- Results-based **payment and reporting**
- Health care **workforce** development
- **Health information technology** (HIT) adoption
- **Consumer engagement** and **personal responsibility**
- **Expanded coverage** for health care services

Potential payment initiatives to address issues within the BH system

Focus today

PRELIMINARY

	Initiative	Description
1	**Health homes** (& link to medical homes)	Deliver integrated care management to facilitate quality care and positive outcomes through: – Ensuring effective treatment of BH conditions – Integrating care coordination across BH, medical, developmental disabilities, and long-term supports
2	**Episode-based care delivery**	Increase adoption of evidence-informed practices by creating accountability for all services related to a specific BH condition (e.g., ADHD, and potentially ODD, depression and bipolar disorder)
3	**Reimbursement adjustments**	Modify reimbursement rules to encourage appropriate diagnosis and utilization of services (e.g., placing appropriate time limits on unspecified diagnoses)
4	**Reimbursement for new services**	Add reimbursement for selected new services that are known to be cost-effective and evidence-informed (e.g., crisis intervention, substance abuse treatment services, medication management and community-based services)
5	**Reimbursement for pharmacy** (including polypharmacy)	Build on recent work in pharmacy management utilization rules to ensure appropriate use of medications (includes polypharmacy, therapy interactions, and dosage)
6		Develop policy changes or initiatives that enable or compliment the payment initiatives (e.g., changes to certifications for all BH providers, specialty certifications, new screenings)

Contents

- **Behavioral health homes**
- Proposed behavioral health services

Goals of the behavioral health home

To deliver integrated care management in a manner that facilitates quality care and positive outcomes through:

Providing care coordination

- Providing clients with integrated care coordination within and across BH, medical health, developmental disabilities, long-term supports, and other systems

Managing core care delivery

- Ensuring effective treatment of behavioral health conditions, including pharmacy effects

Guiding principles for health home development

- Health homes must address **comprehensive needs of individuals** by utilizing a “whole person” and “person centered” approach while ensuring personal choice assurances through service planning and delivery
- Health homes will provide services that address issues of **access to care, accountability, and active participation** on behalf of both providers and individuals/families receiving services, **continuity of care** across all medical, behavioral, and social supports, and comprehensive coordination/integration of all needed services
- Health homes will provide services that seek to **align a fragmented system** of needs assessment, service planning, care management, transitional care, and direct care service delivery
- Health homes must **demonstrate the use of health information technology** as a means to improve service delivery and health outcomes of the individuals served

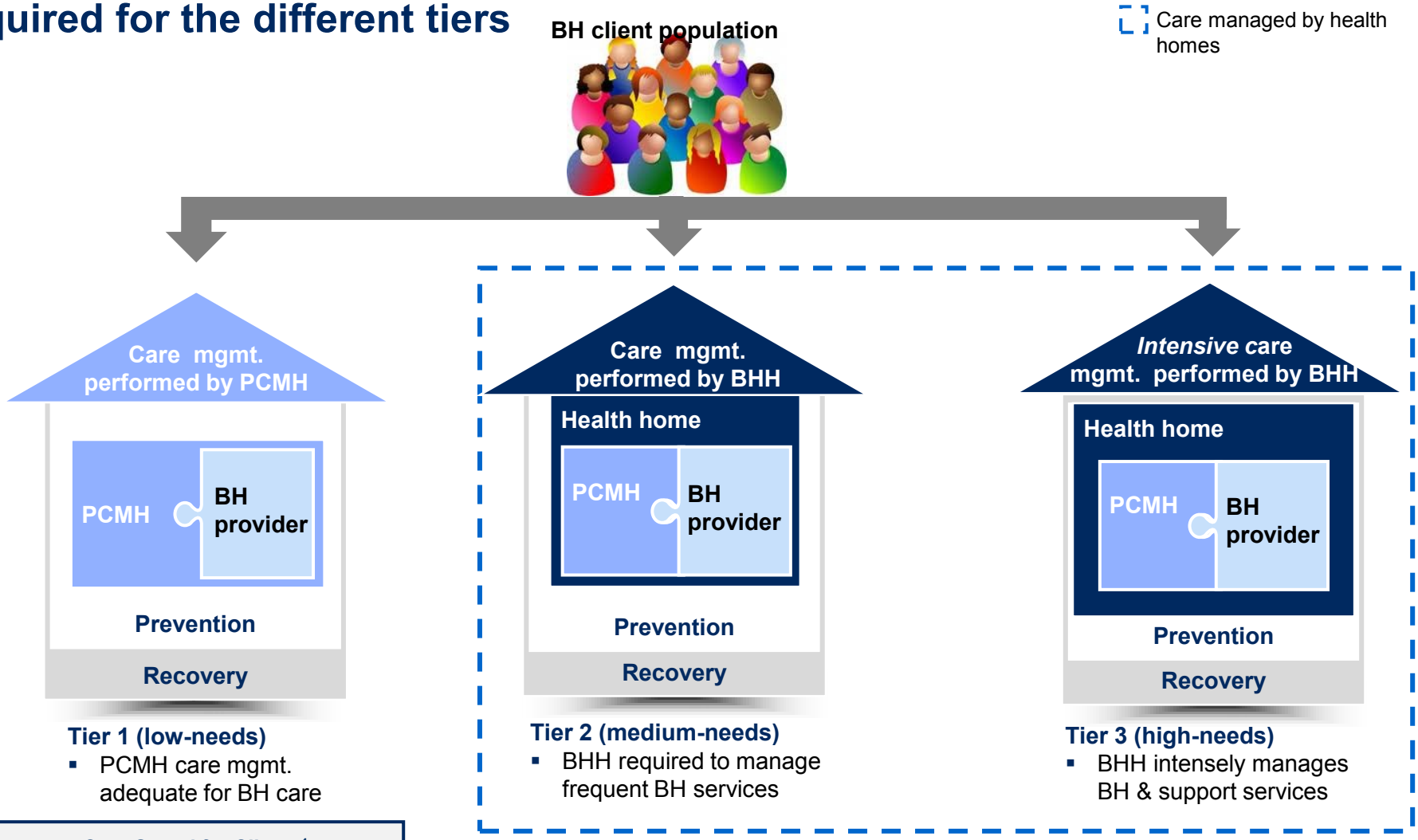
Introduction to a health home

What a BH health home is…	What a BH health home is not…
▪ A provider of behavioral health services ▪ Extra support for people who need an increased level of care management or who face greater challenges in navigating the healthcare system ▪ Enhanced support for clients who have needs in multiple areas, including DD, LTSS, housing, justice system, etc. ▪ Opportunity to promote quality in the core provision of behavioral health care ▪ Encourage providers to work in teams to improve outcomes for the clients ▪ A way of aligning financial incentives around evidence-informed practices, wellness promotion, and health outcomes	▪ NOT a direct provider of medical services ▪ NOT a gatekeeper restricting a client's choice of providers ▪ NOT a physical "house" where all health home activities take place ▪ NOT an organization that is required to contract with other providers (e.g., medical providers) to serve their clients

The new behavioral health system will be conscious of varying severity of needs as well as intensity of care management required for the different tiers

ILLUSTRATIVE

Care managed by health homes



Tier 1 (low-needs)
- PCMH care mgmt. adequate for BH care

Tier 2 (medium-needs)
- BHH required to manage frequent BH services

Tier 3 (high-needs)
- BHH intensely manages BH & support services

Core Spend for Clients[1]		
Tier 1	79%OP	21% IP
Tier 2	83%OP	17%IP
Tier 3	44%OP	56% IP

1IP=

Example profiles of children in different tiers

ILLUSTRATIVE

Tier 1 client: Ben

- Ben, age 6, has been diagnosed for 1 year with level I ADHD.
- Ben's family is engaged in treatment and he resides with his family including one sibling.
- Ben's performance in school has been average and he meets the typical cognitive development of a 6 year old.
- Ben is known to be easily distracted in school, tends to be the class clown, and he has difficulty keeping friends. He is generally friendly but he is often impulsive and socially immature. His teacher has reported some improvement in his behavior over the past few months.

Tier 2 client: Tom

- Tom, age 8, has been diagnosed comorbid for 2 years with depression and ODD.
- Tom continues to display very oppositional behavior at home and school which is beginning to impact academic performance and result in disciplinary issues.
- Tom's family is very involved in his treatment, regularly attending family therapy sessions with Tom's therapist. However, the family has not been successful in implementing therapeutic strategies in the home.
- Tom's parents would like additional supports in the home and teacher supports and education in the school.
- Tom's therapist and his parents agree he does not need to be placed in a residential treatment facility.

Tier 3 client: Annie

- Annie, age 14, has been diagnosed with Bipolar Disorder and presents with oppositional symptoms as well. She has recently started to make suicidal statements.
- Annie is currently living in foster care and has been with her current family for 2 years.
- Annie has had multiple acute inpatient stays in the recent months due to her suicidal threats.
- Annie's academic performance has also significantly declined over the past 2 years.
- Annie's family service worker and her therapist are considering admission into a psychiatric residential treatment facility.

Example profiles of adults in different tiers

ILLUSTRATIVE

Tier 1 client: George

- George, age 26, was diagnosed with depression 2 years ago.
- George had previously been in a Tier 2 health home but has greatly improved.
- George now manages his depression through regular medication appointments and occasional clinic-based therapy appointments; he does not need a case manager.
- George is living independently and maintaining a steady job.

Tier 2 client: Roy

- Roy, age 32, has been diagnosed with depression and drug addiction, but he is on a path of recovery.
- During his recovery, Roy experienced a crisis event. He relapsed, lost his job, and lost his apartment. He was undergoing intensive outpatient substance abuse treatment at the time of his relapse.
- Roy and his therapist are of the opinion that his recovery would likely be successful if he was provided with the opportunity to enter a partial hospitalization program and had a peer specialist working with him in the community.

Tier 3 client: Liz

- Liz, age 44, has been diagnosed with schizophrenia and has substance abuse issues.
- Liz had recently been hospitalized and she is currently in a residential substance abuse program.
- Liz needs ongoing behavioral health and substance abuse treatment after she discharges from residential treatment.
- Liz will also need housing support, assistance with her budget, and help meeting her nutritional needs including meal planning.
- Liz has a history with the criminal justice system and is at risk of returning to jail is she relapses.

Tier 2 and 3 clients will receive care management services from health homes

Care management activities			
Care coordination	**Health promotion**	**Support services**	**Comprehensive transitional care**
▪ Support and enable care plan adherence by providing assistance with referrals, scheduling and getting to appointments, etc. ▪ Regularly check-in with client to understand barriers to plan adherence ▪ Maintain client documentation ▪ Monitor chronic disease indicators and performance metrics ▪ Integration of care plans across systems	▪ Arrange for / provide client-specific health education services ▪ Educate and support client on self-management plans and routine clinical care	▪ Match individuals (and families) to support services and advocate on their behalf for participation ▪ Maintain awareness of and interact with key services to ensure they are meeting client needs	▪ Establish process to ensure prompt informing on unplanned care ▪ Coordinate and share transition planning with relevant coordinators ▪ Provide regular education on client access to services, especially at transition points ▪ Develop crisis intervention plan, including creating options for increased access

Contents

- Behavioral health homes
- **Proposed behavioral health services**

Guiding principles for Behavioral Health system changes

We will optimize our system to ensure that behavioral health care…

- Is family/consumer-driven and person-centered;
- Supports and promotes evidence-based, recovery-oriented practices that guide service delivery and payment efficiency;
- Provides customized, culturally and linguistically competent, community-based services;
- Offers the least restrictive care;
- Utilizes a team-based approach to treatment decisions to address service needs; and
- Ensure services are high quality based on data from outcomes and evaluation tools

These principles will support our "Triple Aim" of improving health, increasing quality, and lowering the growth of health care costs.

In addition to care management, the new behavioral health system will reimburse new, tier-specific services to deliver necessary care

- **New community and evidence-based practices** will be reimbursed through the 1915(i)[1] Medicaid funding mechanism
- 1915(i) allows drawing down **federal funds to support reimbursement of needed services for the first time**
- **Benefits can be targeted** to a specific population, services can differ in amount, duration, and scope

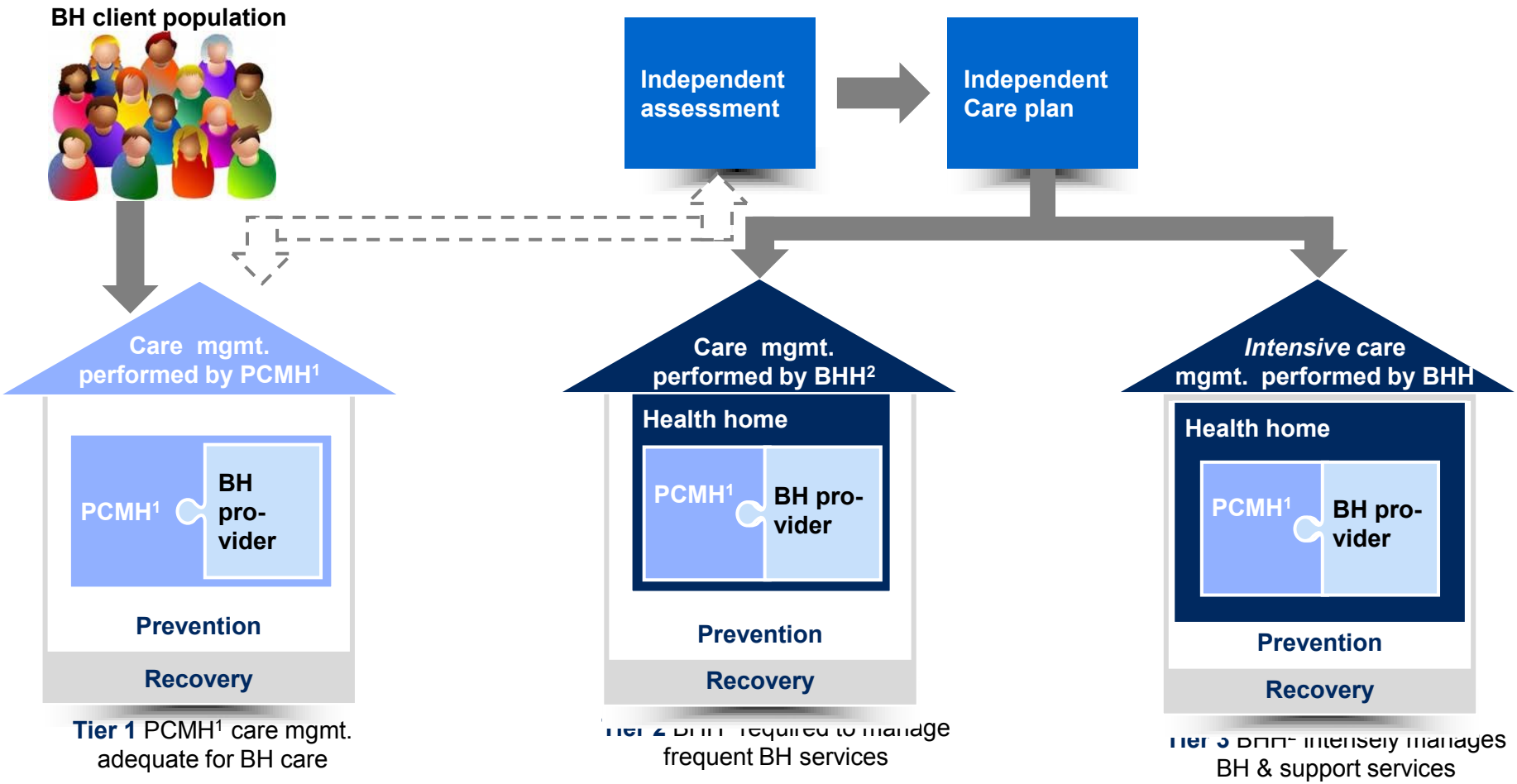
1 This Federal state plan option allows states to offer Home and Community Based Services under a Medicaid state plan to individuals who are Medicaid-eligible.

1915(i) requires an Independent Assessment and Individualized Care Plan

	Requirements
Independent Assessment	▪ Face-to-face ▪ Determines necessary level of services & supports ▪ Evaluates functional needs ▪ Consults individual as well as family/significant others & treating providers as well as individual ▪ Reviews patient history ▪ Establishes individualized plan of care
Independent Care Plan	▪ Person-centered care plan development ▪ Based on the independent assessment ▪ Developed in consultation with individual, treating providers or others ▪ Identifies necessary home & community based services to be delivered ▪ Should prevent inappropriate care ▪ Beneficiaries must be re-evaluated at least every 12 months to see if service needs have changed ▪ Provider of the services may not conduct evaluation, assessment or care plan development

This integrated system includes health homes, behavioral health services, independent assessments and care plans

ILLUSTRATIVE



Population by Tier			Core Spend by tier[1]		
Tier 1 - Total: ~90,000	70% youth	30%adult	Tier 1 - 79%OP	21% IP	
Tier 2 - Total: ~10-15,000	82%youth	18%adult	Tier 2 - 83%OP	17% IP	
Tier 3 - Total: ~5,000	72%youth	28% adult	Tier 3 - 44%OP	56% IP	

1 Patient centered medical home
2 B

Preliminary: new behavioral health services to be offered

BH client population

Existing Services
Expanded Services
1915(i) Services

Tier 1

Clinic-Based

- *Individual behavioral health counseling*
- *Group behavioral health counseling*
- *Marital/family behavioral health counseling*
- *Multi-family behavioral health counseling*
- *Psychoeducation*
- *Mental health diagnosis*
- *Interpretation of diagnosis*
- *Substance abuse assessment*
- *Psychological evaluation*
- *Psychiatric assessment*
- Pharmacologic management

Tier 2[1]

Includes low needs services +…

Home/Community-Based

- Master treatment plan
- Home and community individual psychotherapy
- Community group psychotherapy
- Home and community marital/family psychotherapy
- *Home and community family psychoeducation*
- *Partial hospitalization*
- *Peer support*
- *Family support partners*
- *Behavioral assistance*
- *Intensive outpatient substance abuse treatment*
- *Aftercare recovery services*

Clinic/Home/Community-Based

- Psychiatric diagnostic assessment

Tier 3[1]

Includes medium needs services +…

Home/Community-Based

- *Individual life skills development*
- *Group life skills development*
- *Child and youth support services*
- *Individual recovery support*
- *Group recovery support*

Residential

- *Planned respite*
- Residential treatment unit and center
- *Crisis residential treatment*
- *Therapeutic communities*

Health Home services available in Tiers 2 & 3

- *Care management (Tier 2)*
- *Intensive care management (Tier 3)*
- *Wraparound facilitation (Tier 3)*

Crisis services available to all Tiers[1]

- Acute psychiatric hospitalization
- *Mobile response and crisis stabilization*
- *Acute crisis units*
- *Substance abuse detoxification*

1 S e available in Tier 3

What's coming up

PRELIMINARY

Agenda for next workgroup

- Client entry and exit from health homes
- Health home payment methodology
- Provider qualifications

For more information…

Online

- More information on the Payment Improvement Initiative can be found at www.paymentinitiative.org

Phone / email

- For behavioral health specific inquiries, contact Marquita Little:
  - Email: marquita.little@arkansas.gov
  - Phone: 501-682-8154

1. The Health Care System and Integration

During the 2015 Legislative Session, Act 23 " TO CREATE THE ARKANSAS HEALTH REFORM" was passed. This statute created a legislative task force to examine the traditional Medicaid system and Arkansas' version of Medicaid Expansion, the Healthcare Independence program or Private Option. Additionally, this act extended the Private Option until December 31, 2016. The task force must have recommendations on how to move forward with the entire Medicaid program by December 31, 2015. These recommendations must include a way forward with the Medicaid Expansion program.

Arkansas Medicaid has multiple programs that support behavioral health services:

- Rehabilitative Services for Persons with Mental Illness
  Administered by the DBHS and DMS, the RSPMI program provides for mental health treatment for individuals who are Medicaid eligible and identified as needing mental health services There are 53 (including the 13 CMHCs) providers eligible to bill Medicaid through RSPMI. These entities can be private or non-profit. Available services include:
  - Group Outpatient
  - Individual Psychotherapy
  - Master Treatment Plan
  - Acute Day Treatment
  - Interpretation of Diagnosis
  - Psychological Evaluation
  - Crisis Intervention
  - Marital/Family Psychotherapy
  - Rehabilitative Day Service

- Substance Abuse Treatment Services
  Administered by the DBHS and DMS, effective March 1, 2011, the SATS program expanded non-residential substance abuse treatment options to women who are pregnant up to one month post-partum and to youth eligible for Medicaid. The change in the state's Medicaid policy allows state money used for substance abuse treatment for this targeted population to be matched 3:1 with federal Medicaid dollars to significantly increase money to serve pregnant women and children. The state allocated $5 million per year for this program. When matched with federal money, the total annual expenditure has the potential to reach approximately $18 million per year for direct services. Available services include:
  - Assessment
  - Group Counseling
  - Individual Counseling
  - Medication Management
  - Treatment Planning
  - Care Coordination
  - Marital/Family Counseling

- Licensed Mental Health Practitioner
  Individual mental health professionals in private practice in Arkansas may apply to become a Licensed Mental Health Practitioner (LMHP). A DBHS certified LMHP provides outpatient mental health services for the Arkansas Medicaid population under the age of 21, and is eligible to bill the Arkansas Medical Assistance Program (Medicaid) for reimbursable services. The applicant must apply and become certified as an LMHP provider by the Division of Behavioral Health Services prior to applying for Medicaid provider enrollment. There are currently 38 LMHPs across the state of Arkansas.

The Division of Behavioral Health Services (DBHS) has worked and continues to work closely with the Division of Medical Services (DMS), the State's Medicaid agency, to policies to transform the behavioral health Medicaid system. The transformations are part of the state's Payment Improvement Initiative and for behavioral health would include the implementation of care coordination, recovery oriented services, and home and community based services.

Additionally, the Division of Medical Services has implemented the Patient Center Medical Home initiative. The Patient-Centered Medical Home (PCMH) is a team-based care delivery model led by Primary Care Physicians (PCPs) who comprehensively manage beneficiaries' health needs with an emphasis on health care value. The goal of the PCMH program is to achieve the Arkansas Payment Improvement Initiative Triple Aim, which is to (1) Improve the health of the population, (2) Enhance the patient experience of care, and (3) Reduce or control the cost of care. PCMH supports practices in establishing meaningful change and incentivizes practices by sharing cost savings. Arkansas Medicaid partners with providers to invest in improvement through care coordination and practice transformation support. Providers are awarded for performance on quality and cost of care through shared savings.

Additionally, all mental health and substance use providers receiving Block Grant funds are required to implement an EHR. This step will allow for patient information to be shared through the State HIE leading to better coordinated care.

The Division of Behavioral Health Services (DBHS) is not involved in the services reimbursable through QHPs. Additionally, DBHS is not responsible for monitoring access to behavioral health services through QHPs or complaints/violations of MHPAEA. This responsibility remains with the Arkansas Insurance Department.

All substance abuse providers contracted with DBHS to provide block grant funded services are required to develop a "Tobacco Free" policy and procedure for their campus. DBHS is dedicated to continuing to push the bar on tobacco cessation through contract and policy changes.

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.

[52] http://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

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

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

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

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

DBHS would like to specifically request technical assistance for the following activities:

- Developing a feasible plan for addressing health disparities and improving cultural and linguistic competency

- Collecting data (DBHS is in the process of moving towards a new integrated data collection system and would like assistance in assuring the collection of appropriate data elements to measure and address health disparities.)

- Training (For providers and staff on cultural and linguistic competency)

Footnotes:

2. Health Disparities

The Division of Behavioral Health Services (DBHS) collects demographic information for all clients of substance abuse treatment providers and Community Mental Health Centers (CMHCs). All substance abuse treatment data is collected through the ADMIS system, while the CMHC data is collected through SPQM.

DBHS would like to request technical assistance in this area. DBHS does not have specific funds to dedicate to this area and therefore has struggled to develop and execute a plan to reduce health disparities.

DBHS would like to specifically request technical assistance for the following activities:

- Developing a feasible plan for addressing health disparities and improving cultural and linguistic competency
- Collecting data (DBHS is in the process of moving towards a new integrated data collection system and would like assistance in assuring the collection of appropriate data elements to measure and address health disparities.)
- Training (For providers and staff on cultural and linguistic competency)

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). NREPP[59] 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 General[60], The New Freedom Commission on Mental Health[61], the IOM[62], 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.

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[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:

3. Use of Evidence in Purchasing Decisions

The state's licensure and certification team along with Programs staff are responsible for tracking and disseminating information regarding evidence-based or promising practices within the state. Funded substance abuse treatment services are governed by the Rules of Practice and Procedure and Licensure Standards which lay out quality measures as well. Tracking is done mostly through site visits and progress reports. Disseminating information is primarily done through fact sheets, newsletters, and trainings.

The Division of Behavioral Health Services (DBHS) utilizes the state procurement process to purchase services for various mental health and substance abuse prevention, treatment, and recovery support services. The process supports providers in offering quality services, which includes requiring evidence -based approaches and are made aware of the importance of utilizing these approaches to obtain desired results.

Providers are required and encouraged to use evidence based programs, practices, and/or approaches in their programs. The evidence-based approaches requirement is outlined in the provider's performance deliverables and indicators. Solicitations outline the information regarding evidence-based and promising practices in contracts to ensure the user of these practices statewide.

Arkansas utilizes provider involvement in planning value-based purchases and the state has an evaluation plan to assess the impact of its purchasing decisions through quarterly monitoring of each providers status.

DBHS has been working closely with the State Medicaid Authority to incorporate evidence based practices in to the Medicaid State Plan.

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs 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.

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[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:

4. Prevention of Serious Mental Illness

Due to a lack of funding, the Division of Behavioral Health Services is not directly pursuing activities focused on the prevention of serious mental illness.

No technical assistance is requested at this time.

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:

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

Arkansas will begin to address early intervention for those persons diagnosed with Schizophrenia; Schizophreniform; Schizoaffective Disorder; Delusional Disorder and Psychosis Not Otherwise Specified who may be experiencing First Episode of Psychosis. In state fiscal years 2014 and 2015 for those between the of 18-23, we have been able to identify a combined total of 319 persons diagnosed with Psychotic Disorder Nos; 181 diagnosed with Schizoaffective Disorder and 235 diagnosed with Schizophrenia treated at one of Arkansas's 13 Community Mental Health Centers. We are unable to determine how many of those meet the criteria for the first episode of illness.

Providers have elected to incorporate specific evidenced –based components of the Coordinated specialty Care model. Clinicians will be trained to use Cognitive Behavioral Therapy for Psychosis and Family Psycho-education for. Physicians will receive training on prescribing low dose medications.

Data will be submitted on a monthly basis to DBHS. It will include the following the following domains:

- Geographic Coverage Area
- Client Demographics
- Method of First Contact
- Use of Evidence-Based Practices
- Team composition
- Estimated Length of Untreated Psychosis
- Payor Method
- Unfunded Treatment
- Use of contracted funds for other CSC components (e.g. supported employment)

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 though 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:

6. Participant Directed Care

The Division of Behavioral Health Services (DBHS) recognizes and embraces the national movement to implement policies that support self-determination and improve person-centered service delivery. Below are activities DBHS has embraced to move towards a more person-centered delivery system:

- In 2010, DBHS was awarded a four year grant to operate Arkansas Access to Recovery (AR ATR). AR ATR provided funding to individuals through vouchers to purchase services and supports linked to their recovery from substance use disorders. Unfortunately when the grant ended and was not awarded again to Arkansas this vouchering system ceased to exist.
- Beginning in 2013, DBHS partnered with the State Medicaid agency to develop the Behavioral Health Transformation plan as part of the Payment Improvement Initiative. This plan includes Behavioral Health Homes and 1915i home and community based services. The overall plan places high emphasis on person centered/evidenced based approaches and overall peer support services. At the end of the Payment Improvement/Behavioral Health Home initiative Arkansas experienced a change in Governor's. The newly elected Governor and a newly formed legislative Health Care Task Force is reviewing the overall Medicaid system, including the Arkansas's Payment Improvement Initiative, to provide guidance on how best to move forward serving Specialty Populations.
- DBHS, working in partnership with BRSS TACS grant, held thirteen "Community Conversations" encompassing all Community Mental Health Center regions in Arkansas, whereby stakeholders provided input on knowledge of peer operated services. Thus from the stakeholder meetings and with guidance from National Empowerment Center, Oryx Cohen, DBHS developed two informational DVD's supporting Certified Peer Specialist/Peer Support services. The first DVD is geared towards peers and the second DVD is geared towards informing providers of the benefit of peer operated programs. Included in each DVD are Arkansas peers, providers and DBHS staff who as a team visited the states of Georgia, Kansas, and Pennsylvania reviewing each states successful peer services programs. Together both DVD's completely support peer operated services being implemented in Arkansas.
- DBHS is working meticulously with the Arkansas Behavioral Health Planning and Advisory Council (ABHPAC) and its strategic plan. The four outlined areas of the ABHPAC's strategic plan is Managed Care for Behavioral Health, Self-Determination, Lack of funding for Certified Peer Specialist/Peer Services and Under Utilization of thirty trained Recovery Coaches within the State of Arkansas. Presently, ABHPAC is working with Advocates for Human Potential, Inc. with Technical Assistance and would embrace a continued partnership in exploring platforms such as the vouchering system program to ensure individuals of Arkansas have a genuine, free, and independent choice among a network of eligible providers.

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:

ARKANSAS
DEPARTMENT OF HUMAN SERVICES, DIVISION OF BEHAVIORAL HEALTH SERVICES

ALCOHOL AND DRUG ABUSE PREVENTION

RULES OF PRACTICE AND PROCEDURE

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INTRODUCTION

The Arkansas Department of, Human Services, Division of Behavioral Health Services, Alcohol and Drug Abuse Prevention's *Rules of Practice and Procedure* replaces and supersedes any and all previous editions of the *Rules of Practice and Procedure.*

The Arkansas Department of Human Services, Division of Behavioral Health Services, Alcohol and Drug Abuse Prevention* (DHS/DBHS/OADAP or OADAP), is the single state agency responsible for developing and promulgating standards, rules and regulations for alcohol and other drug abuse prevention and treatment programs within the State, and operation of a comprehensive management evaluation and community research process for the allocation of resources. It is the primary point of contact in the state for the award of federal funds to be used in alcohol and other drug abuse prevention and treatment programs in the state.

It is determined that, in order to combat the abuse and misuse of alcohol, tobacco and other potentially harmful drugs, a comprehensive prevention and treatment strategy must be developed in Arkansas. This strategy shall include the development and administration of a wide range of activities and campaigns deemed effective and tailored to the needs of Arkansas citizens.

MISSION

To help Arkansas Citizens live productive lives free from the abuse of alcohol, tobacco and other drugs.

GOALS

1. To act as a strong advocate for comprehensive alcohol, tobacco and other drug abuse, education, intervention, prevention and treatment services in Arkansas and to assure that these programs are identified and presented to lawmakers and to key decision makers.

2. To assure the provision of comprehensive treatment and prevention services to citizens of Arkansas who have an alcohol, tobacco and/or other drug abuse problem or potential problem.

3. To assure that comprehensive services are tailored to the specific needs of individuals within each county and region of the State.

4. To assure that all services provided for the alcohol and drug abuser meet minimum standards required for quality care.

5. To distribute available resources in the most cost efficient and cost effective process available.

6. To coordinate with others to maximize utilization of available resources and services.

7. To provide comprehensive educational and training resources that are responsive to the changing and diverse needs of alcohol, tobacco and drug abuse services in Arkansas.

8. To create and sustain a constituency of citizens to serve as advocates for substance abuse services.

OADAP PHILOSOPHY

The philosophies of OADAP recognize that:

1. Even though there are generally accepted solutions to the problems of alcohol, tobacco, other drug abuse and youth violence, local communities' problems and needs must be considered when determining successful prevention approaches.

2. Effective alcohol, tobacco, other drug abuse and youth violence prevention and treatment activities must have local citizen input, community support, and community involvement.

3. An effective alcohol, tobacco and other drug (ATOD) plan must provide opportunities for persons to become functional and productive citizens, either through prevention, intervention or treatment activities. All components are important in effectively addressing ATOD problems.

4. Effective prevention, intervention and treatment programs cannot rely on a single source of support but must utilize local resources such as existing sources of supportive services, community programs, neighborhood organizations, social services and others.

5. In order to assist local communities in the development of alcohol, tobacco, other drug abuse and youth violence prevention activities, OADAP must first assist the community by generating community awareness of alcohol, tobacco and other drug abuse problems. This includes an understanding of the nature and extent of the alcohol, tobacco and other drug abuse problems, the deeper issues underlying the problems, and the need for efforts to deal with the problems.

6. Alcohol, tobacco, other drug abuse, and youth violence may reflect or contribute to underlying individual and/or community problems; the most successful measures are those that deal with helping a person in the development of his/her inner resources (feelings, attitudes, values clarification, communication skills, etc.) so that he can deal more effectively with his/her role in life.

7. Alcohol, tobacco, other drug abuse and youth violence are problems found in rural areas as well as metropolitan areas. Programs should be available to rural and small communities.

8. Information on alcohol, other drugs and youth violence should be presented in a clear, unbiased and factual method. OADAP believes "scare tactics" are an inappropriate mechanism for conveying information to the general public.

9. ATOD services are based on the knowledge that alcohol and other drug abuse is a multifaceted, complex problem, and that alcoholism and other drug addiction is a primary, progressive, but treatable disease.

PREVENTION PHILOSOPHY

1. Prevention is defined as a **proactive** process **designed** to empower individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles (Center for Substance Abuse Prevention, 1996).

2. Prevention begins within communities by helping individuals to learn that they can have an impact in solving their local problems and setting local norms. Prevention emphasizes collaboration and cooperation, both to conserve limited resources and to build on existing relationships within the community. Community groups are routinely used to explore new, creative ways to use existing resources.

3. Prevention is part of a broader health promotion effort, based on the knowledge that addiction is a primary, progressive, chronic, and fatal disease. As such, it focuses on helping people develop new, more positive views of themselves. It is aimed at both users and non-users, with a goal to helping community members to achieve healthier life-styles.

4. Community activities sometimes incorporate problem identification and referral activities, which attempt to assist individuals who may have already developed inappropriate means of dealing with anger, or who have begun inappropriate use of alcohol or other drugs. Problem identification may include referral to a diagnostic or treatment center.

5. Comprehensive prevention efforts target many agencies and systems, and use many strategies in order to have the broadest possible impact. Therefore, evaluation is crucial in order for communities to identify their successful efforts and to modify or abandon their unproductive efforts.

6. The overall goal for prevention is the development of healthy, responsible, productive citizens who will be unlikely to experience youth-related violence, alcohol or drug-related problems in their lives.

7. OADAP promotes the risk and protective factor approach to prevention of problem behaviors which is based on the work of Drs. J. David Hawkins and Richard F. Catalano and their colleagues at the University of Washington. This approach addresses risk factors in important areas of daily life: 1) the community, 2) the family, 3) the school, and 4) within individuals themselves and their peer interactions. Many of the problem behaviors faced by youth--delinquency, substance abuse, violence, school dropout and teen pregnancy—share many common risk factors. Thus, reducing those common risk factors will have the benefit of reducing several problem behaviors.

8. Building coordinated prevention efforts that offer multiple strategies, provide multiple points of access and coordinate and expand citizen participation in community activity is a most promising approach to preventing alcohol and other drug problems, and youth-related violence.

9. OADAP supports a holistic approach to preventing youth violence, drug, alcohol, and other education including health education, self-appreciation and personal development for grade kindergarten through 12.

10. OADAP supports the development of alcohol and other drug abuse education, conflict resolution and violence prevention in schools. It is the philosophy of OADAP that effective education is dependent upon quality teacher training.

SECTION I
OADAP PROGRAM POLICY

1. Any activity or program funded by OADAP must be consistent with the goals established by OADAP; however, funding requirements must be flexible to allow ~~a~~ responsiveness to individual community needs.

2. State level responsibilities to alcohol, tobacco, other drug abuse and youth violence prevention and treatment activities in Arkansas shall be in management, coordination and technical assistance areas.

3. An applicant may be afforded an opportunity to appear before the Treatment and Prevention Committee of the Alcohol and Drug Abuse Coordinating Council in matters of the award of funds, review of an application, or adjustment to an existing contract or grant.

4. OADAP shall not enforce or develop a policy or guideline for the awarding of contracts or grants, or to continue to disburse funds, which it knowingly finds to be in conflict with any state or federal rule or regulation.

5. OADAP shall not recommend for funding any application that does not comply with OADAP *Rules of Practice and Procedure*.

6. OADAP shall present the *Rules of Practice and Procedure* affecting all contracts and grants prior to its implementation. The *Rules of Practice and Procedure* will be reviewed and updated at least annually.

7. OADAP shall present applications/proposals for service delivery which are recommended for award to the Arkansas Alcohol and Drug Abuse Coordinating Council for review and approval. This procedure does not apply to administrative contracts such as equipment purchases, newspaper contracts, training contracts, planning contracts or pilot projects.

8. OADAP shall encourage development of standards for alcohol and drug abuse professionals in the state.

9. OADAP shall develop a management information system for all programs, whereby OADAP can conduct program planning activities.

10. OADAP shall allocate funds in each area of the state based on federal or state mandates, special projects and a needs based funding formula.

11. OADAP shall allocate regional/area funding for Alcohol Safety Education, Detoxification and Treatment services.

12. OADAP shall initiate, if funds are available, the development of pilot projects in treatment, prevention and education that shall be evaluated for future development of model programs and activities.

13. OADAP shall assist local communities in securing all available financial assistance for provision of treatment and prevention activities.

14. In conformance with the Health Insurance Portability and Accountability Act (HIPAA), OADAP may coordinate with any public or private agency or organization which can assist in collecting data on incidence and prevalence of alcohol and other drug abuse and youth violence.

15. OADAP shall require that any funded prevention and treatment program make available continuing education in prevention and/or treatment activities to employees of the program.

16. OADAP shall require that each funded program coordinate prevention and treatment activities with the provision of other appropriate services (including health, social, correctional and criminal justice, educational, vocational rehabilitation, and employment) within their service area.

SECTION II
POLICIES AFFECTING PREVENTION

1. Prevention programs approved for funding must:

   - Be designed to create measurable changes in risk and/or protective factors of an identified target population;
   - Identify the specific population to receive services including numbers, age(s), gender, ethnicity and geographical location;
   - Use developmentally appropriate strategies and approaches proven effective on substance abuse indicators/measures.
   - Assure adequate measures to recruit and retain participants;
   - Be designed to impact multiple life domains and provide ample dosage, duration, and intensity to create change;
   - Establish action plans necessary to complete outcome objectives; and

- Have adequate evaluation methodology which includes both process and outcome evaluation.
- Be aligned with the direction and requirements of the federal funding sources.

2. OADAP shall encourage all primary prevention programs to become self-sustaining after initial funding**.**

3. Prevention programs shall emphasize zero tolerance of youth violence, the use of alcohol and tobacco by youth, and illicit drug use by all persons.

SECTION III
POLICIES AFFECTING TREATMENT

Mission Statement- Program Compliance and Outcome Monitoring: To assure that quality treatment services are provided to those persons receiving alcohol, tobacco and/or other drug abuse treatment in the State of Arkansas.

1. OADAP shall develop a plan for each area of the State which shall include the present funding, utilization and need.

2. OADAP shall determine a plan for allocations of funding, (e.g., Federal mandates, special projects and a statewide funding formula, etc.).

3. OADAP will purchase a continuum of alcohol and other drug abuse services within a reasonable rate.

4. OADAP supports the concept that non-medical as well as medical treatment models are viable and effective approaches in providing quality care.

5. Successful treatment and rehabilitation must utilize the total range of services that the individual can appropriately and productively use in the recovery process.

6. While client work may be an important part of the recovery process, the program should develop policies which safeguard the client from inappropriate work. Active clients cannot be employed by the program.

7. OADAP shall not initiate, encourage, or approve neither the development nor funding of programs seeking to provide treatment by modifying behavior through the use of psychosurgery, aversion therapy, or chemotherapy as a primary treatment method.

8. OADAP shall serve as the State Authority for Methadone and shall develop standards, provide coordination and oversight of all Opioid Treatment Programs (OTP) applications, exemptions, waivers, monitoring and

closings in coordination and cooperation with the various federal agencies having regulatory oversight for methadone and Opioid Treatment Programs.

9 OADAP shall require that funded treatment programs provide priority admission in the following order: (1) Pregnant Injecting Drug Users (IDU), (2) Pregnant Substance Abusers, (3) Injecting Drug Users, (4) Clients with the greatest clinical need, (5) Clients from the Catchment area as specified by OADAP, (6) Clients from the State of Arkansas, and (7) Clients from other states.

10. OADAP funded treatment programs shall be designated as mandatory receiving facilities for voluntary admissions and involuntary commitments in compliance with Act 1268 of 1995 or its successor. Non-funded treatment programs may be designated as receiving facilities at their request.

11. OADAP shall develop licensure standards for all treatment programs. All alcohol and other drug abuse/addiction treatment programs must comply with OADAP Licensure Standards.

12. Any program currently licensed by OADAP that fails a scheduled licensure review may be given a Probationary License, depending upon the severity of noted deficiencies. The Probationary License shall not exceed six months from the date of its issue. Any program issued a probationary license shall submit a corrective action plan to the Director, OADAP within thirty (30) calendar days from the receipt of the Probationary License. Any program receiving a Probationary License must bring all applicable failed standards into compliance prior to the end of the six-month period.

13. OADAP shall require that OADAP funded treatment programs shall comply with all federal and state funding criteria and shall meet all program Licensure Standards as defined in Arkansas Code §20-64-901 et seq.

14. Programs meeting the alcohol and drug abuse treatment program standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHCO), ~~or~~ the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA) will automatically receive Alcohol and Drug Abuse Prevention licensure as a licensed alcohol and drug abuse treatment program. Such license shall be awarded by the Office of Alcohol and Drug Abuse Prevention upon presentation by the program of evidence of Joint Commission of Health Care Organizations, the Council on Accreditation or the Commission on Accreditation of Rehabilitation Facilities' accreditation. Termination of licensure/accreditation by JCAHO, CARF or COA for alcohol and/or drug treatment services will result in a termination of OADAP licensure.

15. OADAP shall not use Substance Abuse Prevention and Treatment (SAPT) Block Grant funds to carry out any program of distributing sterile needles for the hypodermic injection of any illegal drug or distributing bleach for the purpose of cleansing needles for such hypodermic injection.

16. OADAP shall not fund testing for the etiologic agent for acquired immune deficiency syndrome unless such testing is accompanied by appropriate pre-test counseling and appropriate post-test counseling.

17. It is the policy of OADAP and the State of Arkansas that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance in a state agency's workplace is prohibited. This policy is established in compliance with the Drug Free Workplace Act of 1988 and Governor's Policy Directive A5 (GPD-5).

18. OADAP has established the following policies affecting special emphasis program development:

    A. OADAP shall place a high priority on programming for pregnant women and women with dependent children.

    B. OADAP may plan and develop special emphasis programs for special population groups that include, but are not limited to, the elderly, youth, women and other minorities.

    C. Any action strategy designed by OADAP will be to expand and coordinate with existing programs to assure that needs of special groups are met.

SECTION IV
POLICIES AFFECTING MONITORING

1. OADAP will review all contracts and grants for utilization and overall effectiveness and performance. The review will include but not be limited to the following:

    A. A site visit at least annually.

    B. Review of Prevention Information System reports, and/or ADMIS, audits, program files, incident and expenditure reports, etc.

    C. A desk audit review of monthly billing may be performed on a random basis. Contract/grant providers may be required to submit documentation to support billing to facilitate the review.

    D. Treatment Licensure reviews will be performed in accordance with the licensure standards. The frequency of licensure reviews will occur as dictated by the program's licensure status.

2. Independent Peer Review

Purpose: The purpose of the independent peer review process is to assess the quality, appropriateness, and efficacy of treatment services provided by funded

treatment programs. At least 5% of the funded programs shall be reviewed annually. Programs reviewed shall be representative of the total population of the funded programs. The review will focus on the substance abuse service system and the quality and appropriateness of treatment services. "Quality" is the provision of treatment services which, within the constraints of technology, resources, and patient/client circumstances, will meet accepted standards and practices which will improve patient/client health and safety status in the context of recovery. "Appropriateness" means the provision of treatment services consistent with the individual's identified clinical needs and level of functioning.

Qualifications of Peer Reviewers: Independent peer reviewers shall be individuals with expertise in the field of alcohol and drug abuse treatment and shall be representative of the various disciplines utilized by the programs under review. The peer reviewers must be knowledgeable about the modality being reviewed and its underlying theoretical approach to addictions treatment and be sensitive to the cultural and environmental issues that may influence the quality of the services provided.

Review Procedures: Independent peer reviewers shall review a sample of patient/client records to determine quality and appropriateness of treatment services while adhering to all Federal and State confidentiality requirements, including 45 CFR Part 2. Peer reviewers shall examine the following:

1. Admission criteria/intake process;
2. Assessments;
3. Treatment planning, including appropriate referral, e.g., prenatal care and tuberculosis and HIV services;
4. Documentation of implementation of treatment services;
5. Discharge and continuing care planning; and
6. Indications of treatment outcomes.

Questions arising during the implementation of the independent peer review process shall be resolved in consultation with the Office of Alcohol and Drug Abuse Prevention.

OADAP shall ensure that the independent peer review will not involve practitioners/providers reviewing their own programs, or programs in which they have administrative oversight, and that there be a separation of peer review personnel from funding decision makers. The independent peer review process shall not be conducted as part of the licensing/certification process.

Goal: The goal of the independent review process is to seek continued quality improvement of client treatment.

SECTION V
POLICIES AFFECTING PLANNING AND COORDINATION

1. OADAP shall develop an annual state plan for the delivery of alcohol and other drug abuse services.

2. OADAP shall do planning on a regional basis or as special needs dictate.

3. OADAP shall involve special interest groups and professions in the planning process.

4. Agreements may be developed or coordinated with other state governmental units that have some involvement in the areas of alcohol and other drug abuse.

SECTION VI
POLICIES AFFECTING TREATMENT FUNDING

1. OADAP will allocate not less than 70 percent (70%) of the Substance Abuse Prevention and Treatment (SAPT) Block Grant for alcohol and other drug treatment services.

2. Priority for expanded level programming shall be given to the following programs:

   A Programs that provide specialized services as identified by OADAP (e.g., pregnant women, women with children, adolescents, high-risk youth, etc.)

   B. Not more than 3% may be spent from the general program portion for the administration of the SDFSCA program.

3. Unexpected and/or unallocated funding that becomes available during the fiscal year, but which will not be continued in subsequent fiscal years, may be allocated to programs which are over utilizing funds or to activities which will not be ongoing programs.

SECTION VII
POLICIES REGARDING FEDERAL FUNDING REQUIREMENTS

OADAP and its program providers shall adhere to the following federal funding mandates:

1. Substance Abuse Prevention and Treatment (SAPT) Block Grant:

A. At least 20% of the SAPT Block Grant shall be spent for prevention services.

B. SAPT Block Grant funds that are spent for services to women will include an emphasis on specialty services for pregnant women and women with children according to a formula provided by the Center for Substance Abuse Treatment.

C. No more than 5% of the SAPT Block Grant may be spent on administration.

D. Maintenance of Effort for State expenditures. P.L. 102-321, Subpart II, Section 1930 of the SAPT regulations provides that the State agrees to maintain State expenditures for alcohol and drug abuse services at a level that is not less than the average level of such expenditures maintained by the State for the two (2) year period preceding the fiscal year for which the State is applying to receive block grant payments.

E. Maintenance of Effort for HIV and TB Services. The state agrees to maintain State expenditures for HIV and TB services at a level that is not less than an average of such expenditures maintained by the State for the two year period preceding the first fiscal year for which the state received such a grant. In making this determination, states shall establish a base for fiscal year 1993.

F. Charitable Choice/Right to Services from an Alternative Provider.

(a) General requirements. If an otherwise eligible program beneficiary or prospective program beneficiary objectsto the religious character of a substance abuse treatment program, such program beneficiary shall, within a reasonable period of time after the date of such objection, have rights to notice, referral, and alternative services, as outlined in paragraphs (b) through (c) of this section.

(b) Notice. Programs that refer an individual to alternative providers shall ensure that notice of the individual's rights to services from an alternative provider is provided to all program beneficiaries or prospective beneficiaries. The notice must clearly articulate the program beneficiary's right to a referral and to services that reasonably meet the requirements of timeliness, capacity, accessibility, and equivalency. The notice required to be provided is set out below:

Notice to Individuals Receiving Substance Abuse Services

No provider of substance abuse services receiving federal funds from the U.S. Substance Abuse and Mental Health Services Administration through OADAP may discriminate against you on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice. If you object to the religious character of a substance abuse treatment provider, federal law gives you the right to a referral to another provider of substance abuse services. The referral, and your receipt of alternative services, must occur within a reasonable period of time after you request them. The alternative provider must be accessible to you and have the capacity to provide substance abuse services. The services provided to you by the alternative provider must be of a value not less than the value of the services you would have received from the organization from which you were referred.

(c) Referral to Services from an Alternative Provider. When an OADAP funded substance abuse treatment program beneficiary or prospective program beneficiary objects to the religious character of a program that is a religious organization, that participating religious organization shall, within a reasonable time after the date of such objection, refer such individual to an alternative provider. OADAP will monitor program compliance with this section and ensure that such referrals are made in accordance with the following requirements:

(i) The religious organization that is an OADAP funded treatment program participant shall, within a reasonable time after the date of such objection, refer the beneficiary to an alternative provider;

(ii) In making such referral, the religious organization shall consider any list that OADAP makes available to entities in the geographic area that provide program services;

(iii) All referrals are to be made in a manner consistent with all applicable confidentiality laws, including, but not limited to, 42 CFR part 2 ("Confidentiality of Alcohol and Drug Abuse Patient Records") and the Health Insurance and Portability and Accountability Act (HIPAA), 45 C.F.R Parts 160 and 164).;

(iv) Upon referring a program beneficiary to an alternative provider, the religious organization shall notify OADAP of such referral; and

(v) The religious organization shall ensure that the program beneficiary makes contact with the alternative provider to which he or she is referred.

2. Safe and Drug-Free Schools and Communities Act of 1994 (SDFSCA):

   A. Not more than 3% may be spent from the general program portion for the administration of the SDFSCA program.

   B. All recipients of these funds must also follow the guidelines for administration as described in the Education Department General Administration Regulations (EDGAR) and National Regulatory Guidelines (NRG).

3. United States Department of Education "Principles of Effectiveness"

   To ensure that Safe and Drug-Free Schools and Communities dollars are used in ways that are most likely to reduce drug use and violence among youth, all grantees shall coordinate their programs with other available prevention efforts, thereby maximizing the impact of all the drug and violence prevention programs and resources available to the state, school district, or community, and shall:

   IN GENERAL – For a program or activity developed pursuant to this subpart to meet the principles of effectiveness, such program or activity shall:

   A. be based on an assessment of objective data regarding the incidence of violence and illegal drug use in the elementary schools and secondary schools and communities to be served, including an objective analysis of the current conditions and consequences regarding violence and illegal drug use, including delinquency and serious discipline problems, among students who attend such schools (including private school students who participate in the drug and violence prevention program) that is based on ongoing local assessment or evaluation activities;

   B. be based on an established set of performance measures aimed at ensuring that the elementary schools and secondary schools and communities to be served by the program have a safe, orderly and drug-free learning environment;

   C. be based on scientifically based research that provides evidence that the program to be used will reduce violence and illegal drug use;

   D. be based on an analysis of the data reasonably available at the time, of the prevalence of risk factors including high or increasing rates of reported cases of child abuse and domestic violence; protective factors, buffers, assets; or other variables in schools and

communities in the State identified through scientifically based research; and

E. include meaningful and ongoing consultation with an input from parents in the development of the application and administration of the program or activity.

PERIODIC EVALUATION

A. REQUIREMENT – The program or activity shall undergo a periodic evaluation to assess its progress toward reducing violence and illegal drug use in schools to be served based on performance measures.

B. USE OF RESULTS – The results shall be used to refine, improve, and strengthen the program and to refine the performance measures, and shall also be made available to the public upon request, with public notice of such availability provided.

4. Other Federal Funds: OADAP will administer other federal funds according to the laws and guidelines of the federal funding source.

5. OADAP will comply with the mandates of the Cash Management Improvement Act of 1990 as amended.

6. All sub-grantees shall adhere to the cost principles set forth in the United States Office of Management and Budget (OMB) Circular A-122, as applicable, in the use of OADAP funds.

1.00 PURPOSE OF RULES OF PRACTICE AND PROCEDURE

1.01 Scope
1.02 Where to obtain information and assistance
1.03 Availability of Funds
1.04 Manual content and organization

1.00 PURPOSE OF RULES OF PRACTICE AND PROCEDURE

This manual provides information on the conduct of programs and activities related to the education, treatment and prevention of alcohol and other drug abuse in the State of Arkansas, and which have funds provided by the Department of Human Services, Division of Behavioral Health Services, Alcohol and Drug Abuse Prevention (OADAP). It provides guidance to prospective applicants about the steps in making application for such funds, and guidance to contractors/grantees, hereinafter referred to as "Providers," on their responsibility for accounting for such funds, reporting on progress, and observing applicable laws and regulations.

1.01 SCOPE

The provisions of this manual are applicable to all OADAP operations, including contract and grant applications administered by OADAP.

1.02 WHERE TO OBTAIN INFORMATION AND ASSISTANCE

Persons needing help in using this manual should contact OADAP. A new applicant should contact the Director, Program Compliance and Outcome Monitoring for information regarding treatment services, and the Director, Prevention Services for information regarding prevention programs/activities, or that person's designee.

1.03 AVAILABILITY OF FUNDS

Although it is the intent of OADAP to address as many of the appropriate approaches to education, prevention and treatment as may be brought to it, applicants and providers should be aware that there is no certainty that funds will be available for every program and every proposed project however worthwhile. Projects selected for funding may be limited geographically and numerically so that the awards will have a measurable impact on the State. Furthermore, it is also possible that funds may not be available for the continuation of every contract/grant, even if approved for the first year.

1.04 MANUAL CONTENT AND ORGANIZATION

The following sections of this manual will cover: Contract/Grant specifications and the Application Process, Financial Provisions, General Requirements, Specific Requirements and Definitions.

2.00 **CONTRACT/GRANT SPECIFICATIONS AND THE APPLICATION PROCESS**

2.01 Projects Considered Eligible for Funding By OADAP
- 2.011 Treatment
- 2.012 Primary Prevention
- 2.013 Drug and Alcohol Safety Education Program (DASEP)
- 2.014 Data, Research and Analysis
- 2.015 Training

2.02 Eligible Applicants
- 2.021 Non-profit Organizations
- 2.022 Local Education Agencies
- 2.023 Local Units of Government
- 2.024 Public and Private Non-Profit Service Agencies
- 2.025 IRS Certified 501(c)3 entity

2.03 Accessibility of Facilities

2.04 Equal Opportunity

2.05 Licensure

2.06 Prohibitions on Fund Use
- 2.061 Prohibitions on Substance Abuse Prevention and Treatment (SAPT) Block Grant Funds

2.07 Application Submission and Procedures
- 2.071 OADAP Guidelines
- 2.072 Assurances and Certifications
- 2.073 OADAP Access to Records
- 2.074 Financial Disclosure
- 2.075 Processing

2.08 Prerequisites to Funding of the Application
- 2.081 Administrative and Fiscal Structure
- 2.082 Clear Purpose
- 2.083 Specific, Measurable Goals
- 2.084 Referral Agreements
- 2.085 Community Support and Assistance
- 2.086 Coordination with Regional Prevention Resource Center

2.09 Continuation Support Policy

2.10 Award Period

2.11 Grant Approval Process

2.00 CONTRACT/GRANT SPECIFICATIONS AND THE APPLICATION PROCESS

2.01 PROJECTS CONSIDERED ELIGIBLE FOR FUNDING BY OADAP: Federal and State laws and regulations designate certain categories that OADAP may address. An appropriate Request for Proposal (RFP) or Request for Application (RFA)~~,~~ will be developed for each category. The RFP~~,~~ or RFA~~, or CAP~~ will include requirements and instructions for the applicant. The categories are as follows:

2.011 Treatment. Any program that delivers alcohol and/or other drug abuse treatment services to a defined client population.

The intent of the program of treatment services is to insure the restoration of a client to the fullest physical, mental, social, vocational, and economic usefulness of which he or she is capable. Rehabilitation may include, but is not limited to, residential and outpatient counseling, medical treatment, psychological therapy, occupational training, job counseling, social and domestic rehabilitation and education.

2.012 Primary Prevention. Primary prevention programs are those directed at individuals and families who have not been determined to require treatment for substance abuse. Such programs are aimed at educating and guiding individuals to prevent and/or reduce violent behavior or substance abuse and providing activities to reduce the risk of violent behavior or substance abuse. Primary prevention includes a broad array of prevention activities and services including strategies to discourage the use of illicit substances and/or violence, alcoholic beverages and tobacco products by minors. These activities and services must be provided in a variety of settings for both the general population, as well as targeted subgroups who are at high risk for violence or substance abuse. A variety of strategies, as appropriate for each target group, shall be used. These include, but are not limited to the following: (1) Information Dissemination; (2) Education; (3) Alternative Activities; (4) Problem Identification and Referral; (5) Community Based Processes; and (6) Environmental Changes. See Definitions, Section 7.15.

2.013 Drug and Alcohol Safety Education Program (DASEP). A program for persons who plead guilty, nolo contendere or found guilty of Driving While Intoxicated (DWI), Minor In Possession (MIP), Possession of fraudulent or altered personal identification under certain circumstances, Underage Refusal to Submit or Driving Under the Influence (DUI). The DASEP program provides an investigation, screening/assessment, referral to treatment, or at least twelve (12) contact hours of education for level I. This includes classes for English speaking individuals and for all other languages as well. Level II classes will be at least fifteen (15) hours in length. Marathon (all day) classes are prohibited. Because the standardized DASEP curriculum is participatory in nature and requires assignments that are to be done away from

class (homework), it is advised that classes not exceed 4 hours per session. Under no circumstances will classes exceed six (6) hours per session. The preliminary investigation will consist of a Pre-sentence Screening Report which will include the offender's driving record, an alcohol problem assessment, a victim impact statement (if applicable), and the blood-alcohol content (BAC) at the time of arrest. Based upon the investigation and assessment, the DASEP will make a recommendation to the court for the offender to complete a DASEP school or an alcohol/drug treatment program approved by the Arkansas Department of Human Services, Division of Behavioral Health Services, Office of Alcohol and Drug Abuse Prevention. Completion of one of these programs is required to have the offender's driver's license reinstated. All DASEP schools/programs must be approved under the administration and authority of OADAP, as provided under Ark. Code Ann. 5-65-104 (b) (1) (A).

2.014 Data, Research and Analysis. Approaches to and mechanisms for the collection of data on alcohol and other drug abuse in the state or local area; also the development of systems to evaluate the data for use in planning processes for Arkansas alcohol and other drug treatment and prevention services.

2.015 Training. Includes knowledge transfer and skills development targeted to workers in alcohol or other drug abuse treatment, alcohol or other drug prevention or problem identification and referral programs, and other targets including professionals and paraprofessionals in local communities, including physicians, teachers, law enforcement, etc.

2.02 ELIGIBLE APPLICANTS

2.021 Non-profit corporations
2.022 Local Education Agencies
2.023 Local units of government
2.024 Public and private non-profit service agencies
2.025 All applicants for funding, other than state and local governmental agencies, must provide IRS Certification of their 501(c)3 status as an eligible entity.

Applications must be made by an official authorized to sign for the eligible applicant.

2.03 ACCESSIBILITY OF FACILITIES

Facilities, programs, and services supported in part or in whole with funds provided by OADAP will be so located and operated as to be readily accessible, available, and responsive to the needs of the population to be served without discrimination because of sex, race, disability, age, religion, color, national origin, or duration of residence. Treatment providers must have Policies and Procedures that address grievances that are a result of non-compliance with the Americans With Disabilities Law of 1990, as specified in the OADAP Licensure

Manual. Services for alcohol and other drug abuse prevention and treatment will be actively publicized so as to be generally known to the population to be served.

2.04 EQUAL OPPORTUNITY

As recited under Ark. Code Ann. 15-4-312, it is the policy of the State of Arkansas to support equal opportunity as well as economic development in every sector. Accordingly, OADAP is committed to support, to the fullest, all possible participation of firms owned and controlled by minority persons, as defined under Ark. Code Ann. 15-4-313 (5), in the purchase of goods and services from the State of Arkansas.

All programs must furnish assurance of compliance with applicable civil rights laws and regulations.

2.05 LICENSURE

All persons, partnerships, associations or corporations establishing, conducting, managing, or operating and holding themselves out to the public as an alcohol, drug, or alcohol and drug abuse treatment program must be licensed by the Arkansas Department of Human Services, Division of Behavioral Health Services, Alcohol and Drug Abuse Prevention as provided by Arkansas Code §20-64-901 through §20-64-906.

2.06 PROHIBITIONS ON FUND USE

Applications will not be considered for programs using any procedures which seek to provide treatment by modifying behavior by means of psychosurgery, aversion therapy, or chemotherapy (except as a part of routine clinical care). This does not apply to those programs of behavior modification which involve environmental changes or social interaction where no medical procedures are used.

2.061 Prohibitions on Substance Abuse Prevention and Treatment (SAPT) Block Grant Funds. The State shall not use SAPT Block Grant funding to carry out any projects which include (1) the exchange of sterilized needles for hypodermic injection of any illegal drug, or (2) distribution of bleach.

SAPT Block Grant funds may not be used to (1) provide inpatient services; (2) make cash payments to intended recipients of health services; (3) purchase or improve land, construct or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment; (4) satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds; or (5) provide financial assistance to any entity other than a public or non-profit private entity, except for subcontractors who may be private for-profit organizations

2.07 APPLICATION SUBMISSION AND PROCEDURES

2.071 OADAP Guidelines. The application must comply with state and federal guidelines and must be consistent with established priorities

of OADAP for the prevention and reduction of alcohol and other drug abuse.

2.072 Compliance with State and Federal Law/Certifications.

The applicant must comply with state and federal laws, regulations and policies governing the operations of purchase of service programs operated by the Arkansas Department of Human Services, and, upon request, execute certain certifications appertaining thereto These include:.

A. Certification Regarding Lobbying. OADAP and its funded contract/grant providers shall complete the Certification Regarding Lobbying statement for contracts of $100,000 or more. This certification assures that no federal funds have been paid or will be paid for the purposes of lobbying in connection with the awarding of any Federal contract, grant, loan, cooperative agreement, and the extension, renewal, amendment or modification of any Federal contract, grant, loan or cooperative agreement.

B. Confidentiality Requirements. The treatment services applicant must certify familiarity and agreement to comply with the confidentiality requirements of 42 CFR, Part 2, which prohibit the unlawful disclosure of client records or any other client identifying information by alcohol or other drug abuse treatment programs which are partially or totally funded by Federal funds, and/or licensed by OADAP., as well as the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Parts 160 AND 164, Subparts A and E, also known as the "Privacy Rule".

C. Contract and Grant Disclosure and Certification Form. The applicant must complete the Contract and Grant Disclosure and Certification Form in compliance with the requirements of Executive Order 98-04 and Section 504 of the Rehabilitation Act of 1973, prohibiting discrimination on the basis of handicap in federally funded programs.

D. The Fair Labor Standards Act of 1938, as amended (FLSA), which sets a floor for a minimum rate of compensation to employees, along with provisions for overtime compensation for hours worked exceeding a 40 hour work week.

E. Certification Regarding Debarment and Suspension. The applicant must complete the requirements for the Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower tier Covered Transactions. Under Executive Order 12549 entities receiving federal funding are prohibited from doing business with persons suspended or barred from doing business with any agency of

the Executive Branch of the Federal Government.

F. The Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin in all federally funded programs.

G. Americans With Disabilities Act of 1990, which prohibits discrimination on the basis of disability and provides equal opportunities in employment, state and local government entities, public accommodations, transportation, and telecommunications for persons with disabilities.

H. Drug-Free Workplace Act of 1988, which requires contractors and grantees of federal agencies to certify that they will provide drug-free workplaces.

2.073 OADAP Access to Records. The applicant must allow access to all records related to the grant or contract or licensure at OADAP's request. OADAP assures compliance with all state and federal requirements regarding confidentiality.

2.074 Financial Disclosure. The applicant must provide financial disclosure for the total agency, if part of a larger organization, if so requested by OADAP.

2.075 Processing. Deadlines for submission of the final application must be observed to receive consideration for review.

The applicant is required to submit sufficient copies of the RFP, RFA, or Continuation Application Package (CAP), as designated in the Specifications Sheet of the RFP, RFA, or as noted in the CAP.

2.08 PREREQUISITES FOR FUNDING OF THE APPLICATION

A proposed program cannot be considered for funding without the following prerequisites. Applicants should review the Request for Proposal, Request for Application or Continuation Application Package for the prerequisites specific to the program for which they are making application. Compliance with the following does not, however, guarantee funding.

2.081 Administrative and Fiscal Structure. The applicant must be responsible to an administrative and fiscal structure, capable of administering an alcohol or other drug treatment, education or prevention program or a youth violence prevention program. Consideration of ability to administer a program shall include any past experience that OADAP has had with either the recipient institution or the project director. Past failure to meet minimum standards of a grant/contract by a recipient institution or project director may be the basis for denial of support.

2.082 Clear Purpose. The purpose, objectives and scope of the project shall be clear.

2.083. Specific, Measurable Objectives. The applicant must establish specific, attainable, measurable outcome objectives that logically support goal attainment. These must be capable of being evaluated by OADAP. Programs will be required to participate in OADAP Evaluation System, including client, program and financial management review, and site visits by OADAP staff or outside evaluators retained by OADAP to evaluate its various programs/grantees.

2.084 Referral Arrangement. The applicant for treatment services must have written referral agreements with local or state agencies which may provide supportive services to the clients served in the proposed program or which may refer potential clients to the proposed program. These arrangements refer to formal written referral agreements signed by both parties and not to support letters.

2.085 Community Commitment. There must be validated evidence for the need for such a program with adequate community commitment to insure continuation after termination of the contract/grant funding. Such commitment must consist of defined offers of support and assistance, and must be clearly documented giving details of the plan for continuation. These should include but are not limited to: volunteers, funding and equipment donations from community groups (e.g., churches, civic organizations), participation by local units of government, participation by private industry or business. OADAP must be assured that services do not duplicate existing effective and efficient programs.

2.086 Coordination with Regional Prevention Resource Center. In addition, applicants for community prevention services should have a letter from Regional Prevention Resource Coordinator (RPRC) acknowledging awareness of the proposed services. Applicants for school-based efforts need the letter from the RPRC, and also need to provide a letter from the school district drug coordinator documenting that proposed services are appropriate to the district's Safe and Drug Free Schools and Communities (SDFSC) plan.

2.09 CONTINUATION SUPPORT POLICY

Funding of a project does not imply approval for subsequent years.

2.10 AWARD PERIOD

Grant awards are usually made for a twelve-month period, normally coinciding with the state or federal fiscal year. Contracts or grants may be made for shorter periods after the start of the fiscal year.

3.00 **CONTRACT AND GRANT FINANCIAL PROVISIONS**

- 3.01 Policies Affecting Funding
- 3.02 General Considerations
- 3.03 Income Eligibility
  - 3.031 OADAP Income Eligibility
  - 3.032 Social Services Block Grant Income Eligibility
- 3.04 Rate Characteristics
- 3.05 Reimbursable Treatment Services
- 3.06 Treatment Service Capacity
- 3.07 Provision of Services to Indigent Clients
- 3.08 Audit
  - 3.81 Independent Audit
  - 3.83 Audit/Review Performed by OADAP
  - 3.82 Audit Settlement
- 3.09 Use of Funds - Specific Requirements
  - 3.91 Restrictions
  - 3.92 Transfer of Funds
  - 3.93 Replacement of Other Funds
  - 3.94 Deviation from Budget
  - 3.95 Retention of Financial Records
  - 3.96 Third Party Reimbursement - Treatment
  - 3.97 Third Party Reimbursement - Prevention
  - 3.98 Deobligation of funds
  - 3.99 Program Implementation Requirements
- 3.10 Allowable Costs
  - 3.101 Salaries and Fringe Benefits
  - 3.102 Maintenance and Operation
    - 3.102.01 Accounting and Auditing
    - 3.102.02 Advertising and Publicity
    - 3.102.03 Bonding and Insurance
    - 3.102.04 Building Space and Related Facilities
    - 3.102.05 Communications
    - 3.102.06 Depreciation and Use Allowance
    - 3.102.07 Equipment Expenditures
    - 3.102.08 Equipment Rental
    - 3.102.09 Field Trips
    - 3.102.10 Food Service Supplies
    - 3.102.11 Freight
    - 3.102.12 Indirect Costs
    - 3.102.13 Inspections
    - 3.102.14 Insurance
    - 3.102.15 Lease Costs
    - 3.102.16 Maintenance and Repair
    - 3.102.17 Materials and Supplies
    - 3.102.18 Meetings and Conferences
    - 3.102.19 Memberships
    - 3.102.20 Postage
    - 3.102.21 Printing and Reproduction
    - 3.102.22 Public Information Costs
    - 3.102.23 Rental Costs
    - 3.102.24 Subcontracted Services

3.102.25 Subscriptions or Reference Materials
3.102.26 Taxes
3.102.27 Training, Meetings and Conferences
3.102.28 Travel
3.102.29 Utilities

3.11 Unallowable Costs
3.12 Unduplicated Salaries
3.13 Cash Depositories
3.14 Program Income
3.15 Reimbursement
3.151 Billing
3.152 Billing for Services
3.153 Advance Payment
3.154 Billing Due Dates - Reimbursement Requests
3.16 Notification of Change
3.17 Termination of Contract/Grant

3.00 CONTRACT AND GRANT FINANCIAL PROVISIONS

3.01 POLICIES AFFECTING FUNDING

3.011 OADAP shall make funds available for the delivery of services through funding mechanisms known as contracts, grants and interagency agreements.

3.012 OADAP shall not award an application that is not consistent with its funding plan and allocations approved by the Arkansas Alcohol and Drug Abuse Coordinating Council.

3.013 Allocated funding for programs that do not demonstrate the ability to utilize at least 90% of the programs' funds may be reallocated to other programs based on need and utilization of funds. Evaluation of utilization shall be done quarterly throughout the budget year and, when applicable, project period.

3.02 GENERAL CONSIDERATIONS

All sub grantees shall adhere to the cost principles set forth in the U.S. Office of Management and Budget (OMB) Circular A-122 or its successors. All providers shall adhere to generally accepted accounting principles and/or applicable industry accounting principles established by the American Institute of Certified Public Accountants and the Comptroller General of the United States of America.

3.03 INCOME ELIGIBILITY

3.031 OADAP Income Eligibility. OADAP makes every effort to provide quality services to clients while keeping costs as low as possible. For example, third party benefits are applied to offset costs first. These benefits can come from private or public health insurance policies. If these payments are insufficient, a client or his family is asked to contribute a portion of the costs based on the family's ability to pay for care given to a client.

Providers may collect payment for services over and beyond OADAP contracted rate schedule using the following tables. OADAP has developed an Income Scale based on the 2006 Food Stamp Certification Basis of Issuance eligibility rate of $6.13 per hour or $12,744 annually. A client whose income exceeds 80% of the OADAP Income Scale shall not be eligible for OADAP funding.

Table 1 –ALCOHOL AND DRUG ABUSE PREVENTION INCOME SCALE

Family Size	Annual Income	Monthly Income
1	$12,744	$1,062
2	17,160	1,430
3	21,588	1,799
4	26,004	2,167
5	30,420	2,535
6	34,848	2,904
7	39,264	3,272
8	43,680	3,640
9	48,108	4,009
10	52,536	4,378

Table 2 — EXAMPLE
Family Of One (1)

Family of One	Maximum fee that may be charged to the client
Less than or equal to $12,744	**$**0 – OADAP pays for all treatment services
Income up to $15,293 (+20% of $12,744)	Treatment cost paid by OADAP plus 20% of cost in Table 3
Income up to $17,842 (+40% of $12,744)	Treatment cost paid by OADAP plus 40% of cost in Table 3
Income up to $22,939 (+80% of $12,744)	Treatment cost paid by OADAP plus 80% of cost in Table 3

OADAP will not pay for treatment services for a client whose income exceeds 80% of the OADAP Income Scale. A client whose income exceeds 80% of the OADAP Income Scale may be charged the full amount for treatment services.

Table 3 -FEE COLLECTION SCHEDULE

Type of Service	**Maximum per episode Cap**
Intake and Assessment	$200 per episode
Residential	$1,860 per 30 days
Partial day	$1,560 per 30 days
Out Patient	$480 per 30 days
SWS	$3,000 per 30 days
RADD Observation	$250 per episode

To determine the maximum allowable per treatment episode fee for service that a provider may charge a client in addition to OADAP payment, the provider shall perform an in-depth financial assessment to the client prior to admitting the client, except in an emergency admission, i.e. RADD, and Act 1268. Prior to admission, the provider shall furnish to the client a written estimated statement of charges that the client may incur if admitted to treatment.

A financial assessment shall be completed which will take into consideration income earned over the last twelve months. A client's Social Security number, proof of dependents (copy of Income Tax Form), and proof of residency should be obtained. Sources of income to consider are public assistance, Veterans Administration income, wages, Social Security retirement, pension, annuities, Supplemental Security Income, spousal income, child support, alimony, unemployment insurance, workers compensation, rental income, etc. A client shall provide documentation of proof of income (i.e., Income Tax Return, W-2's, check stubs, bank statements, etc.) A client must prove income or lack of income. A client's insurance coverage shall be documented, shall include the name of the company, address, policy or group number and type of coverage.

3.032 Social Services Block Grant (SSBG) Income Eligibility.

Clients being billed for alcohol and drug treatment utilizing Social Services Block Grant (SSBG) funds must use the SSBG Services eligibility criteria for determining eligibility. Vendors must use SSBG forms when submitting billing. A copy of the Social Services Block Grant Program Manual and Social Services Block Grant Service Income Scale can be obtained through the internet by accessing

http://www.arkansas.gov/dhhs/webmanuals/ssbg/ssbg.toc.htm

3.04 RATE CHARACTERISTICS

All rates must be reasonable to ensure the efficient and economic provision of quality services. The Department of Human Services is not liable for payment in excess of the maximum contract/grant liability or for payment in excess of OADAP rates where applicable. OADAP does not enter into open-ended agreements with no limitations on the total liability to the State or Federal Government.

Payment to providers is final payments regardless of the actual cost to the provider, and is not subject to adjustments other than recoupment.

3.05 Reimbursable Treatment Services - See Section 7.00 for definitions of these services.

Intake and Assessment for Substance Abuse
Medical Detoxification
Observation Detoxification
- Outpatient Service - Family
- Outpatient Service - Group
- Outpatient Service - Individual

Partial Day Treatment
- Residential

Residential Services for Adolescents - Comprehensive
Specialized Women's Services (SWS**)**

3.~~0~~6 TREATMENT SERVICE CAPACITY

Treatment programs shall provide treatment services, if OADAP funding is available, within fourteen (14) days of receipt of request for admission by a person with intravenous drug abuse (IDU). Treatment programs shall provide treatment services within forty-eight (48) hours for pregnant women who request admission.

For IDUs who cannot be placed in comprehensive treatment within 14 days from the date of the request for admission, or pregnant women within 48 hours from the date of request, "interim services" will be provided within 48 hours of the request, until the time of admission to treatment. See Definitions Section, 7.07 for "Interim Services."

Treatment programs must notify OADAP when they reach 90% of their capacity to admit individuals to their program. Therefore, each program must develop and implement a "waiting list system." This waiting list system will include a unique patient identifier for each pregnant woman or IDU seeking treatment. The list shall include those receiving interim services while awaiting admission to such treatment. The program shall develop a mechanism for maintaining contact with the individual awaiting admission, and to ensure that individuals on waiting lists are transferred at the earliest possible time to a program providing treatment. The program must document if individuals cannot be contacted or refuse treatment, and are therefore, removed from the waiting list. The waiting list system must document what interim services were offered and when they were delivered. Furthermore, information from this waiting list system must be submitted to OADAP in a manner and within a timeframe designated by OADAP.

3.~~0~~7 PROVISION OF SERVICES TO INDIGENT CLIENTS

No client may be refused treatment services due solely to an inability to pay so long as the provider has available OADAP funds. When a provider has exhausted the reimbursable amount of their contract, clients may be refused due to inability to pay.

OADAP is considered a payor of last resort for client treatment services.

3.~~0~~8 AUDIT

3.81 Independent Audit: An annual audit for the fiscal period of the provider contract/grant shall be conducted by a Certified Public Accountant and shall be prepared to the generally accepted governmental audit standards as determined by the American Institute of Certified Public Accountants, the Comptroller General of the United States, United States General Accounting Office (GAO), and the United States Office of Management and Budget (OMB).

All sub recipients, regardless of organizational structure, receiving $500,000 or more in aggregate federal assistance for the contract/grant period will be audited in accordance with the provisions of the Office of Management and Budget (OMB) Circular

A-133. Circular A-133 is available on the internet by accessing the following site:
www.whitehouse.gov/omb/circular/a133/a133.html

The independent audits will be reviewed for compliance with program requirements. If the audit reveals that the program is not in compliance, OADAP will determine the steps necessary for the corrective action, notify the provider accordingly, and advise the provider of available administrative appeal procedures.

3.82 Audit/Review Performed By OADAP: There must be maintained within the state agency administering the program the authority and responsibility for overall supervision, control and oversight of program activities. Therefore, in the best interest of the providers and the State, circumstances may indicate a need for various other types of audit activities. Such audits may encompass a variety of procedures including, but not limited to, service to billing reviews, limited financial management audits, management reviews and special investigations. The cost principles for non-profit organizations are governed by Circular A-122, as issued and revised by the federal Office of Management and Budget. Circular A-122 may be located on the internet by accessing the following site:
http://www.whitehouse.gov/omb/circulars/a122/a122_2004.html

OADAP audits include, but are not limited to, the review and examination of documents, records, reports, systems, internal controls and accounting and financial procedures pertaining to the grant/sub grant, for one or more of the following purposes:

1. To ascertain whether the statements contained within an independent audit present fairly the financial position and results of financial operations in accordance with Generally Accepted Accounting Principles;

2. To determine the mathematical accuracy of the financial transactions;

3. To ascertain whether all financial transactions have been properly recorded;

4. To confirm that eligible clients received reimbursable services in accordance with the agreement;

5. To investigate reported irregularities of the program involving the provider, its staff, or Board of Directors; and

6. To determine compatibility with Federal and State laws, regulations and guidelines.

3.83 Audit Settlement: If the independent audit or OADAP review/audit results in a repayment due to OADAP, the provider will choose, upon the approval of OADAP Director either of the following recoupment methods;

1. Payment in full to DHS/OADAP within 90 days.

2. Negotiated recoupment schedule with installments deducted from payments made by OADAP to the provider.

3.~~0~~9 USE OF FUNDS - SPECIFIC REQUIREMENTS

3.91 Restrictions. Contract/grant funds may be used specifically and only for costs attributable to the execution of the particular alcohol or other drug abuse related program as approved by OADAP and as detailed in the individual contract/grant. Also, services paid with OADAP funding may only be provided in a catchment area as determined by OADAP, where applicable. If there is a potential presence of supplanting, the applicant or grantee will be required to supply documentation demonstrating that the reduction in resources occurred for reasons other than the receipt or expected receipt of Federal or state funds.

3.92 Transfer of Funds. Contract/grant funds may not be transferred, consigned, assigned, or used to subcontract for services without the prior written consent of OADAP Director.

3.93 Replacement of Other Funds. No funds allocated from contract/grant funds will be used to supplant or otherwise replace funds which may be available from other federal, state, or local sources for the purchase of services, supplies, equipment, etc.

3.94 Deviation from Budget. For contracts awarded as budget based, contract/grant funds cannot be spent in any category other than that specified in the contract/grant. OADAP recognizes, however, that situations may arise which will cause some deviation from the approved budget of a program. If such a situation arises, the provider must submit a written request to OADAP asking approval to transfer monies from one budget category to another and showing the revision by line item amounts. This request must also include a clear programmatic explanation for why the identified line item cost(s) is no longer needed as originally budgeted and why it is now necessary to move these monies to another line item(s).

Approval must be received before liabilities are incurred. OADAP budget revision forms must be used to show the transfer of funds. Also, any changes in the approved equipment list included in the funding application must have a similar written request made before the change can be made. In no case are changes effective without the written approval of OADAP. Justification for the changes must accompany the budget revision.

3.95 Retention of Financial Records. Records of the provider, including books of original entry, source documents, supporting accounting transactions, the general ledger, subsidiary ledgers, personnel and payroll records, canceled checks, and related documents and

records, to include electronic files, must be retained for a period of six (6) years following conclusion or termination of the term of the applicable grant or contract, with the following qualifications: (1) the records shall be retained beyond the six year period if audit findings have not been resolved, (2) if the provider ceases to operate, all records concerning the OADAP funded program shall be available to OADAP.

3.96 Third Party Reimbursement - Treatment. Treatment programs supported with funds from OADAP for the delivery of alcohol and other drug abuse services are expected to develop, to the extent possible, independence from OADAP support. Therefore, these projects will be encouraged and assisted in the development and use of alternate funding sources to supplement or replace OADAP support where possible. These funding sources include third-party payers, other available federal, state, local and private funds, and beneficiaries who are able to pay.

Where third-party payers, including government agencies, are authorized or under legal obligation to pay all or a portion of charges for health care services, all such sources must be billed for covered services and every effort must be made to obtain payment. The provider must have an operative procedure for identifying all persons served who are eligible for third party reimbursement.

Where a significant percentage of the cost of care and services provided the project is to be reimbursed by a third party, there should be a written agreement with such third party.

3.97 Third Party Reimbursement - Prevention. OADAP encourages Prevention programs to access additional funding sources; however, full time equivalent prevention staff paid with OADAP contract funds shall not charge for those contracted services. If an honorarium is received, see Section 3.18, Program Income.

3.98 Deobligation of Funds. All contracts/grants shall automatically be deobligated 90 days following the end of the award period. Bills, not to exceed the amount of the obligated funds, submitted after the contract is deobligated may not be paid unless the Director approves of the delay, only upon a showing of good cause, and if allowed by federal funding regulations.

3.99 Program Implementation Requirements. Contracts/grants must be implemented within the time authorized by OADAP (90 days from date of award or approved project start date). Contracts/grants not implemented within this time frame will be deobligated unless the approved applicant can justify to both OADAP Director and to OADAP Alcohol and Drug Abuse Coordinating Council why this action should not occur. Deobligated funds will revert to OADAP.

3.10 ALLOWABLE COSTS

The following is a general guideline. For guidance with regard to selected items of cost, reference OMB Circular No. A-122. Federal and State regulations specific to the program being funded may differ. See the RFP/RFA ~~or CAP~~ for exceptions. In all cases cost must be reasonable and necessary.

3.10.1 Salaries and Fringe Benefits: The costs of salaries are allowable to the extent that compensation of each employee is (1) reasonable and necessary, (2) comparable to that paid for similar work in the labor market and (3) supported by time-records. NOTE: Budgeted positions that are vacant should be filled within sixty (60) days of the effective date of the contract, or the related funds will be removed from the budget.

FICA, life and health insurance, unemployment coverage, worker's compensation, retirement and pension plans are allowable if reasonable and made available to all employees in the program.

The cost of housing and/or food is allowable only if it is part of an employee's compensation because of required attendance at the facility.

Fringe benefits for volunteers are not allowable; however, they may be reimbursed for expenses directly related to the program.

3.10.2 Maintenance and Operation

3.10.2.01 Accounting and Auditing: The expense of establishing and maintaining accounting and other information systems required in the performance of the contract is an allowable expense. The cost of the required annual independent audit is also allowable.

3.10.2.02 Advertising and Publicity: Contract/grant funds to be spent for advertising or publicity must be clearly identified in the program contract/grant line item budget and the advertising or publicity materials must have prior written approval of OADAP before implementation. All publicity and advertising materials, releases, etc. must identify the program as an affiliate of the Alcohol and Drug Abuse Prevention. In addition, programs funded with Federal funds must identify the source of the funds. Treatment programs shall conduct an active publicity campaign for alcohol and other drug abuse treatment utilizing all available public service announcements in the local news media.

3.10.2.03 Bonding and Insurance: The costs of bonding and insurance are allowable if in accordance with sound business practice and the rates are competitive.

3.10.2.04 Building Space and Related Facilities: Costs associated with lease or rental of building space and related facilities used for the benefit of the program are allowable. Funds may not be utilized for the purchase, construction or permanent improvement (other than minor remodeling) of any building. See 3.15, item 4, Capital Payments.

3.10.2.05 Communications: Allowable costs include (1) Telephone costs for local and long-distance calls, service charges, installation costs, and similar expenses. (2) Postage used in the office for communication related to the program.

3.102.06 Depreciation and Use Allowance: A depreciation schedule must be provided and supported by adequate records and inventory.

3.10.2.07 Equipment Expenditures: Expenditures for equipment costing less than $2500 or with a useful life of less than one year are allowable. If the total costs of all components of a system (such as for computers or stereos) are $2500 or more, it must be considered a capital expense (see 3.15).

Capital equipment is personal tangible property with a total acquisition price of $2500.00 or more and useful life of at least one year. Only equipment listed in the contract/grant approved budget may be purchased. This must be done at a cost equal to or less than the price listed in the original contract/grant. Unexpended funds at the end of a contract/grant period may not be used to purchase or lease items of capital expense such as office furniture and equipment to include typewriters, calculators, copy equipment, postage meters, VCR, TV's, camcorders, stereo equipment, computers, cell phones, or films, without special approval from the Director, Division of Financial and Data Management. All requests for reimbursement for capital expenditures must be accompanied by an OADAP inventory form. All equipment purchased with federal and state funds within the contract/grant period must be inventoried and returned to OADAP within 30 days after the contract/grant ends unless special permission has been granted to retain the equipment.

OADAP shall discourage the funding of programs whose major purpose is the purchase of equipment (i.e., films, audio-visual, recreational equipment, etc.). Approval shall be given only if the program is able to adequately justify that the application is for a total program that shall be assisted through the purchase of equipment. OADAP shall not furnish equipment that will be used to supplement

programs funded for purposes other than alcohol and other drug primary prevention, education, treatment, intervention or youth violence prevention.

A. OADAP Retention of Ownership. In accordance with state and federal law, title to all property and/or capital equipment purchased by any program with contract or grant funds is vested in Department of Human Services, Alcohol and Drug Abuse Prevention, unless the Department or OADAP and/or the applicable Federal grantor agency specifically agrees in writing to a title transfer or other disposition.

No Department property may be sold, transferred, or Used in another program without the consent of the Department or OADAP. All Department/OADAP property will be clearly marked, inventoried and properly maintained. All compensation for loss or damage to Department property will be paid to the Department unless the Department directs otherwise. It is the responsibility of the provider to maintain adequate insurance on all property

B. Inventory Requirements. Under a line item cost reimbursement contract/grant, all equipment purchased with contract/grant funds remain the property of OADAP and must be kept on both the provider's inventory list and the OADAP inventory list. Each item shall be affixed with an identification tag provided by OADAP. The program should provide OADAP with an inventory list of all equipment costing over $500.00 purchased with contract/grant funds. The list should include a description of the item and its serial number. This equipment is the property of OADAP and all equipment shall be returned to OADAP within 48 hours of the program's closing,

3.10.2.08 Equipment Rental: The cost of rental equipment is allowable. Lease-purchase of equipment must be recovered through depreciation.

3.10.2.09 Field Trips: The cost of educational and recreational outings for clients, including the cost of admission, transportation (if not provided for under another line item), snacks, beverages, and food costs directly associated with field trips are allowable, if an integral part of the program.

3.10.2.10 Food Service Supplies: Costs of supplies (such as plates, silverware, etc.) directly associated with the provision of meals to clients is allowable.

3.10.2.11 Freight: Costs incurred for freight, postage, and other transportation costs directly relating to goods purchased, delivered or moved from one location to another are allowable.

3.10.2.12 Indirect Costs: Indirect costs shall be allowable only when special approval is given, in writing, from the OADAP Director. Generally this shall not exceed 10% of the direct cost. Indirect costs are costs incurred by an organization that are not readily identifiable with a particular project or program but are necessary to the operation of the organization and the performance of its program.

A copy of the federally approved indirect cost rate, or a cost allocation showing the items and expense included, and the method used to equitably distribute the cost must be maintained by the provider. Submission of a copy to OADAP is required before indirect costs are allowed for a particular OADAP grant or contract.

3.10.2.13 Inspections: The cost of required inspections such as health and fire inspections is allowable if such inspections are not available without charge.

3.10.2.14 Insurance: Prevention and treatment programs funded by OADAP shall be required to have liability insurance and a fidelity bond approved by OADAP that provides for the protection of the physical and financial resources of the program, coverage of the building and equipment and coverage of its clients, staff and general public. If the program is part of a governmental agency, in lieu of liability insurance and a fidelity bond, the program must have other appropriate means of protection such as statewide or federal insurance coverage for the items specified above. See also Bonding and Insurance.

3.10.2.15 Lease Costs: See Rental Costs

3.10.2.16 Maintenance and Repair: Costs incurred for necessary maintenance, repair or upkeep of property, including motor vehicles. (For major renovations or capital improvements, see section 3.15)

3.10.2.17 Materials and Supplies: The cost of materials and supplies necessary to carry out the objectives of the program is allowable. This line item should be broken into the following categories: Office Supplies (paper, folders, pencils, etc.), Janitorial Supplies (brooms,

mops, soap, etc.); Program Supplies (classroom materials, etc.). (See Section 5.021 regarding audio-visuals, books, tapes, etc.).

3.10.2.18 Meetings and Conferences: See Training, (Section 3.142.27).

3.10.2.19 Memberships: The cost of membership in trade, technical, and professional organizations is allowable if: (1) related to the cost of the program; (2) is for provider membership; (3) cost is reasonable; and (4) not for membership in an organization which devotes a substantial part of its activities to influencing legislation.

3.10.2.20. Postage: See Communications (Section 3.142.05).

3.10.2.21 Printing and Reproduction: Costs for printing and reproduction services necessary for the program, including but not limited to forms, reports and manuals are allowable.

3.10.2.22 Public Information Costs: Costs for pamphlets, news releases, and other forms of information services are allowable when the primary purpose of such activities is to inform the public about the availability of services. (Prior approval from OADAP is required. See Section 3.142.02 for additional information.)

3.10.2.23 Rental Costs: Rental costs are allowable to the extent they are reasonable and necessary and the provider does not gain a material equity in the property.

3.10.2.24 Subcontracted Services: May be allowable: (1) Based on services rendered in relation to the contract; (2) the necessity of contracting for the services; (3) the past pattern of such costs; (4) whether contracting is more economical than service performed by employee; (5) the qualifications of the individual or firm and fees charged; and (6) written contractual agreement for services. (Also see Section 4.04.)

3.10.2.25 Subscriptions or Reference Materials: The cost of books and subscriptions to trade, business or professional periodicals is allowable when related to and subscribed for the program.

3.10.2.26 Taxes: In general, tax payments that the program is legally required to pay are allowable. (See Section 3.15 - 9).

3.10.2.27 Training, Meetings and Conferences: Cost of in-service training is allowable where the primary purpose is the dissemination of technical information of direct benefit to the program. Costs may include meals, transportation, lodging, registration fees, materials, etc. A copy of conference information such as agenda, registration fee, room rates, etc. are required for approval of these costs. The cost may not exceed allowable limits for State employees on State business.

3.10.2.28 Travel: Applies to line item cost reimbursement contracts/grants only. The cost may not exceed allowable limits for State employees on State business. Reimbursement for travel expenses will be made only if specified in the contract/grant. Reimbursement for meals, lodging, fees, etc., will not be allowed unless specified in the program contract/grant. Out-of-state travel must have prior written approval from OADAP to be eligible for reimbursement except for travel into Texarkana, Texas, Memphis, Tennessee or similar such immediate border areas.

3.10.2.29 Utilities: The cost of utilities is allowable.

3.11 UNALLOWABLE COSTS

The following costs are unallowable:

1. Bad Debts
2. Bidding and Proposal Costs
3. Capital Expenditures (unless specifically approved by the funding source)
4. Capital Payments (mortgage payments, investments, etc.)
5. Contingency Funds
6. Contributions and Donations
7. Deposits (for utilities, etc.)
8. Entertainment (This is not intended to apply to clients receiving socialization services with meals, congregate meal services, or field trips.)
9. Fines and Penalties
10. Interest and Other Financing Cost
11. Legal Services
12. Line Item Overages
13. Lobbying
14. Organization Costs (incorporation fees, fund raising costs, etc.)
15. Profits and Losses on Disposition of Capital Assets
16. Purchase or Improvement of Land or Buildings
17. Severance Pay
18. Costs incurred prior to contract/grant effective date.

3.12 UNDUPLICATED SALARIES

Any individual whose salary is directly paid through OADAP funds is not allowed to contract similar services for remuneration to another agency that is using OADAP funding to provide that service.

Any individual whose salary is directly paid through OADAP funds who contracts with others to perform services that are the same or similar to the employee's normal job duties outside the employee's contracted work hours shall be performing as a Private Consultant. The agency of that employee is responsible for ensuring that any time or use of equipment spent in preparation, solicitation and marketing of the private consultant services or distribution of materials used in the private consulting business are not financed either directly or indirectly with OADAP funds.

3.13 CASH DEPOSITORIES

OADAP does not impose contract or grant requirements which:

1. Require the provider to use a separate bank account for the deposit of grant funds or reimbursement funds.

2. Establish any eligibility requirement for banks or other financial institutions in which providers deposit funds.

3.14 PROGRAM INCOME

Program income means gross receipts from activities part or all of the cost of which is borne as a direct cost by a contract or grant. It includes but is not limited to such income in the form of fees for services performed during the award period, proceeds from sale of tangible or real property, usage or rental fees, interest, investments and patent or copyright royalties. If income meets this definition, it shall be considered program income regardless of the method used to calculate the amount paid to the provider - whether, for example, by a cost reimbursement method or fixed price arrangement.

Program income may be retained by the provider only if allowed by the federal funding source and specifically authorized in writing by OADAP. If retention of program income is approved it must be deducted from the funded amount or, if approved by OADAP, used for costs which are in addition to allowable costs of the program but support the objectives of the funded program.

3.15 REIMBURSEMENT

No payment can be made until a completed W-9 and a Vendor Maintenance Request Questionnaire is on file with the Arkansas Department of Human Services. The W-9 must reflect the legal name of the entity as shown on the Articles of Incorporation and 501(c) 3. Any change in the name requires the completion and submission of a revised W-9 and a Vendor Maintenance Request Questionnaire. The address shown on the W-9 will be the address used for mailing the reimbursement. Changes in address for reimbursement must be sent in writing (no fax or e-mail) to the attention of the Director, Financial and Data Management.

3.15.1 Billing All reimbursements must be submitted on the appropriate forms provided by OADAP. These must be for the actual units of service delivered or expenses incurred, and if budget based, may not exceed the limits of the contract/grant nor OADAP ceiling rates for the fixed price contracts/grants.

3.15.2 Billing for Services All OADAP providers must bill for services utilizing the prescribed OADAP Invoice Form. All funded treatment providers must enter client information online utilizing the Alcohol and Drug Management Information System (ADMIS) or as otherwise directed by OADAP. All reimbursement requests for any treatment service must be reconciled with client information as reported for the particular report month.

When the amount requested for services cannot be reconciled with reported client information and correction or clarification cannot be made by telephone or e-mail, the payment request will be adjusted or returned immediately to the provider for correction and resubmission.

3.15.3 Billing Due Dates - Reimbursement Requests. All programs are required to submit their requests for reimbursement or expenditures monthly ~~to be postmarked~~ no later than the seventh of the month. Billing received late in the month may be held for payment until the start of the next month. All providers are requested to send a reimbursement request each month. If no service or reimbursement activities occurred a bill for $0.00 should be submitted.

3.16 NOTIFICATION OF CHANGE

Contractors/grantees must notify OADAP in writing within one week when there is a change in the program status. This includes the vacancy of a key staff position or a change in the program address, telephone number, e-mail address or fax number. In some instances, replacement of key prevention staff may be subject to prior approval by OADAP.

3.17 TERMINATION OF CONTRACT/GRANT

Either party has the right to terminate a contract/grant on 30-day written notice to the other party. Immediate termination may also result by failure of the provider to meet contractual or grant obligations or licensure standards.

OADAP reserves the right to immediately terminate a contract/grant if the public health or safety is in peril.

4.00 GENERAL REQUIREMENTS

4.01 Treatment Requirements
- 4.011 Basic Requirements
- 4.012 Client Records
- 4.013 Retention of Client Records
- 4.014 Confidentiality
- 4.015 Client Input and Client Grievance Procedures
- 4.016 Treatment Service Capacity
- 4.017 Waiting List System
- 4.018 Incident Reporting

4.02 Participation in Conference

4.03 Subcontracted Services
- 4.03.1 Restriction of Services
- 4.03.2 Other Agency Subcontractor
- 4.03.3 Subcontract Requirements

4.04 Volunteers

GENERAL REQUIREMENTS

4.01 TREATMENT REQUIREMENTS

4.01.1 Basic Requirements. All prospective contractors/ and grantees for funds for treatment programs must comply with all applicable state and federal laws, regulations and policy, including the OADAP Licensure Standards for Alcohol and/or Other Drug Abuse Treatment Programs. OADAP will not award funds to programs that fail to meet licensure/regulation laws or rules.

4.01.2 Client Records. Treatment facilities must establish a uniform client record system to document and monitor client care. These client records will conform to all applicable state and federal laws and regulations, including the OADAP Licensure Standards.

4.01.3 Retention of Client Records. The provider shall retain all records and other documents relating to services rendered and the individuals in receipt of the services for a minimum of six (6) years from the expiration of the agreement for the purpose of client follow-up, evaluation of the program and for completion of compliance and/or other reviews.

4.01.4 Confidentiality. Confidentiality of alcohol/drug abuse client records shall be assured by the provider and shall be in accordance with all pertinent state and federal regulations. Existing federal law (42 CFR, Part 2) provides for safeguarding files or any other client identifying information from access by any unauthorized individuals, and requires that records be maintained in a secure manner. All records, unless exempted by federal law, including clients not billed to OADAP, however, are subject to review by OADAP at any time for the purpose of monitoring proper execution of the contract/grant, and must be made available to OADAP upon request.

4.01.5 Client Input and Client Grievance Procedures. Each program will develop and implement a procedure whereby persons served by the program can provide input on the operation and services of the program. Each program shall also develop and implement a procedure whereby persons served by the program can communicate a grievance against that program and the means whereby the program will respond to the grievance. The program will also develop and implement a procedure that documents the mechanism whereby persons served by the program are informed of this procedure.

4.01.6 Treatment Service Capacity. Treatment programs shall provide for preference in admission utilizing the following hierarchy:

1. Pregnant women who are injecting drug users;
2. Pregnant women;
3. Injecting Drug Users;

4. All other substance abusers.

If treatment admission is not immediately available for a pregnant woman, the treatment program must immediately offer "interim services". Interim services are defined under Section 7.07 herein. The purposes of interim services are designed and intended to reduce the adverse health effects of substance abuse, promote the health of the individual, and reduce the risk of transmission of disease. For pregnant women, interim services specifically include counseling on the effects of alcohol and drug abuse on the fetus, as well as a referral for prenatal care, which is to be made within 48 hours of the request for services. Treatment programs unable to admit a pregnant woman requesting services shall immediately refer the individual to OADAP by notifying their assigned OADAP Program Consultant.

For pregnant women and injecting drug users the treatment programs shall carry out activities designed to encourage such individuals in need of treatment to undergo treatment.

4.01.7 Waiting List System. Funded treatment programs shall establish and maintain a waiting list management program that includes a unique patient identifier, as established by OADAP, for each drug abuser seeking treatment, including those receiving interim services while awaiting admission to treatment. Treatment programs must have a mechanism for maintaining contact with individuals awaiting admission. OADAP will assist funded treatment programs to ensure that individuals on waiting lists are admitted at the earliest possible time to a program providing treatment within a reasonable geographic area. Treatment programs must document the interim services offered to individuals on the waiting list and when they were delivered. Information from each program's waiting list system must be submitted to OADAP in a manner and within a timeframe designated by OADAP.

4.01.8 Incident Reporting. Each treatment program shall report serious incidents/situations to OADAP within 24 hours in compliance with OADAP Incident Reporting Policy, incorporated herein by reference.

4.02 PARTICIPATION IN CONFERENCE

The provider must participate in local or statewide sponsored coordinating conferences, training seminars, or training workshops as ~~so~~ directed by OADAP.

4.03 SUBCONTRACTED SERVICES

4.03.1 Restriction of Services. Unless subcontracted services are specifically identified in the OADAP approved program contract/grant budget, they may not be purchased with contract/grant funds.

4.03.2 Subcontract Requirements. All subcontractors are subject to the same requirements as the prime contractor/grantee. Subcontract arrangements must contain, at a minimum, the following conditions.

1. A statement describing the particular services and/or deliverable(s) to be provided and clarifying the level of quality required.

2. A statement setting forth the number of hours or description of other rate computation which the subcontractor has agreed to provide.

3. A statement of the amount of compensation to be paid and the payment schedule (e.g., upon satisfactory completion of deliverables, etc).

4. A clear understanding that the fee-for-services, or other compensation is available only from the funded program and not from OADAP or other program participants.

5. Provision for termination of the subcontract if the above requirements are not met.

6. A statement identifying the person responsible for oversight of contract for both the contractor and subcontractor.

4.04 VOLUNTEERS

If volunteer services are included in the terms of the contract/grant, the provider is responsible for the overseeing of the volunteers and for the monitoring of services provided by these individuals. Volunteers shall not supplant paid staff in programs. A job description of each volunteer position shall be included in the program. Volunteers must comply with the confidentiality provisions in Section 2.072 B.

5.00 SPECIFIC REQUIREMENTS

5.01 Alcohol/Drug Treatment Contract/Grant Requirements
- 5.011 Report Requirements
  - 5.0111 ADMIS Compliance
  - 5.0112 ADMIS Billing Reports
  - 5.0113 ADMIS Client Records
  - 5.0114 Other Reports

5.02 Primary Prevention Contract/Grant Requirements
- 5.021 Audio-Visual Materials, Books, Tapes, Films and Other Literature
- 5.022 Report Requirements
  - 5.0221 Billing Reports
  - 5.0222 Prevention Reporting Compliance

5.00 SPECIFIC REQUIREMENTS

5.01 ALCOHOL/DRUG TREATMENT CONTRACT/GRANT REQUIREMENTS

5.011 Report Requirements

5.0111 ADMIS Compliance. All alcohol and other drug abuse treatment programs in Arkansas are required to report client-related data in accordance with the requirements of the current ADMIS. For acute care, hospital based alcohol and drug abuse treatment programs, failure to report may result in notification to the Arkansas Department of Health, Division of Health Facility Services, of failure to comply with requirements of Act 25 of 1991. Licensure awarded automatically pursuant to Act 173 of 1995 shall not be affected by failure to report. For all other treatment programs, failure to report may result in the suspension or termination of an OADAP treatment grant or contract, and/or loss of OADAP required licensure.

5.0112 ADMIS Billing Reports. All funded treatment programs are required to submit their requests for reimbursement on a monthly basis as specified in Section 3.152.

5.0113 ADMIS Client Reports. ADMIS liaisons shall complete ADMIS Reports on the Web-Based ADMIS System, including Admission Reports (AR), Environmental Change Reports (ECR), and Discharge Reports (DR). The AR Reports must be submitted on all clients. The Web-Based ADMIS System calculates monthly billing, which is created on the 8th of the month at 4:00 p.m. Providers mailing their ADMIS Reports must ensure that their reports are postmarked by the 15th of each month.

5.0114 Other Reports. All providers shall comply with any additional reporting requirements which may be required by OADAP.

5.02 PRIMARY PREVENTION CONTRACT/GRANT REQUIREMENTS

All prospective applicants must comply with OADAP procedures and the appropriate RFP or RFA format when making application.

5.021 Audio-Visual Materials, Books, Tapes, Films and Other Literature.

The policy review guidelines set forth by the Center for Substance Abuse Prevention must be followed when developing or purchasing materials. Review copies must, where feasible, be furnished to OADAP before purchase obligation is incurred. The guidelines for materials are provided in the Appendix of the *Rules of Practice and Procedure*.

5.022 Report Requirements

5.0221 Billing Reports. All prevention programs are required to submit their requests for reimbursement or reports of expenditures by the 7th of the month. All providers are requested to send a reimbursement request each month. If no services or reimbursement activities occurred, a bill For $0.00 should be submitted. The actual time periods Are specified in the individual contract or grant.

5.0222 Prevention Reporting Compliance. Any program receiving funds for prevention is required to participate in the Prevention Information System. All prevention programs are required to submit reports of progress, including level of activity, on a regular basis as identified in the individual contract or grant, a final report at the end of the contract/grant, and any additional or special reports required in either written or electronic format. Failure to report may result in suspensio~~n~~ or termination of the current contract/grant.

6.00 APPEAL PROCESS FOR ADVERSE ACTION

An appeal process is available to provide a mechanism by which a provider or grant applicant may appeal adverse action by the Alcohol and Drug Abuse Prevention relating to a program/contract/grant. Complaints which solely assert an objection to federal or state laws or regulations are not subject to appeal under this procedure.

6.01 Alcohol and Drug Abuse Prevention and Treatment Programs. When a provider or grant applicant wishes to appeal an action by OADAP, he/she may do so by submitting a written request to the Chairperson, Alcohol and Drug Abuse Coordinating Council. The Chairperson must receive the request no later than thirty days from the date of receipt of notification of the adverse action by the provider or grant applicant.

The notice of appeal must contain:

1. A statement of the specified action which is being appealed.
2. The reason the provider/grant applicant believes the action was incorrect.
3. The specific relief requested.

When a request for appeal is received, the Chairperson of the Alcohol and Drug Abuse Coordinating Council will initiate the process by establishing a date for hearing the complaint.

The Council may act on the matter, or it may refer the matter to the Prevention and Treatment Committee for its recommendation. The Director of OADAP shall abstain from discussion and voting, either in committee or in a meeting of the Council or both, with respect to any such action, but the Director may respond to any factual question posed by another member of the Council. If the matter is referred to the Prevention and

Treatment Committee, the Committee shall consider the matter and shall forward its recommendation to the Council. Upon receipt of the recommendation, the Council shall act on the recommendation.

The decision of the Alcohol and Drug Abuse Coordinating Council is final. Those decisions that meet the definition of "adjudication" under the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201, et seq., may be appealed in accordance with the Arkansas Administrative Procedure Act.

7.00 DEFINITIONS

7.01 Alcohol and Drug Abuse Coordinating Council
7.02 Alcohol/Drug Management Information System (ADMIS)
7.03 Budget Period
7.04 Continuation Application Package (CAP)
7.05 Drug and Alcohol Safety Education Program (DASEP)
7.06 Intake and Assessment for Substance Abuse
7.07 Interim Services
7.08 Licensure Standards for Alcohol and/or Other Drug Abuse Treatment Programs
7.09 Medical Detoxification
7.10 Observation Detoxification
7.11 Outpatient Service -Family
7.12 Outpatient Service - Group
7.13 Outpatient Service - Individual
7.14 Partial Day Treatment
7.15 Primary Prevention Strategies
  7.151 Information Dissemination
  7.152 Education
  7.153 Alternatives
  7.154 Problem Identification and Referral
  7.155 Community-Based Process
  7.156 Environmental
7.16 Project Period
7.17 Regional Alcohol and Drug Detoxification Services (RADD Services)
7.18 Regional Detoxification Specialist
7.19 Request for Application (RFA)
7.20 Request for Proposal (RFP)
7.21 Residential Service
7.22 Residential Services for Adolescents (Comprehensive)
7.23 Specialized Women's Services (SWS)

7.00 **DEFINITIONS**

The definitions provided here are intended to assist the reader in understanding some major terms and documents as used routinely by OADAP. The list is not all inclusive. The reader is referred to OADAP Licensure Standards, the ADMIS Manual, the Request for Proposal (RFP), Request for Application (RFA), or Continuation Application Package (CAP) of instructions, and to the appropriate contract or grant document for further clarification or specific project areas.

7.01 **ALCOHOL AND DRUG ABUSE COORDINATING COUNCIL.** - A twenty-seven member board of review authorized by Act 855 of 1989, as amended. The Coordinating Council has the responsibility for overseeing all planning, budgeting and implementation of expenditures of state and federal funds allocated for alcohol and drug education, prevention, treatment and law enforcement. The Coordinating Council has established a committee structure that includes a Treatment and Prevention Committee and a Law Enforcement Committee. The Treatment and Prevention Committee reviews applications for funding through DHS/DBHS Alcohol and Drug Abuse Prevention.

7.02 **ALCOHOL/DRUG MANAGEMENT INFORMATION SYSTEM (ADMIS).** A data collection system developed and operated by OADAP to be used in alcohol and drug abuse prevention and treatment programs. See Section 5.0111 – 5.0113 for ADMIS reporting on treatment services and Section 5.023 for reporting on prevention services.

7.03 **BUDGET PERIOD.** The budget period is defined as the interval of time (usually 12 months) into which a project period is divided for funding and reporting purposes.

7.04 **CONTINUATION APPLICATION PACKAGE (CAP).** - The non-competitive process by which current contracted providers of prevention or treatment services with multiyear commitment are evaluated, and their grant is either renewed, not renewed, or renewed pending contingencies placed by the Arkansas Alcohol and Drug Abuse Coordinating Council. This process involves submitting to OADAP, or an outside evaluator, a document that reports the activities of the provider during the current grant period, and outlines a proposed program for the upcoming grant period. Other performance indicators such as licensure visits, service-to-billing audits, case reviews, site visit reports, and ADMIS or progress reporting are taken into account during this process.

7.05 **DRUG AND ALCOHOL SAFETY EDUCATION PROGRAM (DASEP).** A program for persons who plead guilty, nolo contendere or found guilty of Driving While Intoxicated (DWI), Minor In Possession (MIP), Underage refusal to Submit, Possession of fraudulent or altered personal identification (under certain circumstances) or Driving Under the Influence (DUI). The DASEP program provides an investigation, screening/assessment, referral to treatment, or at least twelve (12) contact hours of education for level I, including underage refusal, possession of fraudulent or altered identification. All level II classes will be at least fifteen (15) hours in length. No individual class session will last

more than six (6) hours. It is preferred that classroom instruction/classes last no longer than four (4) hours per class/session. MARATHON (ALL DAY) CLASSES ARE PROHIBITED. The preliminary investigation will consist of a Pre-sentence Screening Report which will include the offender's driving record, an alcohol problem assessment, a victim impact statement (if applicable), and the blood-alcohol content (BAC) at the time of arrest. Based upon the investigation and assessment, the DASEP will make a recommendation to the court for the offender to complete an DASEP school or an alcohol/drug treatment program approved by the Arkansas Department of Human Services, Alcohol and Drug Abuse Prevention. Completion of one of these programs is required to have the offender's driver's license reinstated. If an offender has multiple offenses, that offender must complete a program/intervention for each offense prior to driver's license reinstatement. In some instances completion of an approved treatment program **may** be counted as more than one program/intervention. In cases where this **might** apply, the DASEP state manager must be consulted prior to issuance of multiple certificates. The manger must approve each instance of these occurrences.

7.06 **INTAKE AND ASSESSMENT FOR SUBSTANCE ABUSE.** A one-time process per client per admission. Admission is designed as a unit of Residential, a unit of Partial Day, or a unit of Outpatient services. **The client cannot be admitted and discharged on the same day. Intake and Assessment for Substance Abuse must include** the administration of an interview to provide information on the client, the client's alcohol/drug use history, employment history, family background and prior treatment episodes. **The administration of the Addiction Severity Index (ASI) must be included.** Other items may include physical exam, drug testing, and other screening or assessment tools for substance abuse and mental health.

7.07 **INTERIM SERVICES.** - Interim substance abuse services means services that are provided until an individual is admitted to a substance abuse treatment program. The purposes of interim services are to reduce the adverse health effects of substance abuse, promote the health of the individual, and reduce the risk of transmission of disease. At a minimum, interim services include counseling and education about HIV and tuberculosis (TB), about the risks of needle-sharing, the risks of transmission to sexual partners and infants, and about steps that can be taken to ensure that HIV and TB transmission does not occur, as well as referral for HIV or TB services if necessary. For pregnant women, interim services also include counseling on the effects of alcohol and drug use on the fetus, as well as referral for prenatal care to be made within 24 hours of the request for admission for treatment.

7.08 **LICENSURE STANDARDS FOR ALCOHOL AND/OR OTHER DRUG ABUSE-TREATMENT PROGRAMS.** Those Licensure Standards that were developed and revised by OADAP and OADAP Standards Review Committee. They contain criteria by which treatment programs are reviewed in the Licensure process.

7.09 **MEDICAL DETOXIFICATION.** Includes 24-hour medically supervised care in a hospital setting or medical model facility. Includes a short-term treatment up to three (3) days, during which time prescribed medication is used to restore physiological functioning after it has been upset by toxic agents, including alcohol. Service shall be under the supervision and guidance of a licensed physician. Service is allowable only after a Regional Alcohol and Drug Detoxification (RADD) evaluation. The unit of service is a day and the limit per client is three days. Additional days require **prior** OADAP approval.

7.10 **OBSERVATION DETOXIFICATION.** Includes monitoring on a 24-hours per day basis of a client who is undergoing mild withdrawal in a residential setting. Vital signs will be taken by a staff member trained and certified by OADAP, a Medical Doctor, Registered Nurse, Licensed Psychiatric Technical Nurse or Licensed Practical Nurse. The facility shall establish approved emergency medical procedures. These services shall be available should the client's condition deteriorate and emergency procedures be required. A unit of service is one day.

7.11 **OUTPATIENT SERVICE – FAMILY.** Counseling provided in an outpatient environment to a substance abuse client and/or family members and/or significant other. Although the client is usually present at these sessions, these sessions are reimbursable if the client is not present. Services to all members of the family or significant other may be reimbursed. A unit of service is 15 minutes or any part thereof.

7.12 **OUTPATIENT SERVICE – GROUP.** Counseling provided in an outpatient environment to more than one substance abuse client. Services to all members of the group may be reimbursed. A unit of service is 15 minutes or any part thereof.

7.13 **OUTPATIENT SERVICE – INDIVIDUAL**. Includes care provided to a substance abuse client in an outpatient environment. Outpatient service is provided to the client **only.** A unit of service is 15 minutes or any part thereof.

7.14 **PARTIAL DAY TREATMENT**. Includes care provided to a substance abuse client who is not ill enough to need admission to medical detoxification or observation detoxification, but who has need of more intensive care in the therapeutic setting. This service shall include at a minimum intake, individual and group therapy, psychosocial education, case management and a minimum of one hot meal per day. Partial day treatment shall be a minimum of (4) four hours per day for (5) five days per week. In addition to the minimum services, partial day treatment may include drug testing, medical care other than detoxification and other appropriate services. A unit of service is a day.

7.15 **PRIMARY PREVENTION STRATEGIES.**

7.151 Information Dissemination: This strategy provides awareness and knowledge of the nature and extent of alcohol, tobacco and drug

use, abuse and addiction, youth violence and their effects on individuals, families and communities. It also provides knowledge and awareness of available prevention programs and services. Information dissemination is characterized by one-way communication from the source to the audience, with limited contact between the two. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following: (1) clearinghouse/information resource center(s); (2) resource directories; (3) media campaigns; (4) brochures; (5) radio/TV public service announcements; (6) speaking engagements; (7) Health fairs/health promotion; and (8) information lines.

7.152 Education: This strategy involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of its activities. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (e.g. of media messages) and systematic judgment abilities. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following: (1) classroom and/or small group sessions (all ages); (2) parenting and family management classes; (3) peer leader/helper programs; (4) education programs for youth groups; and (5) children of substance abusers groups.

7.153 Alternatives: This strategy provides for the participation of target populations in planning and implementing activities to promote lifestyles that exclude alcohol, tobacco, other drug use and youth violence. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco, other drugs, youth violence and/or crime and would, therefore, minimize or obviate resort to the latter. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following: (1) dug free dances and parties; (2) youth/adult leadership activities; (3) community drop-in centers; and (4) community service activities.

7.154 Problem Identification and Referral: This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following: (1) employee assistance programs; (2) student assistance programs; and (3) driving while under the influence/driving while intoxicated education programs.

This strategy assesses whether youth who have been engaged in inappropriate violent behavior would respond favorably to

education. If the behavior cannot be corrected through mere education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment or therapy.

7.155 Community-Based Process: This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco and drug abuse disorders and youth violence prevention services. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of service implementation, inter-agency collaboration, coalition building and networking. Examples of activities conducted and methods used for this strategy include (but are not limited to) the following: (1) community and volunteer training, e.g., neighborhood action training, training of key people in the system, staff/officials training; (2) systematic planning; (3) multi-agency coordination and collaboration; (4) accessing services and funding; and (5) community team-building.

7.156 Environmental: This strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco, other drug use, youth violence and/or crime in the general population. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives. Examples of activities conducted and methods used for this strategy shall include (but not be limited to) the following: (1) promoting the establishment and review of alcohol, tobacco, drug use and youth violence policies in schools; (2) technical assistance to communities to maximize local enforcement procedures governing availability and distribution of alcohol, tobacco and other drug use; (3) modifying alcohol and tobacco advertising practices; (4) product pricing strategies, and (5) technical assistance to communities to maximize the availability of conflict resolution courses and crime prevention initiatives.

7.16 **PROJECT PERIOD.** The total time for which support of a project has been approved.

7.17 **REGIONAL ALCOHOL AND DRUG DETOXIFICATION SERVICES (RADD SERVICES).** The RADD services process will provide the client detoxification services that shall include an aftercare plan. All or part of these services may be provided to individualize the treatment to meet the client's needs. A unit of service will include the following: (1) initial evaluation, (2) referral to the appropriate level of detoxification services, (3) development of an aftercare plan, and, (4) referral.

7.18 **REGIONAL DETOXIFICATION SPECIALIST.** A person trained and certified by the Alcohol and Drug Abuse Prevention. A person must be recertified every three years. Training will provide competency at a minimum, in the following areas:

(1) Current RADD Program Policy and Procedure,
(2) Taking of vital signs,
(3) Evaluation of presenting symptoms and compiling an accurate substance abuse history,
(4) Current certification in cardiopulmonary resuscitation (CPR),
(5) Current certification in a First Aid course,
(6) Current Non-violent Crisis Prevention and Intervention (CPI) training in diffusing hostile situations, and
(7) Knowledge of alternate social, rehabilitative and emergency referral resources.

7.19 **REQUEST FOR APPLICATION (RFA).** A document that solicits applications for a grant program to be developed within parameters defined by OADAP. The RFA may be a competitive process.

7.20 **REQUEST FOR PROPOSAL (RFP**). A document that solicits proposals for a contract to procure or acquire products and/or services to assist OADAP in conduct of its responsibilities. The RFP outlines the terms and conditions of the resulting contract. The RFP may be a competitive process.

7.21 **RESIDENTIAL SERVICE.** Includes care provided to a substance abuse client who is not ill enough to need admission to medical detoxification or observation detoxification, but who has need of more intensive care in the therapeutic setting with supportive living arrangements. This service shall include at a minimum, intake, individual and group therapy, case management and room and board. In addition to the minimum services, residential service may include drug testing, medical care other than detoxification, and other appropriate services. A unit of service is a day. Note: Clients must be physically present at the facility for at least a part of any day billed. Exceptions require **prior** OADAP approval.

7.22 **RESIDENTIAL SERVICES FOR ADOLESCENTS (COMPREHENSIVE) (CRSA).** At facilities designated as a Comprehensive Residential Services for Adolescents (CRSA), a unit of service will be one day for the client. Services at a minimum include: A multidisciplinary treatment staff, including certified/licensed alcohol and drug counselors, licensed mental health counselors, nursing staff, certified service coordinators (case managers), licensed teacher(s), a psychiatrist, daily available nursing care, a licensed school as a component of the program and family therapy. Licensure by OADAP, DCFS, and CARF or JCAHO is required. Programming for dually diagnosed clients is available.

7.23 **SPECIALIZED WOMEN'S SERVICES (SWS).** At facilities designated as (SWS) a unit of service will be one day for a family. Services at a minimum include case management, alcohol and other drug treatment, child care, transportation, medical treatment, housing, education/job skills training, parenting skills aftercare, family education and support and house rules. Payment received from OADAP covers all services except for day care, which may be billed separately on other OADAP Agreements, if the provider so desires.

Other services may be established as needed and defined in the appropriate RFP/RFA or CAP**.**

APPENDIX

CENTER FOR SUBSTANCE ABUSE PREVENTION (CSAP) GUIDELINES FOR MATERIALS

These (abbreviated) Guidelines were taken from the Message and Material Review Process, Office of Substance Abuse Prevention (OSAP), April 1989. They are available from the National Clearinghouse for Alcohol and Drug Information (NCADI) as publication RPO726 if a fuller explanation is necessary.

S**CIENTIFIC REVIEW GUIDELINES:**

- The material is scientifically significant, based on valid assumptions, supported by accurate citations, and appropriately used.
- The scientific methods and approaches used are adequate, appropriate, and clearly described.
- Findings reported are accurate, current, applicable to the subject matter, and appropriately interpreted. The findings follow from the methods and approach used. For instance, facts should not be exaggerated nor purposely understated.

POLICY REVIEW GUIDELINES:

- Material makes clear that illegal and unwise drug use (including alcohol for those under 21) is unhealthy and harmful for all persons.
- Material gives a clear message that risk is associated with using any form or amount of alcohol or other drugs.
- Material gives a clear message of no alcohol use for persons under 21 years of age, pregnant women, recovering alcoholics and drug addicts, and persons taking prescription or non-prescription drugs.
- Material states clearly that pregnant women must not use any drugs (prescription or nonprescription) without first consulting their physicians.
- Material does not glamorize or glorify the use of alcohol and other drugs.
- Prevention material does not contain illustrations or dramatizations that could teach people ways to prepare, obtain, or ingest illegal drugs, and whenever feasible, materials for youth contain no illustrations of drugs. Intervention material does not contain illustrations or dramatizations that may stimulate recovering addicts or alcoholics to use drugs.
- Material does not "blame the victim."

- Material targeting youth does not use recovering addicts or alcoholics as role models.
- Material supports abstinence as a viable choice.
- Material supports cultural and ethnic sensitivity.

COMMUNICATIONS REVIEW GUIDELINES:

- Material is appropriate for target audience at cognitive and developmental levels.
- The institutional source is credible for the target audience.
- The individuals delivering the source are appropriate for the target audience. (Recovering addicts and alcoholics are not good sources for children/youth because they often misinterpret the messages of these individuals.)
- Language should be appropriate and grammatically correct. If Spanish is used, it should be grammatically correct and appropriate to the particular Hispanic/Latino target audience.
- The tone should not be condescending, judgmental, or preachy.
- The length of the product should allow sufficient time for a conclusion to be drawn. It should be short enough to prevent boredom without sacrificing the message.
- The product should be as professional in appearance as possible, attractive, and well written with the format (type, size and layout) appropriate to the audience.
- Messages must be appealing, believable, create awareness, persuasive, call for action and be pre-tested.
- Needs to be combined with other messages and/or materials to be effective.
- Readability level should reflect the skills of the target audience.

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES

OFFICE OF ALCOHOL AND DRUG ABUSE PREVENTION

LICENSURE STANDARDS FOR ALCOHOL AND OTHER DRUG ABUSE TREATMENT PROGRAMS

REVISED 3/1/2011

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LICENSURE STANDARDS
FOR
SUBSTANCE ABUSE TREATMENT PROGAMS

AUTHORITY

The Department of Human Services, Division of Behavioral Health Services, Office of Alcohol and Drug Abuse Prevention (OADAP) is vested by A.C.A.§ 20-64-901 *et seq.* with the authority and duty to establish and promulgate rules for licensure of substance abuse treatment programs in Arkansas. All persons, partnerships, associations, or corporations establishing, conducting, managing or operating and holding themselves out to the public as an alcohol and other drug abuse treatment program must be licensed by OADAP, unless expressly exempted from these requirements. Programs administered by the Department of Defense, the Veterans Administration, acute care hospital based alcohol and drug abuse treatment programs governed by § 20-9-201, § 20-10-213 and § 20-64-903, and persons exempted from licensure under Arkansas Code § 20-64-903 are not required to be licensed by OADAP, but may voluntarily seek licensure.

The OADAP is designated as the State Authority (SA) governing opioid treatment in Arkansas. Opioid Treatment Programs (OTPs) providing opioid treatment services shall comply with the applicable Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs including the specific standards for opioid treatment developed by OADAP. Opioid treatment services shall comply with all applicable federal, state and local laws and regulations including those under the jurisdiction of the Substance Abuse Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), the Drug Enforcement Administration (DEA) and the State Authority (SA).

As a condition of OADAP licensure approval, or funding, programs must comply with all laws and regulations regarding alcohol or drug treatment, programming, services, accreditation, or education.

HISTORY

Act 644 of 1977 created the Arkansas OADAP and charged the office with the responsibility for developing and promulgating standards, rules and regulations for accrediting alcohol and other drug abuse prevention and treatment programs/facilities within the state. Accreditation standards for alcohol and other drug abuse treatment programs were implemented in response to state and federal legislation, as well as the changing needs of the alcohol and drug abuse treatment programs. The first accreditation standards were adopted and implemented on January 1, 1983. Act 597 of 1989 delegated OADAP as the sole agency responsible for accrediting all alcohol and other drug abuse treatment programs. Revisions to the Accreditation Manual were promulgated on September 1, 1989. Act 173 of 1995 changed the accreditation process to a licensure process.

With the advent of the 1995 legislation, the Standards were promulgated and implemented as a Licensure Manual on July 1, 1995. The first Methadone Treatment Program Standards were developed and promulgated by OADAP on October 1, 1993. The Methadone/LAAM Treatment Program Standards were revised to include LAAM treatment on July 1, 1997. Subsequently LAAM treatment has been discontinued as a practice. More recently Buprenorphine has been recognized for use as an Opioid treatment. Thus, per designation of OADAP, the State Methadone Authority (SMA) has given way to the current designation of OADAP as the State Opioid Treatment Authority (SOTA) governing opioid treatment in Arkansas.

ABSTRACT

The Licensure Standards for Substance Abuse Treatment Programs Manual are State issued rules and regulations governing the licensure process. The Manual includes:

(1) Procedures for Licensure
(2) Licensure Types
(3) Substance Abuse Treatment Standards
(4) Application for Licensure

The Procedures for Licensure explains the licensure process for treatment programs, the Standards Review Team and other issues regarding licensure.

The Application for Licensure must be completed by all programs seeking licensure as an alcohol and/or other drug abuse treatment program in Arkansas prior to the on-site initial review.

An alcohol and other drug abuse treatment program must be in compliance with all applicable Standards in order for a program to obtain a one year or a three year license.

Questions concerning the licensure of alcohol and other drug abuse treatment programs in Arkansas may be directed to:

Department of Human Services
Division of Behavioral Health Services
The Office of Alcohol and Drug Abuse Prevention
Director, Program Compliance and Outcome Monitoring
305 South Palm Street, Administration
Little Rock, Arkansas 72205

Physical Address:
4800 West Seventh Street
Little Rock, AR 72205

Phone: 501-686-9866
Fax: 501-686-9396

http://www.arkansas.gov/dhhs/dmhs/

PROCEDURES FOR LICENSURE

Licensure is required of any individual, partnership, association or corporation operating or seeking to operate a substance abuse treatment program in the State of Arkansas. Upon promulgation of revisions to the standards, OADAP will provide to each of the programs known to be operating within Arkansas, a copy of the newly issued Licensure Standards for Alcohol and other Drug Abuse Treatment Programs manual.

A schedule for the licensure process for each treatment program with the participation of the program under review will be developed by OADAP. The entire licensure process for a program is shown below, with explanatory comments following.

Step 1
- a) Programs currently licensed shall be notified by OADAP of the upcoming licensure review.
- b) First time applicants seeking licensure shall submit a completed application for licensure to OADAP.
- c) Unlicensed alcohol and other drug abuse treatment programs will be notified by OADAP of the need to make application for licensure.

Step 2 Receipt by OADAP of the program's completed application for licensure. First time applicants shall submit a non-refundable $75.00 application fee. All licensed programs are billed annually by OADAP for a $75.00 renewal fee.

Step 3 OADAP staff shall develop the schedule and requirements for the review of the program.

Step 4 OADAP will provide written confirmation and notification to the program to include:

- a) Timetable developed in Step 1 – 3 above.
- b) Members of the Standards Review Team for that program (see Standards Review Team Member selection process).
- c) Notice of Requirement Form (form must be signed and returned to OADAP prior to the start of the licensure review)

Step 5 Formal on-site reviews by the OADAP Standards Review Team.

Step 6 Report by the OADAP Standards Review Team and recommendations to the Director of Program Compliance and Outcome Monitoring, Alcohol and Drug Abuse Prevention.

Step 7 Formal report to the program including findings and recommendations of the OADAP Standards Review Team with the type of license awarded.

Step 8 When applicable, responses to the program's appeal and/or scheduling of a follow-up Licensure Review.

Step 9 Submission to OADAP, by the program, of a $1,500.00 non-refundable licensure review fee (for first time applicants only) due after the review. **NOTE: The formal license will only be issued upon receipt of payment of the licensure review fee.**

APPLICATION PROCESS FOR OPIOID TREATMENT PROGRAMS (OTP)

An OTP shall not operate in the State of Arkansas prior to completion of the application process. The following criteria must be met:

a) Program has approval from the Drug Enforcement Administration (DEA) on file with OADAP; and,
b) Program has approval from the Center for Substance Abuse Treatment (CSAT).
c) The program has received licensure as an Alcohol and Other Drug Abuse Treatment Program;

NEW PROGRAMS COMMENCING OPERATION

Programs seeking licensure, or required to receive a licensure review, will complete all steps specified in the application process. OADAP shall review standards applicable to programs that have not yet provided substance abuse treatment. If the program has met the requirements outlined below, OADAP will issue a six (6) month operational permit.

1. Governing Board Authority and Procedures
2. Program Planning and Evaluation Processes
3. Employment and Personnel Practices
4. Program Services (to include applicable specialized services applied for)
5. Inspection of the Physical Plant
6. Articles of Incorporation/By Laws on file with the Arkansas Secretary of State
7. Board Minutes on file
8. Insurance Documentation
9. Evidence of current valid certifications of building, fire, safety and health inspections.
10. Policies and Procedures Manual
11. Client Handbook

Prior to expiration of the six (6) month operational permit, a formal review, with a Standards Review Team (SRT) will be performed to determine the program's level of compliance with all applicable standards. If the program under review is found to be in full compliance with all applicable standards, then the SRT shall recommend a one (1) year license.

STANDARDS REVIEW TEAM

The members of the Standards Review Team (SRT) for each program will consist of members who participate in the formal on-site review. OADAP reserves the right to adjust the size of the SRT as appropriate to conform to the size and complexity of the program under review. The SRT ordinarily will be composed of representatives from:

a) At least one team member from OADAP. If more than one member, one member will be designated as "team leader".
b) At least one team member from another treatment program, as selected by OADAP. Representative(s) from other organizations or agencies may be selected as deemed appropriate by OADAP.

The program to be reviewed will be notified prior to the licensure review as to the composition of the SRT. If, for a valid reason, the program objects to a particular team member from another treatment program, OADAP may select a different member.

The minimum requirements for a SRT Member from another treatment program are:

a) A minimum of three (3) years experience in program administration and/or substance abuse treatment.
b) The SRT member must not be a current or former employee or client of the program to be reviewed.
c) The SRT member must currently hold a license or certification that would allow the signing of comprehensive treatment plans as specified in the Standards.
d) Peer Reviewer information will be forwarded for background check thirty (30) day's prior to a review at the Department of Corrections.

Note: A SRT member reviewing only administrative functions is not required to hold the credentials specified in item "c" above.

FORMAL LICENSURE REVIEW

The SRT shall make a formal on-site review. Minimally, OADAP shall inspect the facilities prior to the expiration of the program's license. OADAP may extend a program's license for no longer than six (6) months. The licensure review will include examination of program documents and records, client case records, fiscal audits, interviews with staff and clients (in accordance with confidentiality laws) and interviews with various community agencies/individuals. Other sources may be used to determine compliance as

applicable. OADAP reserves the right to contact former clients of the program under review to determine compliance with applicable standards.

Prior to the exit interview, there will be a meeting of the SRT members. During the meeting, each member will present his/her findings and recommendations on the area(s) assigned to him/her. All areas in terms of strengths, weaknesses or deficiencies, as well as the decision of compliance on each applicable standard will be discussed and evaluated.

EXIT INTERVIEW

Following the SRT meeting, the SRT will meet with the Chief Executive Officer, Program Director or Clinical Director, and at least one (1) member of the Governing Board (if applicable). The team members will present the review findings. The purpose of this meeting will be to discuss and clarify the findings and recommendations noted by the team members. The Director of the OADAP will make the final determination as to whether licensure will be granted.

LICENSURE DETERMINATION

Within fifteen (15) working days of the last day of the on-site review, a written report will be completed by the SRT team leader and forwarded to the Program Director. Based upon this report OADAP shall award the appropriate type of license.

OADAP reserves the right to contact the clients of licensed programs to aid in the determination of compliance with specific standards. OADAP reserves the right to conduct a full licensure review prior to the expiration of the program's current license. In addition, OADAP reserves the right to use peer reviewers, as deemed appropriate, to assist in audits, client record reviews, investigations or other monitoring/compliance processes.

LICENSURE REVOCATION

OADAP may at its discretion revoke the operational permit of any program applying for licensure unable to meet compliance with the Standards for licensure. OADAP shall also initiate action to revoke the license of any program found not to be in full compliance with the Standards.

COMPLIANCE REVIEW

In addition to the licensure review, OADAP will conduct, at least two (2) announced or unannounced compliance reviews. A compliance review will primarily consist of a case record review, but could include the review of any or all of the Standards. Opioid Treatment programs will receive unannounced reviews, at least quarterly, to determine the program's ongoing compliance with opioid treatment specific standards.

ADMIS COMPLIANCE

All alcohol and other drug abuse treatment programs in Arkansas are required to report client-related data in accordance with the requirements of the current ADMIS. For acute care, hospital based alcohol and drug abuse treatment programs, failure to report may result in notification to the Arkansas Department of Health, Division of Health Facility Services, of failure to comply with requirements of Act 25 of 1991. Licensure awarded automatically pursuant to Act 173 of 1995 shall not be affected by failure to report. For all other treatment programs, failure to report may result in the loss of OADAP required licensure.

TYPES OF LICENSES

Six-Month Operational Permit

If the program seeking licensure is not currently licensed, OADAP staff, along with any appropriate outside agencies, shall perform an initial licensure review of those Standards applicable to programs not currently licensed. If the program is in substantial compliance with all applicable Standards, as determined by OADAP staff at the time of the review, then OADAP will issue a six (6) month operational permit. No later than six (6) months after the according of the permit, a formal review with a SRT will be performed to determine the program's level of compliance with all applicable standards. A one-time six (6) month extension of the operational permit will be considered for extenuating circumstances.

One-Year License

Following completion of a licensure review by an SRT, a one-year license will be accorded to a program that previously held a six-month operational permit, if all applicable Standards are found to be in full compliance.

Three-Year License

All applicable standards must be in compliance at the time of the formal licensure review to be accorded a three-year license. A program operating under a one-year or three-year license may be accorded a three-year license.

Probationary License

A license can be revoked at any time OADAP determines (by licensure or compliance reviews), that a program is not in compliance with the licensure standards. A six-month probationary license will be accorded to allow the program to bring the program into full compliance with the Standards. The probationary license shall not exceed six months from the date of its issue. Any programs issued a probationary license shall submit a corrective action plan to the Director of Program Compliance and Outcome Monitoring within thirty (30) calendar days from receipt of the probationary license. Once in compliance, they will be accorded a one-year license, and continue to operate.

If the program fails to fully comply with applicable standards, during the probationary period, and fails to bring standards into full compliance prior to the end of the six-month period and formal review, that would allow a one-year license, then the program will become non-licensed (see next page).

The program may request that the review be performed prior to the end of the probationary license. Programs with a probationary license shall not receive an extension.

Non-Licensed
Programs failing to comply with all applicable licensure Standards after the expiration of a six-month operational permit or a probationary license shall receive a non-licensed status. Programs receiving a non-licensed status shall not be allowed to operate as an alcohol or other drug abuse treatment program in the State of Arkansas. Programs receiving a non-licensed status shall wait a minimum of six (6) months before they can apply for a six-month operational permit.

CARF, JCAHO AND COA ACCREDITED PROGRAMS

Programs meeting the alcohol and drug abuse treatment standards of the Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission on the Accreditation of Health Care Organizations (JCAHO), or the Council on Accreditation (COA) shall automatically receive OADAP licensure as licensed alcohol and drug abuse treatment programs provided they also met Licensure Standards for Alcohol and/or Other Drug Abuse Treatment Programs in the following areas:

(1) Treatment Plan development
(2) Progress Note development
(3) Treatment Plan reviews
(4) Clinical Supervision
(5) Health and Safety issues
(6) Physical Plant requirements

The license shall be awarded by the office upon presentation by the program of evidence of accreditation by JCAHCO, CARF, or COA and verification of compliance of the above listed areas by the office personnel. This subsection does not apply to methadone treatment programs operating in the State of Arkansas. All methadone treatments programs shall be licensed by the office.

APPEAL PROCESS

If, for any reason, a program does not agree with the licensure decision, the program may appeal the adverse decision in accordance with the provisions of section VII, 6.00, Appeal Process for adverse action, set out in the Rules of Practice and Procedure. Written

notification must be received by the Chairperson of the Arkansas Alcohol and Drug Abuse Coordinating Council, no later than thirty (30) calendar days after the program's receipt of the licensure decision.

The appeal must contain:

1. A statement of the specific action which is being appealed.
2. The reason the licensure applicant believes the adverse action was incorrect.
3. The specific outcome requested.

When the written appeal is received, the Chairperson of the Alcohol and Drug Abuse Coordinating Council will establish a date for the administrative hearing and notify the parties in writing. All hearings shall be conducted in accordance with the Arkansas Administrative Procedures Act codified at A.C.A. § 25-15-201 et seq.

Compliance required: As a condition of the Office of Alcohol and Drug Abuse Prevention, licensed programs must comply with all laws, rules and regulations regarding alcohol or drug treatment. Programs licensed under theses standards are not authorized to provide educational services to DUI/DWI offenders. In order to provide theses services, programs must be an OADAP contracted alcohol education program.

LICENSURE STANDARDS FOR ALCOHOL AND OTHER DRUG ABUSE TREATMENT PROGRAMS

GOVERNING BODY (GB) - The governing authority or legal owner of a program has the primary responsibility to create and maintain the organization's core values and mission via a well-defined and annually updated strategic plan which sets out authority over and responsibility for all programs. The authority shall ensure compliance with all applicable legal and regulatory requirements and supervise the recruiting of staff members that are competent and representative of the specific cultures and populations served. The governing body shall advocate for needed resources to carry out the mission of the organization and actively collaborate with the management staff to ensure the success of day to day operations.

GB1 There shall be a governing body which has the ultimate authority for the overall operation of a program, which is one of the following as verified by the program's articles of incorporation:

a. A public, non-profit organization; or
b. A private, non-profit organization; or
c. A private, for-profit organization; or
d. A foreign corporation authorized to do business in Arkansas

GB2 Each program shall have a governing body or other responsible person that is accountable for the development of policies and procedures to guide the daily operations. If a program is governed by a board of directors, minutes and records of the board of directors meetings shall document that the program administrator has reported to the governing body or its designated representative a minimum of four times per year.

GB3 Each program shall retain written documentation that describes the means by which the governing body shall maintain written documentation for all of the following:

a. The election or appointment of its officers and members;
b. The orientation of new governing body members and any subsequent training;
c. The appointment of committees as necessary to effectively discharge responsibilities;
d. The scheduling of meetings; and
e. Determination of quorum requirements; and, keeping minutes of all meetings;

GB4 The governing body shall hold meetings and keep minutes that include:

a. Date(s);
b. Names of the members attending;

c. Summary of discussion;
d. Actions taken;
e. Target dates for implementation and recommendations;
f. The minutes shall be signed by a member, as designated by the governing body; and
g. The minutes shall be available to staff, persons served and the general public upon request (applies to non-profit organizations only).

GB5 The governing body for the organization shall:

a. Delegate a Chief Executive Officer for the program that is not a member of the governing body (applies to non-profit organizations only);
b. Prohibit any employee from being a voting member of the governing body;
c. Delegate authority and responsibility to the Chief Executive Officer for the management of the program in accordance with established policy; and
d. Perform an employment evaluation of the Chief Executive Officer at least annually.

GB6 The governing body shall:

a. Maintain an authorized policy and procedures manual that describes the regulations, principles, and guidelines that determine the substance abuse treatment program operations;
b. Review and update the policy and procedures manual as needed, but at least annually (as verified in the board minutes);
c. This policy and procedures manual shall be made available to the public upon request (applies to non-profit organizations only).

PROGRAM PLANNING/EVALUATION (PP&E)

PP&E 1 A program plan will be developed and approved by the governing body which addresses outcome measures and includes:

a. A written statement of the substance abuse treatment program goals and objectives;
b. A written plan for implementation of the goals and objectives; and,
c. An organizational chart that includes the structure including lines of authority, responsibility, communication and staff assignments.

PP&E2 The Governing Body will evaluate the plan annually based on the goals and objectives of the program. This includes operational definitions of the criteria to be applied in determining achievements of established goals, objectives and a mechanism for:

a. Assessment of the progress toward attainment of the goals;
b. Documentation of program achievements not related to original goals;
c. Assessing the effective utilization of staff and program resources;
d. Documentation verifying the implementation of the evaluation plan; and
e. Identify the results of the evaluation process.

FISCAL MANAGEMENT (FM) - The Governing Body shall oversee the management of a program which maintains a comprehensive written schedule of service fees and charges and which offers a reasonable payment plan that takes into account the clients' income, resources and dependents. This will be reviewed and approved annually by the governing body and shall be accessible to the public (applies to non-profit organizations only).

FM1 The Governing Body shall ensure that the program has liability insurance that provides for the protection of the physical and financial resources of the program:

a. To cover its clients, staff and general public;
b. To include coverage of the building, equipment, and vehicles; and
c. If part of a governmental agency, in lieu of liability insurance, the program has other proper means of protection for the items specified.

FINANCIAL EVALUATION (FE) - Each client shall receive a financial evaluation that includes all sources of income. The sources shall be verified and documented. Sources must include all household income (i.e. public assistance, retirement, social security and VA). If specific amounts are unavailable, averages or reasonable estimates may be used. A client's insurance coverage shall be documented.

ADMINISTRATIVE OPERATIONS (AO) - The program shall have written policy and procedures with supporting documentation for all the following:

AO1 Ownership Change. The program shall provide written notification to OADAP at least thirty (30) calendar days prior to any change of name, ownership, location, control of the facility, or make major programmatic changes using the OADAP form (see Addendum 1).

AO2 Access Policy. The program has a policy defining the program's areas that may be accessed by clients and visitors that includes medication areas, dispensing and food preparation areas.

AO3 Directory. The program shall maintain a log of all visitors to the program to protect client confidentiality in accordance with 42 CFR Part 2.

AO4 Tobacco Products. The program shall have a written policy and procedure prohibiting the use of any tobacco products within the facility in accordance with the Arkansas Clean Indoor Act of 2006. If the program provides a designated smoking area it shall be located a minimum of 25 feet from any entrance to the facility and shall not be in a common area that non-smoking individuals must transverse to gain access into the facility. In addition the program shall prohibit the use of alcohol, tobacco and illicit drugs by staff which includes:

a. Providing, distributing, or facilitating the access of tobacco products to clients;
b. Use of tobacco products in the presence of clients or visitors; and
c. Prohibits the public display of tobacco products by staff.

AO5 HIV/AIDS. The Program shall implement a written policy that states the Program shall not deny treatment to a person based on his or her actual or perceived sero status, HIV related condition or AIDS.

AO6 Advertising. The Program shall not use incentives or rewards or unethical advertising practices to attract new clients. This shall not forbid the Program from rewarding clients that maintain exemplary compliance with program rules and their individualized treatment plans.

AO7 Privacy. The private counseling area used provides sufficient privacy to maintain confidentiality of the communication between counselor and client. A private meeting area shall be available for clients to meet with their legal representatives, service providers, family members or persons providing assistance in attaining treatment goals.

AO8 Emergency/Natural Disaster. The program shall develop written policies and procedures for continued safety and treatment of clients in the event of an emergency or natural disaster. Emergency policy and procedures are readily available to all staff; the program has a written internal disaster plan which includes the training of staff in disaster and evacuation procedures, a list of alternate resources and the monthly rehearsal of various disastrous scenarios of the procedure are documented.

AO9 Critical Care Referral. The program will have policies and procedures for referring clients for services needed at a critical care facility.

AO10 Workforce Safety. The program has implemented work practice controls and provided personal protective equipment to reduce exposure to bodily fluids through the normal performance of their duties.

AO11 Infection Control. The Program shall have written policies for infection control, which are in compliance with the Center for Disease Control and Prevention. Guidelines.

AO12 STD Control. The program shall have policies and procedures describing the programs services for HIV/AIDS, Sexually Transmitted Diseases (STDs), Tuberculosis (TB) and Hepatitis to include:

a. The provision of testing and treatment at the program or through a written referral agreement with a medical entity qualified to provide such services;
b. Testing shall be available to all clients upon request;
c. All testing shall be voluntary;
d. All clients shall receive HIV/AIDS, STD, Hepatitis and TB education per admission; and
e. There will be documentation of all above.

AO13 Client Handbook. The Client Handbook shall clearly state that the program shall not be held responsible for any medical costs incurred by clients or children occupying the program and transported to medical appointments. The provider's responsibility is limited to arranging for the clients to access these services and providing transportation for them.

AO14 Grievance Policy. The Program shall have a grievance policy which states that there is a reasonable, specific deadline for completing the grievance process. At the program level, once received, client grievances must be reviewed and a decision reached in accordance of the program's policies and procedures. Grievances to be reviewed by the governing board shall be heard no later than the board's next scheduled meeting.

AO15 The program will maintain a publicly listed or local telephone number.

AO16 Hours of operation are scheduled to make services accessible to clients and the general public.

AO17 There shall be no less than one (1) staff on duty at all times per twenty-five (25) clients, per physical site. (Not Applicable to Criminal Justice System).

AO18 There shall be no less than one (1) treatment staff per twenty (20) clients during scheduled treatment activities.

AO19 A counselor's caseload shall not exceed the 25 to one (1) client/counselor ratio in a residential setting.

AO20 The program has at least one staff person present during operating hours who maintains a valid certification in First Aid, Cardio-Pulmonary Resuscitation (CPR) and Non-violent Crisis Prevention and Intervention (NCPI). All Specialized Women Services programs will have at least one staff person who is certified in child and infant CPR. This documentation will be verified by the staff member's personnel record.

AO21 The program has procured an agreement with a mental health provider licensed or certified in the State of Arkansas to provide consulting services for dually diagnosed treatment applicants or clients. The agreement must be updated every two years.

AO22 The program maintains a comprehensive resource directory (updated every 2 years) of local community and government agencies within the service area which contains at least:

a. The name and location of the resources;
b. The type of services provided by the resource;
c. The eligibility criteria for the resource; and
d. The phone number(s) and name(s) of the contact person(s).

AO23 Documenting outreach and referral activities necessary to educate judges, prosecuting attorneys, law enforcement personnel, community service providers, substance abuse treatment programs, and the public as to the operations of the program.

AO24 The program will provide written referral to or coordinate introduction of available resources and services through community and government agencies that will assist with specialized needs to maintain a continuum of client care. These agreements shall include:

a. The services the resource agrees to provide;
b. The duration of the agreement;
c. The procedures to be followed in making referral;
d. A statement of conformity to federal, state, and program confidentiality requirements;
e. Date, time and signatures of both parties; and
f. The agreements must be updated every two years.

AO25 Services are available to provide a variety of diagnostic and primary substance abuse treatment on both a scheduled and non-scheduled basis. Services provided by the program include, but are not necessarily limited to the following:

a. Case management;
b. Orientation to the program's operations and procedures;
c. Screening of applicants for substance abuse treatment service for referral, or treatment purposes;
d. Individual, group and family counseling sessions;
e. Crisis intervention; and
f. Interdisciplinary treatment services.

AO26 Residential services are provided seven (7) days per week, 24 hours per day and provide;

a. A minimum of twenty-eight (28) hours of structured treatment weekly
b. A minimum of five (5) hours daily (Monday through Friday) and
c. A minimum of three (3) hours daily on Saturday and/or Sunday.

(See Definitions Section for an explanation of "structured treatment.")

AO27 Partial day treatment programs provide services at a minimum of four (4) hours per day and at least five (5) days per week.

AO28 Protocol for administrative discharge to include: threats of violence or actual bodily harm, disruptive behavior, sexual misconduct, loitering, sale, purchase or use of drugs or alcohol, continued unexcused absences from counseling.

AO29 When a program determines to administratively discharge a client, the program shall provide a written statement containing:

a. The reason(s) for discharge;
b. Written notice of his or her right to request review of the decision by the Program Director or his or her designee; and
c. A copy of the appeal procedures.

HUMAN RESOURCES (HR) - The Governing Body shall ensure that the program has written personnel policies and procedures that apply to employees and those working under the supervision of individuals employed by the program (i.e. contracted workers, interns, volunteers, visitors). These shall include but not be limited to the following:

HR1 Ensure compliance with all legal, ethical, and regulatory codes in accordance with Title VI/Title VII of the 1964 Civil Rights Law, Equal Employment Opportunities Commission (EEOC) (race, color, sex, religion, national origin, age or disability).

HR2 Prohibiting harassment of any nature including that of race, color, religion, age, sexual orientation, physical or mental disability and unwanted sexual advances.

HR3 The program shall designate an employee who will monitor the programs compliance with the Americans with Disability Act (ADA), and educate all staff.

HR4 Consequences for unethical conduct and violations of the harassment policy will include:

a. Steps for reporting violations;
b. Process for investigating allegations; and
c. Disciplinary process for violations.

HR5 Background investigations shall be required for all staff that have direct contact with clients or client records. Results will determine eligibility for employment in accordance with program policies.

HR6 A program cannot employ any person currently receiving substance abuse treatment services. This also prohibits the use of clients to monitor the program.

HR7 Former substance abuse clients shall not provide direct treatment services for 12 months after their discharge from substance abuse treatment.

HR8 An employee assistance program or provisions for referral to such services must be available.

HR9 Employee grievance protocol which is reviewed, updated and approved annually by the governing body. Documentation of employee grievances shall be confidential and shall be stored separately from personnel records.

HR10 Personnel shall meet all local, state, or federal legal requirements for their position. (e.g. licensing and certification)

HR11 All non-certified or non-licensed staff, including volunteers, providing counseling and treatment related services, shall be registered with the Arkansas Substance Abuse Certification Board (ASACB). An exception is granted for those staff involved in an internship or practicum from another human services or behavioral discipline.

HR12 Students or interns shall be supervised by a paid staff member and shall not be used to supplant direct treatment service employees.

HR13 A Counselor in Training (CIT) shall provide evidence that a minimum of thirty (30) clock hours of continuing education is obtained per year toward the certification process.

HR14 CITs providing direct treatment services must be receive at least one hour of individual supervision or ninety minutes of group supervision weekly. Such supervision must be documented and must be performed by persons authorized to approve treatment plans, as specified in this manual.

HR15 Policy includes a specific process for completion of a comprehensive evaluation of personnel performance on at least an annual basis for all staff.

HR16 The process for evaluation of personnel performance requires a written report and requires documentation that the evaluation is reviewed with the employee.

HR17 The program has established an appropriate staff development plan for all employees and volunteers. The plan is to include:

a. An orientation program for each staff person, which includes a documented review of the program's policies and procedures;
b. A training program based upon the identified needs of staff, volunteers (volunteers working less than ten hours monthly are exempt) and designated staff development representative. The needs are identified and documented at least annually. The plan must include staff signatures; and
c. Employees signature.

HR18 Personnel records will be kept on all employees, volunteers and professionals contracted to provide direct treatment services that contain at least:

a. Job descriptions for all positions will be reviewed annually and include:

(1) Qualifications to include, education, experience, licensing and certifications relevant to the position;
(2) Reporting supervisor's position;
(3) Position(s) supervised; and

(4) Duties and responsibilities.

b. Application/resume;
c. License/certification, where applicable;
d. Proof of Professional liability insurance (if required by license/certification)
e. Verification of academic records (when required by job descriptions);
f. Results of criminal background checks, if required for the position;
g. A signed statement acknowledging receipt and compliance with the following:

(1) Confidentiality of Alcohol and Drug Abuse Patient Records (42 C.F.R. Part 2);
(2) Health Insurance Portability and Accountability Act (HIPPA) (45 C.F.R. Parts 160 and 164);
(3) Client Rights as listed in these standards;
(4) Program Policy and Procedure Manual;
(5) Employee assistance plan;
(6) Emergency Policies;
(7) Organizational chart;
(8) Job Description; and
(9) Annual employee evaluation.

HR19 Employee records are stored in a secure and confidential place.

CLINICAL PROCEDURES (CP) - The program will have written policy and procedure for the following:

CP1 The Program shall comply with state and federal regulations governing confidentiality of alcohol and drug abuse client records and other client identifying information. Existing federal regulation include the Health Insurance Portability and Accountability Act and 42 CFR, Part 2. Both regulations provide for safeguarding files or other client identifying information from disclosure or access by unauthorized individuals, and require that records be maintained in a secure manner. OADAP shall review records for the purpose of monitoring execution of the policies and standards required by these regulations.

CP2 Documentation shall not contain slang, technical jargon, or abstract terms.

CP3 Errors in the treatment chart should never be corrected with "white-out" or Marker, by pasting paper over the error or by any other method, which would obliterate the original words. When an error is corrected, the original text must remain readable. A single line is to be drawn through the error, the correct information added with the date and initials of the person making the correction.

CP4 No documentation shall be signed and dated prior to completion;

CP5 The program's treatment services, lectures, and written material shall be appropriate to the clients served, age-appropriate and easily understood by clients.

CP6 There is documentation of planned programs, consistent with the needs of the clients, for social, educational, and recreational activities for all clients for daytime, evenings and weekends.

CP7 The program shall retain all documentation for at least six (6) years and shall ensure that all individual client records are disposed of in a secure manner. The written policies and procedures shall ensure:

a. The program exercises its responsibility for safeguarding and protecting loss, tampering, or unauthorized disclosure of information, and the file cabinets and files are marked "CONFIDENTIAL;"
b. Client case records are readily accessible to those individuals specifically authorized by program policy.
c. Content and format of client records are kept uniform;
d. Entries in the client record are signed, dated and time noted;
e. Client records which are part of an unresolved audit, investigation or other legal process shall be maintained for a minimum of six years or at least until the audit, investigation or other legal process is resolved;

f. Forms in each client record are bound in such a manner to minimize accidental loss;
g. Allergies and/or other serious conditions are "flagged" on the outside of the record;
h. The Program shall make records available to OADAP upon request; and
i. Each new admission, readmission or transfer admission is interviewed and the interview is documented in the client record.

CP8 The program has standardized screening protocol to determine applicants eligibility and appropriateness for admission to treatment.

CP9 The program has a uniform intake process and documentation shall include:

a. The types of information to be gathered on all clients;
b. Procedures to be followed when accepting referrals;
c. Offering case management, withdrawal risk assessment, outpatient services, education, and referral to another licensed program when the program is at full capacity; and
c. Procedures for the provision of emergency services (i.e. after hour admission, medical emergencies) and other special circumstances.

CP10 A client handbook is made available to all clients and a receipt must be in the client record. The client handbook shall include the following:

a. A written statement of the services provided by the program and a description of the kinds of problems and types of clients the program can serve;
b. A written statement describing admission and discharge procedures;
c. A written statement describing living conditions and standards of behavior expected;
d. The organization's client grievance process.

CP11 Personal Property Inventory shall be taken upon admission to a residential environment. Items of value shall be securely stored by the program at the request of the client. The inventory list will include the stored items, date received and returned, and signatures of staff and client.

CP12 The program shall provide a specialized plan for treatment by assessment and then addressing the specialized needs of each client of the program.

CASE MANAGEMENT (CM) - The program shall assure that the following services are provided to the clients:

CM1 Arranging and facilitating for the provision of all services as documented in the treatment plan.

CM2 Holding regular, and as needed, meetings with the client to monitor and reevaluate the individualized comprehensive plan.

CM3 Holding regular, and as needed, meetings with the program staff and others involved in the delivery of services to the client to monitor and evaluate progress.

CM4 Maintaining records of other documentation of all services delivered to the client.

CM5 Developing an aftercare plan with the client prior to discharge.

SCREENING AND INITIAL ASSESSMENT (SA)

SA1 A pre-admission screening shall be used to determine a client's eligibility and appropriateness. It is to include:

a. Substance Use History;
b. Current detoxification level determination;
c. Past psychiatric treatment;
d. Past chemical dependency treatment;
e. Significant medical history;
f. Current health status;
g. Current medications;
h. Known food allergies;
i. Known drug allergies; and
j. Current emotional state and behavioral functioning.

SA2 Documentation of client information and history is to include:

a. Confirmation of identity;
b. Name, address (street and number, town, county, state, zip), phone, current housing arrangements, guardianship (if applicable), photograph of client, social security number;
c. Client's date of birth, sex, race or and ethnicity;
d. Name of referral source. Document if treatment was mandated by the referral source;
d. If treatment was mandated, the complete address and telephone number of the referral source. Documented conditions of referral and/or information needs of the referral source;
f. Types of problems experienced by the client that are in need of resolution;
g. Substance abuse history to include most recent use patterns (amount per type, route of administration) ages of first use per substance and age of regular and/or addictive patterns. Document any injection use;
h. Document the client's family history to include current marital status, effect of substance use on current and past relationships, history of family members' use, any family members "in recovery", names and ages of dependents and who has custody of dependents while the client is in treatment;
i. Client's highest grade completed, major (if applicable), effect of substance use on the client's educational process. The client's reading and writing levels must be evaluated when appropriate;
j. Current/most recent vocations, any trained skills, effects of substance use on employment, adequacy of current employment;
k. Legal history, which includes the dates and type of charges, arrests, convictions and sentences;

l. Medical and health history to include chronic medical problems, significant medical/physical events, problems that could influence treatment, medical conditions that could prompt a crisis, special diet needs, current medications (does client have sufficient supply during treatment), purpose of current medications, history of alcohol or other drug related conditions (i.e. blackouts, DT's, etc.), "at-risk" behaviors (multiple sex partners, unprotected sex), pregnancy status, allergies. (allergies and/or other serious conditions are "flagged" on the outside of the record);
m. Medication records for both prescriptions and over the counter medications. Drug type, dosage strength, how many, time/date of dispersion, which dispensed/witnessed dosing;
n. Psychological/psychiatric treatment history to include dates of any treatment, type of problem(s), who provided treatment, outcome of treatment, any current psychotropic medications;
o. Other relevant information to include military service (branch of service, dates of service, discharge status, highest rank, classifications, and any combat experience), copies of court or parole orders, and other information that will aid in assessing the client;
p. A completed Addiction Severity Index (ASI). When applicable, results of other tests or standardized assessment tools;
q. Re-admissions and transfers to another environment are clearly delineated;
r. Summary of client problems and corresponding needs, as based on client information;
s. Summary of the client's strengths and weaknesses, as based on the client information; and,
t. Based upon the assessment each client will be assigned a Diagnostic and Statistical Manual for Mental Disorders (DSM), substance abuse disorder diagnosis and code.
u. Only staff authorized to approve comprehensive treatment plans as specified in this manual will assign the diagnosis code.
v. Counseling personnel registered as Counselors in Training with the Arkansas Substance Abuse Certification Board may assign the diagnosis provided the diagnosis is approved, in writing, by personnel authorized to sign comprehensive treatment plans. The diagnosis and code will meet the current substance abuse disorder criteria as per Diagnostic and Statistical Manual of Mental Disorders.

SA3 An assessment to determine severity and environment placement to include a completed Addiction Severity Index (ASI) for adults or an equivalent assessment tool for adolescents is to be completed within 72 hours of admission. When applicable, results of other tests or standardized assessments, including the ASAM patient placement criteria or other nationally recognized placement tool must also to be included.

INITIAL TREATMENT PLAN - The initial treatment plan is to be developed and implemented within twenty-four (24) hours, based on assessments that determined all immediate problems and needs such as; medical condition, nutrition, clothing, personal hygiene, legal issues and emergency contacts and the actions taken to meet those needs.

COMPREHENSIVE (MASTER) TREATMENT PLAN (CTP)

CTP1 The comprehensive treatment plan is to be developed and implemented no later than seven (7) days from admission to residential services and partial day treatment and no later than twenty-one (21) days from admission to outpatient services and is to include:

a. A clear and objective statement of the client's needs to be addressed;
b. Clearly stated and goals and objectives that the client is capable of understanding;
c. The means of achieving each goal is documented;
d. The method and frequency of treatment per goal or objective are documented;
e. The projected date of completion, per goal, is documented;
f. The staff person responsible for carrying out the treatment plan is specified; and
g. The CTP is signed and dated by both the counselor and client

CTP2 All comprehensive treatment plans are reviewed and approved by one of the following, as licensed or certified in the State of Arkansas:

a. Advanced Certified Alcohol and Drug Counselor,
b. Certified Alcohol and Drug Counselor,
c. Certified Clinical Supervisor
d. Licensed Marriage and Family Therapist,
e. Licensed Clinical Social Worker;
f. Licensed Master Social Worker;
g. Licensed Physician;
h. Licensed Psychologist;
i. Licensed Professional Counselor;
j. Licensed Psychological Examiner;
k. Licensed Alcoholism and Drug Abuse Counselor;
l. Licensed Associate Alcoholism and Drug Abuse Counselor;
m. Certified Criminal Justice Professional (applies to ADC and DCC only);
n. Certified Co-Occurring Disorder Professional – Diplomat; and
o. Certified Co-Occurring Disorder Professional – Bachelor

CTP3 The client's progress in meeting treatment plan goals is reviewed no later than every seven (7) days in the residential environment (unless clinically contra-indicated) and every ninety (90) days in an outpatient environment. The

review must be approved by an individual specified in “CTP2” above; (Not Applicable to Criminal Justice System).

CTP4 The client’s progress in meeting treatment plan goals will be assessed at the time of discharge.

PROGRESS NOTES (PN)

PN1 Progress notes shall contain: the date and time the session ended: the purpose of the session; topics discussed; client behavior and response to the treatment provided during the session; significant events; and the name, signature and title of the staff person conducting the session.

PN2 Group and individual treatment sessions progress shall be documented per session.

PN3 Outpatient treatment is documented per session.

PN4 Partial day treatment notes contain information required by but may be compressed into a single note that addresses treatment provided on a per day basis.

PN5 Residential treatment shall be documented at least daily.

PN6 The client's progress in meeting treatment plan goals will be assessed at the time of discharge.

PN7 Significant client events that fall within the provisions of the "Incident Reporting Policy" shall be documented as soon as possible after the event. The administration of first aid to a client shall be documented as soon as possible. Any client behavior that could lead to a disciplinary action shall be documented as soon as possible. Any other event, that could effect the client's treatment, shall be documented as soon as possible.

PN8 When a client refuses to divulge information and/or follow the recommended course of treatment, this refusal is noted in the case client record.

PN9 When a client transfers from one program to another, the transferring program shall send copies of the transferring client's records to the licensed receiving program prior to admission.

AFTERCARE PLAN (AP)

AP1 The aftercare plan will be written one-week prior to target date of completion. The aftercare plan, implemented at discharge, shall minimally contain: a summary of client needs not treated; established goal(s) that address the untreated needs; and the means by which the goals will be met;

a. The staff person responsible for the aftercare plan is documented;
b. There is evidence of the client's participation in, and understanding of the treatment and aftercare planning process (client's signature);
c. Upon request by the client, the program shall provide a copy of the plans to the client.

AP2 Discharge Summary shall include but not be limited to the date, time, conditions of discharge, environmental change, client's perception of treatment offered, referrals made, date and signature, and credentials of staff.

AP3 The program shall have written policy and procedure denoting protocol for discharging clients abruptly to ensure the safety and welfare of clients during discharge. Documentation for such discharges shall include:

a. Reason for discharge;
b. Staff present at time of discharge;
c. All actions taken by program to remedy the situation to avoid discharge;
d. Notification of persons listed on emergency contact list;
e. Signed statement that personal property and medications has been returned to client upon discharge;
f. The transportation arrangement assistance offered, available and the method ultimately taken.

AP4 In the case where a client is discharged against medical advice, for non-compliance or in abstentia the program shall document that the Aftercare Plan has not been developed for these specific reasons.

CLIENT CONFIDENTIALITY (CC)

CC1 There are written policies and procedures for the protection of client's privacy with regard to program visitors which require:

a. The clients are informed in advance of scheduled visitations; and
b. Visitations are conducted when they will minimally interrupt the client's usual activities and therapeutic programs.

CC2 A client's authorization shall be obtained before releasing information. A proper consent form must be in writing and contain the following items:

a. The name or general designation of the program(s) making the disclosure;
b. The name of the individual or organization that will receive the disclosure;
c. The name of the client who is the subject of the disclosure;
d. The purpose or need for the disclosure;
e. A description of how much and what kind of information will be disclosed;
e. The clients right to revoke the consent in writing, and the exceptions to the right to revoke or, if the exceptions are included in the program's notice, a reference to the notice;
g. The program's ability to condition treatment, payment, enrollment or eligibility of benefits on the client agreeing to sign the consent, by stating either that the program may not condition these services on the client signing the consent, or the consequences for the client refusing to sign the consent;
h. The date event or condition upon which the consent expires if not previously revoked;
i. The signature of the client (and/or other authorized person); and
j. The date on which the consent is signed.

CC3 The program has written procedures for responding to requests for confidential client information when presented with telephone inquiries; written inquiries; subpoenas; court orders; search warrants; arrest warrants; and for reporting child abuse.

CC4 Every authorization for release of information becomes part of the client's permanent case record; and, according to HIPAA programs, must provide client with copies of all signed authorizations.

CC5 In a life-threatening situation or where an individual's condition or situation precludes the possibility of obtaining written consent, the program does allow for the release of pertinent medical information to the medical personnel responsible for the individual's care without a client or applicant's

authorization, and without the authorization of the Chief Executive Officer or his or her designee, if obtaining such authorization would cause an excessive delay in delivering treatment to the individual.

CC6 In the event information has been released without the individual's authorization, the staff member responsible for the release of information enters into the individual's case record all details pertinent to the transaction, including at least: the date the information was released; persons to whom the information was released; the reason the information was released; the nature and details of the information given.

CC7 The client or applicant is informed that the confidential information was released as soon as possible after the incident occurs.

CLIENT RIGHTS (CR)

CR1 There are policies and procedures to inform all clients of their legal and human rights. At the time of admission, each client shall be informed of his or her rights in a language that he/she understands, and shall receive a written copy of these rights, which shall include:

a. To be fully informed, as evidenced by a client's written acknowledgment, of the rights, responsibilities, rules and regulations that apply to the client's conduct and the consequences of non-compliance;
b. To the receipt of adequate and humane services, regardless of sources of financial support;
c. To the receipt of services within the least restrictive environment possible;
d. To receive an assessment that is used to develop an individual comprehensive treatment plan;
e. To participate in the planning of his/her treatment plan and to treatment based on same;
f. To a periodic staff review of the client's treatment plan;
g. The right to access or amend their individual client record in accordance with the HIPAA laws.
h. To an adequate number of competent, qualified and experienced professional clinical staff to implement and supervise the treatment plan;
i. To be informed of treatment alternatives or alternative modalities;
j. To be encouraged and assisted throughout treatment to understand and exercise his/her rights as a client and a citizen, including:

    (1) The right to report any cases of suspected abuse, neglect, exploitation of clients being served in the program, in accordance with applicable State law and abuse reporting procedures;
    (2) The right to a grievance and appeal process;
    (3) The right to recommend changes in policies and services;

k. To be informed regarding the financial aspects of treatment, including the consequences of nonpayment of required fees;
l. To be informed of the extent to and limits of confidentiality, including the use of identifying information for central registry and/or program evaluation purposes;
m. To receive a copy of consent for a release of confidential information after the form is signed by the client.
n. To give informed consent prior to being involved in research projects.
o. To not be used for the solicitation of funds or other contributions by the program.
p. To communicate with family and significant others outside the program including:

(1) To conduct private telephone conversations with family and significant others, unless otherwise justified in the client's case record and explained to the client; and,

(2) To send and receive mail in uncensored condition. Mail may be inspected in the presence of a staff member.

q. To be informed if visitors are expected at the program;

r. Appeal treatment decisions made by staff in accordance with the programs grievance policy.

PHYSICAL ENVIRONMENT (PE) - The program will apply these standards to all sites operated by the program regardless of ownership. The primary concern of the program should always be the safety and well being of the clients and staff.

PE1 Programs are to ensure compliance with all local, state and federal laws and regulations regarding the condition and maintenance of its facility.

PE2 Provide evidence of current valid certifications, which are maintained on site of all applicable buildings, fire and safety, health, and all other applicable inspections. All items of concern noted in these inspections shall immediately be addressed/corrected.

PE3 Private residences shall not be used to provide treatment unless:

a. There is a separate entrance to areas in which services are rendered; and
b. Services are provided in an area used exclusively for treatment.

PE4 Provides adequate physical facilities for the storage, processing and handling of client records by means of suitable locked, secured rooms or file cabinets;

PE5 Maintain a suitably stocked first aid kit(s), with contents as defined in the program's policies and procedures at all sites.

PE6 Maintain fire extinguisher(s) that are accessible, in working order and have attached documentation of annual inspection;

PE7 Evacuation routes are prominently posted throughout all facilities;

PE8 All exits must be clearly marked.

PE9 The programs telephone number(s) and actual hours of operation will be posted at all public entrances.

PE10 Conspicuous warning signs must be posted at all public entrances informing staff, volunteers, clients and visitors as to the following requirements:

a. No alcohol or illicit drugs are allowed in the facilities;
b. No firearms, or other dangerous weapons, are allowed in the facilities with the exception of law enforcement while in the performance of their duties; and
c. The use of tobacco is not allowed in the facilities.

PE11 A copy of compliance with law Title VI/Title VII of the 1964 Civil Rights Law shall be prominently displayed for the viewing public.

PE12 Programs must provide a safe and sanitary environment.

PE13 Residential facilities shall:

a. Provide separate bedroom areas for males and females; adults and adolescents; (13 through 17 years of age)
b. Provide separate bathroom facilities for males and females; adults and adolescents; (13 through 17 years of age)
c. Provide adequate barriers to divide the population; as determined by the OADAP
d. Window coverings to allow for privacy;
e. Sufficient lighting so as to avoid injury;
f. Provide sufficient clean linens with covered storage; and
g. Sleeping areas shall have at least:

(1) Fifty (50) usable square feet per person in single occupancy rooms;
(2) Forty-eight (48) usable square feet per person in multiple occupancy rooms;
(3) Individual storage for clothes and personal items; and,
(4) Bedrooms used for detoxification must have single beds (no bunk beds allowed).

PE14 Adult clients shall remain separated from adolescent population during all times with the exception of mixed therapy sessions.

PE15 Programs will maintain this separation by any means necessary including a structural separation, continuous monitoring or any combination of efforts required to assure compliance with this standard.

PE16 Plumbing must be:

a. In working condition and to avoid any health threat; and
b. All toilets, sinks and showers shall be clean and in working order.

PE17 There shall be at least one toilet, one sink, and one shower or tub per every eight (8) residential clients.

PE17 Laundry facilities shall be available in the facility or on a contractual basis. When provided at the facility laundry rooms shall be kept separate from bedrooms, living areas, dining areas and kitchen.

PE19 Storage will be least twelve (12) inches above the floor.

PE20 A secure locked storage is available for client valuables when requested.

PE21 Separate storage areas are provided and designated for:

a. Food, kitchen, and eating utensils;
b. Clean linens;
c. Soiled linens and soiled cleaning equipment; and
d. Cleaning supplies and equipment.

PE22 When handling soiled linen or other potentially infectious material Universal Precautions are to be followed.

PE23 Hazardous and regulated waste is disposed of in accordance with federal requirements.

PE24 Poisons, toxic materials and other potentially dangerous items shall be stored in a secured location.

MEDICATION (MD) - If the program maintains, administers, or dispenses medications, the medication distribution services shall be in conformance with all appropriate state and federal pharmacy laws and shall adopt written policies and procedures for the following:

MD1 The documentation of handling; administration; observation and self administration; witnessed disposal process; medication errors, adverse reactions and use of medication. Chain of custody will be maintained at all times.

MD2 Medication Errors and Adverse reactions are to be reported to OADAP following the Incident Reporting Policy. OADAP will receive follow-up reports throughout the programs process of investigation and bringing the incident to a close.

MD3 A list of prescription medications and over the counter (OTC) medications to be kept in stock on units that dispense medication shall be developed.

MD4 Both lists will be developed in conjunction with the program's physician who shall sign and date denoting his approval. Any future additions/deletions must follow the same procedure.

MD5 The medication list shall be reviewed at least annually.

MD6 Programs who do not employ or contract with a Medical Doctor shall not maintain stocked prescription medications.

MD7 The program shall use an effective inventory system to track and account for all prescription medications.

MD8 A system is in place to monitor and to dispose of all outdated medication in compliance according to the program's disposal policy.

MD9 Medication orders may be given by telephone to licensed or registered nurse. The orders must then be signed by the authorizing physician ordering the medication within 72 hours.

MD10 Medications shall be stored at appropriate temperatures based on the manufacturer’s product inserts.

MD11 Medications requiring refrigeration shall be stored in a locked compartment separate from food.

MD12 External use medications in liquid, tablet, capsule or powder form shall be stored separately from medications for internal use.

MD13 Urine or blood samples shall not be stored with food or medicines.

MD14 The program shall keep all prescriptions and non-prescription medications, syringes and needles in locked storage.

MD15 Medications, syringes and needles shall be accessible only to staff who are authorized to provide medication

MD16 Used needles and syringes shall be placed in secure, rigid, puncture proof containers and disposed of according to OSHA's Hazardous Waste Standards.

FOOD AND NUTRITION (FN)

FN1 If the program prepares meals on site, the program shall have a current food establishment health inspection as required by the Arkansas Department of Health.

FN2 When meals are provided by a food service, a written contract shall be maintained and shall require the food service to have a current food establishment health inspection as required by the Arkansas Department of Health.

FN3 A licensed dietitian or certified dietary manager shall approve menus and written guidelines for substitutions in advance.

a. Approve a meal planning manual with sample menus and guidelines for substitutions;
b. Approve age appropriate menus and healthy food choices for children residing in SWS facilities;
c. Approve menus prepared by new staff before they plan meals independently;
d Review a sample of menus served at least annually; and
e. Provide kitchen staff training as needed.

FN4 The program shall provide modified diets to residents who medically require them as determined by a licensed dietitian or certified dietary manager. Special diets shall be prepared in consultation with a licensed dietitian or certified dietary manager.

FN5 The program shall provide at least three meals daily, with no more than fourteen (14) hours between any two meals.

FN6 Clients in a Partial Day Treatment setting shall be offered a minimum of one meal per day provided by the program.

FN7 Outpatient programs shall allow a meal break after five consecutive hours of scheduled activities.

FN8 All food shall be stored, prepared, and served in a safe, healthy manner;

FN9 Non-perishable items shall not be used that contain a sell by date that has expired by more than two years.

FN10 Perishable items shall not be used once they exceed their sell by date.

FN11 Documentation of a Negative TB test (with one year) will be required for all persons working in the kitchen or meal preparation environment.

FN12 All persons working in the kitchen or meal preparation environment shall wear hairnets and gloves.

FN13 If menu planning and independent meal preparation are part of the client's treatment program, a licensed dietician or certified dietary manager shall provide training or approve a training program for staff who instruct and supervise clients in meal preparation

FN14 The program shall define duties in writing and have written instructions posted or easily accessible to clients.

FN15 Clients in detoxification treatment shall not prepare meals.

DETOXIFICATION SERVICES (DS) - Programs funded by OADAP to provide Detoxifications Services shall in addition to the General Standards meet the requirements of the standards listed in Detoxification Services.

DS1 The Regional Alcohol and Drug Detoxification Program will not admit any client under 18 years of age.

DS2 While a client is in observation detoxification (with or without medical supervision), Medical Doctor(s), registered or licensed practical nurse or Regional Detoxification Specialists (RDS), must be present and specifically assigned to monitor the client on a twenty-four (24) hour basis.

DS3 Clients in detoxification services will receive three (3) meals per day, with no more than fourteen (14) hours between any two (2) meals. Their meals will be served separately from other residential clients. If eating in a common area, they will receive their meal prior to or after other clients have vacated the area.

DS4 Only an RDS, Medical Doctor, registered or licensed nurse are authorized to document progress notes, vital signs, fluid/food intake, withdrawal risk assessments and stabilization plans. All documentation is to include the authorized persons' signature and credentials.

DS5 An RDS must hold current certifications in the following;

a. Cardiopulmonary Resuscitation (CPR);
b. First Aid;
c. Nonviolent Physical Crisis Intervention (NPCI); and
d. Regional Alcohol and Drug Detoxification (RADD Training)

DS6 All staff assigned to monitor detoxification clients shall know the signs and symptoms of withdrawal, the implication of those signs and symptoms; and emergency procedures, as defined in facility policy and procedure manual.

DS7 Clients in detoxification services will have their vital signs taken upon admission and documented; and at least every two (2) hours thereafter, until within normal limits for eight (8) consecutive hours.

Exception: Once vital signs are within normal limits for eight (8) consecutive hours, they will be taken no less than every six hours. At this time, blood pressure, temperature and pulse may be omitted one (1) time per twenty-four (24) hour period; observation will continue as evidenced by documentation of reason for vital sign omission, client behavior observed and respiration count. (e.g. Vital signs completed at 10:00 p.m., description of behavior client exhibiting at midnight and resume vital signs at 2:00 a.m.);

DS8 Observation detoxification, with or without medical supervision, will include:

a. Gender separate sleeping areas with:

(1) One-level bed (no bunk beds);
(2) Individual storage for clothing and personal items;
(3) Window coverings to allow for privacy; and
(4) Sufficient clean linen

b. Gender separate bathroom/shower areas with:

(1) Sufficient lighting so as to avoid injury;
(2) Plumbing in working condition so as to avoid any threat to health; and
(3) Sufficient clean linen supply

DS9 A complete set of vital signs will include blood pressure reading (systolic and diastolic), temperature, pulse and respirations.

DS10 Once vital signs are within normal limits for eight (8) hours, they will be taken no less than every six (6) hours. There will be documentation in the client's case record verifying each vital sign taken during the client's stay in detoxification.

DS11 Oral fluids and food shall be easily accessible to clients.

DS12 There will be documentation of meals offered, consumed and/or refused; and the amount consumed or refused, every two (2) hours.

DS13 There will be documentation of consumption of oral fluids indicating amount offered, consumed, or refused, every (2) hours.

DS14 There will be documentation of reason for not offering nutrition. (e.g. client absent during meal time to see personal physician).

DS15 Medication that is prescribed to an individual for withdrawal must be documented in the withdrawal risk assessment, stabilization plan and progress notes.

DS16 A file will be maintained for each client, per admission; it will contain:

a. Proof of client identity;
b. A signed Voluntary Admission Agreement; or,

c. Involuntary Admission Agreement, as appropriate;
d. Consent to Treat Agreement signed prior to admission;

    (1) Must obtain signed, dated and timed consent, even if client is impaired by substance; and,
    (2) Must obtain another signed, dated and timed consent once said substance no longer impairs client.

e. The withdrawal risk assessment will be initiated on admission, completed and filed in the client record within four (4) hours of admission. If an emergency of the client's physical condition prevents documentation within four (4) hours, staff will explain the circumstances in the client record and obtain the information as soon as possible;
f. Qualified staff member(s) (physicians, registered and/or licensed practical nurses or Regional Detoxification Specialists) will perform withdrawal risk assessment; it will include:

    (1) Substance Use History;
    (2) Current Detoxification Level Determination;
    (3) Past psychiatric treatment;
    (4) Past chemical dependency treatment;
    (5) Significant medical history;
    (6) Current health status;
    (7) Current medications;
    (8) Known food allergies;
    (9) Known drug allergies;
    (10) Current living situation;
    (11) Current employment situation; and,
    (12) Current emotional state and behavioral functioning.

g. Completed and signed authorization(s) to release confidential information, as appropriate;
h. Medication records, as appropriate (In programs utilizing MD's, LPN, LPTN and/or RNs); Clients must provide all previously prescribed prescription medications during admission. All previously prescribed prescription medications must be documented in client file including: type of medication, amount/dosage, route in which medication is administered, how often medication is taken, medical condition for prescription, prescribing physician and count of medication provided at admission.
i. Personal Property Inventory, signed by staff or authorized agent, and client;
j. Confirmation of client receiving and understanding of handbook;
k. Confirmation of client receiving notice of Federal Confidentiality Regulations; to be signed when client is capable of rational communication;

l. A staff person, authorized by the program, will identify the client's short-term needs (based on the withdrawal risk assessment and medical history) and develop an appropriate detoxification plan (stabilization plan):

(1) An RDS, LPN, LPTN, RN or MD will sign the plan;
(2) The client will sign the detoxification plan, unless medically contraindicated; staff will explain the circumstances in the client record and obtain the signature as soon as possible;
(3) The completed and signed detoxification plan will be filed in the client record within eight (8) hours of admission;
(4) The program will review and, if necessary, revise the detoxification plan (stabilization plan) every twenty-four (24) hours or more often, should client need(s) change significantly;
(5) The program will implement the detoxification plan (stabilization plan) and document the client's response to interventions in the progress notes.

m. Progress notes in detoxification will be documented every two (2) hours until stable for eight (8) hours (additional notes will be documented as appropriate) and will include:

(1) The client's physical condition observed by staff (signs);
(2) Client statements about the client's condition (symptoms);
(3) Client statements about their needs;
(4) The client's mood and behavior;
(5) Any medications that have been prescribed by the program's Medical Director (for programs utilizing medical staff), and
(6) Information about the client's progress or lack of progress in relation to detoxification (stabilization) goals.

ADOLESCENT TREATMENT (AT) - Applies to Residential and Out-Patient

AT1 The program shall limit admissions to adolescents 13 through 17 years of age. The policies and procedures shall specify any exceptions to this requirement, and OADAP must be notified and a waiver obtained prior to admission.

AT2 The program shall address the special needs (i.e., self-esteem, peer pressure, etc. classes) of adolescents and protect their rights.

AT3 The program shall provide separate groups and activities for adolescents.

AT4 The program shall obtain consent for admission and authorization to obtain medical treatment at the time of admission for all clients under 18 years of age, unless adjudicated as an emancipated minor.

AT5 Residential and day treatment programs shall have policies and procedures that govern access to client education as required by the Arkansas Department of Education.

AT6 The program shall allow regular communication between an adolescent client and the client's family and shall not arbitrarily restrict any communication without clear, written individualized clinical justification documented in the client record.

AT7 Program staff that plan, supervise, or provide chemical dependency education or counseling to adolescents shall have the following:

a. Qualified credentials for counselors; and
b. Direct care employees shall have documentation of continuing education in human adolescent development, family systems, adolescent psychopathology and chemical dependency and addiction in adolescents, and adolescent socialization issues. This may include in-service training.

AT8 Clients shall be under direct supervision at all times.

AT9 In public places, clients shall be within eyesight at all times.

AT10 Staff shall conduct visual checks at least once every hour. Bed checks will be made and documented every four (4) hours.

AT11 All Incidents will be recorded and reported as appropriate.

AT12 The treatment plan shall address adolescent specific needs and issues.

AT13 The program shall involve the adolescent's family or an alternate support system in the treatment process or document why this is not happening.

AT14 The program shall prohibit adolescent clients from using tobacco products.

AT15 The program shall prohibit tobacco products within the confines of any program housing adolescents.

AT16 Staff employed with adolescent programs will have training specific to the clients served, such as: impact of substance abuse on children; identifying domestic violence; abuse; neglect; empowering the client and families to restore family functioning; development and age appropriate behaviors; parenting skills; self-esteem; peer pressure; and bullying.

SPECIALIZED WOMEN'S SERVICES (SWS) - Programs authorized by OADAP to provide Specialized Women's Services shall in addition to the General Standards meet the requirements of the standards listed in Specialized Women's Services sections. The program shall address the specialized needs of the parent and include services for children. These services may be provided on the premises or through written service agreements with other providers.

SWS1 Treatment shall include intensive primary treatment and clients must participate in at least thirty (30) hours of therapeutic services per week, including substance abuse group counseling, education, parenting, family reunification, and child development services.

SWS2 Job Skills:

a. The program shall assure that residents attend G.E.D. classes, receive job-training skills, or be employed.
b. At a minimum, all clients shall register at the Employment Security Division (ESD)
c. At a minimum, all women shall register at the Arkansas Department of Workforce Services. If employed the client shall receive a minimum of 15 hours per week of therapeutic services as determined by the client's treatment plan.

SWS3 Parenting Skills:

a. The program will assure all adult residents receive training in early child development and other parenting skills.
b. These services may be provided on the premises or the clients may be transported to other locations.

SWS4 Children in the facility shall receive age appropriate therapy as needed.

SWS5 All clients with children will attend and participate in parent/child interactive education either individual or group (1 hour minimum) per week.

SWS6 The program shall assess and document parent-child interaction weekly and any identified needs shall be addressed in treatment.

SWS7 Residential programs shall not accept dependents over the age of six (6), unless the program has prior written approval from OADAP.

SWS8 The program shall inform and educate pregnant clients of the Child Abuse Prevention and Treatment Act in accordance with state and federal laws.

SWS9 Programs will provide training specific to the clients served, such as: substance abuse impact on children; identifying domestic violence; abuse; neglect;

empowering the client and families to restore family functioning; child development and age appropriate behaviors; parenting skills; self-esteem; peer pressure; and bullying.

SWS10 The program shall inform and educate pregnant clients of the dangers and effects that alcohol and illicit drug use has on the fetus.

SWS11 Other education to be provided will include, but not be limited to, the topics of HIV/AIDS, STDs, TB, family planning, nutrition, sexual abuse and spousal abuse.

SWS12 Family Education and Support:

a. The program shall establish a family-counseling program for each client.
b. Family members shall receive basic drug abuse prevention information, and support skills, especially in relapse prevention, family dynamics and communication.

SWS13 Aftercare: Prior to discharge the program shall be responsible for establishing an aftercare plan and will encourage the client to participate in support activities.

SWS14 The program will provide access and referral to the fullest possible range of medical care for clients and children to include but not be limited to: Pre-natal and post-partum health care; emergency health care; health screening; dental; well-child health care; screening in speech/language; hearing and vision; and verification of immunization records.

SWS15 Childcare: The program shall ensure parents or qualified childcare providers directly supervise the children at all times. The program is always responsible for providing oversight and guidance to ensure children receive appropriate care, when they are supervised by clients.

SWS16 Child Care for residents with small children/day care will be provided either on the program's premises (by an authorized child care provider), or through a licensed day care center.

SWS17 Childcare shall be arranged for services delivered in the evenings, such as, an AA meeting, or for an emergency. (Clients cannot provide this service).

SWS18 The program shall have a current schedule showing who is responsible for the children at all times;

SWS 19 Physical discipline by program staff is strictly prohibited.

SWS20 The program shall provide a variety of age-appropriate equipment, toys, and learning materials;

SWS21 Transportation shall be provided for any other services necessary to meet treatment goals.

SWS22 Program shall have policies and procedures that state staff shall not allow anyone except the legal guardian or a person authorized by the legal guardian to take a child away from the facility. If an individual shows documentation of legal custody, staff shall record the person's identification before releasing the child.

SWS23 The program will provide room, board and laundry services.

SWS24 Pregnant women; women with children and, children will be fed apart from other clients. If being fed in a common area they will receive their meals prior to or after other clients have vacated the area.

SWS25 The program may assess any amount for rent not to exceed the actual cost per day.

SWS26 The program staff are mandatory reporters, and program shall have a procedure to use if a parent abuses or neglects a child, including reporting, intervention and documentation.

SWS27 The program must provide a safe and sanitary environment appropriate for children, to include at a minimum:

a. Heating equipment shall be cool to touch safely;
b. Heavy furniture and equipment shall be securely installed to prevent tipping or collapsing;
c. Electrical outlets accessible to children shall have child-proof covers or safety devices;
d. There shall be no cords or strings hanging within reach of a child's.
e. Cupboards, cabinets, closets and refrigerators shall be secured to prevent trapping a child inside.
f. Air conditioners, fans, and heating units shall be mounted out of children's reach or have safety guards;
g. Grounds shall be kept free of standing water and sharp objects;
h. Tap water shall be no hotter than 110° Fahrenheit;
i. Items potentially dangerous for children (i.e. poison's bleach, etc.) shall be stored in a secure, locked environment.
j. Areas that are more than two feet above ground level (such as stairs, porches, and platforms) shall have railings low enough for children to reach;

k. Outdoor play areas shall be enclosed by a fence at least four feet high and shall not be viewable by the general public or anyone not associated with the SWS program;
l. Tanks, ditches, sewer pipes, dangerous machinery, and other hazards on the grounds shall be fenced;
n. Outdoor play equipment shall be in a safe location and securely anchored (unless portable by design);
o. Buildings, furniture, and equipment shall not have openings or angles that could trap or injure a child or any part of the child's body; and
p. Swing seats shall be durable, lightweight, and relatively pliable.

SWS28 Neither staff nor clients will use tobacco products within twenty-five feet of any program housing children.

CRIMINAL JUSTICE SYSTEM (CJS) - Programs requesting licensure to provide alcohol and drug treatment within the Criminal Justice System that may include Therapeutic Community (TC) or Drug Court shall in addition to the General Standards meet the requirements of the appropriate standards as it relates to their program found in the Criminal Justice System section.

CJS1 Any person providing direct treatment services must receive at least four (4) hours of individual supervision or six (6) hours of group supervision monthly. Such supervision must be documented. Persons authorized to approve treatment plans, as specified in this manual, must perform this supervision.

CJS2 Provides sufficient privacy to maintain confidentiality of the communication between counselor and client.

CJS3 If the program uses space provided by another organization, there is a written agreement specifying the terms of such usage.

CJS4 The program has at least one staff person present at all times who maintains a valid certification in First Aid, CPR and NCI.

CJS5 The program shall not operate a new treatment site or make major programmatic changes at a present site without OADAP approval.

CJS6 Residential Treatment provides for a minimum of twenty (20) hours weekly (Sunday through Saturday) of structured treatment. (See Definition Section for an explanation of "structured treatment").

CJS7 A counselor's caseload shall not exceed the 25 to one (1) client/counselor ratio.

CJS8 The initial treatment plan is completed within seven (7) days of admission.

CJS9 The comprehensive treatment plan is developed and implemented no later than twenty-one (21) days from admission to residential services, thirty days (30) to outpatient services (including drug courts), and within forty-five (45) days from admission to therapeutic community (TC) programs.

CJS10 Residential treatment shall be documented at least weekly and shall minimally document: treatment provided during the week; the time frame that the note covers; the client's response to the treatment provided; significant client events that occurred; and the name, signature and title of the staff person who wrote the note. TC programs will meet this requirement using a monthly (every 30 days), treatment plan review.

Additionally, TC units will adhere to the following standards:

CJS11 Develop and implement a written mission and philosophy that addresses the beliefs, attitudes and purpose of the Therapeutic Community (TC).

CJS12 The TC program operates within a distinct space separate from the main prison population.

CJS13 The TC shall provide a handbook or manual providing an explicit and comprehensive outline of the program, its mission, and its philosophy.

CJS14 The handbook will be given to each participant upon entering the program and each staff member upon onset of employment.

CJS15 The handbook shall provide a comprehensive section on the TC perspective on the substance abuse disorder.

CJS16 The program will ensure that confrontation and consequence tools used by the TC shall not infringe upon the clients rights as defined and posted.

CJS17 The staff member facilitating the confrontation group shall closely monitor and provide appropriate supervision

OPIOID TREATMENT (OP) - Programs seeking licensure as an Opioid Treatment program shall in addition to the General Standards meet the requirements of the standards listed in the Opioid Treatment section.

The Department of Human Services (DHS), Division of Behavioral Health Services (DBHS), Office of Alcohol and Drug Abuse Prevention (OADAP) have developed these standards specifically for the administration of Opioid Treatment Programs (OTPs) in Arkansas.

The goal of opioid treatment is total rehabilitation of the client. While eventual withdrawal from the use of drugs, including methadone/buprenorphine, may be an appropriate treatment goal, some clients may remain on opioid maintenance for relatively long periods of time. Periodic consideration of withdrawing from methadone/buprenorphine maintenance is appropriate only if it is in the individual client's interest. Such considerations are between the client and the treatment program.

The program shall be progressive in nature, addressing the client's individual need with methadone/buprenorphine as only one component of comprehensive treatment services.

The Program shall make records available to OADAP upon request. In addition, access by the CSAT and the Drug Enforcement Administration (DEA) is also allowed for determination of compliance with CSAT and DEA regulations.

APPLICANT SCREENING

OP1 Applicant screening shall be extensive and thorough and shall form the basis for effective, long-term treatment planning. It shall include a staff assessment as to appropriateness of treatment that admission is voluntary, and the client understands the risks, benefits, and options.

OP2 Prescription methadone is a highly addictive substance and entry into a Program is a critical decision for both the client and the Program. Before admitting an applicant to methadone treatment, the Program shall satisfy itself that the applicant fully understands the reasons for and ramifications of administrative detoxification and that the applicant voluntarily enters the Program with that knowledge.

ADMISSION CRITERIA

OP3 The Program shall verify the applicant's name, address, date of birth and other critical identifying data.

OP4 The Program shall document a one (1) year history of addiction and current physiological dependence. A one (1) year history of addiction means a period of continuous or episodic addiction for the one (1) year period immediately prior to application for admission to the Program. Documentation may consist of the

applicant's past treatment history, with presence of clinical signs of addiction, such as, old and fresh needle marks, constricted or dilated pupils, or an eroded or perforated nasal septum.

OP5 For applicants who are under the age of eighteen (18) the Program shall document two (2) unsuccessful attempts at drug-free treatment, prior to being considered for admission to a Program. Note: No person under the age of eighteen (18) years of age shall be admitted to maintenance treatment unless a parent, legal guardian, or responsible adult designated by the relevant state authority consents in writing to such treatment.

OP6 The Program shall give admission priority to pregnant women.

OP7 The Medical Director may refuse treatment with a narcotic drug to a particular client if, in the reasonable clinical judgment of the Medical Director, the client would not benefit from such treatment. Prior to such a decision, appropriate staff may be consulted, as determined by the Medical Director.

OP8 Upon admission the Program shall:

a. Obtain the applicant's signature on a voluntary agreement admitting the applicant to the Program.
b. Verify the applicant's identification, including name, address, date of birth and other critical identifying data from a social security card, birth certificate, driver's license, etc. Copies of this identifying information shall include social security card and official photo identification and will become a part of the client's record.
c. Obtain a complete medical history from each client being admitted to treatment. The medical and laboratory examination of each client shall include:

    (1) Investigation of the possibility of infectious disease and possible concurrent surgery problems;
    (2) The complete blood count and differential;
    (3) Serological tests for syphilis;
    (4) Routine and microscopic urinalysis toxicology screening for drugs;
    (5) Multiphase chemistry profile;
    (6) Intradermal Tuberculin Purified Protein Derivative (PPD) administered and interpreted.
    (7) A chest x-ray, Pap smear, biological test for pregnancy or screening for sickle cell disease if the examining medical personnel request these tests.

OP9 The Program shall not require a medical examination for a client transferring to a new Program who received a medical and laboratory examination within three (3) months prior to admission to the new Program. The Program physician may

request a medical and laboratory examination for a transferring client. However, the new Program physician shall have, as part of the transfer summary, a medical summary and statement from the client's previous Program that indicates a significant medical problem. The transferred record shall include copies of the previous examination prior to admission.

OP10 Conduct and complete a counseling intake interview and develop a narrative psychosocial history within twenty-one (21) days of the client's admission date. This psychosocial narrative shall form the basis for preparing future treatment plans.

OP11 Develop a written statement, signed by the Medical Director, that the applicant is competent to sign the voluntary agreement admitting them to the Program.

OP12 Verify that the client is not currently enrolled in another opioid treatment program.

READMISSION CRITERIA

OP13 Readmission to a program depends on whether a client who is seeking readmission previously withdrew from methadone on a voluntary basis or as a result of an administrative decision due to the client's violation of Program policies.

OP14 A client, treated and later voluntarily detoxified from methadone maintenance treatment, may be readmitted to the Program without evidence to support findings of current physiological dependence, up to two (2) years after discharge, if the Program attended is able to document prior opioid maintenance treatment of six (6) months or more, and the admitting physician, in his or her reasonable clinical judgment, finds readmission to opioid maintenance treatment medically justified.

OP15 Clients seeking readmission to a Program after an administrative detoxification shall at a minimum wait thirty (30) days prior to applying for readmission. If a Program administratively detoxifies a client twice in a year then the client shall wait twelve (12) months to reapply for readmission.

EXCEPTIONS TO MINIMUM ADMISSION REQUIREMENTS

OP16 An applicant who has been residing in a correctional institution for one (1) month or longer may enroll in a Program within fourteen (14) days before release or discharge or within six (6) months after release from such an institution without evidence of current physiological dependence on narcotics provided that prior to his or her institutionalization the client would have met the one (1) year admission criteria.

OP17 A program shall place a pregnant applicant on a maintenance regimen if the applicant has had a documented narcotic dependency in the past and may be in direct jeopardy of returning to narcotic dependency, with its attendant dangers during pregnancy. The applicant need not show evidence of current physiological dependence on narcotic drugs if a program physician certifies the pregnancy and, in his or her reasonable clinical judgment, justifies medical treatment.

SERVICES TO WOMEN

OP18 The Program shall test women of childbearing age for pregnancy at the time of admission unless medical personnel determine that the test is unnecessary.

OP19 In addition to federal laws and regulations regarding pregnant clients, the Program shall implement written policies and procedures to ensure the accessibility of services to pregnant women. The Program shall:

a. Give priority to pregnant women in its admission policy and;
b. Arrange for medical care during pregnancy by appropriate referral, and verify that the client receives medical care as planned;

OP20 The Program shall inform pregnant clients of the Child Abuse Prevention and Treatment Act in accordance with state and federal laws.

OP21 The program will have specific policies and procedures developed to educate pregnant clients of the dangers and effects that alcohol and illicit drug use has on the fetus.

OP22 Conduct a special staffing with the entire treatment team to provide intensive case management for pregnant clients who are non-compliant with phase requirements. The Medical Director will develop specific protocols to ensure the safety of the fetus.

TREATMENT STRUCTURE

OP23 The Program shall provide the client a full range of treatment and rehabilitative services.

OP24 The absence of the use of controlled substances, except as medically prescribed; social, emotional, behavioral and vocational status; and other individual client needs shall determine the frequency and extent of the services.

OP25 The assessment and treatment team shall consist of a Medical Director, medical staff and counselors who shall assess the client's needs and, with the client's input, develop a treatment plan.

OP26 As part of developing a treatment plan, the client shall have input in establishing or adjusting dosage levels.

OP27 The assessment and treatment team shall staff each case at least once each thirty (30) days during the first ninety (90) days of treatment and at least once each ninety (90) days thereafter.

OP28 The Medical Director shall sign off on the initial treatment plan when developed and the comprehensive treatment plan on an annual basis.

OP29 Services to each client shall include individual, group and family counseling at the following minimum levels:

a. Phase I. Phase I consists of a minimum of a ninety (90) day period in which the client attends the Program for observation daily or at least six (6) days a week. During the first ninety (90) days of treatment, the take-home supply is limited to a single dose each week. Phase I requires at least four (4) hours of counseling per week. The counseling sessions at a minimum shall consist of two (2) hours of group therapy sessions, one (1) hour of individual counseling, and one (1) hour of twelve step/self help meeting per week. The assessment and treatment team and the client shall determine the client's assignment of group therapy attendance. The issues to be discussed in group therapy sessions shall consist of at least a minimum but not limited to the following:

(1) Family or Significant Others;
(2) Living Skills;
(3) Methadone Maintenance;
(4) Peer Confrontation;
(5) Positive Drug Screen;
(6) Educational Training;
(7) Vocational Training and/or Employment; and
(8) Acquired Immunodeficiency Syndrome (AIDS) Education as related to Human Immunodeficiency Virus (HIV).

Prior to a client moving to Phase II, the client shall demonstrate a level of stability as evidenced by the following:

(1) Absence of recent (past thirty (30) days) abuse of drugs (opioid or non-narcotic), including alcohol;
(2) Clinic attendance as required in phase I;
(3) Absence of serious behavioral problems at the clinic;
(4) Absence of known criminal activity within the last thirty (30) days, e.g., drug dealing;
(5) Stability of the client's home environment and social relationships;
(6) Length of time in comprehensive maintenance treatment;

(7) Assurance that take-home medication can be safely stored within the client's home; and
(8) Whether the rehabilitative benefit the client derived from decreasing the frequency of attendance outweighs the potential risks of diversion.

In addition, the client shall provide assurance to the Program regarding safe transportation and storage of take-home medication.

b. Phase II - Level 1. A client, admitted more than ninety (90) days and successfully completing Phase I, shall attend the Program no less than four (4) times weekly. The Program may issue no more than two (2) take-home doses per week. A client must have continuous clean drug screens for the past thirty (30) days, while in Phase I, prior to advancement into Phase II Level 1. A client must spend a minimum of ninety (90) days in Phase II Level I. Prior to a client moving to Phase II Level 2, the client shall demonstrate a level of stability as evidences by the following:

(1) Absence of recent [past sixty (60) days] abuse of drugs (opioid or non-narcotic), including alcohol;
(2) Clinic attendance as required in Phase II, Level 1;
(3) Absence of serious behavioral problems at the clinic;
(4) Absence of known criminal activity within the last sixty (60) days, e.g., drug dealing;
(5) Stability of the client's home environment and social relationships;
(6) Length of time in comprehensive maintenance treatment;
(7) Assurance that take-home medication can be safely stored within the client's home; and
(8) Whether the rehabilitative benefit the client derived from decreasing the frequency of attendance outweighs the potential risks of diversion.

c. Phase II - Level 2. A client, admitted more than one hundred and eighty (180) days and successfully completing Phase II Level 1, shall attend the program no less than three (3) times per week. The Program may issue no more than three (3) take-home doses per week. A client must spend a minimum of ninety (90) days in Phase II Level 2. Prior to a client moving to Phase II Level 3, the client shall demonstrate a level of stability as evidenced by the following:

(1) Absence of recent [past ninety (90) days] abuse of drugs (opioid or non-narcotic), including alcohol;
(2) Clinic attendance as required in Phase II, Level 2
(3) Absence of serious behavioral problems at the clinic;
(4) Absence of known criminal activity within the last ninety (90) days, (e.g., drug dealing);

(5) Stability of the client's home environment and social relationships;
(6) Length of time in comprehensive maintenance treatment;
(7) Assurance that take-home medication can be safely stored within the client's home; and
(8) Whether the rehabilitative benefit the client derived from decreasing the frequency of attendance outweighs the potential risks of diversion.

d. Phase II - Level 3. A client admitted more than two hundred and seventy (270) days and successfully completing Phase II Level 2 shall attend the program no less than one (1) time per week. The Program may issue no more than six (6) take-home doses at a time. A client must spend a minimum of ninety (90) days in Phase II Level 3.

During Phase II Level 1 a client shall attend at least two (2) hours of counseling (one of which shall be individual) and two (2) self-help group meetings per week. For the remainder of Phase II Levels 2 and 3 the client, primary counselor, medical director and other appropriate members of the treatment team shall determine a client's counseling and self-help activities provided that the minimum level of service delivery shall be one (1) hour of counseling per month and one (1) self-help group meeting per week.

e. Phase III. A client admitted more than one (1) year and successfully completing Phase II shall attend the Program no less than one (1) time bi-weekly. (Not to exceed fifteen (15) calendar days). The Program may issue no more than fourteen (14) take home doses in fifteen (15) calendar days at a time. A client must have at least six (6) months of continuous clean screens, while in Phase II, prior to advancement into Phase III.

Phase III, the client, primary counselor, and medical director shall determine a client's counseling and self-help activities provided that the minimum level of service delivery shall be one (1) hour of counseling per month and two (2) self-help group meeting per month. The one (1) hour counseling may be either individual counseling or group therapy, as determined by staff and client.

f. Phase IV. The Program may provide a twenty-eight (28) day supply of methadone if a client, admitted for two (2) years has successfully completed Phase III. A client must have at least twelve (12) months of continuous clean screens, while in Phase III, prior to advancement into Phase IV.

Phase IV requires at least one (1) hour counseling per month in addition to attendance at one (1) self-help group meetings per month as long as the client maintains a twenty-eight (28) day take-home medication status.

g. Phase V. During the above four (4) phases a client, in consultation with the assessment and treatment team may elect to enter Phase V.

(1) This phase implements the methadone detoxification plan. The Program physician determines the take-home dosage schedule for the client. The primary counselor determines the number of counseling sessions provided during this phase based on the clinical judgment of the primary counselor with input from the client. At the onset of Phase V, the client may require an increased level of support services (i.e., increased levels of individual, group counseling, etc.). Prior to successful completion of Phase V the primary counselor and client shall develop a plan that shall integrate the client into a drug-free treatment regimen for ongoing support. The client's use of controlled substances except as medically prescribed, deterioration of social, emotional, vocational or behavioral status; and or other individual needs shall result in increased frequency and extent of treatment and rehabilitation services.

(2) The Program shall assess each client for referral, if appropriate, to Employment Security Division, vocational training and or enrollment in school. The Program shall conduct a follow-up at least every thirty (30) days.

(3) The assessment and treatment team and the client shall negotiate a methadone detoxification plan with potential target dates for implementation in Phase V. Such a plan may be short-term or long-term in nature based on the client's need and may include intermittent periods of methadone/buprenorphine maintenance between detoxification attempts.

SPECIAL STAFFING

OP30 The Program shall conduct a special staffing to determine an appropriate response whenever a client has two (2) or more drug screenings in a one (1) year period that are positive for illicit drugs other than methadone/buprenorphine. .

OP31 The Medical Director shall use test results as a guide to change treatment approaches and not as the sole criteria to force a client out of treatment.

OP32 When using test results, the Medical Director shall distinguish presumptive laboratory results from definitive laboratory results.

OP33 Clients in Phase II, Level III having a positive drug screen for illicit drugs and alcohol will be placed in Phase II, Level II to be completed in its entirety prior to moving back to Phase II, Level III.

OP34 Clients in Phase III or IV having a positive drug screen for illicit drugs and alcohol will be placed in Phase II, Level III to be completed in its entirety prior to moving back to Phase III.

OP35 Patients who are non-compliant with all requirements of their current phase level (i.e. positive toxicology screens and unexcused dosing and counseling absences) shall result in a decrease in phase level and take-home dose privileges. In addition, program staff must conduct a special staffing with the client present to determine corrective action protocol.

PROGRAM POLICIES

OP36 The Program shall implement a written policy that states the Program shall not deny treatment to a person based on his or her actual or perceived sero status, HIV related condition or AIDS.

OP37 Program staff shall receive yearly training on the subject of HIV and Hepatitis C infection and treatment of HIV and Hepatitis C infected clients.

OP38 The Program shall have written policies for infection control, which are in compliance with the Center for Disease Control and Prevention Guidelines.

OP39 The Program shall provide AIDS education to clients and shall provide or refer clients for HIV pre-test counseling and voluntary HIV testing. If the Program does test for AIDS, it shall be with the informed consent of the client. The Program shall assure the provision of pre and post-test counseling for the clients.

OP40 The Program shall provide annual medical evaluations to clients as appropriate for dose level sero status and identified medical concerns.

OP41 The Program shall provide or refer clients for tuberculosis and sexually transmitted disease (STD) testing upon admission and at least annually thereafter. However, Programs shall not require clients to receive HIV/AIDS testing.

OP42 The Program shall develop written policies and procedures for continued treatment with methadone or buprenorphine in the event of an emergency or natural disaster.

OP43 The Program shall have hours, which provide for early morning or late evening services to meet the needs of their client population.

OP44 The Program shall implement written policies and procedures to ensure positive identification of the client before methadone or buprenorphine is administered.

OP45 The Program shall develop written policies regarding the recording of client medication intake and a daily methadone/buprenorphine inventory. These policies shall comply with DEA, Arkansas State Pharmacy Board and Arkansas State Medical Board as appropriate.

OP46 The Program shall develop and implement written policies and procedures to contact other opioid treatment programs within a two hundred (200) mile radius to prevent duplication of services to an individual. The policy shall be in accordance with Federal Confidentiality Regulations (42 CFR, Part 2).

OP47 The Program shall monitor a client's progress and shall satisfy itself that the client is continuing to benefit from treatment.

OP48 The Program shall not use incentives or rewards or unethical advertising practices to attract new clients. This shall not forbid the Program from rewarding clients that maintain exemplary compliance with program rules and their individualized treatment plans.

OP49 The Program has the right to randomly schedule telephone requests to clients who have take home privileges requiring them to report to the treatment facility and to bring their remaining take-home medication with them. At least twice annually the Program shall randomly select at least five per cent (5%) of these clients who have take home privilege for this purpose.

OP50 Programs shall be responsible for contacting the previous Programs of transferring clients regarding such issues as their stability in treatment and take home status, before initiating take home privileges for these clients.

OP51 To prevent relapse, programs shall place transferring clients with take-home privileges on an increased drug screening surveillance schedule for the first thirty (30) days after admission.

OP52 Client to counselor ratios shall not exceed 40:1.

OP53 Programs shall employ at least one full-time medical doctor, as licensed to practice medicine in the State of Arkansas, for every 300 clients.

OP54 The medical director of an opioid treatment program will be ASAM certified; have documented references of working experience in an opioid treatment program, or have documented continuing education in addiction treatment.

OP55 The Medical Director will be available to the program on a continual basis, seven (7) days per week, twenty-four (24) hours per day.

OP56 Direct observation shall be used in collecting urine specimens. Observation shall be conducted professionally, ethically and in a manner, which respects clients privacy and does not damage the client-clinic relationship.

OP57 Random, periodic testing, including Breathalyzer tests for alcohol, shall be done to ascertain use of other substances, for clients with a history of abusing these substances.

OP58 The program has policies and procedures that address the dangers associated with the use of benzodiazepines when taking methadone. This will include provisions for admission/discharge protocol for illicit use and obtaining a release of information with the prescribing physician's acknowledgement that the patient is also being prescribed methadone. The patient must sign and date and informed consent of the program's policy.

OP59 When appropriate, family involvement shall be requested through a consent form to release information to family members.

OP60 Each client whose daily dose is above 100 milligrams is required to be under observation while ingesting the drug at least six (6) days per week irrespective of the length of time in treatment, unless the Program has received prior approval from the State Authority (SA).

OP61 In addition to federal reporting requirements, the program will have specific policies and procedure to report lost or stolen doses, theft and diversion, and fatalities of overdose to OADAP (incident reporting policy).

OP62 The program will have specific policies and procedures delineating staff access into the medication storage area(s).

EXCEPTIONAL TAKE HOME

OP63 Take home medication exceptions must be approved in writing, by the State Authority (SA) prior to dispensing. Exceptional take homes will not normally be granted to Phase I, Phase II, Phase III, and Phase IV clients. Reasons for exceptional requests, may include, but are not limited to the following:

a. A client is found to have a physical disability which interferes with his or her ability to conform to the applicable mandatory schedule; the client may be permitted a temporary or reduced schedule, provided the client is also responsible in handling narcotic drugs.
b. A client, because of exceptional circumstances such as illness, personal or family crisis, travel, or other hardship, is unable to conform to the applicable mandatory schedule, provided the client is also responsible in handling narcotic drugs. The rationale for the exception shall be based on

the reasonable clinical judgment of the program's physician. The client's record shall document the rationale. The rationale is endorsed via the physician's signature.

c. If the program is not in operation due to the observance of an official state holiday, clients may be permitted one extra take home dose and one fewer program visit per week on the day in which the holiday occurs. An official state holiday is the day on which state agencies are closed and routine state government business is not conducted.
d. In the event that a winter storm watch is issued by the National Weather Service, a three (3) day take home dose may be dispensed. Additional days shall require SA approval. The SA retains the right to reduce or revoke the take home dosing.

OP64 The dosing area(s) used will be a separate area that provides sufficient privacy to maintain confidentiality of the client's identity and communication between staff and the client.

OP65 Any client receiving l00mg or larger methadone dose shall not be allowed exceptional take-home privileges unless approved via the SMA.

OP66 All requests for methadone take-home medication exceptions must be submitted to the SMA in writing or through SAMHSA/CSATEXTRANET. Each request must document the following:

a. The name of the client for whom the request is made;
b. The address, phone number and Social Security number of the client;
c. Date of admission
d. Date of last request
e. Program number
f. The dates for the requested take-home;
g. The rationale for the exceptions;
h. The current dosing amount;
i. Date of last positive drug screen;
j. Current Phase; and
k. Medical Director's signature.

These requests submitted in writing can be mailed, hand delivered or faxed to:

Department of Human Services
Division of Behavioral Health
Alcohol and Drug Abuse Prevention
Director of Program Compliance and Outcome Monitoring
305 South Palm Street, Administration
Little Rock, Arkansas 72205
FAX: (501) 686-9035

Patient Exception Requests must be submitted online via SAMHSA's OTP Extranet Web site.

PROGRAM SECURITY

OP67 Programs are subject to Drug Enforcement Administration regulations concerning the Registration of Manufacturers, Distributors, and Dispensers of Controlled Substances (Chapter II Parts 1301 - 1307). Clients shall be physically separated from the narcotic storage and dispensing area.

OP68 The Program shall not allow clients to congregate or loiter on the grounds or around the building(s) wherein the Program operates.

OP69 Entrances that have windows will be tinted or have coverings so the client's identity and confidentiality is protected from the view of the public.

CLIENT RECORDS

OP70 In addition to client record criteria OTP shall also contain:

a. Documents and test results as generated by activities on admission;
b. Client progress in treatment case notes;
c. Results of case staffing;
d. Results of drug screening tests;
e. Such treatment plan reviews as required by Standard CTP2 herein; and
f. Any other client related material deemed appropriate by the Program.

DRUG SCREENING

OP71 The Program shall complete an initial drug screening test or analysis for each client upon admission.

OP72 The Program shall conduct new client drug screening weekly for the first three (3) months in treatment. The Program may place a client who completes three (3) months of drug screening showing no indications of drug abuse on a monthly urine-testing schedule.

OP73 Programs shall implement procedures, including the random collection of samples, to effectively minimize the possibility of falsification of the sample.

OP74 The Program shall use drug screening as a clinical tool for the purposes of diagnosis and the development of treatment plans. After admission, the results of a single screening report shall not determine significant treatment decisions.

OP75 Clients on a monthly schedule for whom screening reports indicate positive results for drugs other than methadone shall return to a weekly schedule for a period of time clinically indicated by the physician.

OP76 The Program shall analyze each sample for opiates; methadone; amphetamines; crack/cocaine; benzodiazepines; marijuana and other drugs as may be indicated by clients use patterns.

OP77 Laboratories that perform the testing required under this regulation shall be in compliance with applicable Federal proficiency testing and licensing standards and applicable state standards.

DOSAGE REPORTING REQUIREMENTS

OP78 The Medical Director may order methadone dosages in excess of 100 milligrams but less than 120 milligrams only where medically indicated. The Medical Director shall fully document the reasons for the dosage level and report such orders to the SMA.

OP79 The Medical Director shall obtain prior written approval from the SA for methadone dosage orders in excess of 120 milligrams.

TAKE-HOME MEDICATION

OP80 The requirement of time in treatment is a minimum reference point after which a client may be eligible for take-home medication privileges. The time reference does not mean that a client in treatment for a particular time has a specific right to take-home medication. Since the use of take-home privileges creates a danger of not only diversion, but also accidental poisoning, the Medical Director must make every attempt to ensure that take-home medication is given only to clients who will benefit from it and who have demonstrated responsibility in handling methadone.

Thus, regardless of time in treatment, a Medical Director may, in his or her reasonable judgment, deny or rescind the take-home medication privileges of a client. Concurrently, the client shall provide assurance to the Program that take-home medication can be safely transported and stored by the client for the client's use only. Warning labels identifying the dangers associated with the ingestion of methadone shall be placed on every take home dose.

24-HOUR EMERGENCY SERVICES

OP81 Clients shall have access to the Program in case of an off-hour emergency. The Program shall maintain a 24-hour Emergency Hot-Line with individuals designated as on-call to handle client emergencies.

TRANSFERRING OR VISITING CLIENTS

OP82 When a client transfers from one Program to another, the transferring Program shall send copies of the transferring client's records to the licensed receiving

Program prior to admission. Transferring clients shall enter Phase I for a minimum of two (2) weeks. With successful completion of Phase I, they enter the appropriate treatment phase.

OP83 Individuals visiting the State of Arkansas, who are part of a methadone treatment, program, shall have their home program provide information to a licensed Program prior to the individual's arrival in the state.

OP84 The Arkansas program shall provide qualified visiting clients up to twenty-eight (28) days of methadone medication. However, take-home privileges shall not be greater than the privileges accorded by the home program, and in no case for longer than six (6) days.

DISCHARGE PROCEDURES

OP85 In order to remain in the Program and to successfully move through treatment, clients shall be in compliance with Program rules or risk administrative detoxification from methadone. For the purpose of these standards, an infraction means threats of violence or actual bodily harm to staff or another client, disruptive behavior, community incidents (loitering, diversion of methadone, sale or purchase of drugs), continued unexcused absences from counseling and other serious rule violations. Clients may also be discharged for failure to benefit from the Program. When a Program determines to discharge a client, the Program shall provide a written statement containing:

a. The reason(s) for discharge;
b. Written notice of his or her right to request review of the decision by the Program Director or his or her designee; and
c. A copy of the appeal procedures.

COMMUNITY LIAISON AND CONCERNS

OP86 A Program shall instruct clients not to cause unnecessary disruption to the community by loitering in the vicinity of the Program, or engaging in disorderly conduct or harassment.

The Program may discharge clients who cause such disruption to the community pursuant to the Standards.

OP87 Each Program shall provide the SA with a specific plan to avoid disrupting the community and the actions it shall take to assure responsiveness to community needs. The plan will include forming a committee of representative members of the community. Such committee shall meet at least once annually.

OP88 Further actions include assigning a staff member to act as community liaison, to establish an open dialog between the community and the program administration. Educational material shall be made available to the immediate community regarding the treatment of opioid addiction.

STAFF TRAINING

OP89 In an effort to maintain quality care, the program shall develop a training plan for personnel that foster consistency of care in accordance with rapidly evolving knowledge in the opioid treatment field.

OP90 The program shall develop a method of rapidly disseminating information about pharmacological issues and other advances in the field.

RECORD KEEPING AND REPORTING REQUIREMENTS

OP91 The program shall keep records and make such reports required by the DEA 1304.01 - 1304.38 of Chapter II - Drug Enforcement Administration, Department of Justice, part 1304 Records and Reports of Registrants.

OP92 The program shall adhere to record keeping and reporting requirements of the CSAT, HHS, 291.505 (d) (13). These records shall include but not be limited to (i) Client Care, (ii) Drug Dispensing, (iii) Client's Record.

OP93 The program shall provide other reports as required by the SOTA with records as required by DEA and CSAT regulations.

OP94 The program shall provide other reports as required by the SOTA.

CLIENT APPEAL RIGHTS

OP95 Decisions regarding a client's treatment by staff are subject to appeal. The program shall develop appeal procedures that allow clients to directly appeal to the SOTA.

OP96 The SOTA shall approve the procedures. In addition, procedures shall include a provision that a central file of client appeals be maintained at the program site for review by the SOTA staff.

OP97 The program shall post a list of client's rights in a conspicuous place for the public.

PROGRAM APPEAL RIGHTS

OP98 An entity may appeal the disapproval of an application or Program closure by the SOTA. Refer to Section 6.00 of Alcohol and Drug Abuse Prevention's Rules of Practice and Procedure for the Appeal Process for Adverse Action.

PROGRAM CLOSURE

OP99 Failure of the program to adhere to CSAT/DEA regulations or Standards of the SA may result in revocation of program approval and/or licensure.

OP100 The SA shall report Programs recommended for closure to the CSAT/DEA for revocation of the right to receive shipments of narcotic drugs in accordance with 21 CFR, 291.505(h).

DEFINITIONS

Relative to Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs

Addiction Severity Index (ASI) - A semi-structured assessment instrument designed to be used with clients presenting for substance abuse treatment. It covers seven (7) important areas of a client's life: medical, employment/support, drug and alcohol use, legal, family/social, opinions about alcohol and drug use, and psychological. The instrument documents lifetime difficulties in these seven (7) areas and focuses on difficulties in the thirty (30) days prior to assessment.

Administrative Detoxification - The gradual, medically controlled withdrawal of methadone.

Admission - The point in an alcohol or drug abuser's relationship with the program at which the intake process has been completed and the individual is entitled to receive services.

Aftercare - The component of the treatment program which assures the provision of continued contact with the client following the termination of services from a primary care modality, designed to support and to increase the gains made to date in the treatment process. Aftercare plan development should start prior to discharge, but is not implemented until discharge.

Alcohol and Drug Management Information System (ADMIS) - Alcohol and Drug Management Information System (ADMIS) is the management information system for the collection and reporting of client related data prescribed by the State.

Alcohol or Drug Abuser/Addict - An abuser is a person who voluntarily uses alcohol or other drugs in such a way that their social or economic functioning is disrupted. An addict is a person who is physically and/or psychologically dependent on alcohol or other drugs and has little or no control over the amounts consumed, leading to substantial health endangerment, or social functioning disruption and economic functioning disruption.

Applicant - Any individual who has applied for admission to a treatment program, but is not yet admitted to the program.

Applicant Screening - The act of determining eligibility for treatment.

Assessment - The process of collecting sufficient data to enable evaluation of an individual's strengths, weaknesses, problems and needs so that a treatment plan can be developed.

Chief Executive Officer - The individual appointed by the governing board to set in behalf of the overall daily management of the organization.

Client - An individual who has an alcohol or other drug abuse problem, for whom intake procedures have been completed, who is admitted to the program, and remains active in the treatment provided by the program, and has not been discharged.

Counselor - An individual who, by virtue of education, training or experience, provides treatment, which includes advice, opinion, or instruction to an individual or in a group setting to allow opportunity for a person to explore their problems related directly or indirectly to alcohol and/or other drug abuse or dependence:.

Definitive Laboratory Results - Confirmatory tests conducted by a National Institute of Drug Abuse (NIDA) certified laboratory.

Detoxification - The withdrawal of a person from a physiologically addicting substance.

Detoxification Treatment for Opioid Dependence - The dispensing of a narcotic drug in decreasing doses to an individual to alleviate adverse physiological and psychological effects of withdrawal from the continuous or sustained use of a narcotic drug and as a method of bringing the individual to a narcotic drug-free state within such period.

Direct Care - Any individual who provides chemical dependency education or counseling of treatment related activities.

Documentation - Provision of written, dated and authenticated evidence (signed by person's name and title) to substantiate compliance with standards (e.g., minutes of meetings, memoranda, schedules, notices, announcement).

Emergency Admission - An admission that does not meet the intake process due to the extreme nature of the circumstances involved.

Emergency Care - A network of services that provides all persons having acute problems related to alcohol and other drug use and abuse readily available diagnosis and care, as well as appropriate referral for continuing care after emergency treatment.

Family - Individuals as defined by law, or significant others that claim relationship to the client.

Fiscal Management System - Procedures that provide management control of the financial aspects of program operations. Such procedures include cost accounting, program budgeting, materials purchasing, and client billing standards.

Governing Board - That person or persons with the ultimate authority and responsibility for the overall operation of the program.

Intake - The process of collecting and assessing information to determine the appropriateness of admitting an individual in an alcohol and drug abuse treatment program.

Licensure - The process by which the Alcohol and Drug Abuse Prevention determines if a person, partnership, association or corporation may operate an alcohol and drug abuse treatment program.

Licensure Standards for Alcohol and/or Other Drug Abuse Treatment Programs - The standards developed by the Office of Alcohol and Drug Abuse Prevention, which licensed treatment programs shall comply with.

May - Term in the interpretation of a standard to reflect an acceptable method that is recognized, but not necessarily preferred.

Medical Director - A physician licensed to practice medicine in the State of Arkansas who assumes responsibility for the administration of medical services performed by the Program, ensuring that the Program is in compliance with federal, state and local laws and regulations. In an Opioid Treatment Program the Medical Director assumes the responsibility regarding the medical treatment of narcotic addiction with a narcotic drug.

Methadone Hydrochloride - An opioid (a synthetic opiate) that is primarily used for the treatment of narcotic addiction in detoxification or maintenance programs.

Narcotic Dependent - A narcotic dependent is an individual who physiologically needs opiate or a synthetic opiate to prevent the onset of signs of withdrawal.

NCPI - Crisis Prevention Institute's training in Non-violent Crisis Prevention and Intervention.

Observation Detoxification - Includes monitoring on a 24-hours per day basis of a client who is undergoing mild withdrawal in a residential/live in setting. Monitoring will consist of taking the client's vital signs. Vital signs will be taken by a staff member trained and certified by OADAP, a Medical Doctor, Registered Nurse, Licensed Psychiatric Technical Nurse or Licensed Practical Nurse. The facility shall establish approved emergency medical procedures. These services shall be available should the client's condition deteriorate and emergency procedures be required.

Opioid Maintenance - The dispensing of methadone for more than 180 days in the treatment of an individual for dependence on opiates.

Opioid Treatment Program - An entity that:

(1) Administers or dispenses an approved narcotic drug to a narcotic addict for maintenance or detoxification treatment;
(2) Provides a comprehensive range of medical and rehabilitative services;
(3) Is approved by the State Methadone Authority (SMA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT);
(4) Is registered with the Drug Enforcement Administration (DEA) to use a narcotic drug for the treatment of narcotic addiction; and
(5) Is open at least six (6) days a week.

Outpatient Program - A non live-in program offering treatment or rehabilitation services to alcohol or drug abusers on a scheduled or non-scheduled basis.

Outpatient Service - Family - Counseling provided in an outpatient environment to a substance abuse client and family members or significant other.

Outpatient Service - Group - Counseling provided in an outpatient environment to more than one substance abuse client.

Outpatient Service - Individual - Includes care provided to a substance abuse client in an outpatient environment.

Outreach Public Education and Information - The dissemination of relevant information specifically aimed at increasing the awareness, receptivity, and sensitivity of the community and stimulating social action to increase the services provided for people with problems associated with the use of alcohol and/or other drugs. It also includes the process of reaching into a community systematically for the purpose of identifying persons in need of services, informing individuals and their families as to the availability of services, locating additional services, and enhancing the entry into the service delivery system.

Partial Day Treatment - Care provided to a substance abuse client who is not ill enough to need admission to medical detoxification or observation detoxification, but who has need of more intensive care in the therapeutic setting. This service shall include at a minimum intake, individual and group therapy, psychosocial education, case management and a minimum of one hot meal per day. Partial Day Treatment shall be a minimum of four (4) hours per day for five (5) days per week. In addition to the minimum services, treatment may include drug testing, medical care other than detoxification and other appropriate services.

Presumptive Laboratory Results - Screening test results that have not been confirmed by a National Institute of Drug Abuse (NIDA) certified laboratory.

Program - An individual, partnership, corporation, association, government subdivision or public or private organization that provides treatment services.

Program Component - A category into which a specific group of interrelated services can be classified (e.g., outpatient care).

Program Sponsor - A person (or representative of an organization) who is responsible for the operation of a Program and who assumes responsibility for its employees, including practitioners, agents or other persons providing services at the Program and is knowledgeable of substance abuse treatment issues.

Progress Note - That portion of the client's case which describes the progress of the client and his (her) current status in meeting the goals set in the treatment plan, as well as describing the efforts of staff members to help the client achieve those stated goals. Progress notes also include documentation of those events and activities related to the client's treatment.

Referral Agreement - A written document defining a relationship between the program and an outside resource for the provision of client services not available within the alcohol and/or other drug abuse treatment program.

Regional Alcohol And Drug Detoxification Services (RADD Services) - A process providing the client with up to three days detoxification services and aftercare plan.

Regional Detoxification Specialist - A person trained and certified by Alcohol and Drug Abuse Prevention. Training will provide competency, at a minimum, in the following areas:

1. Current RADD Program Policies and Procedures;
2. Taking of vital signs (temperature, pulse, respiration and blood pressure);
3. Evaluation of presenting symptoms and compiling an accurate substance abuse history;
4. Current certification in cardiopulmonary resuscitation (CPR);
5. Current certification in a first aid course;
6. Current Non-Violent Crisis Intervention certification (CPI) in defusing hostile situations; and,
7. Knowledge of alternate social, rehabilitation and emergency referral resources.

Rehabilitation - The restoration of a client to the fullest physical, mental, social, vocational and economic usefulness of which he or she is capable. Rehabilitation may include, but is not limited to, medical treatment, psychological therapy, occupational training, job counseling, social and domestic rehabilitation and education.

Residential Program - A twenty-four (24) hour, seven (7) days per week, non-medical, live-in facility offering treatment and rehabilitation services to facilitate the alcohol and/or other drug abuser's ability to live and work in the community. Includes care provided to a substance abuse client who is not ill enough to need admission to medical detoxification or observation detoxification, but who has need of more intensive care in the therapeutic setting with supportive living arrangements. This service shall include at a minimum, intake, individual and group therapy, case management and room and board. In addition to the minimum services, residential service may include drug testing, medical care other than detoxification, and other appropriate services.

Services - Services are program components rendered to clients which shall include, but are not limited to: (1) Medical evaluations; (2) Counseling; and (3) Rehabilitative and other social programs (e.g., vocational and educational guidance, employment placement) which shall support the client in becoming a productive member of society.

Shall - Term used to indicate a mandatory statement, the only acceptable method under the present standards.

Significant Other - An individual who has an intimate relationship with another, but who is not related by heredity or law.

Specialized Women's Services (SWS) – At facilities designated as SWS a unit of service will be one day for a family. A family is considered one mother and up to two children below the age of seven (7). Services at a minimum include case management, alcohol and other drug treatment, child care, transportation, medical treatment, housing, education/job skills training, parenting skills, aftercare, family education and support and house rules.

Staff - Any individual who provides services to the program on a regular basis as a paid employee.

Standards - Specifications representing the minimal characteristics of an alcohol and/or other drug abuse treatment program, which are acceptable for the licensing of a program.

State Authority (SA) – The Director, or designee, of the Arkansas Department of Human Services, Division of Behavioral Health Services, Alcohol and Drug Abuse Prevention, or its successor.

State Opioid Treatment Authority (SOTA) - The Director, or designee, of the Arkansas Department of Human Services, Division of Behavioral Health Services, Alcohol and Drug Abuse Prevention, or its successor.

Structured Treatment - An activity facilitated by a staff member, an appropriate volunteer, or a representative from an outside agency (client meditation and study groups are not structured treatment).

Substance Abuse Treatment - A process whereby services are provided to an individual with the intent of the cessation of harmful or addictive use of alcohol and/or other drugs. Treatment must include, but should not be limited to, counseling. Treatment promotes the ultimate goal of the individual reaching their fullest physical, mental, social, vocational and economic capabilities possible.

Take-Home Medication - Take-Home medications refer to those doses of methadone consumed by the client under conditions of no direct observation by a medical provider.

Treatment Plan - A written plan developed after assessment, which specifies the goals, activities and services appropriate to meet the objective needs of the client.

Treatment Program - Any program that delivers alcohol and/or other drug abuse treatment services to a defined client population.

Treatment Staff - The group of personnel of the alcohol and/or other drug abuse treatment program, which is directly involved in client care or treatment.

Update - A dated and signed review of a report, plan or program with or without revision.

Volunteer - Any person who of their own free will provides goods or service without any financial gain. Volunteers may not supplant paid staff.

Working Agreement - A written contract, letter of document, or other document that defines the relationship.

(Addendum 1)
ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
305 South Palm Street
Little Rock, Arkansas 72205
(501) 686-9164 – FAX (501) 686-9396

APPLICATION FOR LICENSURE

First time applicants shall submit a $75.00 application fee

☐ **NEW APPLICANT** ☐ **RENEWAL**

☐ **CHANGE IN STATUS** (check **ALL** that apply): ☐ New Site ☐ New Address ☐ New Owner
☐ Adding a new level of service ☐ Increase in Bed Capacity ☐ Change in Client Population (adult or adolescent)

NAME OF FACILITY TO BE LICENSED (dba if used):

Legal Name of Facility

Mailing Address (Headquarters)

Physical Address (Headquarters)

City State Zip Code

Telephone County
( )

Facility Contact Person for Licensure (Name and Title)

Telephone FAX Number
( )

SERVICES NEEDING LICENSURE:

☐ Residential ☐ Outpatient ☐ Partial Day ☐ Drug Court
☐ SWS ☐ Adolescent Services ☐ Therapeutic Community
☐ Opioid ☐ Other (Specify) ☐ SATP

FACILITY CLASSIFICATION:
☐ Medical Facility ☐ Independent Facility
☐ Community Mental Health Facility
☐ Correctional Facility

LEGAL STATUS:
☐ Non-Profit
☐ For Profit
☐ Public

ACCREDITATION:
☐ JCAHO
☐ CARF
☐ COA

Projected Date to Open for New Facilities and Programs: / /

TO THE BEST OF MY KNOWLEDGE, ALL INFORMATION ON THIS APPLICATION IS TRUE AND CORRECT.

Typed Name of Chief Executive Officer

Signature of Chief Executive Officer Date

Arkansas Department of Human Services

Division of Behavioral Health Services

Certification Manual for Rehabilitative Services for Persons with Mental Illness (RSPMI)

Revised: 1/1/11

www.arkansas.gov/dhs/dmhs

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ARKANSAS DEPARTMENT OF HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES

Rehabilitative Services for Persons with Mental Illness (RSPMI)

Provider Certification Rules

The DBHS Mission Statement: To improve the quality of life for Arkansans by providing recovery-based, consumer driven behavioral health care utilizing evidence-based practices.

I. PURPOSE:

A. To assure that Rehabilitative Services for Persons With Mental Illness ("RSPMI") care and services comply with applicable laws, which require, among other things, that all care reimbursed by the Arkansas Medical Assistance Program ("Medicaid") must be provided efficiently, economically, only when medically necessary, and is of a quality that meets professionally recognized standards of health care.

B. The requirements and obligations imposed by §§ I-XIII of this rule are substantive, not procedural.

II. SCOPE:

A. Current RSPMI certification under this policy is a condition of Medicaid provider enrollment.

B. Division of Behavioral Health Services ("DBHS") RSPMI certification must be obtained for each site before application for Medicaid provider enrollment. An applicant may submit one application for multiple sites, but DBHS will review each site separately and take separate certification action for each site.

III. DEFINITIONS:

A. "Accreditation" means full accreditation (preliminary, expedited, probationary, pending, conditional, deferred or provisional accreditations will not be accepted) as an outpatient behavioral health care provider issued by at least one of the following:

- Commission on Accreditation for Rehabilitative Facilities (CARF)
  Behavioral Health Standards Manual
- The Joint Commission (TJC)
  Comprehensive Accreditation Manual for Behavioral Health Care
- Council on Accreditation (COA)
  Outpatient Mental Health Services Manual

B. "Adverse license action" means any action by a licensing authority that is related to client care, any act or omission warranting exclusion under DHS Policy 1088, or that imposes any restriction on the licensee's practice privileges. The action is deemed to exist when the licensing entity imposes the adverse action except as provided in Ark. Code Ann. § 25-15-211 (c).

C. “Applicant” means an outpatient behavioral health care agency that is seeking DBHS certification as an RSPMI provider.

D. “Certification” means a written designation, issued by DBHS, declaring that the provider has demonstrated compliance as declared within and defined by this rule.

E. “Client” means any person for whom an RSPMI provider furnishes, or has agreed or undertaken to furnish, RSPMI services.

F. “Client Information System” means a comprehensive, integrated system of clinical, administrative, and financial records that provides information necessary and useful to deliver client services. Information may be maintained electronically, in hard copy, or both.

G. “Compliance” means conformance with:

1. Applicable state and federal laws, rules, and regulations including, without limitation:

a. Titles XIX and XXI of the Social Security Act and implementing regulations;
b. Other federal laws and regulations governing the delivery of health care funded in whole or in part by federal funds, for example, 42 U.S.C. § 1320c-5.
c. All state laws and rules applicable to Medicaid generally and to RSPMI services specifically.
d. Title VI of the Civil Rights Act of 1964 as amended, and implementing regulations;
e. The Americans With Disabilities Act, as amended, and implementing regulations;
f. The Health Insurance Portability and Accountability Act (“HIPAA”), as amended, and implementing regulations.

2. Accreditation standards and requirements.

H. “Contemporaneous” means within a single work period of the performing provider, that is, before the performing provider goes off duty for any reason other than a scheduled work break or meal.

I. “Coordinated Management Plan” means a plan that the provider develops and carries out to assure compliance and quality improvement.

J. “Corrective Action Plan” (CAP) means a document that describes both short-term remedial steps to achieve compliance and permanent practices and procedures to sustain compliance.

K. “Covered Health Care Practitioner” means: Allopathic physicians; allopathic interns and residents; osteopathic physicians; and osteopathic physician interns and residents; dentists and dentist residents; and other practitioner types which

may be or have been reported to the NPDB: pharmacists; pharmacy interns; pharmacists, nuclear; pharmacy assistants; pharmacy technicians; registered (professional) nurses; nurse anesthetists; nurse midwives; nurse practitioners; clinical nurse specialists; licensed practical or vocational nurses; nurses aides; certified nurse aides/certified nursing assistants; home health aides (homemakers); health care aides/direct care workers; certified or qualified medication aides; EMTs, basic; EMTs, cardiac/critical care; EMTs, intermediate; EMTs, paramedic; social workers; podiatrists; podiatric assistants; psychologists; school psychologists; psychological assistants, associates, examiners; counselors, mental health; professional counselors; professional counselors, alcohol; professional counselors, family/marriage; professional counselors, substance abuse; marriage and family therapists; dental assistants; dental hygienists; denturists; dieticians; nutritionists; ocularists; opticians; optometrists; physician assistants, allopathic; physician assistants, osteopathic; art/recreation therapists; massage therapists; occupational therapists; occupational therapy assistants; physical therapists; physical therapy assistants; rehabilitative therapists; respiratory therapy technicians; medical technologists; cytotechnologists; nuclear medicine technologists; radiation therapy technologists; radiologic technologists; acupuncturists; athletic trainers; homeopaths; medical assistants; midwives, lay (non nurse); naturopaths; orthotics/prosthetics fitters; perfusionists; psychiatric technicians; and any other type of health care practitioner which is licensed in one or more States.

L. “Cultural Competency” means the ability to communicate and interact effectively with people of different cultures, including people with disabilities and atypical lifestyles.

M. “DBHS” means the Arkansas Department of Human Services Division of Behavioral Health Services.

N. “Deficiency” means an item or area of noncompliance.

O. “DHS” means the Arkansas Department of Human Services.

P. “Emergency RSPMI services” means nonscheduled RSPMI services delivered under circumstances where a prudent layperson with an average knowledge of behavioral health care would reasonably believe that RSPMI services are immediately necessary to prevent death or serious impairment of health.

Q. “Medical Director” means a physician that oversees the planning and delivery of all RSPMI services delivered by the provider.

R. “Mental health paraprofessional” or “MHPP” means a person who:

1. Does not possess an Arkansas license to provide clinical behavioral health care;

2. Works under the direct supervision of a mental health professional;

3. Has successfully completed prescribed and documented courses of initial and annual training sufficient to perform all tasks assigned by a mental health professional;

4. Acknowledges in writing that all mental health paraprofessional services are controlled by client care plans and provided under the direct supervision of a mental health professional.

S. “Mental health professional” or “MHP” means a person who possesses an Arkansas license to provide clinical behavioral health care. The license must be in good standing and not subject to any adverse license action.

T. “Mobile care” means a face-to-face intervention with the client at a place other than a certified site operated by the provider. Mobile care must be:

1.Either clinically indicated in an emergent situation or necessary for the client to have access to care in accordance with the care plan;

2. Delivered in a clinically appropriate setting; and

3. Delivered where Medicaid billing is permitted if delivered to a Medicaid eligible client.

Mobile care may include medically necessary behavioral health care provided in a school that is within fifty (50) miles of a certified site operated by the provider.

U. “Multi-disciplinary team” means a group of professionals from different disciplines that provide comprehensive care through individual expertise and in consultation with one another to accomplish the client’s clinical goals. Multi-disciplinary teams promote coordination between agencies; provide a "checks and balances" mechanism to ensure that the interests and rights of all concerned parties are addressed; and identify service gaps and breakdowns in coordination or communication between agencies or individuals.

V. “NPDB” means the United States Department of Health and Human Services, Health Resources and Services Administration National Provider Data Bank.

W. “Performing provider” means the individual who personally delivers a care or service directly to a client.

X. “Professionally recognized standard of care” means that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of the profession. Conformity with Substance Abuse and Mental Health Services Administration (SAMHSA) evidence-based

practice models is evidence of compliance with professionally recognized standards of care.

Y. “Provider” means an entity that is certified by DBHS and enrolled by DMS to provide RSPMI.

Z. “Quality assurance (QA) meeting” means a meeting held at least quarterly for systematic monitoring and evaluation of clinic services and compliance. *See also*, Medicaid RSPMI Manual, § 212.000.

AA**. “**Reviewer” means a person employed or engaged by:

1. DHS or a division or office thereof;
2. An entity that contracts with DHS or a division or office thereof.

BB. “RSPMI” means Rehabilitative Services for Persons With Mental Illness.

CC. “Site” means a distinct place of business dedicated to the delivery of RSPMI services within a fifty (50) mile radius. Each site must be a bona fide RSPMI behavioral health outpatient clinic providing all the services specified in this rule and the Medicaid RSPMI Manual. Sites may not be adjuncts to a different activity such as a school, a day care facility, a long-term care facility, or the office or clinic of a physician or psychologist.

DD. “Site relocation” means closing an existing site and opening a new site no more than fifty (50) miles from the original site.

EE. “Site transfer” means moving existing staff, program, and clients from one physical location to a second location that is no more than fifty (50) miles from the original site.

FF. “Supervise” as used in this rule means to direct, inspect, observe, and evaluate performance.

GG. “Supervision documentation” means written records of the time, date, subject(s), and duration of supervisory contact maintained in the provider’s official records.

IV. COMPLIANCE TIMELINE:

A. Certified RSPMI providers in operation as of the effective date of this rule must comply with this rule within forty-five calendar days.

B. DBHS may authorize temporary compliance exceptions for new accreditation standards that require independent site surveys and specific service subset accreditations. Such compliance exceptions expire at the end of the provider’s accreditation cycle and may not be renewed or reauthorized.

V. APPLICATION FOR DBHS RSPMI CERTIFICATION:

A. Applicants must complete DBHS application Form #1 and #2 which can be found at the following website: www.arkansas.gov/dhs/dmhs or

See Appendix # 5 and # 6

B. Applicants must submit the completed application forms and all required attachments for each proposed site to:

Department of Human Services

Division of Behavioral Health Services

Attn. Certification Office

305 S. Palm

Little Rock, AR 72205

C. Each applicant must be an outpatient behavioral health care agency:

1. Whose primary purpose is the delivery of a continuum of outpatient behavioral health services in a free standing independent clinic;
2. That is independent of any DBHS certified RSPMI provider.

D. RSPMI certification is not transferable or assignable.

E. The privileges of RSPMI certification are limited to the certified entity.

F. Providers may file Medicaid claims only for RSPMI care delivered by a performing provider engaged by the provider.

G. Applications must be made in the name used to identify the business entity to the Secretary of State and for tax purposes.

H. Applicants must maintain and document accreditation, and must prominently display certification of accreditation issued by the accrediting organization in a public area at each site. Accreditation must recognize and include all the applicant's RSPMI programs, services, and sites.

1. Initial accreditation must include an on-site survey for each service site for which provider certification is requested. Accreditation documentation submitted to DBHS must list all sites recognized and approved by the accrediting organization as the applicant's service sites.
2. Accreditation documentation must include the applicant's governance standards for operation and sufficiently define and describe all services or types of care (customer service units or service standards) the applicant intends to provide including, without limitation, crisis intervention/stabilization, in-home family counseling, outpatient treatment, day treatment, therapeutic foster care, intensive outpatient, medication management/pharmacotherapy.

3. Any outpatient behavioral health program associated with a hospital must have a free-standing behavioral health outpatient program national accreditation.

I. The applicant must attach the entity's family involvement policy to each application.

VI. APPLICATION REVIEW PROCESS

A. Timeline:

1. DBHS will review RSPMI application forms and materials within ninety (90) calendar days after the DBHS RSPMI certification policy office receives a complete application package. (DBHS will return incomplete applications to senders without review.)

2. For approved applications, a site survey will be scheduled within 20 calendar days of the approval date.

3. DBHS will mail a survey report to the applicant within 10 calendar days of the site visit. Providers having deficiencies on survey reports must submit an approvable corrective action plan to DBHS within thirty-five (35) calendar days after the date of a survey report.

4. DBHS will accept or reject each corrective action plan in writing within ten (10) calendar days after receipt.

5. Within thirty (30) calendar days after DBHS approves a corrective action plan, the applicant must document implementation of the plan and correction of the deficiencies listed in the survey report. Applicants who are unable, despite the exercise of reasonable diligence, to correct deficiencies within the time permitted may obtain up to ten (10) additional days based on a showing of good cause.

6. DBHS will furnish site-specific certificates via postal or electronic mail within ten (10) calendar days of issuing a site certification.

B. Survey Components: An outline of site survey components is available on the DBHS website: www.arkansas.gov/dhs/dmhs and is located in appendix # 7.

C. Determinations:

1. Application approved.

2. Application returned for additional information.

3. Application denied. DBHS will state the reasons for denial in a written response to the applicant.

VII. DBHS Access to Applicants/Providers:

A. DBHS may contact applicants and providers at any time;

B. DBHS may make unannounced visits to applicants/providers.

C. Applicants/providers shall provide DBHS prompt direct access to applicant/provider documents and to applicant/provider staff and contractors, including, without limitation, clinicians, paraprofessionals, physicians, administrative, and support staff.

D. DBHS reserves the right to ask any questions or request any additional information related to certification, accreditation, or both.

VIII. ADDITIONAL CERTIFICATION REQUIREMENTS

A. Training: Upon certification, applicants must enroll at least the following personnel: clinical supervisors, corporate compliance officers and billing personnel who must successfully complete the "DBHS RSPMI Operation Technical Assistance Training Program" ("Program") within five (5) months of the certification date. DHS will offer the program at least quarterly. *See* Appendix # 4 for training agenda.

B. Care and Services must:

1. Comply with all state and federal laws, rules, and regulations applicable to the furnishing of health care funded in whole or in part by federal funds; to all state laws and policies applicable to Arkansas Medicaid generally, and to RSPMI services specifically, and to all applicable Department of Human Services ("DHS") policies including, without limitation, DHS Participant Exclusion Policy § 1088.0.0. The Participant Exclusion Policy is available online at https://dhsshare.arkansas.gov/DHS%20Policies/Forms/By%20Policy.aspx

2. Conform to professionally recognized behavioral health rehabilitative treatment models.

3. Be established by contemporaneous documentation that is accurate and demonstrates compliance. Documentation will be deemed to be contemporaneous if recorded by the end of the performing provider's first work period following the provision of the care or services to be documented, or as provided in the RSPMI manual, § 252.110, whichever is longer.

C. Applicants and RSPMI providers must:

1. Be a legal entity in good standing;
2. Maintain all required business licenses;
3. Adopt a mission statement to establish goals and guide activities;

4. Maintain a current organizational chart that identifies administrative and clinical chains of command.

D. Applicants/providers must establish and comply with operating policy that at a minimum implements credible practices and standards for:

1. Compliance;

2. Cultural competence;

3. Provision of services, including referral services, for clients that are indigent, have no source of third party payment, or both, including:

a. Procedures to follow when a client is rejected for lack of a third-party payment source or when a client is discharged for nonpayment of care.

b. Coordinated referral plans for clients that the provider lacks the capacity to provide medically necessary RSPMI care and services. Coordinated referral plans must:

i. Identify in the client record the medically necessary RSPMI services that the provider cannot or will not furnish;

ii. State the reason(s) in the client record that the provider cannot or will not furnish the care;

iii. Provide quality-control processes that assure compliance with care, discharge, and transition plans.

E. Minimum Staffing: Staffing shall be sufficient to establish and implement care plans for each RSPMI client, and must include the following:

1. **Chief Executive Officer/Executive Director (or functional equivalent) (full-time position or full-time equivalent positions):** The person or persons identified to carry out CEO/ED functions:

a. Is/are ultimately responsible for applicant/provider organization, staffing, policies and practices, and RSPMI service delivery;

b. Must possess a master's degree in behavioral health care, management, or a related field and experience, and meet any additional qualifications required by the provider's governing body. Other job-related education, experience, or both, may be substituted for all or part of these requirements upon approval of the provider's governing body.

2. **Clinical Director (or functional equivalent) (full-time position or full-time equivalent positions):** The person or persons identified to carry out clinical director functions must:

a. Report directly to the CEO/ED;

b. Be the DBHS contact for clinical and practice-related issues;

c. Be accountable for all clinical services (professional and paraprofessional);

d. Be responsible for RSPMI care and service quality and compliance;

e. Assure that all services are provided within each practitioner's scope of practice under Arkansas law and under such supervision as required by law for practitioners not licensed to practice independently;

f. Assure and document in the provider's official records the direct supervision of MHP's, either personally or though a documented chain of supervision.

g. Assure that licensed mental health professionals directly supervise paraprofessionals. Direct supervision ratios must not exceed one licensed mental health professional to ten (10) mental health paraprofessionals;

h. Possess independent Behavioral Health licensure in Arkansas as a Licensed Psychologist, Licensed Certified Social Worker, (LCSW), Licensed Psychological Examiner – Independent (LPE-I), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), or an Advanced Practice Nurse or Clinical Nurse Specialist (APN or CNS) with a specialty in psychiatry or mental health and a minimum of two years clinical experience post master's degree.

3. **Mental Health Professionals:**

a. MHP's may:

i. Provide direct behavioral health care;

ii. Delegate and oversee work assignments of MHPP's;

iii. Ensure compliance and conformity to the provider's policies and procedures;

iv. Provide direct supervision of MHPP's;

v. Provide case consultation and in-service training;

vi. Observe and evaluate performance of MHPP's.

b. MHP Supervision:

i. Communication between an MHP and the MHP's supervisor must include each of the following at least every twelve (12) months:

1. Assessment and referral skills, including the accuracy of assessments;

2. Appropriateness of treatment or service interventions in relation to the client needs;

3. Treatment/intervention effectiveness as reflected by the client meeting individual goals;

4. Issues of ethics, legal aspects of clinical practice, and professional standards;

5. The provision of feedback that enhances the skills of direct service personnel;

6. Clinical documentation issues identified through ongoing compliance review;

7. Cultural competency issues;

8. All areas noted as deficient or needing improvement.

ii. Documented client-specific face-to-face and other necessary communication regarding client care must occur between each MHP's supervisor and the MHP periodically (no less than every ninety (90) calendar days) in accordance with a schedule maintained in the provider's official records.

4. Mental Health Paraprofessionals:

a. Are MHP service extenders;

b. MHPP supervision must conform to the requirements for MHP supervision (*See* § VIII (E)(3)(b)) except that all requirements must be met every six (6) months, and one or more licensed health care professional(s) acting within the scope of his or her practice must have a face-to-face contact with each MHPP for the purpose of clinical supervision at least every fourteen (14) days, must have at least twelve (12) such face-to-face contacts every ninety (90) days, and such additional face-to-face contacts as are necessary in response to a client's unscheduled care needs, response or lack of response to treatment, or change of condition;

c. Providers must establish that MHPP supervision occurred via individualized written certifications created by a licensed mental health professional and filed in the provider's official records on a weekly basis, certifying:

i. That the licensed mental health professional periodically (in accordance with a schedule tailored to the client's condition and care needs and previously recorded in the provider's official records) communicated individualized client-specific instructions to the mental health paraprofessional describing the manner and methods for the delivery of paraprofessional services;

ii. That the licensed mental health professional periodically (in accordance with a schedule tailored to the client's condition and care needs and previously recorded in the provider's official records, but no less than every 30 days) personally observed the mental health paraprofessional delivering services to a client; that the observations were of sufficient duration to declare whether

paraprofessional services complied with the licensed mental health professional's instructions;

iii. The date, time, and duration of each supervisory communication with and observation of a mental health paraprofessional.

4. **Corporate Compliance Officer:**

a. Manages policy, practice standards and compliance, except compliance that is the responsibility of the medical records librarian;

b. Reports directly to the CEO/ED (except in circumstances where the compliance officer is required to report directly to a director, the board of directors, or an accrediting or oversight agency);

c. Has no direct responsibility for billings or collections;

d. Is the DBHS and Medicaid contact for DBHS certification, Medicaid enrollment, and compliance.

5. **Medical Director:**

a. Oversees RSPMI care planning, coordination, and delivery, and specifically:

i. Diagnoses, treats, and prescribes for behavioral illness;

ii. Is responsible and accountable for all client care, care planning, care coordination, and medication storage;

iii. Assures that physician care is available 24 hours a day, 7 days a week;

iv. May delegate client care to other physicians, subject to documented oversight and approval;

v. Assures that a physician participates in treatment planning and reviews;

vi. If the medical director is not a psychiatrist, a psychiatrist certified by one of the specialties of the American Board of Medical Specialties must service as a consultant to the medical director and to other staff, both medical and non-medical. If the provider serves clients under the age of twenty-one (21), the medical director shall have access to a board certified child psychiatrist, for example, through the Psychiatric Research Institute child/Adolescent Telephone Consultation Service;

vii. Medical director services may be acquired by contract.

b. If the medical director is not a psychiatrist then the medical director shall contact a consulting psychiatrist within twenty-four (24) hours in the following situations:

i. When antipsychotic or stimulant medications are used in dosages higher than recommended in guidelines published by the Arkansas Department of Human Services Division of Medical Services;

ii. When two (2) or more medications from the same pharmacological class are used;

iii. When there is significant clinical deterioration or crisis with enhanced risk of danger to self or others.

c. The consulting psychiatrist(s) shall participate in quarterly quality assurance meetings.

6. **Privacy Officer:** Develops and implements policies to assure compliance with privacy laws, regulations, and rules. Applicants/providers may assign privacy responsibilities to the Corporate Compliance Officer, Grievance Officer, or Medical Records Librarian, but not the CEO/ED.

7. **Quality Control Manager:** Chairs the quality assurance committee and develops and implements quality control and quality improvement activities. Applicants/providers may assign quality control manager responsibilities to the Corporate Compliance Officer or Medical Records Manager, but not the CEO/ED.

8. **Grievance Officer:**

a. Develops and implements the applicant's/provider's employee and client grievance procedures.

b. Effectively communicates grievance procedures to staff, contractors, prospective clients, and clients. Communications to clients who are legally incapacitated shall include communication to the client's responsible party.

c. The grievance officer shall not have any duties that may cause him/her to favor or disfavor any grievant.

9. **Medical Records Librarian:**

a. Must be qualified by education, training, and experience to understand and apply:

i. Medical and behavioral health terminology and usages covering the full range of services offered by the provider;

ii. Medical records forms and formats;

iii. Medical records classification systems and references such as The American Psychiatric Association's Diagnostic and Statistical Manual – IV-TR (DSM-IV-TR) and subsequent editions,

International Classification of Diseases (ICD), Diagnostic Related Groups (DRG's), Physician's Desk Reference (PDR), Current Procedural Terminology (CPT), medical dictionaries, manuals, textbooks, and glossaries.

iv. Legal and regulatory requirements of medical records to assure the record is acceptable as a legal document;

v. Laws and regulations on the confidentiality of medical records (Privacy Act and Freedom of Information Act) and the procedures for informed consent for release of information from the record.

vi. The interrelationship of record services with the rest of the facility's services.

b. Develops and implements:

i. The client information system;

ii. Operating methods and procedures covering all medical records functions.

iii. Insures that the medical record is complete, accurate, and compliant.

10. **Licensed Psychologist, Licensed Psychological Examiner (LPE), or Licensed Psychological Examiner – Independent (LPE-I):**

a. Provides psychological evaluations;

b. Each licensed psychological examiner or licensed psychological examiner-I must have supervision agreements with a doctoral psychologist to provide appropriate supervision or services for any evaluations or procedures that are required under or are outside the psychological examiner's scope of independent practice. Documentation of such agreements and of all required supervision and other practice arrangements must be included in the psychological examiner's personnel record;

c. Services may be acquired by contract.

F. Multidisciplinary Team(s): Providers must assign each client a multidisciplinary team that includes professionals and paraprofessionals as necessary to insure care coordination of each client's RSPMI care and services.

G. Quality Assurance Meetings:

Each provider must hold a quarterly quality assurance meeting.

H. Health Care Professional Notification/Disqualification:

a. Notice of covered health care practitioners:

i. Within twenty (20) days of the effective date of this rule, applicants/providers must notify the Medicaid Program Integrity Unit of the names of covered health care practitioners who are providing RSPMI services.

ii. On or before the tenth day of each month, providers must notify the Medicaid Program Integrity Unit of the names of all covered health care practitioners who are providing RSPMI services and whose names were not previously disclosed.

b. Licensed health care professionals may not furnish RSPMI services during any time the professional's license is subject to adverse license action.

c. Applicants/providers may not employ/engage a covered health care practitioner after learning that the practitioner:

i. Is excluded from Medicare, Medicaid, or both;

ii. Is debarred under Ark. Code Ann. § 19-11-245;

iii. Is excluded under DHS Policy 1088; or

iv. Was subject to a final determination that the provider failed to comply with professionally recognized standards of care, conduct, or both. For purposes of this subsection, "final determination" means a final court or administrative adjudication, or the result of an alternative dispute resolution process such as arbitration or mediation.

I. Applicants/providers must maintain documentation identifying the primary work location of all MHP's and mental health paraprofessionals.

J. Providers must maintain copies of disclosure forms signed by the client, or by the client's parent or guardian before RSPMI services are delivered except in emergencies. Such forms must at a minimum:

1. Disclose that the services to be provided are RSPMI;

2. Explain RSPMI eligibility, SED and SMI criteria;

3. Contain a brief description of RSPMI services;

4. Explain that all RSPMI care must be medically necessary;

5. Disclose that third party (e.g., Medicaid or insurance) RSPMI payments may be denied based on the third party payer's policies or rules;

6. Identify and define any services to be offered or provided in addition to RSPMI care, state whether there will be a charge for such services, and if so, document payment arrangements;

7. Notify that services may be discontinued by the client at any time;

8. Offer to provide copies of RSPMI rules;

9. Provide and explain contact information for making complaints to the provider regarding care delivery, discrimination, or any other dissatisfaction with RSPMI care;

10. Provide and explain contact information for making complaints to state and federal agencies that enforce compliance under § III(F)(1).

K. RSPMI services maintained at each site must include:

1. Psychiatric Evaluation and Medication Management;

2. Intervention Services;

3. Outpatient Services, including individual and family therapy at a minimum;

4. Crisis Services.

L. Providers must tailor all RSPMI care and services to individual client need. If client records contain entries that are materially identical, DBHS and the Division of Medical Services will rebuttably presume that this requirement is not met.

M. RSPMI for individuals under age eighteen (18): Providers must establish and implement policies for family identification and engagement in treatment for persons under age eighteen (18), including strategies for identifying and overcoming barriers to family involvement.

N. Emergency Response Services: Applicants/providers must establish, implement, and maintain a site-specific emergency response plan, which must include:

1. A 24-hour emergency telephone number;

2. The applicant/provider must:

a. Provide the 24-hour emergency telephone number to all clients;

b. Post the 24-hour emergency number on all public entries to each site;

c. Include the 24-hour emergency phone number on answering machine greetings;

d. Identify local law enforcement and medical facilities within a 50-mile radius that may be emergency responders to client emergencies.

3. Direct access to a MHP within fifteen (15) minutes of an emergency/crisis call and face-to-face crisis assessment within two (2) hours;

4. Response strategies based upon:

a. Time and place of occurrence;
b. Individual's status (client/non-client);
c. Contact source (family, law enforcement, health care provider, etc.).

5. Requirements for a face-to-face response to requests for emergency intervention received from a hospital or law enforcement agency regarding a current client.

6. All face-to-face emergency responses shall be:

a. Available 24 hours a day, 7 days a week;

b. Made by a MHP within two (2) hours of request (unless a different time frame is within clinical standards guidelines and mutually agreed upon by the requesting party and the MHP responding to the call).

7. Emergency services training requirements to ensure that emergency service are age-appropriate and comply with accreditation requirements. Providers shall maintain documentation of all emergency service training in each trainee's personnel file.

8. Requirements for clinical review by the clinical supervisor or emergency services director within 24 hours of each after-hours emergency intervention with such additional reporting as may be required by the provider's policy.

9. Requirements for documentation of all crisis calls, responses, collaborations, and outcomes;

10. Requirements that emergency responses not vary based on the client's funding source. If a client is eligible for inpatient behavioral health care funded through the community mental health centers and the provider is not a community mental health center with access to these funds, the provider must:

a. Determine whether the safest, least restrictive alternative is psychiatric hospitalization; and

b. Contact the appropriate community mental health center (CMHC) for consult and to request the CMHC to access local acute care funds for those over 21.

O. Each applicant/provider must establish and maintain procedures, competence, and capacity:

1. For assessment and individualized care planning and delivery;
2. For discharge planning integral to treatment;
3. For mobile care;
4. To assure that each MHP makes timely clinical disposition decisions;
5. To make timely referrals to other services;
6. To refer for inpatient services or less restrictive alternative;
7. To identify clients who need direct access to clinical staff, and to promptly provide such access.

P. Each applicant/provider must establish, maintain, and document a quality improvement program, to include:

1. Evidence based practices;

2. Use of the Youth Outcome Questionnaire (YOQ) for all clients over age four (4) and under age 21, except that the YOQ is not required for persons age eighteen (18) through twenty-one (21) who are certified to be seriously mentally ill.

3. Requirements for informing all clients and clients' responsible parties of the client's rights while accessing services.

4. Regular (at least quarterly) quality assurance meetings that include:

a. Clinical Record Reviews: medical record reviews of a minimum number of randomly selected charts. The minimum number is the lesser of a statistically valid sample yielding 95% confidence with a 5% margin of error; or 10% of all charts open at any time during the past three (3) months;

b. Program and services reviews that:

i. Assess and document whether care and services meet client needs;

ii. Identify unmet behavioral health needs;

iii. Establish and implement plans to address unmet needs.

Q. Technical Training and Consultation: Applicants may attend a "technical training for provider applicants" in-service training that will be conducted at least quarterly. The training explains the DBHS RSPMI certification application process and includes a review of RSPMI requirements. *See* Appendix # 4 for training agenda.

IX. HOME OFFICE

A. Each provider must maintain and identify a home office in the State of Arkansas;

B. The home office may be located at a site or may be solely an administrative office not requiring site certification;

C. The home office is solely responsible for governance and administration of all of the provider's Arkansas sites;

D. Home office governance and administration must be documented in a coordinated management plan;

E. The home office shall establish policies for maintaining client records, including policies designating where the original records are stored.

X. SITE REQUIREMENTS

A. All sites must be located in the State of Arkansas;

B. Accreditation documentation must specifically include each site.

XI. SITE RELOCATION, OPENING, AND CLOSING (Note: temporary service disruptions caused by inclement weather or power outages are not "closings.")

A. Planned Closings:

1. Upon deciding to close a site either temporarily or permanently, the provider immediately must provide written notice to clients, DBHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization.

2. Notice of site closure must state the site closure date;

3. If site closure is permanent, the site certification expires at 12:00 a.m. the day following the closure date stated in the notice;

4. If site closing is temporary, and is for reasons unrelated to adverse governmental action, DBHS may suspend the site certification for up to one (1) year if the provider maintains possession and control of the site. If the site is not operating and in compliance within the time specified in the site certification suspension, the site certification expires at 12:00 a.m. the day after the site certification suspension ends.

B. Unplanned Closings:

1. If a provider must involuntarily close a site due to, for example, fire, natural disaster, or adverse governmental action, the provider must immediately notify clients and families, DBHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization of the closure and the reason(s) for the closure.

2. Site certification expires in accordance with any pending regulatory action, or, if no regulatory action is pending, at 12:00 a.m. the day following permanent closure.

C. All Closings:

1. Providers must assure and document continuity of care for all clients who receive RSPMI at the site;

2. Notice of Closure and Continuing Care Options:

a. Providers must assure and document that clients and families receive actual notice of the closure, the closure date, and any information and instructions necessary for the client to obtain transition services;

b. After documenting that actual notice to a specific client was impossible despite the exercise of due diligence, providers may satisfy the client notice requirement by mailing a notice containing the information described in subsection (a), above, to the last known address provided by the client; and

c. Before closing, providers must post a public notice at each site entry. The public notice must include the name and contact information for all RSPMI providers within a fifty (50) mile radius of the site.

3. An acceptable transition plan is described below:

Transition Plan:
1. Identify and list all certified sites within a 50 mile radius. Include telephone numbers and physical addresses on the list.
2. Provide clients/families with the referral information and have them sign a transfer of records form/release of information to enable records to be transferred to the provider of their choice.
3. Transfer records to the designated provider.

4. Designate a records retrieval process as specified in Section I of the Arkansas Medicaid RSPMI Provider Policy Manual § 142.300.

5. Submit a reporting of transfer to DBHS (Attn: Policy & Certification Office) including a list of client names and the disposition of each referral. See example below:

Name	Referred to:	Records Transfer Status:	RX Needs Met By:
Johnny	OP Provider Name	to be delivered 4/30/20XX	Provided 1 month RX
Mary	Private Provider Name	Delivered 4/28/20XX	No Meds
Judy	Declined Referral	XX	

6. DBHS may require additional information regarding documentation of client transfers to insure that client needs are addressed and met.

A site closing Form is available at: www.arkansas.gov/dhs/dmhs *See* appendix # 9

D. New Sites: Providers may apply for a new site by completing the new site Form available at www.arkansas.gov/dhs/dmhs

See appendix # 10 DBHS Form # 5 – (Adding Site)

E. Site Transfer:

1. At least forty-five (45) calendar days before a proposed transfer of an accredited site, the provider must apply to DBHS to transfer site certification. The application must include documentation that:

a. The provider notified the accrediting entity, and the accrediting entity has extended or will extend accreditation to the second site; or

b. The accrediting entity has established an accreditation timeframe.

2. The provider must notify clients and families, DBHS, the Division of Medical Services, the Medicaid fiscal agent, and the accrediting organization at least thirty (30) calendar days before the transfer;

3. DBHS does not require an on-site survey, nor does the Division of Medical Services require a new Medicaid provider number. The moving or transferring site form is available at: www.arkansas.gov/dhs/dmhs

See appendix # 9 – DBHS Form # 4 (Closing and Moving Sites)

F. Site Relocation: The provider must follow the rules for closing the original site, and the rules for opening a new site.

XII. PROVIDER RE-CERTIFICATION

A. The term of DBHS site certification is concurrent with the provider's national accreditation cycle, except that site certification extends six months past the accreditation expiration month if there is no interruption in the accreditation. (The six-month extension is to give the RSPMI provider time to receive a final report from the accrediting organization, which the provider must immediately forward to DBHS.)

B. Providers must furnish DBHS a copy of:

1. Correspondence related to the provider's request for re-accreditation:

   a. Providers shall send DBHS copies of correspondence from the accrediting agency within five (5) business days of receipt;

   b. Providers shall furnish DBHS copies of correspondence to the accrediting organization concurrently with sending originals to the accrediting organization.

2. An application for provider and site recertification:

   a. DBHS must receive provider and site recertification applications at least fifteen (15) business days before the DBHS RSPMI certification expiration date;

   b. The Re-Certification form with required documentation is available at www.arkansas.gov/dhs/dmhs

   See Appendix # 11 DBHS Form 3 (Re-certification)

C. If DBHS has not recertified the provider and site(s) before the certification expiration date, certification is void beginning 12:00 a.m. the next day.

XIII. MAINTAINING DBHS RSPMI CERTIFICATION

A. Providers must:

1. Maintain compliance;

2. Assure that DBHS certification information is current, and to that end must notify DBHS within thirty (30) calendar days of any change affecting the accuracy of the provider's certification records;

3. Furnish DBHS all correspondence in any form (e.g., letter, facsimile, email) to and from the accrediting organization to DBHS within thirty (30) calendar days of the date the correspondence was sent or received except:

   a. As stated in § XII;

b. Correspondence related to any change of accreditation status, which providers must send to DBHS within three (3) calendar days of the date the correspondence was sent or received.

c. Correspondence related to changes in service delivery, site location, or organizational structure, which providers must send to DBHS within ten (10) calendar days of the date the correspondence was sent or received.

4. Display the RSPMI certificate for each site at a prominent public location within the site

B. Annual Reports:

1. Providers must furnish annual reports to DBHS before July 1 of each year that the provider has been in operation for the preceding twelve (12) months. Community Mental Health Centers and specialty clinics may meet this requirement by submitting the Annual Plan/Basic Services Plan to DBHS.

2. Annual report shall be prepared by completing forms provided by DBHS. The annual report form is available at www.arkansas.gov/dhs/dmhs and at Appendix # 12 DBHS Form # 6

XIV. NONCOMPLIANCE

A. Failure to comply with this rule may result in one or more of the following:

1. Submission and implementation of an acceptable corrective action plan as a condition of retaining RSPMI certification;

2. Suspension of RSPMI certification for either a fixed period or until the provider meets all conditions specified in the suspension notice;

3. Termination of RSPMI certification.

XV. APPEAL PROCESS

A. If DBHS denies, suspends, or revokes any DBHS RSPMI certification (takes adverse action), the affected proposed provider or provider may appeal the DBHS adverse action. Notice of adverse action shall comply with Ark. Code Ann. §§ 20-77-1701-1705, and §§1708-1713. Appeals must be submitted in writing to the DBHS Director. The provider has thirty (30) calendar days from the date of the notice of adverse action to appeal. An appeal request received within thirty-five (35) calendar days of the date of the notice will be deemed timely. The appeal must state with particularity the error or errors asserted to have been made by DBHS in denying certification, and cite the legal authority for each

assertion of error. The provider may elect to continue Medicaid billing under the RSPMI program during the appeals process. If the appeal is denied, the provider must return all monies received for RSPMI services provided during the appeals process.

B. Within thirty (30) calendar days after receiving an appeal the DBHS Director shall: (1) designate a person who did not participate in reviewing the application or in the appealed-from adverse decision to hear the appeal; (2) set a date for the appeal hearing; (3) notify the appellant in writing of the date, time, and place of the hearing. The hearing shall be set within sixty (60) calendar days of the date DBHS receives the request for appeal, unless a party to the appeal requests and receives a continuance for good cause.

C. DBHS shall tape record each hearing.

D. The hearing official shall issue the decision within forty-five (45) calendar days of the date that the hearing record is completed and closed. The hearing official shall issue the decision in a written document that contains findings of fact, conclusions of law, and the decision. The findings, conclusions, and decision shall be mailed to the appellant except that if the appellant is represented by counsel, a copy of the findings, conclusions, and decision shall also be mailed to the appellant's counsel. The decision is the final agency determination under the Administrative Procedure Act.

E. Delays caused by the appealing party shall not count against any deadline. Failure to issue a decision within the time required is not a decision on the merits and shall not alter the rights or status of any party to the appeal, except that any party may pursue legal process to compel the hearing official to render a decision.

F. Except to the extent that they are inconsistent with this policy, the appeal procedures in the Arkansas Medicaid RSPMI Provider Manual are incorporated by reference and shall control.

7. Program Integrity

Block grant funds are distributed to providers per performance based contracting. Per this contract providers are required to comply with statutes and regulations applicable to the funding source. The contract language states that providers must utilize funds provided under the contract (which includes all block grant funding distributed to providers) to deliver a wide array of behavioral healthcare services to indigent persons who do not have health insurance and who are not eligible for other health care coverage such as Medicaid, Medicare or private health insurance. For this year's contract a specific deliverable was included stating the requirements for complying with the requirement for the 5% Set Aside of Block Grant funding for 1st Episode of Psychosis.

DBHS has established a Quality Assurance (QA) process to oversee a program improvement plan for Division sponsored and support programs. QA has established monitoring programs to track provider outcome measures and quality improvement goals. QA interfaces with the finance office to conduct service to billing audits, and reviews provider resource plans and measures for program deliverables.

Block Grant funded providers submit an Annual Plans to DBHS for review. The plans include accounts of the services to be provided and the related funds to be expended. However, the expenditures are not broken down to the clients served. These plans are reviewed by Program Staff at DBHS. Additionally, the Contract Support Office of the Department of Human Services also conducts annual audits of all the funded providers.

The substance abuse treatment providers send in monthly invoices for the services rendered to the Division's finance office. The invoices are compared against the billing summaries in the ADMIS database system.

The Quality Assurance unit within DBHS has an audit process assigned to monitor substance abuse providers that receive SAMHSA Grant funds. This process is being refined to include more audit activities and to work closely with the finance office. Additionally, the finance office generates an expenditure and utilization report for the Division which includes a section on how the substance abuse treatment funded providers are spending their money on quarterly basis. The Division also has a staff dedicated to performing service to billing audits of all the substance abuse treatment providers on an annual basis.

All behavioral health and addiction treatment providers are subject to division monitoring of program components and service delivery processes. Providers must comply with state rules regarding standards of care and service guidelines as set forth in the DBHS Rehabilitative Services for Persons with Mental Illness (RSPMI) Rule for Certification. Addiction Treatment providers are regulated by Licensure Standards for Alcohol and Other Drug Abuse Treatment Programs. Providers may be monitored at any time when a need, concern or compliant arises. They are also monitored at least on an annual basis.

Block Grant funded provider services are captured in the ADMIS database for substance abuse treatment, in the SPQM data base for Community Mental Health Centers, and KIT MDS data bases for prevention activities.

Under the terms of their contracts, providers are required to submit a copy of their annual audit report as issued by their independent auditors to the DHS Office of Quality Assurance. After reviewing the audit reports submitted by providers, the DHS Office of Quality Assurance sends a letter to the provider acknowledging receipt of the audit and their opinion of the audit report. The DBHS CFO is copied on all letters sent to solicit or acknowledge receipt of audit reports. The DBHS CFO reviews reports as submitted and if findings were reported, the DBHS Program Manager and DBHS CFO would work with the DHS OQA and the provider management staff to ensure a plan was put in place to correct any identified deficiencies.

Mental Health Block Grant allocations to providers are calculated using population census totals for both adult and children populations. The terms and conditions of the contract define allowable services and payment guidelines. Each provider receives 1/12 of their allocation each month in a scheduled payment for mental health block grant funds. For substance abuse prevention and treatment, RFP's are issued to select providers. As a part of the RFP process providers are required to submit a budget for providing services. The terms and conditions of the contracts define allowable services as well as billing guidelines. Providers submit monthly invoices which are reviewed by DBHS finance and program staff to ensure billing meets grant and contract guidelines prior to payment. All procurement and invoices processing procedures are governed by the Arkansas Department of Finance and Administration Financial Management Guidelines and State Procurement Law.

DBHS makes technical assistance available to any provider with questions or for educational purposes. Technical assistance may be by remote access office contact, or by scheduling an onsite visit at the provider's location. DBHS also makes staff available for any provider organization meeting as requested.

There are interdivisional quarterly trainings provided specifically for behavioral health provider's education that include regulations, compliance, and practice development information. Addiction treatment providers are offered division sponsored trainings to complete various certification requirements for state licensure. Various training and technical assistance activities are offered to the addiction treatment providers on a regular basis.

All funded programs are required to be nationally accredited by either Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission on the Accreditation of Health Care Organization (JACHO), or the Council on Accreditation (CAO). These accrediting bodies require organizations to comply with their quality, safety, and other standards in order to be accredited.

Block Grant and state dollars are distributed to providers per a contract that requires these funds be use to deliver a wide array of behavioral healthcare services to indigent persons who do not have health insurance and for services that do not qualify for coverage such as Medicaid, Medicare or private health insurance. DBHS' Substance Abuse and Mental Health data base

(ADMIS and SPQM) also track funding expended by payor type. Outcome monitoring includes an annual MHSIP consumer satisfaction survey, based on a state-wide random sample of both adult and child consumers. The state for several years has also used the YOQ to monitor outcomes for children's services. However, the Division is currently in the final stages of deciding on a new instrument to use for this purpose.

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:

8. Tribes

The state of Arkansas does not have any federally recognized tribes.

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:

9. Primary Prevention for Substance Abuse

1. Please indicate if the state has an active SEOW. If so, please describe:

The Arkansas State Epidemiological Outcomes Workgroup (AR-SEOW) is actively meeting and producing data reports and informational tools. In addition, the analytics team which supports the workgroup disseminates AR-SEOW data materials, provides technical assistance and conducts trainings.

The types of data collected by the SEOW includes:

- Alcohol, tobacco, and other drug use indicators for youth and adults
- Consequences including developmental, physiological, psychological, and community indicators
- Contributing factors related to individuals, family, peers, school settings, and the community
- Treatment admissions

The populations for which data is collected includes:

- Youth
- Young adults
- Adults
- Minorities
- Rural and urban communities

The data sources used includes:

- American Lung Association, Estimated Prevalence and Incidence of Lung Disease report
- Arkansas Alcoholic Beverage Control (ABC)
- Arkansas Community Mental Health Center (CMHC) client satisfaction surveys
- Arkansas Crime Information Center (ACIC)
- Arkansas Department of Education (ADE)
- Arkansas Department of Finance and Administration
- Arkansas Department of Health (ADH)
- Arkansas Department of Human Services (DHS) Division of Behavioral Health Services (DBHS) Alcohol and Drug Information System (ADMIS)
- Arkansas Prevention Needs student survey (APNA)
- Arkansas State Police, Highway Safety Office
- Arkansas Synar Reports
- Arkansas Tobacco Control Board (ATCB)
- Centers for Disease Control and Prevention (CDC) WISQARS Injury Mortality Reports
- Core Alcohol and Drug Survey
- County Health Rankings and Roadmaps, Robert Wood Johnson Foundation
- Monitoring the Future survey (MTF)
- National Adult Tobacco Survey (NATS)
- National Institute on Alcohol Abuse and Alcoholism (NIAAA)
- National Survey on Drug Use and Health (NSDUH)

- Pregnancy Risk Assessment Monitoring System (PRAMS)
- SAMHSA Centers for Mental Health Services (CMHS) Uniform Reporting System output tables (URS)
- SAMHSA Treatment Episode Data Set (TEDS)
- University of Arkansas at Little Rock (UALR) Survey Research Center
- US Census Bureau
- US Department of Justice, US Drug Enforcement Agency
- US Department of Labor
- Youth Risk Behavior Surveillance System (YRBSS)
- Youth Tobacco Survey (YTS – active survey through 2010)

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds;

The Arkansas Prevention Needs Assessment Survey (APNA) is to collect data on health risk behaviors such as violence and alcohol, tobacco and other drug use that could result in injury and/or impede positive development among youth. The survey also assesses risk and protective factors, which include attitudes and opinions that have been shown through research to predict involvement in the health risk behaviors. Public school districts are offered the opportunity for all students enrolled in grades 6, 8, 10, and 12 to be surveyed.

By comparing the results of the previous surveys, changes in ATOD (alcohol, tobacco and other drugs) use, rates of ASB (antisocial behavior) and levels of risk and protective factors can be determined for a specific grade. Although the target populations for the substance abuse prevention efforts are across the lifespan and not children only, it is a requirement that all of the substance abuse prevention providers' efforts are all data-driven and the Arkansas Prevention Needs Assessment Survey is a key component of the primary prevention data.

The APNA Survey was first administered in the fall of 2002 and has been administered in the fall of each school year since then.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

Capacity development will be accomplished through various initiatives that include information dissemination, education/training, problem identification and referral, alternative activities, community-based process, and environmental strategies. The state intends to build capacity by

- Determining available resources and existing gaps in prevention services. An action plan will be developed to address the identified gaps. This will help the state to determine readiness.
- Engaging behavioral health stakeholders to improve awareness of substance abuse problems in the state and the need to address these problems.
- Strengthening existing partnerships and identifying new opportunities for collaboration with other agencies or organizations to share resources and information needed for prevention planning.
- Developing the workforce and equipping prevention providers with the knowledge to deliver prevention services and interventions. The Division of Behavioral Health

Services is working with Southwest Center for the Application of Prevention Technologies (SWCAPT) to organize (TOTs) for the Regional Prevention Providers.
- Strengthening data collection systems and organizational infrastructure.
- Ensuring cultural competence and sustainability in prevention planning, services and activities to improve the effectiveness of prevention efforts.
-

The primary focus of the programs, practices, and strategies funded through the SABG prevention set-aside is to assist with building capacity within the communities, implement evidence-based prevention programs, and strategies within the communities and to promote understanding of the Strategic Prevention Framework.

4. Please describe if the state has:

a. A statewide licensing or certification program for the substance abuse prevention workforce;
Arkansas Prevention Certification Board- the Arkansas Prevention Certification Board (APCB) oversees and evaluates the certification process for the state of Arkansas. APCB believes all individuals working in the field of prevention have a responsibility to the general public, their clientele, their employers and themselves to be positive role models. APCB is a member of the International Certification and Reciprocity Consortium (IC & RC).

b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
University of Arkansas Little Rock MidSOUTH Center for Prevention and Training is the workforce development initiative that provides technical assistance and training on a variety of prevention topics reflecting the most current, science-based approaches to prevention professionals in their efforts to plan, implement, and evaluate science-based programming around the prevention of substance abuse, violence, and other high-risk behaviors. University of Arkansas Little Rock MidSOUTH Center has five training locations across the state.

c. A formal mechanism to assess community readiness to implement prevention strategies.
The state will implement the Strategic Prevention Process (assessment, capacity, planning, implementation, evaluation). One of the components within the step of assessment is community readiness. To determine the stage of community readiness we will implement the nine (9) stages of readiness.

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)?
Arkansas State Profiles focus on the consumption and consequences of substance use, which is the first step towards developing effective prevention strategies as the information is used to identify the types of substance use disorders and their consequences specific to Arkansas. In an effort to further inform strategic planning of prevention efforts, the current Arkansas State Epidemiological Profile also focuses on shared risk and protective factors that contribute to the

development and continuance of both substance use and mental health disorders. Decreasing the prevalence of these risk factors means decreasing the likelihood of individuals developing substance use or disorders.

6. **Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years?** Yes.

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. Response: Arkansas distributes MHBG funds in contracts to 13 Community Mental Health Centers (CMHC) across the state. Due to state procurement policy, those contracts are developed in January in order for the contract to be completed and effective for the state fiscal year beginning July 1. As such, funds for State Fiscal Year 2015 (beginning July 1, 2014 and ending June 30, 2015) were distributed and are being fully utilized by the CMHCs for program support.

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.
Arkansas State Epidemiological Outcomes Workgroup (AR-SEOW)-The primary focus of the programs, practices, and strategies funded through the SABG prevention set-aside is to assist with building the capacity within communities, implement evidence-based prevention programs, and strategies within the communities and to promote understanding of the Strategic Prevention Framework. DBHS intends to fund an array of statewide, regional and community based primary prevention services, including:

- Eight Regional Prevention Providers (RPPs): RPPs provide prevention capacity development within regions and communities they serve to support statewide prevention efforts and programming. RPPs use the Strategic Prevention Framework to plan, develop, implement, and sustain effective prevention initiatives.
- University of Arkansas Little Rock MidSOUTH Center for Prevention and Training: is a workforce development initiative that provides technical assistance and training on a variety of prevention topics reflecting the most current, science-based approaches to prevention and strives to assist prevention professionals in their efforts to plan, implement, and evaluate science-based programming around the prevention of substance abuse, violence, and other high-risk behaviors.
- The Arkansas Prevention Certification Board (APCB): This body oversees and evaluates the certification process for the state of Arkansas. APCB is a member of the International Certification and Reciprocity Consortium (IC&RC).
- Arkansas Prevention Network (APNet): APNet establishes and facilitates a statewide network of prevention professionals and stakeholders to share information about evidence-based and emerging programs, practices and policies, and the resources to develop and implement these strategies. APNet also advocates for the prevention practitioners by working to promote, establish, and maintain a support system for them.

- Arkansas State Epidemiological Workgroup (AR-SEW): The AR-SEW was founded in 2005 to improve behavior health by using data-driven decision making and analytical thinking to address the causes and consequences of the use of alcohol, tobacco and other drugs. The SEW compiles the Statewide Epidemiological Profile from various national and state agencies to integrate information about the causes and consequences of the use of alcohol, tobacco, and other drugs in both adults and children.

The state supports development and implementation of a wide array of primary prevention interventions to meet community needs and gaps in prevention services. Strategies based on assessment of needs, resources, and readiness are used to ensure funded prevention interventions to reduce risks and enhance protective factors.

SABG dollars set aside for primary prevention services not funded through other means are through prevention initiatives such as Fetal Alcohol Spectrum Disorders (FASD) Initiative, Arkansas Drug and Alcohol Safety Education Program (DASEP), Suicide Prevention and Early Intervention Programs, Gambling Prevention Initiative, Screening Brief Intervention, and early Referral to Treatment Initiative

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.

a. Information Dissemination: This strategy 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 source to the audience, with limited contact between the two. Examples: clearinghouse/information resource centers, media campaigns. Speaking engagements, and health fairs.

b. Education: This strategy 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 abilities. Organizational infrastructure, planning, and evaluation skills are part of capacity development education. There is more interaction between facilitators and participants than in the information strategy. Examples: Coalition training and peer leader/helper programs.

c. Alternatives: This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities and to discourage the use of alcohol and other drugs. Examples: Recreation activities, drug-free dances and parties, and community service activities.

d. Problem Identification and Referral: This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity to

determine if a person is in need of treatment. Example: Employee Assistance programs, student assistance programs, and DWI/DUI education programs.

e. Community-based Process: This strategy provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses grassroots empowerment models using action planning and collaborative systems planning. Examples: Community teambuilding, multi-agency coordination and collaboration, and accessing services and funding.

f. Environmental: This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population. Example: Modifying alcohol and tobacco advertising practices, product pricing strategies, and promoting the establishment of review of alcohol, tobacco, and drug use policies.

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
No state allocation is set aside dollars for primary prevention services. The only other funding available is the SAMHSA approved Partnership for Success (PFS).

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?
DBHS has currently acquired an integrated web-based data based the WITS system. WITS is a web based application designed to meet the growing need to capture client treatment data, Prevention Program Annual plans and satisfy mandatory government reporting requirements for the planning, administration, and monitoring of Prevention Programs. WITS include robust billing capabilities and an integrated contract management module allowing for multiple forms of provider management and billing between the government entity and its community of providers.

WITS consist of numerous clinical, administrative and reporting modules that are organized by the workflow process, giving the Prevention Program to customize the system. The system is used to capture the CSAP prevention categories.

DBHS continues to work with the substance abuse and mental health providers by providing various service utilization and client satisfaction reports and technical assistance on various related topics on a regular and as needed basis.

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?
The Arkansas Prevention Needs Assessment Student Survey will collect the outcome data of 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use, age of first use of ATOD, average age of first been arrested, average age of first attacked to harm, lifetime use, and average of first use and antisocial behavior

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:

A Review of the Arkansas Division of Children and Family Services

July 6, 2015

Conducted by: The Child Welfare Policy and Practice Group

Supported by: Casey Family Programs

Acknowledgements

The Child Welfare Policy and Practice Group is a non-profit technical assistance organization focused on improving child and family outcomes by improving front-line practice. Information about the organization can be seen at www.childwelfaregroup.org.

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Funding for this evaluation was provided by Casey Family Programs. The opinions and recommendations included in this report, however, are those of The Child Welfare Policy and Practice Group

Gratitude is expressed to the many dedicated DCFS staff, stakeholders and individuals who committed time to contribute to this report through interviews and sharing of written materials. Their input was essential to conducting this evaluation.

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Executive Summary

Introduction

In March of 2015, Governor Hutchinson commissioned a broad review of DCFS operations and performance, intended to identify what worked well, what needed improvement and how the system might be strengthened. Paul Vincent, Director of The Child Welfare Policy and Practice Group, a nonprofit technical assistance organization, was asked to conduct the review. Casey Family Programs, which has been assisting the State, agreed to support the review financially.

This review of the Arkansas child welfare system and specifically the Division of Child and Family Services (DCFS) was conducted by reviewing DCFS policy and procedures, agency performance and trend data, internal studies and interviews with approximately 200 DCFS staff and external stakeholders. DCFS staff at all levels were interviewed and external stakeholders consisted of legislators, judges, other state agency representatives, other legal partners, foster and adoptive parents, service providers, former foster youth, advocates and other individuals and groups with an interest in the welfare of children. The input of those individuals was critical to the accurate analysis of the child welfare system. A list of the stakeholder groups interviewed is placed in the Appendix.

This review confirmed the high importance the State places on children in the child welfare system. For example, the rate of child maltreatment reporting in Arkansas at 72.9 reports per 1,000 children, is considerably higher than the average rate of 47.1 nationally (according to the Children's Bureau publication *Child Maltreatment 2013*). It is also higher than surrounding states, where rates are:

Texas – 28.2
Missouri – 56.0
Oklahoma – 63.2
Louisiana – 37.7.

The Arkansas legislature also takes a strong interest in children served by DCFS. Bills guiding DCFS operations are often considered by the legislature, such as recent statutes addressing the child fatality review process, visits with siblings by children in foster care and judicial review of DCFS child protection planning, for example. Arkansas may be the only state in the country to create a role for the State Police in receiving all child maltreatment reports.

The legislature, the judicial system, advocates and concerned citizens also set high performance expectations for DCFS, which now produces a sophisticated array of reports and analyses about its operations. Those data were a major source of information for this report.

DCFS Performance and Challenges

Child Safety:

The annual number of child maltreatment reports assigned to DCFS is now fairly stable, at around 27,800. The rate at which reports were found true (or substantiated) is 22%, near the national average.

DCFS performs at a relatively high level in initiating child maltreatment investigations timely, although the percentage of timely initiations has dropped somewhat from 94% in 2011 for Priority I investigations to 86% in 2015. The thoroughness of investigations has improved, from 58% in 2011 to 70% in 2015. DCFS improved the percentage in which caseworkers had a face-to-face contact with in-home families during the prior three months from 75.8% in 2011 to 82.3 % in 2013. However, monthly visits in in-home cases occurred only in 66 percent of cases.

The percentage of children with true allegations with a subsequent report in six months is 6% currently, slightly higher than the national standard of 5.4%. The percentage has gone down from a high of 9% in 2012. The percentage of children receiving supportive or protective services (in-home) who are abused or neglected within one year is at 9%, down from 15% the two preceding years.

There has been an increase in child fatalities where the family was known to DCFS from 23 fatalities in FY 2011 to 40 (to date) in FY 2015, but no causal effects were evident in this review. Nationally, only two states, Oklahoma and West Virginia, have a higher rate of total child fatalities than Arkansas, which is at 4.09 per100,000 children, according to *Child Maltreatment 2013,* a Children's Bureau Publication.

Child Permanency:

Recently, DCFS began experiencing a declining number of children exiting foster care. The number of children entering care has been stable at 3,835 for 2014, meaning the total number of children in foster care is rising. In the past two months, the total number has risen from 3,875 to 4,323, a significant level of growth. DCFS also has a relatively high number of foster children in non-family settings, at 19%. Only 12 states have a higher percentage. An equally concerning, but not new trend is what DCFS staff and many stakeholders refer to as the placement crisis. Currently nearly 55% of children are placed in a county outside of their own county. The underlying reason for this trend is that there are not enough foster and relative homes to meet the demand. Statewide, there are only 0.66 foster care beds per child. There

has been little or no net growth in the number of family foster home beds, despite recruitment efforts.

Arkansas also has a low rate of placements of children with relatives, which increases the placement challenge. The percentage of relative placements in Arkansas in 14%, which compares with the following in nearby states:

Louisiana 21%
Mississippi 26%
Missouri 21%
Oklahoma 29%
Texas 29%

The foster care placement shortage has become so severe that in the period January-April 2015, 22 children in foster care spent the night in a DCFS office because no placement could be found. There is also a pattern in some areas where children are placed in different foster homes each night until a more long-term placement can be found. Caseworkers spend an inordinate amount of time driving children to distant placements, visiting them and in some cases, taking them to visits with family members. At the front-line, average DCFS caseworker caseloads are over 29 cases, nearly double the national recommended standard of 1/15. Despite these challenges, data show that DCFS generally performs better than national standards relative to the length of time children spend in foster care, reunification within 12 months and rates of re-entry to care.

The placement shortage is having a major impact on child stability, unfortunately. Children are now more likely to be in multiple emergency short-term placements and placement disruptions are rising.

DCFS has been able to decrease the average time to adoption, from 25.4 months in 2011 to 22.1 months in 2014. In 2014, DCFS experienced finalized adoptions with 724 children, a commendable accomplishment for the Division and its adoption partners. DCFS expanded its policy on post-adoptive services in 2015, issuing new policy guidance to staff and providing more information about post-adoptive services to pre-adoptive families.

Organizational Accomplishments and Challenges

To help address the resource challenges, rising staff caseloads and foster care growth, DCFS has implemented a number of major initiatives intended to address some of the problems it faces. DCFS was granted a federal waiver to permit use of federal foster care funds more flexibly, won a federal foster and adoptive recruitment and retention grant, implemented new casework assessment tools, created an Advocacy Council to provide external input, provided new training to staff, implemented provisions of new statutes permitting guardianships and fictive kin to become caregivers and implemented Differential Response, a flexible assessment process for low-risk child protection cases, among many others.

DCFS has struggled to fully engage external stakeholders in some areas and in the counties with the greatest workload burdens, has a frustrated and discouraged work force. This has increased turnover and contributed to workload stresses. The State's mental health system is also experiencing challenges, especially in developing the ability to provide the type of home and community-based mental health supports needed by children in foster care and some adoptive homes.

Recommendations

This report contains 11 recommendations, the first 8 of which could be implemented with little or no additional revenue. Two of the most critical, however, expanding home and community based mental health services and reducing DCFS caseloads, would require additional funding. In summary, the recommendations are as follow:

- Designate a Staff Member in the Governor's Office to Coordinate Interagency Planning and System Collaboration for Children, Youth and Family Services
- Build DCFS Capacity to Partner with Stakeholders
- Address the Shortage of Placements
- Create a DCFS County-Central Office Task Force to Address Local Administrative Flexibility
- Strengthen the DCFS - Administrative Office of Courts Relationship
- Expedite the Process for Filling DCFS Vacancies
- Develop and Implement a Principle-Based DCFS Model of Practice
- Strengthen DCFS Assessment and Family Engagement Skills
- Expand the Availability of Intensive Home and Community-Based Mental Health Services
- Develop a Three-Year Plan to Reduce DCFS Caseloads

DCFS finds itself at the intersection of a growing foster care population, worker caseloads of nearly twice the national standard, an insufficient number of foster home and relative placements and high expectations for performance among its partners. Despite these challenges, the Division is able to meet or exceed a number of national standards for performance, however many obstacles remain. The Division has embarked on an array of ambitious initiatives in an attempt to manage the challenges it faces, but at this point appears to be at the limits of its capacity to make significant additional gains. To progress in improving child and family outcomes, DCFS needs to form strong partnerships with its partners, leading to a shared vision and strategies for serving the State's children and families. In addition, it will need additional resources with which to achieve that goal.

A Review of the Arkansas Division of Children and Families Conducted by The Child Welfare Policy and Practice Group July 6, 2015

I. Introduction

In March, 2015, Governor Hutchinson directed that a broad study of the State's child welfare system be conducted to identify the strengths and challenges within the system. Paul Vincent, the Director of The Child Welfare Policy and Practice Group, a non-profit technical assistance organization, was asked to conduct this study. Casey Family Programs committed to provide financial support for the evaluation. The following is a summary report of the results of that study.

II. Methodology

The study was conducted between April and June 2015 and involved four primary means of evaluation. These included a review of DCFS policies, procedures, standards and guidelines, review of DCFS data on system performance and outcomes, review of internal special studies conducted by the Division and stakeholder interviews with individuals and groups both within and external to DCFS. The findings of those data and information collection activities are summarized below.

III. A Snapshot of the System

The following is a summary of key child and family, workload and resource factors that impact system performance and child and family outcomes.

Period	SFY 2013 – 2nd Quarter	SFY 2014 – 2nd Quarter	SFY 2015 – 2nd Quarter
Reports of Maltreatment	9,166 DCFS 7,670 CACD 1,496	7,697 DCFS 6,518 CACD 1,179	8,177 DCFS 6,757 CACD 1,420.
Number of Children Out-of-Home	3,862	3,855	3,875 By May 14, 2015 total was 4,323 children
In-Home PS Cases (Includes In-Home and Supportive	3,036 cases involving 6,983	2,787 cases involving 6,360	3,875 cases involving 5,921

Services cases)	children	children	children
Children Free for Adoption	398	511	572
Total Family Foster Homes	1,127	1,248	1,190
Number of Children in Emergency Shelter	157	154	155
Number of Children in Residential Group Care	452	424	465
Number of Children in Therapeutic Foster Care	298	308	310
Number of Children Placed Out- of - County	1,989	2,037	2,100
Number of Children Placed Outside of Home County and Neighboring County	1,274	1,298	1,387
Average Worker Caseload	29.8	27.2	28.96

Some of the trends reflected above, such as reports of maltreatment and children in certain settings are stable. However other critical indicators are rising, which has major implications for child and family outcomes and the ability of DCFS to meet its mandates. Most troubling are high caseworker caseloads, the number of children placed outside of their own counties, increasing numbers of children placed in out-of-home care and an insufficient number of family-based placements.

IV. DCFS and System Strengths

In the face growing demands, DCFS has undertaken an ambitious agenda in seeking system improvements over the past several years, implementing a number of initiatives that are considered to be promising and best practices nationally. One of the most significant is securing federal approval for a IV-E Waiver Demonstration Project, which permits child welfare systems to utilize federal foster care funds for families whose children remain at home. States operating with a Waiver have their Title IV-E funding capped.

Other DCFS initiatives have included:

Implementing a Differential Response initiative. DCFS describes Differential Response as:

> Differential Response (DR) is a method that allows the Division to respond to reports of specific, low risk allegations of child maltreatment with a Family Assessment (FA) rather than the traditional investigative response. As with investigations, Differential Response is initiated through accepted Child Abuse Hotline reports and focuses on the safety, permanency and well-being of the child. Having two different response options in the child welfare system recognizes that there are variations in the severity of the reported maltreatment and allows for a Differential Response or an investigation, whichever is most appropriate, to respond to reports of child neglect.

Securing a federal Diligent Recruitment Grant, to recruit and support resource families in the four DCFS Areas in the highest need

Utilizing the respected technical assistance organization, Hornby and Zeller, to support the Division's Quality assurance and quality improvement efforts

Implementing the CANS (for children in out-of-home care) and FAST (foe children living with their own families) assessment tools

Establishing the DCFS Advocacy Council

Implementing Structured Decision Making, a safety and risk assessment tool in national use

Implementing Permanency Roundtables, a Casey Family Programs sponsored approach to moving children and youth to permanency

Beginning Quality Service Reviews of investigative cases

Developing transitional homes for older youth

Conducting Trauma-Informed Care training for staff

Developing a foster care and adoption matching web site

Implementing a New Worker Training structure

Issuing policy implementing a statute allowing fictive kin as provisional homes

Developing and implementing policy for the subsidized guardianship program

In addition to these efforts, the Division of Medical Services, with the support of DCFS and the Division of Behavioral Health Services, reduced the percentage of children on anti-psychotics by 86 percent and reduced the percentage among children in foster care by 90 percent.

V. Child Safety

DCFS shares child protection responsibility with the Crimes Against Children Division (CACD) of the Arkansas State Police, which is responsible for receiving all reports of suspected maltreatment. CACD determines if the report meets the criteria for child maltreatment, assigns response priorities to the report based on risk and severity of the alleged maltreatment and determines whether the CACD or DCFS should be responsible for investigation of the allegations. CACD also has responsibility for investigating Priority I reports and allegations of maltreatment in foster homes. DCFS has responsibility for investigating all other valid allegations of child maltreatment.

Trend and Performance Data

In SFY 2014 the hotline accepted 32,928 reports of maltreatment. Sixteen percent, or 5,123 were assigned to CACD and 84 percent, or 27,805 reports were assigned to DCFS. Of those assigned to DCFS, 3,840, or 14 percent were assigned to Differential Response.

The table below identifies the recent quarterly trend of the number of new cases assigned to DCFS for the 2nd Quarter of the past three years. The volume has been relatively stable for the past two years and slightly higher for 2015.

Number of Child Maltreatment Reports Assigned to DCFS

2nd Qtr SFY 2011 – 7,365
2nd Qtr SFY 2012 – 7,778
2nd Qtr SFY 2013 – 7,670
2nd Qtr SFY 2014 – 6,518 (5,473 investigations / 1,045 Differential Response referrals)
2nd Qtr SFY 2015 – 6,757 (5,844 investigations / 913 Differential Response referrals)

According to the HHS Administration for Children and Families publication *Child Maltreatment 2013*, the rate of child maltreatment reporting in Arkansas was 72.9 reports per 1,000 children. The national average rate was 47.1. In nearby states, the rates were:

Texas - 28.2
Missouri – 56.0
Oklahoma - 63.2
Louisiana - 37.7

Reporting rates have an obvious impact on workload and costs.

The most recent data on the percentage of alleged maltreatment reports being determined as true, meaning substantiated, shows that 19 percent of cases had a true finding in that quarter. Overall for 2014, 22 percent of allegations were found as true.

Relationship between DCFS and CACD

As previously mentioned, DCFS and CACD share a role in in investigating child maltreatment reports. In assessing this relationship staff in both organizations were interviewed and an April 2013 internal DCFS report by Hornby Zeller Associates titled A Review of the Arkansas Child Abuse Hotline was reviewed.

Arkansas is unique among states in separating the child maltreatment response function between DCFS and another agency, in this case the State Police. CACD receives all calls alleging child maltreatment, determines if they the meet the legal criteria for child maltreatment, determines the prospective seriousness of the allegation and assigns the report to either its own investigators or DCFS. The two agencies also share investigative roles. CACD investigates allegations that could constitute serious criminal abuse and alleged maltreatment of children by foster parents and DCFS investigates all other cases.

According to the Hornby Zeller Report, based on a sample of cases, "The Hotline accepted and screened out reports appropriately in the vast majority of calls." According to the report and interviews with CACD leadership, the Hotline experiences some delays in connecting with the caller, with an average wait time of 8 minutes and 18 seconds in the review month in 2012. The report identified three factors affecting wait time: the volume of calls received, limited ability to divert automatically to appropriate resources and the practice of taking all caller information even though it is apparent the allegation doesn't meet the legal criteria of maltreatment. CACD states that they initially take some abbreviated information during peak call time to speed up response timeliness. Additional information is taken later.

Among the recommendations of the report were:

- Train staff to interview callers with sufficient thoroughness that calls not meeting the legal standard aren't unnecessarily accepted
- Upgrade the phone system to provide capacity to automatically divert miscellaneous callers to alternate resources
- Develop a more comprehensive QA process to include reviews of decision-making and documentation

In interviews with DCFS caseworkers and Hotline leadership, caseworkers' main concern was the lack of complete information collected about the allegation in some cases. Hotline staff noted the need for additional staff, particularly at peak call times. There are also circumstances where CACD investigators, having found serious risk and safety concerns in a case, may have to

wait for several hours for a DCFS caseworker to arrive and arrange placement of a child. High DCFS workloads are a factor in these delays.

Basically, there is evidence that despite the bifurcated structure, the two agencies work well together and that the CACD functions effectively in receiving and classifying calls and investigating Priority I cases.

Percent of True DCFS Reports

2nd Qtr SFY 2011 – 26%
2nd Qtr SFY 2012 – 21%
2nd Qtr SFY 2013 – 20%
2nd Qtr SFY 2014 – 23%
2nd Qtr SFY 2015 – 19%

To compare the percentage of Arkansas' true reports with national data, according to the Children's Bureau publication *Child Maltreatment 2013*, "*For FFY 2013, approximately 3.9 million children were the subjects of at least one report (screened-in referral). A child may be a victim in one report and a nonvictim in another report and in this analysis, the child would be counted both times. One-fifth of these children were found to be victims with dispositions of substantiated (17.5%), indicated (0.9%), and alternative response victim (0.4%). The remaining four-fifths of the children were found to be nonvictims of maltreatment.*"

The percentage of true findings has declined somewhat in recent years.

Timely Initiation of DCFS Child Maltreatment Investigations

As shown below, response times for the 2nd quarter of past years have clustered between 80-90 percent timely. Priority I has declined somewhat and Priority II has remained fairly stable. Response times for DR are lower.

Priority I (Within 24 Hours)	Priority II (Within 72 Hours)
2nd Qtr SFY 2011 – 94%	2nd Qtr SFY 2011 – 83%
2nd Qtr SFY 2012 – 96%	2nd Qtr SFY 2012 – 85%
2nd Qtr SFY 2013 – 92%	2nd Qtr SFY 2013 – 81%
2nd Qtr SFY 2014 – 83%	2nd Qtr SFY 2014 – 77% (DR – 74%)
2nd Qtr SFY 2015 – 86%	2nd Qtr SFY 2015 – 85% (DR – 66%)

Timely Completion of DCFS Child Maltreatment Investigations

Timeliness of completion of investigations rose considerably after 2013, and remain around the 70 percent rate.

Priority I (Within 30 Days)	Priority II (Within 30 Days)
2nd Qtr SFY 2011 – 58%	2nd Qtr SFY 2011 – 57%
2nd Qtr SFY 2012 – 67%	2nd Qtr SFY 2012 – 68%
2nd Qtr SFY 2013 – 47%	2nd Qtr SFY 2013 – 46%
2nd Qtr SFY 2014 – 72%	2nd Qtr SFY 2014 – 70% (DR – 79%)
2nd Qtr SFY 2015 – 70%	2nd Qtr SFY 2015 – 71% (DR – 79%)

Data from the DCFS Statewide Meta-Analysis Report state that in December 2013, there were 1,148 overdue investigations statewide. BY May 2014 the number had risen to 1,267 and currently the number has been reduced to 584. It is important to note than an overdue investigation does not necessarily mean that the child victim was not assessed or that safety interventions have not occurred. It may mean that documentation is not complete. DCFS tracks these trends closely and can identify the causes of the overdue cases by Area and county. Most of the overdue cases are in counties that have vacant positions, staff covering an additional county or new staff not carrying full caseloads.

Investigative Practice

DCFS quality assurance processes report that in a study of randomly selected maltreatment investigations in 2014, 98 percent of victims, 97 percent of non-victims, 93 percent of alleged offenders and 90 percent of non-offending caregivers were interviewed by investigators. Staff interviewed 93 percent of known offenders, addressed all of the reported allegations in 95 percent of the interviews and completed interviews with the non-offending parent in 90 percent of the cases. DCFS performance in these areas is relatively high.

However, assessors did not interview 16 percent of reporters, missed at least one interview with a potential collateral source in 39 percent of the cases and while Health and Safety Assessments were documented for almost all children, 68 percent of them were documented after the required time frame. In addition, the study found that for those cases where a protection plan was implemented, 30 percent of those plans did not accurately address the child's safety. The report also states that in this small sample, "thirty-six percent of the investigations reviewed this year were overdue, ranging from one to 262 days late". Assessors continue to cite staff shortages as the primary reason (44 percent) for referrals not being completed within mandated time frames.

Percent of Children with True Allegations with a Subsequent Report within 6 and 12 months

6 Months:		12 Months:
2nd Qtr SFY 2011 –	8%	12%
2nd Qtr SFY 2012 –	9%	12%
2nd Qtr SFY 2013 –	7%	10%
2nd Qtr SFY 2014 –	7%	10% (DR – 0.4%)
2nd Qtr SFY 2015 –	6%	9% (DR – 1%)

The incidence of recurrence can be an indication of the effectiveness of the system's response to maltreatment. The national standard for performance is no more than 5.4 percent of cases should have a subsequent report of maltreatment. DCFS moved closer to the standard in the 2nd quarter of 2015, but missed it by a slight margin.

Percent of Children Receiving Supportive or Protective Services Abused or Neglected within One Year

	Supportive Services	Protective Services
2nd Qtr SFY 2011 –	3%	9%
2nd Qtr SFY 2012 –	9%	12%
2nd Qtr SFY 2013 –	6%	9%
2nd Qtr SFY 2014 –	6%	9%
2nd Qtr SFY 2015 –	2%	7%

DCFS improved its performance by 6 percent in the 2nd quarter of 2015.

Percent of Foster Families with True Reports of Maltreatment

2nd Qtr SFY 2011 – 0.47%
2nd Qtr SFY 2012 – 0.13%
2nd Qtr SFY 2013 – 0.33%
2nd Qtr SFY 2014 – 0.36%
2nd Qtr SFY 2015 – 0.30%

The Children's Bureau and child welfare systems track the incidence of maltreatment of foster care specifically. The incidence of child maltreatment in family foster care In Arkansas declined over the past three years.

Efforts to Protect Children in their own Home

DCFS assesses its safety performance by other means in addition to measuring outcomes. The following table shows system performance related to efforts to assess risk and safety concerns for cases where children are in their own homes. The following table shows a improvement in performance of 7 % between 2011 and 2013 despite continuing high workloads. However, the system still does not meet the national standard of 90%. These data are produced by case reviews conducted by quality assurance staff.

Assessing and Addressing Risk of Harm to Children

Percentage (%) of Total Cases in which DCFS Staff Made Efforts to Assess and Address the Risk and Safety Concerns in the Children's Home			
Area	**2011**	**2012**	**2013**
1	46.7	43.3	63.3
2	56.7	63.3	80.0
3	63.3	50.0	70.0
4	76.7	96.7	96.7
5	73.3	80.0	76.7
6	70.0	80.0	83.3
7	53.3	70.0	80.0
8	60.0	70.0	60.0
9	70.0	43.3	63.3
10	93.3	80.0	73.3
Statewide	***66.3***	***67.7***	***74.7***

Protection Plans

During FY 2014, DCFS reviewed 50 randomly selected child maltreatment investigations from each of 10 service areas. The review found that the plans accurately addressed safety in 70 percent of cases. Four DCFS Areas accurately addressed safety in 100 percent of cases and the others accurately assessed safety ranging from 45 to 67 percent of cases. DCFS advises that a finding that safety is not accurately addressed also includes staff identifying imminent danger when none exists. DCFS has worked to improve the quality of assessment through implementation of a nationally used risk-assessment tool, Structured Decision-Making and provision of additional training of staff on protection plans. To provide an additional layer of safety assessment, Team Decision-Making meetings are being implemented when protection plans are used. DCFS notes that 95 percent of children receiving Supportive Services and 93 percent of children receiving Protective Services one year prior to SFY 2014 were not re-victimized within one year of service initiation.

Worker Contacts

Frequent worker contact is an important process for assisting families to develop adequate caregiving capacity and assuring child safety. As the following chart indicates, in the three years covered by these data, DCFS improved the frequency of family contacts in in-home cases with a face-to-face-contact from 75.8 percent to 82.3 percent.

In-Home Cases with Recent Caseworker Contact at the End of the Year, by Area

Percentage (%) of In-Home Cases in which Caseworker Completed a Face-to-Face Contact with the Family during the Prior Three Months

Area	2011	2012	2013
1	59.4	64.6	78.4
2	70.4	61.8	79.4
3	92.5	60.0	89.3
4	86.4	97.1	98.6
5	82.4	92.5	87.0
6	71.4	84.6	92.4
7	50.4	73.3	80.4
8	78.4	73.7	77.0
9	78.9	74.5	71.9
10	95.6	81.5	91.1
Statewide	***75.8***	***75.4***	***82.3***

However, DCFS data shows that required monthly visits to in-home cases occurred in 66 percent of the cases.

Child Fatalities

According to the Children's Bureau publication *Child Maltreatment 2013*, there are only two other states, Oklahoma and West Virginia, that have a higher rate of child fatalities per 100,000 children than Arkansas. The rate in Arkansas is 4.09.

Using a different metric, DCFS reports on child fatalities with prior DCFS involvement within 12 months prior to the fatality. The trend from 2011 to 2015 as shown below, reflects an increase in these fatalities.

Fatalities w/ Prior DCFS Involvement within 12 Months Prior to Fatality	
SFY	**# Fatalities**
2011	23
2012	35
2013	39
2014	34
2015	*40*

*The SFY15 # represents the fatalities to date, 06/17/2015

It is not clear why fatality numbers are rising. This could be factor of improved reporting or other more complex factors. In many systems, co-sleeping practices account for a high number of child fatalities and other factors, such as parental substance abuse, can contribute to co-sleeping deaths. The fatality review process is the best forum for examining child fatality trends.

The Administrative Office of Courts states that it has different numbers on child fatalities than DCFS uses and the two organizations have not reached agreement on the best measures to use in examining child fatalities. The legislature recently passed a statute establishing a child fatality review process external to DCFS. Once members are appointed, this body should be a neutral forum in which accurate child fatality data can be analyzed. It is important to note that child fatalities can be assessed through a number of analyses, depending on to what questions answer are sought.

VI. Permanency

Selected Permanency Indicators

Number of Children in Foster Care at End of Quarter

The table below shows a slow growth in the number of children in care between 2013 and 2015 until May of 2015, when the number of children grew from 3,875 to 4,323, a substantial increase. According to DCFS, which constantly monitors these data, the increase is mostly related to fewer children exiting foster care, as a table in this section reveals.

2nd Qtr SFY 2011 – 4,072
2nd Qtr SFY 2012 – 4,002
2nd Qtr SFY 2013 – 3,862
2nd Qtr SFY 2014 – 3,855
2nd Qtr SFY 2015 – 3,875
There were **4,374** children in care on 05/27/15

Foster Care Entries and Exits

Period	2011	2012	2013	2014	2nd Qtr 2015
Entries	4,126	3,873	3,901	3,835	715
Exits	4,071	3,894	3,913	3,592	841

These data show slightly more foster care entries than exits in 2014, which means that the 2015 foster care population is growing. The trend was briefly reversed in the 2nd Quarter, but DCFS states that currently there are now fewer exits than entries, which has caused a significant increase in the total number of children in out-of-home care.

Percent of Children in Foster Care per 1000 Children at End of Quarter

The percentage of children in out-of-home care per 1000 children is a rough index of the system's ability to keep children safely in their own homes and provide them permanent homes once they enter care. The national average for FY 14 was 5.3 children per 1,000. For that period the Arkansas rate was 5.4.

Percent of Children in Foster Care by Placement Type End of FY

Percentage of Children in Foster Care by Placement Type					
Placement Type	**SFY 2011**	**SFY 2012**	**SFY 2013**	**SFY 2014**	**SFY 2015**
DCFS Foster Home (Non-Relative)	43%	40%	38%	37%	36%
DCFS Foster Home (Relative)	7%	8%	8%	8%	8%
Provisional Relative Care	6%	8%	6%	6%	6%
Therapeutic Foster Home	7%	7%	7%	7%	8%
Pre-Adoptive Home	5%	5%	4%	6%	6%
Emergency Shelter	3%	4%	4%	4%	4%
Residential Facility	10%	11%	12%	11%	12%

Trial Home Visit	5%	5%	7%	5%	5%
Other	14%	12%	13%	15%	15%

The Annie E. Casey Foundation 2013 report on children in out-of-home placements showed the following regarding children in out-of-home-care in Non-Family Settings (Congregate Placements):

Arkansas – 19%
Louisiana – 9%
Missouri – 11%
Oklahoma – 9%
Tennessee – 17%
Texas – 16%

Oregon was the lowest at 4% and Colorado was highest at 35%. Twelve states had a higher percentage of children in non-family settings than Arkansas. There is considerable evidence that children do better in family-based settings than congregate settings. The lack of suitable foster home and relative placements is most likely the reason a disproportionately high number of children are in non-family settings.

Proximity of Placement to Home County

Percentage of Children Placed in a Setting within the Same County from which they were Removed

Area	**2011**	**2012**	**2013**
1	54.0	55.0	58.3
2	31.9	34.0	31.2
3	57.0	41.2	38.7
4	18.1	27.8	29.5
5	33.4	38.7	31.4
6	79.1	78.7	80.9
7	62.2	60.5	54.8
8	35.9	40.5	43.6
9	43.9	42.6	37.7
10	50.6	49.1	50.0
Statewide	***46.5***	***47.1***	***45.5***

No national data are available to compare Arkansas' out-of-county placement levels with other systems, but having almost half of the children placed outside of their home county is extremely high. This trend produces poorer outcomes for children, huge additional workload demands on caseworkers and limits the ability of staff to respond to the needs of children and their foster parents.

Placement Availability 2nd QTR 2015

Area	Number of Children in Care	Number of Family Foster Care Beds	Child/Placement Bed Ratio
1	417	421	1.01
2	829	272	0.33
3	298	203	0.68
4	224	120	0.40
5	395	264	0.67
6	550	472	0.86
7	222	142	0.64
8	482	385	0.80
9	509	293	0.58
10	169	144	0.85
Total	4095	2716	0.66

This table shows the number of foster care beds compared with the number of children in care in each area and the ratio of foster home beds to children. The data clearly underscore the need for significant numbers of additional foster homes.

Length of Stay in Care 2ND FY 15 QTR Annually

Length of Time in Care					
Length of Stay	**2nd QTR SFY 2011**	**2nd QTR SFY 2012**	**2nd QTR SFY 2013**	**2nd QTR SFY 2014**	**2nd QTR SFY 2015**
Less than 30 days	9% (Nationally - 5%)	8% (Nationally - 5%)	9% (Nationally - 5%)	6% (Nationally - 5%)	6% (Nationally - 11%)
30-90 Days	14% (Nationally - 20%)	13% (Nationally - 20%)	12% (Nationally - 20%)	10% (Nationally - 22%)	9% (Nationally - 15%)
3-6 Months	13% (Nationally - 20%)	13% (Nationally - 20%)	14% (Nationally - 20%)	15% (Nationally - 22%)	14% (Nationally - 15%)
6-12 Months	21% (Nationally - 17%)	22% (Nationally - 17%)	21% (Nationally - 17%)	23% (Nationally - 20%)	25% (Nationally - 20%)
12-24 Months	21% (Nationally - 23%)	21% (Nationally - 24%)	22% (Nationally - 23%)	22% (Nationally - 24%)	22% (Nationally - 27%)

24-36 Months	9% (Nationally - 12%)	9% (Nationally - 12%)	9% (Nationally - 12%)	9% (Nationally - 11%)	9% (Nationally - 13%)
36+ Months	14% (Nationally - 24%)	14% (Nationally - 24%)	14% (Nationally - 24%)	15% (Nationally - 18%)	15% (Nationally - 14%)

In many of the categories above, Arkansas performs better than the national standard, which is commendable given the severe resource limits under which DCFS operates.

Reunification within 12 Months

Percent of Children Reunified within 12 months of Removal

National Standard = 48.4% or more

2011 – 65%

2012 – 63%

2013 – 63%

2014 – 61%

2015 – 61% (2nd Qtr. QPR)

DCFS exceeds the national standard.

Re-entries into Foster Care

Percent of Children Re-entering Care within 12 months of Reunifying

National Standard = 9.9% or less

2011 – 10.1%

2012 – 9.2%

2013 – 8.8%

2014 – 7.5%

2015 – 12.7% (2nd Qtr. QPR)

2015 - 8.4% (3rd Qtr. QPR)

DFCS exceeded the national standard for the 3rd quarter and also did so in 2012, 2013 and 2014.

Placement Stability

Placement Stability					
Number of Placements	**2nd QTR SFY 2011**	**2nd QTR SFY 2012**	**2nd QTR SFY 2013**	**2nd QTR SFY 2014** Data not available	**2nd QTR SFY 2015**

1 to 2	52%	54%	53%		56%
3 to 6	33%	32%	32%		31%
7 to 9	6%	6%	7%		6%
10 or more	9%	8%	8%		7%

Placement Stability					
# of Placements	**2011**	**2012**	**2013**	**2014**	**2015**
2 or Fewer	0.52	0.54	0.53		0.56
3 or More	0.48	0.46	0.47		0.44

The DCFS 2nd Quarter SFY 2015 report states the following:

Length of Stay	National Standard	Arkansas Performance
Children in care less than 12 months	86% experienced 2 or fewer placements	72%
Children in care 12-24 months	65.4% experienced 2 or fewer placements	44%
Children in care more than 2 years	41.8% experienced 2 or fewer placements	16%

DCFS experiences significant challenges with placement stability, which is not surprising given the lack of available placement options for children. When placement resources are limited, placement selection becomes driven largely by bed availability rather than careful matching of child needs to caregiver abilities. Frequent placement changes are traumatic for children already experiencing trauma from removal from their families. Trauma responses can be expressed behaviorally as anger, defiance and depression, which without effective mental health services, can lead to further disruptions.

Engagement of Families in Case Planning

SFY	In-Home	Foster Care Cases
2011	38%	61%
2012	38%	69%
2013	48%	75%
2014	50%	81%

2015	In progress

Nationally, there is agreement that youth and families are more involved and committed to a planning process that meaningfully involves them in setting goals and developing strategies. The table above reflects improvement in engaging families of children in foster care, but significant challenges remain in engaging in-home caregivers.

Completion of Monthly Caseworker Visits

SFY	In-Home	Foster Care Cases
2011	55%	59%
2012	55%	60%
2013	58%	64%
2014	60%	73%
2015	66%	76%

*2015 reflects the end of the 2nd Qtr of SFY 2015.

Largely as a result of high caseloads and placement of children in distant counties, DCFS has difficulty in making monthly caseworker visits. However DCFS visit frequency has improved over the past 5 years. Given caseload constraints, it is commendable that DCFS is able to show improvement in completing monthly contacts. However, further progress is needed. If visits by other DCFS staff, such as program assistants and other support staff are counted, performance is higher.

VII. Adoption

Time to Adoption

2011 – 25.4 Months
2012 – 25.4 Months
2013 – 24.4 Months
2014 – 22.1 Months
2015 – 22.6 Months (end of 2nd Qtr.)

The data show that time to adoption has declined in the past two years.

Annual Adoption Placements

Annual Adoption Placements		
Year	**Legally Free Children**	**Finalized Adoptions**

2011	362	583
2012	444	674
2013	517	677
2014	587	724
2015 To date	596	405

A significant number of children in DCFS custody are placed for adoption annually, thanks to DCFS and its adoption community partners. The number of finalized adoptions has grown by over 140 children since 2011.

Post-Adoptive Supports

DCFS conducted a study of adoption re-entries in March 2015 and noted that since FY 2004, when the foster care population was half that of today, the annual number of adoptions has risen from 360 to 724. It also found that of the 4,055 adoptions finalized between FY 2007 and 2013, 67 children, less than 1.7 percent, returned to foster care. Not all of these children were placed through a DCFS adoption. Behavioral issues were identified as the most common reasons these children re-entered foster care. The study noted that DCFS generally did not find out about these behavioral issues because there is little follow-up with post adoptive parents after the adoption is finalized. DCFS adoption specialists were found to be unaware of any responsibility to provide post-adoption services to parents.

Both central office and local DCFS staff stated during this review that there had not been a practice of staff offering post-adoptive services during a crisis in the past. Recently DCFS sent communications to local staff with guidance about pre-adoptive and post-adoptive supports. The message stated the following:

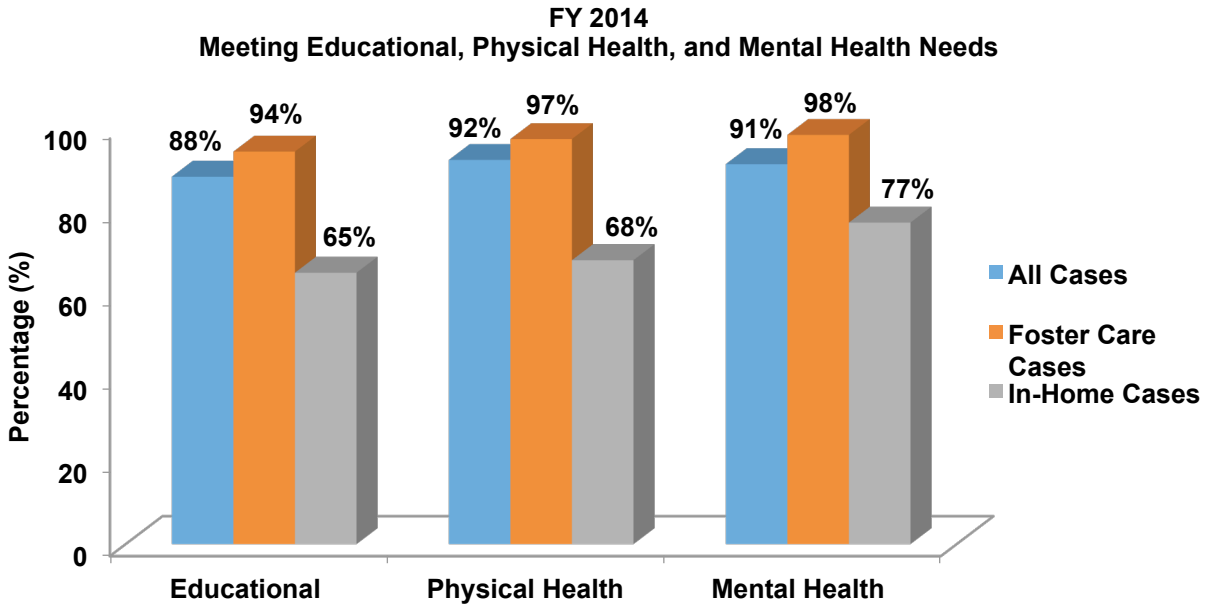
> Recent attention regarding adoptions has highlighted how important it is that we -- in all levels of the division -- are sensitive, non-threatening and professional when families approach us, especially when these families are contacting us about issues they are having in either a pre-adoptive placement or with a finalized adoption. They should walk away from any interaction with us knowing that we are here to help them no matter where they are in the adoption process.
>
> There is always more we can do to ensure families feel that we are listening to and addressing their concerns, including communicating better with them throughout the process; ensuring they know to and how to communicate with us when they have questions or concerns; ensuring they are aware of the services available to them at all stages; and ensuring adoptive families understand how to access post-adoptive services.
>
> With input, we are developing more systemic supports for families and staff to ensure families and children receive the services needed to provide children with “forever” families. I will

share additional information with you all about that once it is available. Thank you for your hard work and dedication to the children and families you serve.

DCFS states that it now provides information about post-adoptive supports to all pre-adoptive families.

VIII. Child Well-Being

Nationally, child welfare does not have a sophisticated ability to assess child well-being and as a result, measures are few in number. Currently, qualitative tools currently are the most frequently used. Some of these often involve case file reviews, which have limited value. More useful approaches employ interview-based approaches which use interviews with children and youth, caregivers, workers, substitute caregivers and professionals. These interview-based methods involve reviews of a modest sample of cases, using interviews to form professional judgements about the quality and effectiveness of interventions. Fortunately, DCFS has established a qualitative review process, the statewide Quality Services Peer Reviews (QSPR) involving 300 cases statewide. Because of the small sample, data are not statistically definitive, but do provide a representative view of overall qualitative performance. DCFS describes the QSPR as mirroring the Federal Child and Family Service Review Process (CFSR). The QSRP process is the source of the following table:



Overall System Trends and Performance

Based on these QSPR measures DCFS does a competent job of addressing Educational, Physical Health and Mental Health needs for children in foster care, but performs less well with in-home cases. Arguably, the Department's obligation to meet these needs is greater for children in its custody than children living with their own families. Typically, child welfare systems do a much

better job in meeting physical health needs than mental health needs. The performance level for meeting mental health needs is surprisingly high, compared to qualitative reviews in other systems. Stakeholders and front-line staff did not describe the Division's response to children with mental health needs as positively as this assessment did.

IX. The Front-Line DCFS Environment

Meetings were held with all Area Directors and with three large groups of DCFS Investigators, Family Service Workers and front-line supervisors, representing offices from throughout the state. The work environment described by many of these staff was one of high caseloads and workloads, constant compliance deadlines, some of which staff stated were not possible to meet, low pay, constant turnover and vacancies and work weeks routinely extending beyond 40 hours. They cited limitations on compensation for overtime, the threat of being disciplined for not meeting compliance measures and the lack of technology, in this case smart phones, as additional stresses. (Note: DCFS recently piloted the use of smart phones and now plans to equip all line staff and supervisors with the technology this year.) Staff also identified the high number of concurrent initiatives undertaken in recent years as a challenge, although they understood the potential value of many of them individually.

Related to compliance, the Division currently tracks 18 specific casework and administrative tasks related to child maltreatment performance, 22 areas related to foster care tasks and 1 related to family foster homes. Some well-being indicators are included under the foster care category. The system performs better on child maltreatment tasks than foster care tasks. Staff face the biggest challenges in complying with expectations related to child visits with parents and siblings, which is not surprising given caseload size and children placed out-of-county. Conformity to notice requirements for parents, CASA and attorneys ad litem about placement changes also needs considerable improvement. Performance related to health care activities is high. This level of performance oversight is common in child welfare systems, but is particularly stressful to staff in systems with the resource challenges Arkansas experiences.

The most urgent challenge cited was the lack of placements for children in out-of-home care, which is creating a host of bad outcomes for children, families and staff. Child protection investigators spoke of driving long distances to other counties to place children because in-county placements were unavailable. Family Service Workers, who provide case management to children in foster care face a similar challenge, compounded by the fact that they have to make at least monthly contacts with children and often transport children to visits with parents, siblings, medical and other appointments. Some DCFS staff noted increases in placements ordered by courts of youth who also have delinquent behaviors, perhaps in an effort to secure more treatment-oriented placement settings. DCFS does not feel equipped to adequately serve some of these youth.

Some staff and supervisors must cover more than one county due to vacancies and limited staff allocations. In rural areas of the state, services needed by children and families are limited and

create additional frustrations for families, staff and legal partners. Within these system challenges, workers must also perform the ongoing work of child welfare, such as attending court hearings, entering data, coordinating with providers, preparing court reports and performing other administrative tasks.

An unexpected practice, largely caused by the lack of placements, was identified by a number of staff. According to retrospective data provided by the Division, between January 1, 2015 and mid-April, 2015, at least 22 children have spent at least one night in a DCFS office with a worker because no placement was available. In another manifestation of the placement crisis, in some offices placements are so limited that staff secure agreement from a number of foster parents to keep a child at least one night, after which the child is placed with a different foster parent until a more long-term placement can be found. While this does not appear to be a routine practice, it occurs frequently enough that the Central office is seeking ways to limit it. The traumatic effect these serial placement changes inflict on children is directly related to the lack of placements.

One sympathetic veteran judicial stakeholder interviewed summed up the Arkansas child welfare environment as one in constant crisis, a status the system shares with many other child welfare systems in the country. He mentioned staff shortages, staff turnover, inexperienced staff and the lack of sufficient placements as stresses that contribute to the crisis-driven environment. He added that DCFS is highly risk-averse, for understandable reasons, which has driven the agency to attempt to control local practice and decision-making with a large number of policies, rules, compliance tracking and layers of approval. The result is a work setting in which constant compliance monitoring and the multiple layers of review and approval required for exceptions or reasonable deviation from standard are perceived by staff as mistrust. This stakeholder noted that staff turnover was not surprising, given the many stresses that diminish job satisfaction.

In the face of these challenges, like all other states, DCFS maintains efforts to establish performance expectations for staff that are intended to produce appropriate and adequate practice. DCFS regularly tracks staff and county performance to make sure vital activities such as contacts with children and families, timely actions and development of case plans, for example are conducted. DCFS is attentive to risk for appropriate reasons and naturally tries to compensate for vulnerabilities such as inexperienced staff, high risk families and limited resources. The challenge public child welfare systems face is creating balance between rules and flexibility. In this regard, DCFS states that it is examining the compliance measures with the intent of limiting the number and focusing on the more important issues.

Front-Line Practice

This report has spoken to the negative impact high caseloads have on DCFS performance; however one factor that needs additional attention is the nature of DCFS practice. Nationally, there is a trend in child welfare for systems to create what is called a practice model. A practice model is a written framework of values and practice principles that is based on best practice,

evidence-based practice and promising practices. The practice model should guide all of the agency's operations, including policy, staff performance expectations, training, resource design, contract expectations, monitoring and quality assurance and outcomes.

Without a coherent and faithfully applied practice model, front-line practice can be driven by crises, individual practitioner values, custom and the latest initiative instead of carefully designed practice. DCFS has a basic practice model, but its detail is limited, making it difficult to apply operationally. An example of the principles that might be included in Arkansas' child welfare practice model is included in the appendix.

Two critical elements of practice in particular, engaging families in planning and decision-making and assessing underlying child and family needs should be strengthened. In group discussions with DCFS front-line staff, it became apparent that many staff either didn't fully understand how to effectively engage families and identify underlying needs or stated "We don't have time to fully listen to parents."

X. Resource Availability

Placements

Limited placement resources underlie many of the Division's challenges. Data and stakeholder input underscore the problems presented by the lack of placements. This issue contributes to child trauma, instability, educational disruption, interruption of therapeutic relationships, poor matching of children to caregiver capacity and the loss of connection of children in care with parents, siblings, school, community, friends and their caseworkers. When children are placed significant distances from home, their permanency prospects are impaired as is their emotional-behavioral well-being. Only 45 percent of children are currently placed in their home county. As previously mentioned, distant placements also increase front-line staff workload. The placement challenge needs to be one of the Division's highest priorities.

A crucial place to look for solutions to the placement challenge is the use of relative placements and guardianships. According to DCFS, only 14 percent of children DCFS children out-of-home are placed in some form of relative care, 8 percent in licensed relative care and 6 percent in provisional relative care. By comparison, according to the Annie E. Casey Foundation, percentages from surrounding states are:

Louisiana 21%

Mississippi 26%
Missouri 21%
Oklahoma 29%
Texas 29%

Ten states have 30% or more children placed with relatives. Stakeholders and DCFS note that there can be delays in initiating children's Medicaid eligibility when children are returned home and in placements with relatives when relatives have custody. DCFS attributes this to backlogs in processing eligibility. Delays such as this can further limit willingness of relatives to serve as placement resources.

The guardianship option is seldom used according to stakeholders, but can be another useful placement option. Several stakeholders noted that considerable time was required to secure approval for use of guardianships.

A significant expansion of family foster homes is also needed. The current child-to-placement bed ratio is .66, meaning that for the 4,095 children in care at the end of the 2nd quarter of 2015, only 2,716 family foster home beds were available. DCFS sought the Diligent Recruitment grant as a strategy to increase the number of foster home beds; however the slow start-up period of the initiative has undermined the utility of this effort. The initiative created a state-level team of Family Engagement Specialists which replaced local staff who carried these duties, based on the assumption that the new staff would have more time and specialized marketing skills to devote to recruitment. Difficulty in securing staff and other barriers slowed implementation and resulted in a large backlog of prospective foster parent inquires, applications and background clearances that the system couldn't respond to in a timely manner. DCFS states that the backlog has been almost eliminated at this point, but it is clear that transition issues heightened the placement challenge.

Local DCFS staff and some stakeholders were highly frustrated over these delays which, unfortunately, further undermined relationships between the Division and some crucial stakeholders, especially those in the faith community. Another source of tension between DCFS and some stakeholders is the DCFS decision to suspend licensing of respite foster homes. DCFC explains that it did so because of the practice of front-line staff in making serial placements in different respite homes because there were no traditional foster homes available. This, in the Division's opinion, has the undesirable effect of increasing the incidence of multiple placements. DCFS notes that there are flexible policies for foster parents related to using family and friends for very short-term "respite".

From a national perspective, respite is seen not only as a valuable foster home retention tool, providing stressed caregivers with a break from parenting without having to ask for help from friends and family. It can also serve as a recruitment tool, permitting new foster parents an opportunity to test and practice their fostering skills over a limited time period before committing to caring for children over the longer term.

Foster parent retention is also critical to having sufficient placement resources. For the last four quarters, DCFS has experienced no net gain in family foster homes. For three of the past four quarters, DCFS lost more homes that it gained. In the 2nd quarter of 2015, it gained 122 homes and lost 138 homes. Foster parents report that having a child placed in their home from a distant county makes it difficult to address issues experienced by children in their care because workers are less accessible. This issue is becoming another reason for foster parents to drop out. It is important to note that losses in foster homes are not necessarily associated with dissatisfaction. Some foster parents drop out due to changing family dynamics, job demands or adopting a child or children in their home. However the difficulty in accessing appropriate mental health services for children with behavioral issues was mentioned as major reason for foster parent frustrations.

Some stakeholders and foster parents felt that the 12 week term for basic foster parent training offered by DCFS is an impediment to recruitment. This involves weekly three-hour sessions. They compared it with the training provided to foster parents recruited by The Call, a faith-based organization. This training, which is said to contain the same content, occurs over one weekend. Undoubtedly there are some trade-offs in the learning process when training sessions compressed into two long days. However the shortened schedule could make fostering more appealing.

Mental Health Services

Numerous staff and stakeholders identified the lack of mental health services, especially high quality mental health services, as a barrier. Rural areas were identified as the most underserved populations within Arkansas. Foster parents and post-adoptive parents identified the limitations in access to mental health services as a major challenge. DCFS staff and stakeholders noted that office-based mental health counseling, which is the predominate service available, is often not sufficient for high-need children and youth. Respondents stated that some of the most effective mental health interventions, which are highly individualized and intensive home-based mental health services, are particularly limited. Wraparound serves are available on a modest basis and one knowledgeable stakeholder noted that providers seem reluctant to develop the service.

There had been plans to expand mental health services through implementation of the Affordable Care Act, but those plans are now on hold. Some mental health professionals stated that there was little attention to the development of evidence-based services and that more trauma-responsive services and mobile crisis services were needed.

An issue that a number of DCFS staff mentioned as a challenge is disputes over authorization by Value Options for some mental health residential placements, where Value Options raises questions about medical necessity. When Medicaid authorization is denied, DCFS has to cover costs for these cases entirely from its limited state dollars. There are complex issues of policy

and clinical judgement affecting decision-making in these cases, so the concerns of both parties deserve consideration. Resolution will require high level discussions between DCFS, mental health and the Medicaid agency and ultimately, a broader mental health continuum of services that serves children in their own homes and communities.

DCFS Waiver

The recent increase in the number of children in out-of-home care, if maintained at that level, could impact the Waiver. DCFS reports that it is already limiting some elements of the Waiver implementation because of concerns about out-of-home costs exceeding the Waiver cap. It is too early to fully assess the full impact of the caseload growth.

XI. Workload and Caseload

DCFS family service worker caseloads now average 28.96 cases, compared to 24.7 in December 2014. An analysis of DCFS local workload data shows the following:

Number of Counties with Average Workloads of 15 or less	- 9
Number of Counties with Average Workloads of 16-20	- 16
Number of Counties with Average Workloads of 21-25	- 28
Number of Counties with Average Workloads of 26-30	- 12
Number of Counties with Average Workloads of 31-40	- 8
Number of Counties with Average Workloads of 40 +	- 4

Child Welfare League of America (CWLA) recommended standards are 15 cases per worker. Average caseloads in Arkansas are almost double the national standard. By way of comparison, among states that have an established workload standard consistent with CWLA recommendations, Oklahoma, New Jersey, and The District of Columbia, for example, all operate within the 15 cases per worker standard. These states happen to be operating under class action settlement agreements. All but 9 Arkansas counties have caseloads exceeding the 1/15 standard and 52 counties exceed the standard by more than 5 cases. An average caseload of over 28 cases is particularly challenging for Arkansas because of the travel necessitated by the number of children placed outside of their home county.

It is not just DCFS front line staff who have high caseloads. DHS legal staff, who represent DCFS in court, also have high caseloads and a high turnover rate. DHS attorneys average 96 cases each and have a 47 percent turnover rate. The American Bar Association recommends 60 cases as a standard. Many attorneys cover multiple counties. There is only a single appellate attorney for the office. DHS attorneys are also paid less than their attorney ad litem and parent attorney colleagues.

This review also identified several recent statutory mandates and interagency agreements that have a high potential for increasing DCFS workloads. House Bill 1624, which passed in the last legislative session, sets out explicit expectations for placement of siblings together, contacts between siblings not placed together, sibling inclusion in case planning for other siblings, notice

of placement changes to siblings, court reviews and other entitlements. All of these are important to optimal well-being and should be a standard best-practice principle. However, now these issues will be subject to litigation and presumably contempt findings if provisions are not met. Data presented previously demonstrates the difficulty DCFS has in meeting some of its own performance standards due to workload, so it can be expected that it will struggle to meet some of these requirements as well.

Another provision of HB 1624, requires DCFS to file a dependency-neglect petition for any case where a protection plan is considered necessary to permit a child to remain safely at home. Prior to the Act's effective date, DCFS did not present protection plans to the court for approval. DCFS describes a protection plan as follows:

> When any safety factors are present, a protection plan must be developed to address each identified safety factor if the child will remain in the home. A protection plan is a written plan developed by DCFS staff in conjunction with the family to address identified safety factors. This documentation describing the actual use or consideration of using protecting interventions establishes reasonable efforts to prevent removal of the child from the home.
>
> The protection plan must be developed and receive DCFS supervisory approval prior to DCFS staff leaving the home. The protection plan serves as a written agreement between the Division and the family. As such, a copy of the plan will be provided to the caregiver and to other members participating in the plan prior to the investigator leaving the home.

With protection plans nationally, there is generally no petition submitted to the court and the case is monitored to assure that the caregiver is following the plan. This structure is utilized with lower risk cases in most states. Strategies such as the DCFS protection plans have a useful place in child welfare systems. They allow an individualized approach to families, providing a less adversarial environment than a court hearing. When used appropriately, they can facilitate safe maintenance of children in their own homes. To be successful, however, a thorough assessment of families is needed, frequent contact by the caseworker is required, and a process is needed to use alternative strategies, such as court, if families do not follow through.

It is likely that this bill was introduced because of doubts on the part of some stakeholders that DCFS could assure child safety without court oversight. Some legal stakeholders criticized a DCFS practice which they called coercive placements, meaning that DCFS would threaten removal unless the caregiver placed the child with another family member, for example, without properly reviewing the alternative caregiver's suitability or petitioning the court. Regardless of the merits of the Act, it will undoubtedly increase the DFCS workload, including administrative tasks and time in court. It is also likely to increase the number of children placed in foster care.

This statute also adds responsibility to DCFS related to provision of background information at dependency-neglect review hearings. Completing this administrative task requires additional staff time.

Another bill, Senate Bill 810, adds educational neglect to the list of qualifying reports of certain types of maltreatment, without the conditions cited in the prior statute. In this context educational neglect is the term usually applied to truancy cases. This statute means that the Child Abuse Hotline must accept each call regarding educational neglect. DCFS will be required to assess the safety of the child upon receipt of the report and assess "each underlying issue or additional child maltreatment concern that may have not been identified in the original hotline report, a new specific mandate. The statute also requires DCFS to "work with" families to remedy the issues that resulted in the report. Some legal partners, including judges, reported that when DCFS accepted educational neglect it was often referred to a DR worker who might admonish the caregiver and elicit a promise to insure attendance, which did not consistently result in a resolution of truancy. These stakeholders also have concern that DCFS ignores more significant underlying family issues, of which truancy is a symptom, such as physical abuse and substance abuse.

Like the intent of the other statutes referenced, the provisions of Senate Bill 180 reflect legitimate concerns about child well-being and in some cases child safety. However it will increase the DCFS workload without any commensurate increase in staff resources.

Several other statutes that add administrative requirements to DCFS were also passed.

XII. DCFS Relationship with State and Community Partners

In collecting information on which to base the findings of the report, a large variety of stakeholders both internal and external to DCFS were interviewed in person and by phone. Some interviews were group interviews and others were individual conversations. Respondents represented legal partners, legislators, foster and adoptive parents, service providers, advocates and others. There were also individual group meetings with DCFS area directors, front-line staff and supervisors and central office staff. As might be expected, stakeholder perceptions of DCFS varied. However many respondents, including some critics, recognized DCFS workload challenges. Several judges complimented their local DCFS staff and stated that they were doing their best within a very challenging environment. From most, DCFS got high marks for its data analysis work. Many stakeholders also recognized that the Division has a sophisticated capacity to develop, collect and present management and outcome data and does so in its written publications, on its web site and in stakeholder interactions. There is considerable transparency from DCFS about both its good and its unflattering performance against selected measures.

A number of contract service providers expressed appreciation for the Division's understanding of their complex fiscal issues. Working relationships between contract providers and DCFS seemed generally positive.

It is possible that the Division's facility with data and numbers inadvertently gives the impression of detachment from some of the human issues of child welfare. Some stakeholders feel distanced from the Division in regard to collaborative planning. While the Division has attempted to reach out to stakeholders through initiatives such as the new DCFS Advocacy Council, stakeholders express a desire for collaboration that goes beyond being briefed on new child welfare initiatives. Stakeholders clearly prefer to help shape planning and policy rather than merely commenting on it. In defense of child welfare systems in this regard, there is a tendency for them to want to demonstrate their own competence first, which can make the planning process seem exclusive.

A number of local DCFS staff and supervisors as well as some stakeholders noted the same high degree of central office oversight of local practice that was referenced earlier in this report.

Some post-adoptive families mentioned being contacted by DCFS staff recently, asking about their child or children's status and advising them to contact the Division if additional supports are needed. The representativeness of this experience is unknown at this time, however DCFS has recently communicated with local staff about the need for responsiveness to post-adoptive needs.

Among stakeholders, DCFS has no greater challenge than the conflictual relationship between DCFS and the Administrative Office of Courts (AOC). A number of influential stakeholders and stakeholder groups stated that the differences between the two organizations are significant enough that this review has to recognize them. Both DCFS and AOC leadership acknowledge the tension, although they continue to communicate and work together on issues of joint concern.

AOC leadership expresses doubts about some DCFS data, such as related to child fatalities and believes that DCFS is inconsistent in following up on commitments. AOC managers are also highly frustrated by what can be described as an inability by DCFS to demonstrate a high level of performance, which they believe can place children at risk of harm and/or lack of permanency and well-being. It is out of this dissatisfaction that AOC supported legislation mandating DCFS actions, such as some of those statutes mentioned previously in this report. DCFS expresses similar frustrations over its own inability to meet some of its expectations, but attributes the shortcomings to lack of staff, turnover and insufficient service resources. AOC staff acknowledge those limits, but feel that they shouldn't impede good outcomes for children.

The tension between child welfare agencies and the juvenile and family courts system is not uncommon nationally. Courts are accustomed to having their orders and agency policy met fully, an expectation overstressed child welfare systems cannot always meet. Attorneys for children feel an uncompromising obligation to ensure that their clients' needs are met, which

means that a perceived lack of responsiveness by the child welfare system is considered unacceptable. Court Appointed Child Advocates (CASA) feel a similar obligation. Parent attorneys expect that safeguards for parents' rights should be respected by DCFS and where they may not be, are obligated to advocate for their clients.

On the child welfare side, state agencies always have limits and when resources are constrained in the way that Arkansas is experiencing, the child welfare agency cannot consistently overcome the fiscal constraints they face. An additional challenge that DCFS experiences is that in a structure which occurs in few if any other states, all of the traditional court critics of the child welfare agency - parent attorneys, children's attorneys and CASAs – are part of the same administrative structure, the AOC, instead of being organizationally independent. Practically speaking, criticism of DCFS which might come from each of these entities is now consolidated into one organizational voice, which magnifies the negative feedback. One result of this dynamic is that DCFS becomes more defensive, fostering greater mistrust.

Against this backdrop, however, both agencies are committed to similar goals with a common interest, improving outcomes for children. The two organizations must re-establish constructive working relationship for those goals to be met.

XIII. Recommendations

Based on the review of DCFS data, policy and studies and stakeholder input, the following recommendations are made to address the challenges present in the Arkansas child welfare system. These recommendations are ordered to begin with simpler, practical strategies that do not necessarily require significant additional resources. They are followed by other essential strategies that do require additional financial investments. The challenges faced by the Arkansas child welfare system are so great that DCFS alone cannot solve them. However it does have many partners in the public and private sector who would be happy to have a role in improving child and family outcomes. To foster greater stakeholder involvement, a number of the recommendations are designed to involve stakeholders in problem-solving, a dual strategy to concurrently strengthen DCFS-Stakeholder relationships.

Arkansas can make meaningful advances by implementing Recommendations 1 through 8, even with its limited resources. However, the system cannot fully meet expectations and more importantly, significantly improve outcomes for families and children without addressing Recommendations 9, Expanding Intensive Home and Community-Based Mental Health Resources and 10, Reducing DCFS Caseloads. Implementing these two recommendations will require additional financial investments.

1. **Designate a Staff Member in the Governor's Office to Coordinate Interagency Planning and System Collaboration for Children, Youth and Family Services**

The Arkansas child welfare system is interdependent not only with its private partners, but also with judges, behavioral health, Medicaid, the Administrative Office of Courts, law enforcement, youth services and the legislature. For DCFS to overcome the challenges it faces, the coordinated support of all of these entities is essential. However, DCFS alone does not have the standing or leverage to facilitate effective partnerships with so many diverse stakeholders. To create a functional coalition of all of these partners, each of which has its own challenges, strong leadership is essential.

Appoint a staff member within the Governor's office to coordinate interagency planning and system collaboration for children, youth and family services. The first objective of this office should be assisting with implementation of improvements in child welfare, including, but not limited to consideration of the recommendations of this report.

2. **Build DCFS Capacity to Partner with Stakeholders**

The resource obstacles to achieving the potential of the Arkansas child welfare system are significant enough that DCFS must engage its community partners in developing and implementing a common strategy to substantially improve outcomes for children and families. Developing this partnership will take time, energy and perseverance, all of which will tax the resources of the current DCFS leadership team. Relationships need to be strengthened not only within the voluntary sector; they also need to be maximized with other Divisions of DHS and other state agencies.

With the support of the proposed Office of Children and Youth, DCFS should establish an independent stakeholder panel to provide input into a formal plan to implement the recommendations of this report. Drafting of the plan should involve stakeholders as active workgroup members. This initiative is important enough to merit a specific accountability process to track not only engagement with stakeholders, but also the implementation of the other recommendations in this report. This accountability process should be facilitated by the independent stakeholder panel, which should issue periodic reports about implementation progress.

Casey Family Programs has extensive experience in developing stakeholder partnerships and reform design. They might be enlisted as an ally in this effort.

3. **Address the Placement Challenge**

Many of the Division's challenges are a result of limited resources; however the lack of appropriate placements in close proximity to children's home is the most critical. And given the recent increase in the number of children placed in out-of-home care, the problem is getting worse. Increasing the use of relative placements is the simplest and most promising next step

toward expanding placement options. DCFS staff and stakeholders identified a number of factors limiting the use of relatives. Attitudes toward the suitability of relatives as caregivers on the part of some staff, judges and other legal partners were frequently mentioned as a barrier. This negative view seems to be most prominent among those who view some extended families as sharing a common lack of caregiving capacities. However there are numerous staff and legal partners who see relatives as a valuable untapped resource and point to system barriers that impede relative availability as placements.

The process of enlisting relatives as caregivers and granting provisional approval as caregivers can be slowed by training requirements, criminal background checks and where relevant, delays in waiver approvals, untimely board payments and delays in Medicaid eligibility. When children need additional assistance, limited supportive services negatively affect relative caregivers to the same degree as they do foster parents. The foster home recruitment and retention process also needs attention. Several stakeholders involved in recruitment shared creative ideas to increase foster and adoptive home capacity.

The following steps are recommended:

- Convene a work group consisting of DCFS recruitment staff, representatives of the major faith-based organizations involved in recruitment and retention activities, current kinship, foster home and adoptive caregivers and judicial representatives and other legal partners to develop a joint plan to expand the use of relatives and guardianships, recruit and retain new placement family foster homes and strengthen post-adoptive supports.
- Provide training to staff on caregiver engagement, especially relative caregivers, and family finding.
- Borrowing a strategy from a judge who was interviewed, develop a process whereby when DCFS determines that a relative might be a suitable placement option, prior to the court hearing DCFS should complete background checks and assess the relative's home. In doing so, the court could approve the relative placement in court, avoiding a short-term, interim placement.
- Resume licensing of respite homes to provide support for current caregivers struggling with challenging children and youth.
- Consider a system used in Utah, where child welfare foster care support staff organize foster parents living in relative proximity to each other in geographic "Clusters". Utah staff convene foster parents in these clusters for information-sharing and problem-solving related to day-to-day fostering issues. Foster parents also use their cluster peers as respite resources and sources of advice and peer support.
- Create an ongoing forum in which Community Engagement Specialists and staff of other foster and adoption recruitment organizations, such as The Call, meet regularly to

coordinate their recruitment efforts, share recruitment and retention strategies and develop new approaches to placement development.

- Develop a strategy to compress the length of time required to complete foster parent training so foster families and relative caregivers will have the option to be licensed or approved more quickly.
- DHS should convene a meeting between DCFS and Medicaid leadership to identify administrative delays in initiating Medicaid so there are no lapses in coverage for caregivers.
- Begin providing reimbursement to kinship providers as soon as provisional approval is granted.
- Develop specific written communications to pre-adoptive and post-adoptive parents about how to access post-adoptive supports.

4. Create a County-Central Office Task Force to Address Administrative Flexibility

A number of stakeholders and local DCFS staff mentioned the large number of local administrative actions that require approval at the executive level of DCFS. In the current practice environment of high caseloads, staff turnover, staff inexperience and the high level of scrutiny which DCFS experiences, the caution of Central Office staff in providing greater autonomy of decision-making at the local level is understandable. However, at some point this oversight becomes experienced as a lack of trust and a barrier to timely decision-making, making it counter-productive. In an effort to improve state-county relationships and to increase timely actions, DCFS should appoint a work group consisting of a supervisor and Family Service Worker from each of the 10 Areas to solicit efficiency recommendations from the field and make recommendations directed at safely enhancing local flexibility. This charge relates to local actions and decisions requiring central office approval as well as local performance measures and tracking, some of which may not be essential. Strategically, members should start with identifying opportunities to use flexibility to address the placement crisis. A county representative should be selected by the group as chairperson.

5. Improve the DCFS – AOC Working Relationship

As mentioned previously, a constructive relationship between DCFS and the Administrative Office of Courts is important to improving the lives of Arkansas children. The agencies share common goals for children and families and this should be a foundation for improving working relationships. The two organizations need to mutually acknowledge two critical facts. On the part of DCFS, the agency should recognize the fact that the court system and attorneys/advocates for children have a right to expect effective action from DCFS in support of child safety, permanency and well-being. AOC should communicate its recognition that high caseloads and limited resources are preventing DCFS from effectively accomplishing this

mission. The ongoing work of the two organizations should be to, within existing resource constraints, jointly develop strategies to improve outcomes for families and children.

- As an initial step, both agencies should reach agreement on a basic set of indicators that accurately reflect the overall performance of each agency. Child welfare outcomes are not totally dependent on DCFS performance. Judicial actions, for example, are also crucial. For DCFS, the indicators are likely to be some of those measures identified in this report. However, DCFS has many other management indicators that might be useful. AOC reports that it has some data about court trends. Data collected relative to parent attorneys and attorneys ad litem are unknown. Relevant AOC areas that might be tracked include but aren't limited to the following:

  By Circuit:
  Time to permanency
  Number of relative placements
  Number of guardianships
  Finalized adoptions
  Attorney ad litem contacts with children between hearings

  Data for DCFS and AOC indicators should be shared broadly among stakeholders.

- The Supreme Court and the legislature should consider moving the parent attorney function to an independent setting. Having parent attorneys in particular under the judicial system, while it may not directly affect DCFS, does raise the questions about the independence of this crucial attorney-client relationship in form if not in substance.

- To demonstrate the efforts of DCFS and AOC to improve their working relationship, the organizations should invite a small number of interested/affected stakeholders to their policy and performance discussions for both information sharing and input.

6. Expedite the Process for Filling DCFS Vacancies

The turnover of DCFS front-line staff heightens the workloads of staff, which increases with each day a position is left vacant. A process should be created to expedite the filling of DCFS vacancies and address other processes that delay hiring new staff.

7. Develop and Implement a Principle-Based Operational DCFS Model of Practice

DCFS should expand its Practice Model to include a core set of specific principles of practice that provide guidance to the field about how children and families should experience the child welfare system. The model should guide system policies, training content, staff performance standards, service contract expectations, accountability measures and quality assurance/quality

improvement methods. The practice model should speak specifically to the importance of family and strengths of kin resources. Existing policies and procedures should be tested against the principles and where incongruent, should be revised. A set of best practice principles used by improving systems nationally is attached in the Appendix. In developing a revised practice model, DCFS should involve key stakeholders in shaping the design.

8. Strengthen DCFS Practice in Assessing Safety Assessment and Engagement Skills

DCFS data and some stakeholder input suggest that DCFS needs to further strengthen its family assessment capacity. DCFS has added new assessment and planning tools, such as Structured Decision-Making, the CANs process and FAST and also is making efforts to improve the Protection Planning Process. These tools are useful in promoting the consistent consideration of safety factors and guiding case decision-making. They are also beneficial when employed with inexperienced staff. Factors that tools such as these cannot provide is critical thinking and insight into underlying child, youth and family needs (meaning the causes of behavior).

- DCFS should provide additional training to staff on Protection Planning, with a focus on the issues that are causing the poor caregiving activities which brought them to the Division's attention. If a parent's inattention to the needs of her child are caused by depression resulting from lifetime trauma experiences, for example, offering parenting training is not likely to enhance child safety. Since concerns about the quality of Protection Plans are frequently anecdotal, DCFS should also track outcomes for families with protection plans to actually determine their effectiveness in keeping children safe.

- DCFS should also provide additional training in family engagement skills. Training should be skills-based and permit engagement skills to be modeled by trainers and practiced by staff in the classroom settings. Training should be followed by coaching, using skilled practitioners. Training should be initially targeted on those counties with the greatest volume of children entering care and remaining in care.

9. Expand the Availability of Intensive Home and Community-Based Mental Health Services

According to key stakeholders, much of the mental health service delivery in Arkansas is office-based rather than home and community-based, is insufficiently evidence-based and trauma-responsive and lacks the intensity required for children with high mental health needs. Foster parent retention, child stability and post-adoptive success are also negatively affected by the limited capacity of mental health agencies. Many systems nationally are transitioning their traditional mental health service delivery to an intensive home and community-based model. It is recommended that the leadership of DCFS, the Division of Behavioral Health and the Division of Medical Services visit two systems implementing innovative approaches to delivery of home

and community mental health services, one in Arizona and one in Los Angeles, to identify opportunities to implement similar approaches in Arkansas. The first priority should be to return those children placed out- of-state to Arkansas.

Implementation of a new mental health system of care will require additional resources as matching for Medicaid funding.

10. Develop a Three-Year Plan to Reduce DCFS Caseloads to an Average of 20

DCFS should provide the state legislature a three-year plan for reducing caseloads from the current average of 29 to an average of 20 by adding staff appropriations in each of the next three budget years. As part of that budgeting process, DHS should include the cost of equalizing the salaries of DHS attorneys to a level comparable with the salaries of attorneys ad litem and parent attorneys. The agency must have the ability to retain experienced attorneys to represent the Department in court.

It is also recommended that DCFS provide a fiscal and workload note to the legislature for any bill that is introduced affecting workloads in the child welfare system. If such a document is not provided, the legislature should request it.

11. Determine Responsibility for Implementing Recommendations

Development of an implementation plan for these recommendations will clarify in detail assignment of responsibilities. However, to initiate the implementation process, the following general assignment of tasks is suggested.

Governor's Office

- Appoint a staff member to coordinate interagency planning and system collaboration for children, youth and family services
- Ensure that administrative steps are taken to expedite the hiring process in DCFS

Legislature

- Request that DCFS provide estimates of costs for reducing DCFS caseloads to a 1/20 ratio over a three year period
- Request that DCFS provide a fiscal/workload note for child welfare related bills passed in the most recent session and in all future sessions
- Assess possible revenue sources for funding additional DCFS staff

Department of Human Services

- Direct that senior staff from the Division of Behavioral Health, Division of Medical Services and DCFS contact the suggested model mental health programs and request an opportunity to observe their operations. The Child Welfare Policy and Practice Group can provide contact information
- Assess the content of the State's Medicaid plan to determine if intensive home and community-based services such as those recommended in the plan would be reimbursable. If plan amendments are needed, propose a revision to the plan and identify possible implementation costs to the legislature

Appendix

Interview Respondents

DCFS Central Office Staff

DCFS Family Service Workers and Supervisors

DCFS Area Directors

DHS Attorneys

DCFS Adoption Staff

DCFS Health Service Workers

DCFS Program Assistants

University Training Staff

CACD Central Office Staff

Supreme Court Justice

Juvenile Court Judges

Administrative Office of Courts Central Office Staff

Other DCFS State Government Partners

CASA Volunteers

Attorneys ad Litem

Parent Attorneys

Legislators

DHS Licensing Division Staff

Foster Parents

Adoptive Parents

Former Foster Youth

Christians for Kids

Merlin Foundation

ACCARDV

Center for Youth and Families

Foster Family Treatment Association

United Methodist Children's Home

Integrity, Inc.

Center for Youth and Families

Arkansas Advocates for Children and Families

Child Abuse Prevention Board

Arkansas Child Welfare Think Tank

Project Zero

Immerse Arkansas

Children's Hospital

Hornby & Zeller

Practice Model Principles

- Children should be protected from abuse and neglect.
- Children should live with their families and if services are needed to permit them to live with families safely, they should be provided.
- If children cannot live with their families safely, they should achieve timely permanency.
- Services to children and their families should be planned and delivered through an individualized service plan crafted by the child and family team. Children, their parents, the family's informal support network, substitute caregivers, providers and foster parents should be full participants on this team. Involvement should include regular participation in child and family team meetings as a point for engagement, assessment, planning, intervention and assessment of progress.
- The assessment process should address the underlying conditions creating the challenges experienced by the child and family, not just the symptoms of functioning. The system's assessment should be developed with the contributions of the full family team.

- The mix of services provided should be responsive to the strengths and needs of the child and family. Development of the needs-based plans should not be constrained by the availability of services. Where needed services are unavailable, appropriate services should be created.

- Children and their families should have access to a comprehensive array of services, including intensive home-based services, designed to enable children to live with their families or to achieve timely permanency.

- Services should be flexible and adapted to child and family needs. Children and families should not be expected to adapt to ineffective services.

- Placements should be made in the least restrictive, most normalized setting responsive to the child's needs. Children should not be placed in congregate settings unless that environment is the only setting in which needed services can be provided.

- The system should avoid temporary, interim placements. To this end, the use of congregate shelter placements should be avoided in favor of family based settings.

- The system should vigorously seek to assure that children are integrated to the maximum extent feasible into normalized school settings and activities and achieve success in school.

- The system should forbid summary discharges of children from placement. The system should develop a policy that describes steps that should be taken prior to a child's discharge from a placement. The system should be based on the philosophy that the disruption of a placement is a failure of the system, not a failure of the child.

- The system should promote smooth transitions for children to adult service. Planning for youth in custody who will reach adulthood without permanence should connect them with caring adults, both relatives and other resources, whom they can turn to for help after system supports are no longer available.

10. Quality Improvement Plan

At this time, there are many unknowns in the behavioral health system in the state of Arkansas. Below is a list of task forces and boards the Division of Behavioral Health Services is working with to make major decisions regarding the future of the behavioral health care system in Arkansas.

- In 2015, the Arkansas legislature passed Act 23 " TO CREATE THE ARKANSAS HEALTH REFORM". This statute created a legislative task force to examine the traditional Medicaid system and Arkansas' version of Medicaid Expansion, the Healthcare Independence program or Private Option. Additionally, this act extended the Private Option until December 31, 2016. The task force must have recommendations on how to move forward with the entire Medicaid program by December 31, 2015. These recommendations must include a way forward with the Medicaid Expansion program.
- Governor Hutchison appointed a Health Care Advisory Committee composed of health stakeholders to make recommendations to him regarding the future of Arkansas' health care system. The Mental Health Council of Arkansas and Arkansas Behavioral Health Planning and Advisory Council are represented on this committee.
- During the 2015 Legislative Session, the Criminal Justice Reform Act of 2015 was passed. The goal of the legislation is to implement measures designed to enhance public safety and reduce the prison population. The act created three task forces charged with making recommendations on how to address prison and jail overcrowding:
  - Criminal Justice Reform Task Force
  - Behavioral Health Treatment Access Task Force
  - Specialty Court Task Force

  All three task forces recognize and are considering the importance of treatment to divert individuals from the criminal justice system and to assist in the reentry process to reduce recidivism.
- Governor Hutchison commissioned an independent review of the child welfare system. The resulting report highlights the need for increased and improved behavioral health services for children and families involved in the child welfare system.
- The Division of Youth Services, the agency responsible for the juvenile justice system, has commissioned a board to assist in making improvements to the juvenile justice system, the Youth Justice Reform Board. The Division of Behavioral Health Services has a representative on this board.

Considering the above mentioned variables and the far reaching impact of the decisions these groups are making will have on the behavioral health system and the utilization of block grant funds, it is not feasible at this time for the Division of Behavioral Health Services to develop a Continuous Quality Improvement/Total Quality Management plan.

11. Trauma

Narrative Question:

Trauma [75] 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 systems [76]. 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 Trauma [78] 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:

11. Trauma

The Division of Behavioral Health Services, being one of the divisions under the Department of Human Services has representation on a Department wide effort to develop a Trauma-Informed Care Policy that will address the needs of all individuals being served by Arkansas Department of Human Services.

The draft policy and planned activities for the Department follows:

Drafted DHS Trauma-Informed Care Policy Statement

In adherence to our mission statement of working together to improve the quality of life of all Arkansans by protecting the vulnerable, fostering independence, and promoting better health, the Arkansas Department of Human Services (DHS) is committed to being a trauma-informed care organization. DHS commits to:

- utilizing trauma screenings and assessments to provide appropriate services, prevent unintentional re-traumatization, and understand behaviors that may be related to trauma-based issues
- providing agency-wide staff trainings regarding trauma-informed care
- requiring applicable providers and contractors to participate in trauma-informed care trainings and incorporating trauma-informed care performance measures into contract deliverables as applicable
- incorporating evidence-based trauma-informed care practices that will result in improved outcomes
- utilizing data and IT systems to facilitate cross-divisional, transitional trauma-informed care efforts

By implementing an agency-wide approach to trauma-informed care, DHS commits to achieving its core values of compassion, courage, respect, integrity, and trust.

Trauma-Informed Care Organizational Plan Activities

These core components of a trauma-informed system of care are nationally recognized:

1. Trauma-informed mission and resource commitment
2. Policies and procedures that reflect mission
3. Universal trauma screening for all youth and adults
4. Values that focus on empowerment
5. On-going staff education and training
6. Improve and target hiring practices

In order to align with the national standard, the following recommendations are being proposed agency wide as trauma is not limited to any one Division of DHS. Trauma can manifest from community violence, complex trauma situations, domestic violence, early childhood trauma,

medical trauma, natural disasters, neglect, physical abuse, refugee and war zone trauma, school violence, sexual abuse, terrorism and traumatic grief. Just as there are many forms of trauma, there are many screening tools, assessments, and practice models to assist in the recovery from traumatic situations. DHS seeks to become a trauma-informed agency while recognizing the individuality of its Divisions. The aim of this workgroup is to provide a framework for DHS as a whole while supporting Divisions as they implement the best trauma-informed care system for their specific population.

Trauma Screenings & Assessments

Trauma screening tools can be used as a relatively quick method to determine if the presence of a traumatic life experience may exist. A trauma screen may be administered in a primary care or other healthcare setting. A trauma screen does not require that the individual administering the screen have a specific set of credentials in order to administer and score the screen. Without screening specifically for a history of trauma, an individual may be misdiagnosed and an inappropriate treatment may be implemented. Two factors are very important when screening for trauma: one, in order to reveal such experiences, the person must be engaged in a sensitive and caring process that allows the person to feel safe and comfortable and two, screening for trauma is a process that may not be revealed during intake; therefore, a system should be in place to screen for trauma post intake and following the development of a trusting relationship with the clinician. (Source: SAMHSA Screening Tools). An example of a screening tool is the Life Event Checklist (LEC-5). The LEC-5 is a brief, 17-item, self-report measure designed to screen for potentially traumatic events in a respondent's lifetime (Source: SAMSA-HRSA). The LEC-5 has an optional extended questionnaire and interview for more in depth screening (Source: National Center for PTSD).

Assessments are more comprehensive than screening tools and capture a range of specific information about the individual. An assessment requires a qualified individual with appropriate credentials to administer and score the instrument. Assessments are chosen based on the target population, age, setting, as well as the reliability and validity of the instrument. Without completing an assessment that identifies if the individual has been exposed to a traumatic event(s), treating the individual will not be as successful, the individual will not be as engaged in treatment and the risk of relapse is greater as all areas of concern are not being addressed (Source: SAMHSA: Trauma-Informed Care in Behavioral Health Services).

See attachment for a list of screening tools and assessment instruments used in a trauma-informed system of care. Items on the list that are in **bold** represent those instruments that appeared most frequently or had the highest recommendations based on research.

Recommendation 1: Each Division will identify and utilize a trauma-informed screening instrument that serves the Division's target population. Each Division may need to utilize a separate instrument or version for children and adults; however, the same version should be utilized for all children or all adults within that target population.

Recommendation 2: Whenever a treatment or intervention plan is created, the trauma-informed care screen will be completed. Based on the results of the screen, the individual may be referred for a trauma-informed care assessment.

Recommendation 3: Each Division will identify and utilize a trauma-informed assessment instrument to serve the Division's target population. Each Division may need to utilize a separate instrument or version for children and adults; however, the same version should be utilized for all children and all adults within that Division.

Evidence-Based, Trauma-Informed Practices

Trauma specific, or trauma focused interventions are the evidence-based, best practice models that have been proven to facilitate recovery from trauma. Trauma-informed care models may be implemented across an agency or a system. In adults, the most successful trauma-informed care models included a combination of cognitive behavioral therapy and antidepressant medication. For children, trauma-focused cognitive behavioral therapy has shown the strongest success rates (Source: American Institutes for Research – Trauma-informed Care and Trauma-specific Services). By implementing a trauma-informed practice intervention model that is evidence-based, the outcomes DHS, as an agency, hopes to achieve are a reduction in the number of individuals who are reliant on DHS for long-term services and a recovery from the traumatic event. See attachment for a list of evidence-based practice models used in a trauma-informed system of care. Items on the list in **bold** represent the evidence-based practice models that appeared most frequently during the research gathering process.

Recommendation 4: Each Division will identify and utilize the evidence-based, trauma-informed practice model that will be supportive to their target population and align with the Mission and Vision Statement for the Division.

Measuring Outcomes to Gauge Effectiveness

The Patient Protection and Affordable Care Act has accelerated the realignment of healthcare payment systems so that providers are reimbursed based more on the value of their care than on volume. Emphasizing value over volume is impossible without the use of reliable and valid outcome measures (Source: National Council for Behavioral Health). Outcomes measures assess clinical outcomes, such as emotional and behavioral functioning, and non-clinical outcomes, such as cost effectiveness and perception of care (Source: Minnesota DHS). Measuring success by tracking outcomes allows DHS to ensure that services being delivered are achieving the desired outcomes. Data from screening and assessments can be used to measure outcomes that will in turn gauge effectiveness of evidence-based practices. At the individual level, the data allows for the matching of specific characteristics and needs with appropriate, responsive interventions. At the system level, the process of reviewing aggregated data can be used to refine the array of services to address the needs of the population. (Source: State Medicaid Director Letter 07/11/13). According to SAMSHA, interventions alone are not enough, the organizational climate and condition in which services are provided play a significant role in maximizing the outcomes of evidence-based practices. (Source: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach)

Outcome measurements should relate to areas of functioning including family, education, employment, mental health, substance abuse, and criminal justice. Surveys during the service period should include client questionnaires, including inquiries about whether clients feel safe at DHS facilities and with DHS staff, and client perception of how well the services are working to

help them improve. DHS clients should achieve and maintain higher levels of functioning during and after receiving DHS services.

Recommendation 5: Each Division will identify the outcomes measures that all community-based and residential care providers serving DHS clients will adhere to. These outcome measures will be required, as part of the contract with DHS, and data will be collected at intake, periodically during the service period, at discharge, and at least once at some point post-discharge. Each Division will establish target levels of improvement.

Trauma-Informed Care Staff Training

Being a trauma-informed agency is not limited to employees who provide direct services. All DHS employees should have an understanding of what it means to be a trauma-informed agency. Frontline employees in the County Offices are often the first and only interaction the public has with DHS. While not everyone who comes into the County Office for assistance may be affected by a traumatic experience, it is important for the employees to have an awareness of trauma and be able to respond with empathy, sensitivity, and respect. Those employees in the administrative offices should be trained as well so that phone calls, emails, and other communications with the public are in the most respectful manner possible.

Recommendation 6: In an effort to further support the mission of DHS "to improve the quality of life for all Arkansans," all DHS staff will complete annual training on being a trauma-informed employee. For new employees, training would need to be completed within 60 days from the date of hire. A single, Department-wide training forum will be established so that all employees receive consistent information

Trauma-Informed Care Provider Training

Ongoing trainings are needed to continue to support direct staff providers in this new system of care methodology. The Texas Department of Family and Protective Services requires annual training for direct staff providers as well as prospective foster parents or adoptive parents. The National Center for Trauma-Informed Care and Alternatives to Seclusion and Restraint (NCTIC), a part of SAMSHA, also provides technical assistance and trainings for a range of service systems including: community-based behavioral health agencies, institutions, criminal and juvenile justice settings, homeless and HIV service providers, domestic violence organizations and state and federal agencies. The National Child Traumatic Stress Network (NCTSN) maintains a calendar of nationwide events on trauma-informed care. Maine's Thrive Initiative offers webinars on the trauma-informed system of care; on-site training is available as well as technical assistance and consultation. Topics from the Thrive Initiative's webinars include:

1. Creating Trauma-Informed, Family-Driven Systems of Care
2. Creating Trauma-Informed, Youth-Guided Systems of Care
3. Next Steps to a Trauma-Informed System of Care
4. Trauma in Schools
5. Culture and Linguistics

A local example is found in the MidSOUTH Foster Parent Program that provides training to prospective foster parents in a 30 hour course that is provided in 3 hour sessions. This training is designed to help foster/adoptive parents understand the challenges and rewards if rearing abused or neglected children.

Another example is from MidSouth offers training on the topic of "Understanding the Relationship between Attachment Disorder and Post Traumatic Stress Disorder." This training provides an overview of the various levels of attachment; the symptoms seen in complex PTSD; the relationship of chronic trauma to symptoms of PTSD; and a review of current evidence-based treatments for the traumatized child/adult. This information will be helpful for those working with children and adults who have experienced chronic abuse, neglect, and trauma.

The ARBEST program through UAMS currently has traditional in person training as well as webinars available on their website covering the following topics:

1. Utilizing TF-CBT with preschool-aged children
2. Assessing for Trauma
3. Supervised visitations and Monitored Exchanges
4. ARCIP Overview & Dependency-Neglect Court Basics for Mental Health professionals
5. Completing a Trauma Narrative in TF-CBT

Recommendation 7: Direct service providers will receive annual training and prospective foster and adoptive parents will receive training in trauma-informed care on an annual basis. For new employees, training would need to be completed within 60 days from the date of hire.

Recommendation 8: All Divisions will include a requirement in their contracts or agreements with providers that a trauma-informed care training plan for their employees has been developed and completed by the employee annually.

Utilizing Data and IT Systems to Facilitate Cross-divisional, Transitional Trauma-informed Care Efforts

Concluding Remarks

By implementing an agency-wide approach to trauma-informed care, DHS commits to achieving its core values of compassion, courage, respect, integrity, and trust. Each Division will be responsible for developing their own trauma-informed approach to address the needs of the individuals they serve. Once developed, each Division will present their plan to the Trauma Informed Care Workgroup for review. Division will need to include any screening instruments, assessment tools, and evidence-based practice models with the submission og their plan for a trauma-informed approach.

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://csgjusticecenter.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.

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

Footnotes:

State of Arkansas *As Engrossed: S2/26/15 H3/20/15*
90th General Assembly
A Bill
Regular Session, 2015 SENATE BILL 472

By: Senators J. Hutchinson, Bledsoe, E. Cheatham, A. Clark, Collins-Smith, J. Cooper, J. Dismang, Files, Flippo, Hester, B. Johnson, U. Lindsey, Maloch, B. Pierce, Rapert, Rice, G. Stubblefield, J. Woods, Elliott
By: Representatives Shepherd, *Gillam, Tucker, Baine, Bragg, Davis, Lemons, Lowery, Lundstrum, Richmond, Scott, B. Smith, Tosh, Vines, Bennett, G. McGill, Leding, V. Flowers, M.J. Gray, Nicks, Sabin, M. Hodges, D. Whitaker, Johnson*

For An Act To Be Entitled

AN ACT TO BE KNOWN AS THE CRIMINAL JUSTICE REFORM ACT OF 2015; TO IMPLEMENT MEASURES DESIGNED TO ENHANCE PUBLIC SAFETY AND REDUCE THE PRISON *POPULATION; TO DECLARE AN EMERGENCY; AND* FOR OTHER PURPOSES.

Subtitle

TO BE KNOWN AS THE CRIMINAL JUSTICE REFORM ACT OF 2015; TO IMPLEMENT MEASURES DESIGNED TO ENHANCE PUBLIC SAFETY AND REDUCE THE PRISON POPULATION; AND TO DECLARE AN EMERGENCY.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. DO NOT CODIFY. Legislative intent.

It is the intent of the General Assembly to implement wide-ranging reforms to the criminal justice system in order to address prison overcrowding, promote seamless reentry into society, reduce medical costs incurred by the state and local governments, aid law enforcement agencies in fighting crime and keeping the peace, and to enhance public safety.

SECTION 2. DO NOT CODIFY. Temporary legislation.

(a) The Department of Correction shall coordinate and, if advantageous, contract with counties, the federal government, governmental agencies of Arkansas and *other states, counties, regional correctional facilities,* political subdivisions of Arkansas, political subdivisions of other states, and private contractors to address the matter of this state's current prison overcrowding problem, as permitted by § 12-27-103(b)(14), in order to provide and improve correctional operations.

(b) The department shall submit a report to the Governor, Legislative Council, the Senate Judiciary Committee, and the House Committee on Judiciary by December 1, 2015, on its efforts under and successful contracting with an entity under subsection (a) of this section.

(c) This section expires on December 1, 2015.

SECTION 3. Arkansas Code § 5-4-501(d)(2), concerning what is considered a "felony involving violence" for the purposes of the habitual offender statute, is amended to read as follows:

(2) As used in this subsection, "felony involving violence" means:

(A) Any of the following felonies:

(i) Murder in the first degree, § 5-10-102;

(ii) Murder in the second degree, § 5-10-103;

(iii) Kidnapping, § 5-11-102;

(iv) Aggravated robbery, § 5-12-103;

(v) Rape, § 5-14-103;

(vi) Battery in the first degree, § 5-13-201;

(vii) Terroristic act, § 5-13-310;

(viii) Sexual assault in the first degree, § 5-14-124;

(ix) Sexual assault in the second degree, § 5-14-125;

(x) Domestic battering in the first degree, § 5-26-303;

(xi) Residential burglary, *§ 5-39-201(a)*;

~~(xi)~~(xii) Aggravated residential burglary, § 5-39-204;

~~(xii)~~(xiii) Unlawful discharge of a firearm from a

vehicle, § 5-74-107;

~~(xiii)~~(xiv) Criminal use of prohibited weapons, § 5-73-104, involving an activity making it a Class B felony; or

~~(xiv)~~(xv) A felony attempt, solicitation, or conspiracy to commit:

(a) Capital murder, § 5-10-101;

(b) Murder in the first degree, § 5-10-102;

(c) Murder in the second degree, § 5-10-103;

(d) Kidnapping, § 5-11-102;

(e) Aggravated robbery, § 5-12-103;

(f) Rape, § 5-14-103;

(g) Battery in the first degree, § 5-13-201;

(h) Domestic battering in the first degree, § 5-26-303; ~~or~~

(i) Residential burglary, *§ 5-39-201(a)*; or

~~(i)~~(j) Aggravated residential burglary, § 5-39-204; or

(B) A conviction of a comparable felony involving violence from another jurisdiction.

SECTION 4. Arkansas Code Title 10, Chapter 3, is amended to add an additional subchapter to read as follows:

Subchapter 28 — Legislative Criminal Justice Oversight Task Force

10-3-2801. Legislative Criminal Justice Oversight Task Force.

(a)(1) There is created the Legislative Criminal Justice Oversight Task Force responsible for studying the performance and outcome measures related to this act.

(2) The Bureau of Legislative Research shall provide staff support for the task force.

(b) The task force shall be composed of no more than *nineteen (19)* members, as follows:

(1) No more than *eleven (11)* members may be appointed by the Governor from the following persons:

(A) One (1) or two (2) members who are circuit court

judges and who operate a specialty court program as defined under § 16-10-139(a);

(B) No more than one (1) county sheriff;

(C) No more than one (1) member from the Arkansas Public Defender Commission;

(D) No more than (1) member who is a prosecuting attorney;

(E) No more than (1) member who is a member of the executive board of the Arkansas Association of Chiefs of Police;

(F) No more than (2) members who are Medicaid providers; and

(G) No more than three (3) at-large members in order to reflect the racial, ethnic, gender, and geographical diversity of the state;

(2) One (1) member of the General Assembly to be appointed by the President Pro Tempore of the Senate;

(3) One (1) member of the General Assembly to be appointed by the Speaker of the House of Representatives;

(4) One (1) member who is the Chair of the Senate Judiciary Committee;

(5) One (1) member who is the Chair of the House Committee on Judiciary;

(6) The Chair of the Board of Corrections, or his or her designee;

(7) The Chair of the Parole Board, or his or her designee;

(8) The Director of the Department of Correction, or his or her designee; and

(9) The Director of the Department of Community Correction, or his or her designee.

(c)(1) The task force shall meet on or before the thirtieth day after the effective date of this act, at the call of the Chair of the Senate Judiciary Committee, and organize itself by electing one (1) of its members as chair and such other officers as the task force may consider necessary.

(2) Thereafter, the task force shall meet at least quarterly and at the call of the chair or by a majority of the members.

(3) A quorum of the task force consists of seven (7) members.

(d) The task force has the following powers and duties:

(1) To track the implementation of and evaluate compliance with

this act;

(2) To review performance and outcome measure reports submitted semiannually by the Department of Correction, Department of Community Correction, Parole Board, Arkansas Sentencing Commission, and Specialty Court Program Advisory Committee under this act and evaluate the impact; and

(3)(A) To prepare and submit an annual report of the performance and outcome measures that are part of this act to the Legislative Council, the Governor, and the Chief Justice of the Supreme Court.

(B) The annual report shall include recommendations for improvements and a summary of savings generated from and the impact on public safety as the result of this act.

SECTION 5. Arkansas Code Title 10, Chapter 3, is amended to add an additional subchapter to read as follows:

Subchapter 29 — Specialty Court Program Advisory Committee

10-3-2901. Specialty Court Program Advisory Committee.

(a) There is created a Specialty Court Program Advisory Committee.

(b) The Specialty Court Program Advisory Committee shall consist of the following members:

(1) The Chief Justice of the Supreme Court or the Chief Justice's designee who shall serve as chair;

(2) The Director of the Administrative Office of the Courts or the director's designee;

(3) Three (3) circuit court judges who preside over a specialty court program as defined under § 16-10-139(a) to be appointed by the Arkansas Judicial Council;

(4) One (1) district court judge who presides over a specialty court program as defined under § 16-10-139(a) to be appointed by the Arkansas District Judges Council;

(5) One (1) circuit court judge who presides over a juvenile drug court program to be appointed by the Arkansas Judicial Council;

(6) The Director of the Department of Community Correction or the director's designee;

(7) The Director of the Department of Human Services or the

director's designee;

(8) The Director of the Division of Behavioral Health Services or the director's designee;

(9) A prosecutor appointed by the Prosecutor Coordinator;

(10) A public defender appointed by the Executive Director of the Arkansas Public Defender Commission;

(11) A member of the Senate appointed by the President Pro Tempore of the Senate;

(12) A member of the House of Representatives appointed by the Speaker of the House of Representatives; and

(13) The Arkansas Drug Director or the director's designee.

(c) The chair or the chair's designee shall promptly call the first meeting within thirty (30) days after the effective date of this act.

(d)(1) The Specialty Court Program Advisory Committee shall conduct its meetings at the State Capitol Building or at any place designated by the chair or the chair's designee.

(2) Meetings shall be held at least one (1) time every three (3) months but may occur more often at the call of the chair.

(e) If any vacancy occurs on the Specialty Court Program Advisory Committee, the vacancy shall be filled by the same process as the original appointment.

(f) The Specialty Court Program Advisory Committee shall establish rules and procedures for conducting its business.

(g) Members of the Specialty Court Program Advisory Committee shall serve without compensation.

(h) A majority of the members of the Specialty Court Program Advisory Committee shall constitute a quorum for transacting any business of the Specialty Court Program Advisory Committee.

(i) The Specialty Court Program Advisory Committee is established to:

(1) Promote collaboration and provide recommendations on issues involving adult and juvenile specialty courts; and

(2) Design and complete the comprehensive evaluation of adult and juvenile specialty court programs as required by § 16-10-139.

SECTION 6. Arkansas Code Title 10, Chapter 3, is amended to add an additional subchapter to read as follows:

Subchapter 30 — Behavioral Health Treatment Access Legislative Task Force

10-3-3001. Behavioral Health Treatment Access Legislative Task Force

(a)(1) There is created a Behavioral Health Treatment Access Legislative Task Force responsible for ensuring that persons in the criminal justice system who have a demonstrated need for behavioral health treatment have access to treatment.

(2) The Bureau of Legislative Research shall provide staff support for the task force.

(b) The task force is composed of no more than nine (9) members, as follows:

(1) No more than four (4) members may be appointed by the Governor from the following persons:

(A) No more than one (1) member who is engaged in providing substance abuse treatment in the private sector;

(B) No more than one (1) member who is engaged in providing mental health treatment in the private sector; and

(C) No more than two (2) members of the general public who advocate for access to behavioral health services;

(2) The Director of the Department of Community Corrections or his or her designee;

(3) The Deputy Chief Counsel of the General Counsel Section for the Department of Human Services or his or her designee;

(4) The Insurance Commissioner of the State Insurance Department or his or her designee;

(5) One (1) member of the General Assembly to be appointed by the President Pro Tempore of the Senate; and

(6) One (1) member of the General Assembly to be appointed by the Speaker of the House of Representatives.

(c)(1) The task force shall meet on or before the thirtieth day after the effective date of this act, at the call of the member of the General Assembly appointed by the President Pro Tempore of the Senate, and organize itself by electing such other officers as the task force may consider necessary.

(2) Thereafter, the task force is to meet at least quarterly and

as often as necessary and at the call of the chair or a majority of the members.

(3) A quorum of the task force consists of five (5) members.

(d) The task force has the following powers and duties:

(1) To facilitate access to behavioral health treatment programs;

(2) To coordinate with other public and private entities to develop and promote access;

(3) To take steps to reduce costs and encourage evidence-based care;

(4) To assess feasibility and make recommendation for changes to state programs to improve access; and

(5) To prepare and submit an annual report by December 1 of each year to the Governor and the Legislative Council.

SECTION 7. Arkansas Code § 12-27-113(e), concerning records kept by the Department of Correction, is amended to read as follows:

(e)(1) The director shall make and preserve a full and complete record of ~~each and~~ every ~~person~~ inmate committed to the Department of Correction, along with a photograph of the ~~person~~ inmate and data pertaining to his or her trial conviction and past history.

(2)(A) To protect the integrity of ~~those~~ records described in subdivision (e)(1) of this section and to ensure their proper use, it ~~shall be~~ is unlawful to permit inspection of or disclose information contained in ~~those~~ records described in subdivision (e)(1) of this section or to copy or issue a copy of all or part of ~~any record~~ a record described in subdivision (e)(1) of this section except as authorized by ~~administrative regulation~~ rule, ~~or~~ by order of a court of competent jurisdiction.

(B) ~~The regulations~~ A rule under subdivision (e)(2)(A) of this section shall provide for adequate standards of security and confidentiality of ~~those~~ records described in subdivision (e)(1) of this section.

(3) For those inmates committed to the Department of Correction and judicially transferred to the Department of Community Correction, the preparation of ~~this record~~ a record described in subdivision (e)(1) of this section may be delegated to the Department of Community Correction pursuant

to policies applicable to records transmission adopted by the Board of Corrections.

(4) ~~Administrative regulations~~ A rule under subdivision (e)(2)(A) of this section may authorize the disclosure of information contained in ~~such records~~ a record described in subdivision (e)(1) of this section for research purposes.

(5)(A)(i) Upon written request, an employee of the Bureau of Legislative Research acting on behalf of a member of the General Assembly may view all records described in subdivision (e)(1) of this section of a current or former inmate.

(ii) A request under subdivision (e)(5)(A)(i) of this section shall be made in good faith.

(B) A view of records under subdivision (e)(5) of this section by an employee may be performed only if the employee is assigned to one (1) or more of the following committees:

(i) Senate Committee on Judiciary;

(ii) House Committee on Judiciary; or

(iii) Charitable, Penal and Correctional Institutions Subcommittee of the Legislative Council.

(C) The Department of Correction shall ensure that the employee authorized under subdivision (e)(5)(B) of this section to view records is provided access to the records.

(D) A record requested to be viewed under subdivision (e)(5) of this section is privileged and confidential and shall not be shown to any person not authorized to have access to the record under this section and shall not be used for any political purpose, including without limitation *political advertising, fundraising, or campaigning.*

SECTION 8. Arkansas Code Title 12, Chapter 27, is amended to add a new section to read as follows:

12-27-144. Department of Community Correction — Receipt of grant money for certain purposes.

(a) The Department of Community Correction may receive money from any source to be deposited into the Accountability Court Fund to be used for adult and juvenile specialty court programs as defined under § 16-10-139, based upon a formula to be developed by the Arkansas Judicial Council,

reviewed by the Specialty Courts Advisory Committee, and approved by the Legislative Council

(b) The department may promulgate rules to implement this section.

SECTION *9*. Arkansas Code Title 12, Chapter 27, is amended to add an additional subchapter to read as follows:

Subchapter 2 — Pay-for-Success Act

12-27-201. Title.

This subchapter shall be known as the "Pay-for-Success Act".

12-27-202. Legislative findings and intent.

(a) The General Assembly finds that:

(1) Incarceration and reincarceration are costly for the government and for taxpayers;

(2) Certain intervention measures have been found to reduce reincarceration rates;

(3) Pay-for-success contracts can serve as an effective tool for addressing certain issues concerning Arkansas correctional facilities, including overcrowding, by enabling the state to finance programs aimed at reducing recidivism rates; and

(4) It is in the best interests of Arkansas residents to encourage and enable the Department of Community Correction to obtain financing for certain intervention services to reduce the recidivism rate in Arkansas correctional facilities.

(b) The General Assembly intends for this subchapter to enable the department to obtain private financing for intervention services on a pay-for-success basis to reduce the reincarceration rate in Arkansas correctional facilities.

12-27-203. Definitions.

As used in this subchapter:

(1) "Incarcerated" means the condition of being committed to a state correctional facility; and

(2) "Pay-for-success program" means a program in which the Department of Community Correction pays for intervention services only if

certain performance targets are met, including without limitation a reduction in the reincarceration rate in Arkansas correctional facilities through intervention measures that focus on improving personal responsibility and decision making.

12-27-204. Pay-for-success programs.

(a) The Department of Community Correction may enter into an agreement *with entities, including without limitation licensed or accredited, as applicable, community-based* providers specializing in behavioral health, case management, and job placement services, and two-year or four-year public universities to create a pay-for-success program for incarcerated individuals or individuals on parole or probation that requires the department to pay for the intervention services only if the performance targets stated in the agreement are achieved.

(b) Before entering into an agreement under subsection (a) of this section, the department shall:

(1) Calculate the amount and timing of the payments that would be earned by the entity providing the intervention services during each year of the agreement if the performance targets are achieved; and

(2) Make a written determination that the agreement will result in specific performance improvements and budgetary savings if the performance targets are achieved.

(c) An agreement entered into under subsection (a) of this section:

(1) Shall include the following:

(A) A requirement that payment be conditioned on the achievement of specific outcomes based on defined performance targets; and

(B) An agreement with an independent third party to evaluate the pay-for-success program to determine whether the performance targets have been achieved;

(2) May contain a graduated payment schedule to allow for varying payments based on different levels of performance targets; and

(3) May include without limitation an agreement with one (1) or more private entities regarding the following:

(A) One (1) or more loans to fund the pay-for-success program's delivery and operations;

(B) One (1) or more guarantees for loans obtained under

this section;

(C) Payment based on reduced rates of reincarceration or other agreed-upon measures of success; and

(D) Oversight and implementation of the pay-for-success program, including without limitation the following:

(i) Making necessary financial arrangements;

(ii) Training staff;

(iii) Selecting service providers;

(iv) Overseeing the intervention measures;

(v) Monitoring pay-for-success program participation; and

(vi) Designation of one (1) entity to serve as a liaison among all parties to the agreement.

SECTION *10*. Arkansas Code § 12-29-112 is amended to read as follows:

12-29-112. Discharge or release.

~~(a) Inmates released upon completion of their term or released on parole shall be supplied with satisfactory clothing and a travel subsidy as prescribed by the Board of Corrections.~~

~~(b) Upon release of any inmate from any unit or center of the Department of Correction, the department shall provide transportation for the inmate to the closest commercial transportation pick-up point.~~

(a) At least one hundred twenty (120) days before an inmate's anticipated release date, the Department of Correction, in collaboration with the inmate and the Department of Community Correction and the Parole Board, *shall complete a prerelease assessment and reentry plan, which may include a travel subsidy and transportation to the closest commercial transportation pick-up point.*

(b) A copy of the reentry plan under this section shall be provided to the inmate and the assigned parole officer, if applicable.

(c) An inmate released upon completion of his or her terms of incarceration shall be provided:

(1) Written and certified proof that he or she completed and satisfied all the terms of his or her incarceration; and

(2) Information on how to reinstate his or her voting rights upon discharge of his or her sentence.

SECTION *11.* Arkansas Code § 12-29-401(e), concerning the application for Medicaid benefits on behalf of an inmate in the Department of Correction or person in the custody of the Department of Community Correction, is amended to add an additional subdivision to read as follows:

(5)(A) The Department of Human Services shall allow applications for Medicaid coverage and benefits to be submitted up to forty-five (45) days before the release of:

(i) An inmate or offender not previously qualified or previously qualified and subsequently suspended; or

(ii) An inmate or offender, eighteen (18) years of age or older, adjudicated as delinquent and not previously qualified or previously qualified and subsequently suspended.

(B) To the extent feasible, the Department of Correction and Department of Community Correction shall provide for Medicaid coverage applications to be submitted online to the Department of Human Services.

(C) A sentencing order shall satisfy the identity verification for Medicaid applications, if required for an application, and if permitted by federal law.

SECTION *12.* Arkansas Code Title 12, Chapter 29, Subchapter 4, is amended to add an additional section to read as follows:

12-29-407. Medicaid suspension.

(a) When an individual who is enrolled in a Medicaid program or the Health Care Independence Program is incarcerated to the custody of the Department of Correction, the Department of Community Correction, or detained *in a county jail, city jail, juvenile detention facility, or other Division of Youth Services commitment, the Department of Human Services shall suspend, to the degree feasible, the individual's coverage during the period of incarceration for up to twelve (12) months from the initial approval or renewal, unless prohibited by law.*

(b) When an individual with suspended Medicaid eligibility receives *eligible medical treatment or is released from custody, the Department of Human Services shall reinstate, to the degree feasible, the individual's coverage for up to twelve (12) months from the initial approval or renewal, unless prohibited by law.*

(c) The Department of Human Services shall ensure that the suspension and reinstatement process is automated and that protocols are developed to maximize Medicaid reimbursement for allowable medical services and essential health benefits.

SECTION *13*. Arkansas Code § 12-41-106, concerning the Medicaid eligibility of an inmate in a local correctional facility, is amended to add an additional subsection to read as follows:

(e) To the extent feasible, the Department of Human Services shall allow an online application for Medicaid coverage and benefits to be submitted up to forty-five (45) days prior to the release of an inmate or offender who is in the custody of the Department of Corrections or Department of Community Corrections and who was not previously qualified or previously qualified and subsequently suspended.

SECTION 14. Arkansas Code Title 12, Chapter 41, Subchapter 1, is amended to add a new section to read as follows:

12-41-107. Medical services billing to a local correctional facility.

(a) As used in this section:

(1) "Healthcare professional" means an individual or entity that is licensed, certified, or otherwise authorized by the laws of this state to administer health care in the ordinary course of the practice of his or her profession or as a function of an entity's administration of the practice of medicine;

(2) "Local correctional facility" means a county jail, a city jail, regional jail, criminal justice center, or county house of correction that is not operated by the Department of Correction, Department of Community Correction, or a federal correctional agency; and

(3) "Medicaid reimbursement rate" means the prevailing cost paid by the Arkansas Medicaid Program for a particular medical service or treatment established by the Division of Medical Services of the Department of Human Services in the Arkansas Medicaid Program fee schedules for a particular medical service, treatment, or medical code.

(b) A healthcare professional that provides medical service or treatment to a local correctional facility under this chapter for the benefit of an inmate housed in a local correctional facility for which the local

correctional facility is responsible for payment shall not charge the local correctional facility more than the Medicaid reimbursement rate for the same or similar medical service or treatment.

SECTION *15*. Arkansas Code Title 16, Chapter 10, Subchapter 1, is amended to add an additional section to read as follows:

16-10-139. Specialty court program evaluation and approval.

(a) As used in this section, "specialty court program" means one of the following:

(1) A pre-adjudication program under § 5-4-901;

(2) A approved drug court program under § 16-98-301 et seq.;

(3) A Swift and Certain Accountability on Probation Pilot Program under § 16-93-1701 et seq.; and

(4) Any other specialty court program that has been approved by the Supreme Court, including without limitation specialty court programs known as:

(A) A DWI court;

(B) A mental health court;

(C) A veteran's court;

(D) A juvenile drug court;

(E) A "HOPE" court;

(F) A "smarter sentencing" court; and

(G) A mental health crisis intervention center.

(b) A specialty court program operated by a circuit court or district court must be approved by the Supreme Court in the administrative plan submitted under Supreme Court Administrative Order No. 14.

(c)(1) The Specialty Courts Advisory Committee shall evaluate and make findings with respect to all specialty court programs operated by a circuit court or district court in this state and refer the findings to the Supreme Court.

(2) An evaluation under this section shall reflect nationally recognized and peer-reviewed standards for each particular type of specialty court program.

(3) *The Specialty Court Program Advisory Committee* shall also:

(A) Establish, implement, and operate a uniform specialty court program evaluation process to ensure specialty court program resources

are uniformly directed to high-risk and medium-risk offenders and that specialty court programs provide effective and proven practices that reduce recidivism, as well as other factors such as substance dependency, among participants;

(B) Establish *an evaluation* process that ensures that any new and existing specialty court program that is a drug court meets standards for drug court operation under § 16-98-302(b); and

(C) Promulgate rules to be approved by the Supreme Court to carry out the evaluation process under this section.

(d) A specialty court program shall be evaluated under the following schedule:

(1) A specialty court program established on or after the effective date of this act shall be evaluated after its second year of funded operation;

(2) A specialty court program in existence on the effective date of this act shall be evaluated under the requirements of this section prior to expending resources budgeted for fiscal year 2017; and

(3) A specialty court program shall be reevaluated every two (2) years after the initial evaluation.

SECTION *16*. Arkansas Code § 16-10-305(a)(6), concerning court costs for possessing less than four ounces (4 oz.) of a Schedule VI controlled substance, is repealed.

~~(6)(A) In circuit court or district court, three hundred dollars ($300) for possessing less than four ounces (4 oz.) of a Schedule VI controlled substance.~~

~~(B) One hundred fifty dollars ($150) of the court costs collected under subdivision (a)(6) of this section shall be remitted to the Treasurer of State by the court clerk for deposit into the Drug Abuse Prevention and Treatment Fund for the Division of Behavioral Health Services to be used exclusively for drug courts or other substance abuse and prevention activities; and~~

SECTION *17*. Arkansas Code Title 16, Chapter 10, Subchapter 7, is amended to add an additional section to read as follows:

16-10-701. Additional fees for specialty court programs.

1 (a) As used in this section:
2 (1) “Pre-adjudication” means the period of time after:
3 (A) The prosecuting attorney files a criminal information
4 or an indictment is filed in circuit court;
5 (B) The person named in the criminal information or
6 indictment is arraigned on the charge in circuit court; and
7 (C) The person enters a specialty court program without a
8 guilty plea or the person enters a plea of guilty but before the circuit
9 court enters a judgment and pronounces a sentence against the person; and
10 (2) "Specialty court program" means:
11 (A) A preadjudication program under § 5-4-901;
12 (B) *An approved* drug court program under § 16-98-301 et
13 seq.;
14 (C) A Swift and Certain Accountability on Probation Pilot
15 Program under § 16-93-1701 et seq.; and
16 *(D) Any other specialty court program that has been*
17 *approved by the Supreme Court, including without limitation specialty court*
18 *programs known as:*
19 *(i) A DWI court;*
20 *(ii) A mental health court;*
21 *(iii) A veteran’s court;*
22 *(iv) A juvenile drug court;*
23 *(v) A "HOPE" court;*
24 *(vi) A "smarter sentencing" court; and*
25 *(vii) A mental health crisis intervention center.*
26 *(b) In addition to any other court cost or court fee provided by law:*
27 *(1) A specialty court program user fee of up to two hundred*
28 *fifty dollars ($250) shall be assessed on any participant in a specialty*
29 *court program and remitted to the Administration of Justice Funds Section of*
30 *the Department of Finance and Administration by the court clerk for deposit*
31 *into the State Treasury as special revenues credited to the Specialty Court*
32 *Program Fund; and*
33 *(2) A specialty court program public defender user fee not to*
34 *exceed two hundred fifty dollars ($250) may be assessed by the court for a*
35 *defendant who participates in a specialty court program designed for*
36 *preadjudication purposes and who is appointed representation by a public*

defender and remitted to the Administration of Justice Funds Section of the Department of Finance and Administration by the court clerk for deposit into the State Treasury to the credit of the Public Defender User Fee Fund within the State Central Services Fund.

(c) A district court or circuit court may not assess and collect a fee under this section if the district court or circuit court is operating a specialty court program that has not been previously approved by or no longer meets the approval criteria of the Supreme Court.

SECTION *18*. Arkansas Code § 16-93-101, concerning definitions, is amended to add an additional subdivision to read as follows:

(12) "Detriment to the community" means a person who has:

(A) Demonstrated a pattern of behavior that indicates disregard for the safety and welfare of others;

(B) Exhibited violence or repeated violent tendencies;

(C) Has been convicted of a felony involving violence, as defined under § 5-4-501(d)(2); or

(D) During the three (3) calendar years before the person's parole hearing:

(i) *Demonstrated a documented* lack of respect for authority towards law enforcement or prison officials while in the custody of the Department of Correction, the Department of Community Correction, or a law enforcement agency; or

(ii) Accrued multiple disciplinary violations while in the custody of the Department of Correction, the Department of Community Correction, or a law enforcement agency, including at least one (1) disciplinary violation involving violence or sexual assault while in the custody of the Department of Correction, the Department of Community Correction, or a law enforcement agency.

SECTION *19*. Arkansas Code Title 16, Chapter 93, Subchapter 1, is amended to add an additional section to read as follows:

16-93-106. Warrantless search by any law enforcement officer for a probationer or parolee.

(a)(1) A person who is placed on supervised probation or is released on parole under this chapter is required to agree to a waiver as a condition

of his or her supervised probation or parole that allows any certified law enforcement officer or Department of Community Correction officer to conduct a warrantless search of his or her person, place of residence, or motor vehicle at any time, day or night, whenever requested by the certified law enforcement officer or Department of Community Correction officer.

(2) A warrantless search that is based on a waiver required by this section shall be conducted in a reasonable manner but does not need to be based on an articulable suspicion that the person is committing or has committed a criminal offense.

(b)(1) A person who will be placed on supervised probation or parole and is required to agree to the waiver required by this section shall acknowledge and sign the waiver.

(2) If the person fails to acknowledge and sign the waiver required by this section, he or she is ineligible to be placed on supervised probation or parole.

SECTION *20*. Arkansas Code Title 16, Chapter 93, Subchapter 1, is amended to add an additional section to read as follows:

16-93-107. Medicaid eligibility of a parolee or a probationer.

(a) The Department of Correction shall screen inmates nearing release from incarceration and the Department of Community Correction shall screen parolees and probationers under supervision for Medicaid eligibility.

(b) If an inmate nearing release from incarceration, parolee, or probationer receives medical services, including substance abuse and mental health treatment, that meet criteria for Medicaid coverage, the parole officer, probation officer, or Department of Correction offical or Department of Community Correction official may apply for Medicaid coverage for the inmate nearing release from incarceration, parolee, or probationer under this section.

(c)(1) The inmate nearing release from incarceration, parolee, or probationer may designate an authorized representative for the purposes of filing a Medicaid application and complying with Medicaid requirements for determining and maintaining eligibility.

(2) However, the parole officer, probation officer, or Department of Correction official or Department of Community Correction official shall be the authorized representative for purposes of establishing

and maintaining Medicaid eligibility under this subsection if:

(A) The inmate nearing release from incarceration, parolee, or probationer does not designate an authorized representative within three (3) business days after request; or

(B) The authorized representative designated under subdivision (c)(1) of this section does not file a Medicaid application within three (3) business days after appointment and request.

(d) An authorized representative under this section:

(1) Shall have access to the information necessary to comply with Medicaid requirements; and

(2) May provide and receive information in connection with establishing and maintaining Medicaid eligibility, including confidential information.

(e)(1) The parole officer, probation officer, or Department of Correction official or Department of Community Correction official or the designee of the parole officer, probation officer, or Department of Correction official or Department of Community Correction official may access information necessary to determine if a Medicaid application has been filed on behalf of the inmate nearing release from incarceration, parolee, or probationer.

(2) Access under subdivision (e)(1) of this section shall be to:

(A) Establish Medicaid eligibility;

(B) Provide healthcare services; or

(C) Pay for healthcare services.

(f) As used in this section, "Medicaid eligibility" means eligibility for any healthcare coverage offered by the Department of Human Services.

SECTION *21.* Arkansas Code Title 16, Chapter 93, Subchapter 1, is amended to add additional sections to read as follows:

16-93-108. Mental health and substance abuse treatment.

A parolee or probationer who is enrolled in a Medicaid program shall be referred to mental health or substance abuse treatment, or both, when the referral is included as part of a court order, supervision plan, or treatment plan.

16-93-109. Medicaid reimbursement for essential healthcare services.

Unless otherwise prohibited by law, the Department of Human Services shall cooperate with the Department of Correction and the Department of Community Correction to establish protocols for utilizing Medicaid to *reimburse the Department of Correction, Department of Community Correction, Division of Behavioral Health Services, Division of Youth Services, a* healthcare provider, or a third party for essential healthcare services, including mental health and substance abuse treatment.

16-93-110. Contracting with Medicaid provider.

The Department of Correction and the Department of Community Correction each may contract with a provider in order to facilitate the enrollment of an inmate, a probationer, or a parolee in Medicaid.

SECTION *22*. Arkansas Code § 16-93-201 is amended to read as follows:

16-93-201. Creation — Members — Qualifications and training.

(a)(1) There is created the Parole Board, to be composed of seven (7) members to be appointed from the state at large by the Governor and confirmed by the Senate.

(2)(A)(i) ~~Seven (7) members~~ A member of the board shall be a full-time ~~officials~~ official of this state~~, one (1) of whom shall be designated by the Governor as the chair of the board~~ and shall not have any other employment for the duration of his or her appointment to the board.

(ii)(a) A member of the board who is currently serving as of the effective date of this act shall terminate any other employment that has not been approved as required by subdivision (a)(2)(A)(ii)(b) of this section.

(b) A member may engage in employment that has a limited time commitment with approval from the Chair of the Parole Board.

(B)(i) The Governor shall appoint one (1) member as the chair who shall be the chief executive, administrative, budgetary, and fiscal officer of the board and the chair shall serve at the will of the Governor.

(ii) The chair shall have general supervisory duties over the members and staff of the board but may not remove a member of the board except as provided under subsection (e) of this section.

(iii) The board may review and approve budget and personnel requests prior to submission for executive and legislative

approval.

(C) The board shall elect from its membership a vice chair and a secretary who shall assume, in that order and with the consent of the Governor, the duties of the chair in the case of extended absence, vacancy, or other similar disability of the chair until the Governor designates a new chair of the board.

(3) Each member shall serve a seven-year term, except that the terms shall be staggered by the Governor so that the term of one (1) member expires each year.

(4)(A) A member ~~must~~ shall have at least a bachelor's degree from an accredited college or university, and the member should have no less than five (5) years' professional experience in one (1) or more of the following fields:

(i) Parole supervision;

(ii) Probation supervision;

(iii) Corrections;

(iv) Criminal justice;

(v) Law;

(vi) Law enforcement;

(vii) Psychology;

(viii) Psychiatry;

(ix) Sociology;

(x) Social work; or

(b) If any vacancy occurs on the board prior to the expiration of a term, the Governor shall fill the vacancy for the remainder of the unexpired term, subject to confirmation by the Senate at its next regular session.

(c) The members of the board may receive expense reimbursement and stipends in accordance with § 25-16-901 et seq.

(d)(1) Four (4) members of the board shall constitute a quorum for the purpose of holding an official meeting.

(2) However, the affirmative vote of at least five (5) of the members of the board is required for any action by the board.

(e)(1) A member of the board may be removed by the Governor after the Governor has received notification from the chair that the member:

(A) Has been derelict in his or her duties as a member of the board; or

(B) No longer meets the eligibility requirements to serve as a member of the board.

(2) The member of the board who has been reported to the Governor under subdivision (e)(1) of this section shall receive written notice of the notification by the chair to the Governor and the member of the board shall be allowed an opportunity to respond within seven (7) days.

SECTION *23*. Arkansas Code § 16-93-202, concerning records and reports of the Parole Board, is amended to add an additional subsection to read as follows:

(e)(1)(A) Upon written request, a member of the General Assembly or an employee of the House of Representatives, Senate, or the Bureau of Legislative Research acting on the member's behalf may view all classification, disciplinary, demographic, and parole hearing records of a current or former inmate or parolee who is currently or was formerly granted parole by the board.

(B) A request made on behalf of a member of the General Assembly shall be made in good faith.

(2) A view of records under subdivision (e)(1) of this section by an employee may be performed only if the employee is assigned to one (1) or more of the following committees:

(A) Senate Committee on Judiciary;

(B) House Committee on Judiciary; or

(C) Charitable, Penal and Correctional Institutions Subcommittee of the Legislative Council.

(3) The board shall ensure that the employee authorized under subdivision (e)(2) of this section to view records is provided access to the records.

(4) A record requested to be viewed under subdivision (e)(1) of this section is privileged and confidential and shall not be shown to any person not authorized to have access to the record under this section and shall not be used for any political purpose, including without limitation political advertising, fundraising, or campaigning.

SECTION *24*. Arkansas Code § 16-93-612(e), concerning parole eligibility procedures for offenses that occurred after January 1, 1994, is

amended to read as follows:

(e) For an offender serving a sentence for a felony committed on or after January 1, 1994, § 16-93-614 governs that person's parole eligibility, unless otherwise noted and except:

(1) If the felony is murder in the first degree, § 5-10-102, kidnapping, if a Class Y felony, § 5-11-102(b)(1), aggravated robbery, § 5-12-103, rape, § 5-14-103, or causing a catastrophe, § 5-38-202(a), and the offense occurred after July 28, 1995, § 16-93-618 governs that person's parole eligibility; ~~or~~

(2) If the felony is manufacturing methamphetamine, § 5-64-423(a) or the former § 5-64-401, or possession of drug paraphernalia with the intent to manufacture methamphetamine, the former § 5-64-403(c)(5), and the offense occurred after April 9, 1999, § 16-93-618 governs that person's parole eligibility; <u>or</u>

<u>(3) If the felony is battery in the second degree, § 5-13-202, aggravated assault, § 5-13-204, terroristic threatening, § 5-13-301, domestic battering in the second degree, § 5-26-304, or residential burglary, § 5-39-201, and the offense occurred on or after the effective date of this act, § 16-93-619 governs that person's parole eligibility.</u>

SECTION *25.* Arkansas Code § 16-93-615(a)(5), concerning inmate interviews by the Parole Board, is amended to read as follows:

(5) Inmate interviews <u>and related deliberations</u> may be closed to the public.

SECTION *26.* Arkansas Code Title 16, Chapter 93, Subchapter 6, is amended to add a new section to read as follows:

<u>16-93-619. Parole eligibility procedures — Certain offenses committed on or after the effective date of this act.</u>

<u>(a) An inmate sentenced for one (1) of the following felonies on or after the effective date of this act is eligible for discretionary transfer to the Department of Community Correction by the Parole Board after having served one-third (1/3) or one-half (1/2) of his or her sentence, with credit for meritorious good time, depending on the seriousness determination made by the Arkansas Sentencing Commission, or one-half (1/2) of the time to which his or her sentence is commuted:</u>

(1) Battery in the second degree, § 5-13-202;

(2) Aggravated assault, § 5-13-204;

(3) Terroristic threatening, § 5-13-301;

(4) Domestic battering in the second degree, § 5-26-304; or

(5) Residential burglary, § 5-39-201.

(b) The transfer of an inmate convicted of an offense listed in this section is not automatic.

(c) All other provisions governing the procedures regarding the granting and administration of parole for persons convicted of an offense listed under subsection (a) of this section shall be governed by §§ 16-93-615 *– 16-93-617.*

SECTION 27. Arkansas Code § 16-93-708 is amended to read as follows:

16-93-708. Parole alternative – Home detention.

(a) As used in this section:

(1) "Approved electronic monitoring or supervising device" means an electronic device approved by the Board of Corrections that meets the minimum Federal Communications Commission regulations and requirements~~,~~ and that utilizes available technology that is able to track a person's location and monitor his or her location;

(2) "Hospice" means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient and the patient's family, and which employs an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses that are experienced during the final stages of illness and during dying and bereavement;

~~(2)~~(3) "Permanently incapacitated" means an inmate who, as determined by a licensed physician:

(A) Has a medical condition that is not necessarily terminal but renders him or her permanently and irreversibly incapacitated; and

(B) Requires immediate and long-term care; and

~~(3)~~(4) "Terminally ill" means an inmate who, as determined by a licensed physician:

(A) Has an incurable condition caused by illness or disease; and

(B) Will likely die within two (2) years due to the illness or disease.

(b)(1)(A) Subject to the provisions of subdivision (b)(2) of this section, a defendant convicted of a felony or misdemeanor and sentenced to imprisonment may be incarcerated in a home detention program when the Director of the Department of Correction or the Director of the Department of Community Correction ~~shall communicate~~ communicates to the Parole Board when, in the independent opinions of either a Department of Correction physician or Department of Community Correction physician and a consultant physician in Arkansas, an inmate is either terminally ill, ~~or~~ permanently incapacitated, or would be suitable for hospice care and should be considered for transfer to parole supervision.

(B) The Director of the Department of Correction or the Director of the Department of Community Correction shall make the facts described in subdivision (b)(1)(A) of this section known to the Parole Board for consideration of early release to home detention.

(2) The Board of Corrections shall promulgate rules that will establish policy and procedures for incarceration in a home detention program.

(c)(1) In all instances ~~where~~ in which the Department of Correction may release any inmate to community supervision, in addition to all other conditions that may be imposed by the Department of Correction, the Department of Correction may require the criminal defendant to participate in a home detention program.

(2)(A) The term of the home detention shall not exceed the maximum number of years of imprisonment or supervision to which the inmate could be sentenced.

(B) The length of time the defendant participates in a home detention program and any good-time credit awarded shall be credited against the defendant's sentence.

(d)(1) The Board of Corrections shall establish policy and procedures for participation in a home detention program, including, but not limited to, program criteria, terms, and conditions of release.

(2) An inmate who is not serving a sentence of life without

parole who is released on parole under this section because he or she is terminally ill, permanently incapacitated, or would be suitable for hospice care may be released to the care of his or her family or to a friend or a facility, subject to board approval.

(e) If the medical condition of a inmate who is released under this section because he or she is terminally ill, permanently incapacitated, or would be suitable for hospice care changes to the point that the inmate is no longer terminally ill, permanently incapacitated, or would be suitable for hospice care, the inmate shall be returned to the custody of the Department of Correction and shall be required to be reconsidered for parole.

SECTION *28*. Arkansas Code § 16-93-711(b)(1)(A), concerning the requirement for electronic monitoring on parole, is amended to read as follows:

(b)(1)(A) Subject to the provisions of subdivision (b)(2) of this section, an inmate serving a sentence in the Department of Correction may be released from incarceration if the:

(i) Sentence was not the result of a jury or bench verdict;

(ii) Inmate has served one hundred twenty (120) days of his or her sentence;

(iii) Inmate has an approved parole plan;

(iv) Inmate does not have a prior felony conviction for a sex offense or for a felony offense that involved the use or threat of violence or bodily harm;

~~(iv)~~(v) Inmate was sentenced from a cell in the sentencing guidelines ~~that does not include incarceration in the presumptive range~~ with:

(a) An incarceration range of thirty-six (36) months or less; or

(b) A presumptive sentence of probation;

~~(v)~~(vi) Conviction is for a Class C or Class D felony;

~~(vi)~~(vii) Conviction is not for a crime of violence, regardless of felony level;

~~(vii)~~(viii) Conviction is not a sex offense,

including failure to register as a sex offender under § 12-12-906, regardless of felony level;

~~(viii)~~(ix) Conviction is not for manufacturing methamphetamine, § 5-64-423(a) or the former § 5-64-401;

~~(ix)~~(x) Conviction is not for possession of drug paraphernalia with the purpose to manufacture methamphetamine, § 5-64-443, if the conviction is a Class C felony or higher;

~~(x)~~(xi) Conviction is not for a crime involving the use or threat of violence or bodily harm;

~~(xi)~~(xii) Conviction is not for a crime that resulted in a death; and

~~(xii)~~(xiii) Inmate has not previously failed a drug court program.

SECTION *29*. Arkansas Code § 16-93-712(d)(2), concerning the authority to sanction a parolee administratively by the Department of Community Correction, is amended to read as follows:

(2)(A)(i) The department shall develop an intermediate sanctions procedure and grid to guide a parole officer in determining the appropriate response to a violation of conditions of supervision.

(ii) The intermediate sanctions procedure shall include a requirement that the parole officer consider multiple factors when determining the sanction to be imposed, including previous violations and sanctions and the severity of the current and prior violation.

(B) Intermediate sanctions administered by the department are required to conform to the sanctioning grid.

SECTION *30*. Arkansas Code Title 16, Chapter 93, Subchapter 7, is amended to add an additional section to read as follows:

16-93-713. Denial of parole — Detriment to the community.

The Parole Board may deny parole to any otherwise eligible person, regardless of the sentence that he or she is serving, if five (5) members of the board determine that the person upon release would be a detriment to the community into which the person would be released.

SECTION *31*. Arkansas Code § 16-98-301(b)(1), concerning the definition

of "evidence-based practices" under the Arkansas Drug Court Act, is amended to read as follows:

(1) "Evidence-based practices" means supervision, policies, procedures, and practices proven through research to reduce recidivism;

SECTION *32*. Arkansas Code § 16-98-303(a), concerning the structure, method, and operation of a drug court, is amended to read as follows:

(a)(1) Each judicial district of this state is authorized to establish a drug court program under this subchapter.

(2) A drug court established under this subchapter shall be approved under § 16-10-139.

~~(2)(A) The structure, method, and operation of each drug court program may differ and should be based upon the specific needs of and resources available to the judicial district where the drug court program is located.~~

~~(B)(i)~~(3)(A) A drug court program may be preadjudication or postadjudication for an adult *offender or a juvenile offender.*

~~(ii)~~(B) A juvenile drug court program or services may be *used in a delinquency case or a family in need of services case ~~pursuant to a diversion agreement under § 9-27-323~~.*

~~(iii)~~(C) A juvenile drug court program or services may be used in a dependency-neglect case under § 9-27-334.

~~(3)~~(4) Notwithstanding the authorization described in subdivision (a)(1) of this section, ~~no~~ a judge of a circuit court, drug court, or juvenile court may not order any services or treatment under subsection (b) of this section or § 16-98-305 unless:

(A) An administrative and programmatic appropriation has been made for those purposes;

(B) Administrative and programmatic funding is available for those purposes; and

(C) Administrative and programmatic positions have been authorized for those purposes.

(5)(A) As determined by the Department of Community Correction, *an adult drug* court program established under this section shall target high-risk offenders and medium-risk offenders.

SECTION *33*. Arkansas Code § 16-98-303(b)(2), concerning the duties of the Department of Community Correction under the Arkansas Drug Court Act, is amended to read as follows:

(2) Subject to an appropriation, funding, and position authorization, both programmatic and administrative, the Department of Community Correction:

(A) ~~shall~~ Shall:

(i) Establish standards regarding the classification of a drug court program participant as a high-risk offender or medium-risk offender;

~~(A)~~(ii) Provide positions for persons to serve as probation officers, drug counselors, and administrative assistants;

~~(B)~~(iii) Provide for drug testing for drug court program participants;

~~(C)~~(iv) Provide for intensive outpatient treatment for drug court program participants;

~~(D)~~(v) Provide for intensive short-term and long-term residential treatment for drug court program participants; and

~~(E)~~(vi) Develop clinical assessment capacity, including drug testing, to identify ~~participants~~ a drug court program participant with a substance addiction and develop a treatment protocol that improves the ~~person's~~ drug court program participant's likelihood of success~~.~~; and

(B) May:

(i) Provide for continuous alcohol monitoring for drug court program participants, including a minimum period of one hundred twenty (120) days; and

(ii) Develop clinical assessment capacity, including continuous alcohol monitoring, to identify a drug court program participant with a substance addiction and develop a treatment protocol that improves the drug court program participant's likelihood of success.

SECTION *34*. Arkansas Code § 16-98-303(b)(4)(B), concerning the responsibilities of the Administrative Office of the Courts pertaining to drug courts, is amended to read as follows:

(B) Administer funds for the maintenance and operation of

local approved drug court programs;

SECTION *35*. Arkansas Code § 16-98-303(f)(6), concerning the duties of the Drug Court Coordinator, is amended to read as follows:

(6) Oversee the disbursement of funds appropriated to the Administrative Office of the Courts for the maintenance and operation of local approved drug court programs based on a formula developed by the Administrative Office of the Courts and reviewed by the ~~*Drug Court Advisory*~~ *Specialty Court Program Advisory Committee; and*

SECTION 36. Arkansas Code § 16-98-304 is amended to read as follows:

16-98-304. Cost and fees.

(a) The adult or juvenile drug court judge may order the offender to pay:

(1) Court costs as provided in § 16-10-305;

(2) Treatment costs;

(3) Drug testing costs;

(4) A local program user fee;

(5) Necessary supervision fees, including any applicable residential treatment fees; ~~*and*~~

(6) Any fees determined or authorized under § 12-27-125(b)(17)(B) or § 16-93-104(a)(1) ~~*which*~~ *that are to be paid to the Department of Community Correction*~~*.*~~*;*

(7) Global Positioning System monitoring; and

(8) Continuous alcohol monitoring fees.

(b)(1) The drug court judge shall establish a schedule for the payment of costs and fees.

(2) The cost for treatment, drug testing, continuous alcohol monitoring if ordered, and supervision shall be set by the treatment and supervision providers respectively and made part of the order of the drug court judge for payment.

(3) Program user fees shall be set by the drug court judge.

(4) Treatment, drug testing, continuous alcohol monitoring if ordered, and supervision costs or fees shall be paid to the respective providers.

(5) Fees determined or authorized under § 12-27-125(b)(17)(B) or

§ 16-93-104(a)(1) shall be paid to the Department of Community Correction.

~~*(6)(A) The MACNUM Drug Court Fund is a special revenue fund created and established on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State.*~~

~~*(B) The MACNUM Drug Court Fund shall consist of other moneys provided by law.*~~

~~*(7)(A)*~~*(6)(A) All court costs and program user fees assessed by the drug court judge shall be paid to the court clerk for remittance to the county treasury under § 14-14-1313.*

(B) All installment payments shall initially be deemed to be collection of court costs under § 16-10-305 until the court costs have been collected in full with any remaining payments representing collections of other fees and costs as authorized in this section and shall be credited to the county administration of justice fund and distributed under § 16-10-307.

(C) ~~*All*~~ *Local program user fees shall be credited to a fund known as the drug court program fund and appropriated by the quorum court for the benefit and administration of the drug court program.*

~~*(8)*~~*(7) Court orders for costs and fees shall remain an obligation of the offender with court monitoring until fully paid.*

SECTION *37*. The lead-in language to Arkansas Code § 16-98-305, concerning the required resources of a drug court program, is amended to read as follows:

Each approved drug court program established under this subchapter, subject to an appropriation, funding, and position authorization, both programmatic and administrative, shall be provided with the following resources:

SECTION *38*. Arkansas Code § 16-98-305(l)(E)(iii), concerning expenditures of funds for treatment services allocated to each drug court program, is amended to read as follows:

(iii) Expenditures of funds for treatment services allocated to each approved drug court program under the formula described in subdivision (l)(E)(i) of this section shall be at the direction of a drug court judge, except as limited by the procedures adopted in the memorandum of

understanding described in subdivision (l)(E)(ii) of this section;

SECTION *39*. Arkansas Code § 16-98-305(3), concerning the duties of the Administrative Office of the Courts under the Drug Court Act, is amended to read as follows:

(3) The Administrative Office of the Courts shall:

(A) Provide funding to be reviewed by the ~~*Drug Court*~~ *Specialty Court Program* Advisory Committee for additional ongoing maintenance and operation costs of a local approved drug court ~~programs~~ program not provided by the Department of Community Correction or the Department of Human Services, including local drug court program supplies, education, travel, and related expenses;

(B) Provide direct support to the drug court judge and drug court program;

(C) Provide coordination between the multidisciplinary team and the drug court judge;

(D) Provide case management;

(E) Monitor compliance of drug court participants with drug court program requirements; and

(F) ~~*Provide drug court program evaluation and accountability*~~ *Provide assistance and support to the Specialty Court Advisory Committee for the evaluation of adult and juvenile specialty court programs*.

SECTION 40. Arkansas Code § 16-98-306 is amended to read as follows:

16-98-306. Collection of data.

(a)(1) ~~*A*~~ *An approved drug court program shall collect and provide monthly data on drug court applicants and all participants as required by the* ~~*Division of Drug Court Programs within the Administrative Office of the Courts*~~ *Specialty Court Program Advisory Committee in accordance with the rules promulgated under* ~~*§ 16-98-307*~~ *§ 10-3-2901*.

(2) The data shall include:

(A) The total number of applicants;

(B) The total number of participants;

(C) The total number of successful applicants;

(D) The total number of successful participants;

(E) The total number of unsuccessful participants and the

reason why each unsuccessful participant did not complete the program;

(F) Information about what happened to each unsuccessful participant;

(G) The total number of participants who were arrested for a new criminal offense while in the drug court program;

(H) The total number of participants who were convicted of a new criminal offense while in the drug court program;

(I) The total number of participants who committed a violation of one (1) or more conditions of the drug court program and the resulting sanction;

(J) The results of the initial risk-needs assessment ~~review for each participant~~ or other appropriate clinical assessment conducted on each participant; ~~and~~

(K) The total amount of time each program participant was in the program; and

~~(K)~~(L) Any other data or information as required by the ~~Division of Drug Court Programs within the Administrative Office of the Courts~~ Specialty Court Program Advisory Committee in accordance with the rules promulgated under ~~§ 16-98-307~~ § 10-3-2901.

(b) The data collected for evaluation purposes under subsection (a) of this section shall:

(1) Include a minimum standard data set developed and specified by the ~~Division of Drug Court Programs~~ Specialty Court Program Advisory Committee; and

(2) Be maintained in the court files or be otherwise accessible by the courts and the ~~Division of Drug Court Programs~~ Specialty Court Program Advisory Committee.

(c)(1) As directed by the ~~Division of Drug Court Programs~~ Specialty Court Program Advisory Committee, after an individual is discharged either upon completion or termination of a drug court program, the drug court program shall conduct, as much as practical, follow-up contacts with and reviews of former drug court participants for key outcome indicators of drug use, recidivism, and employment.

(2)(A) The follow-up contacts with and reviews of former drug court participants shall be conducted as frequently and for a period of time as determined by the ~~Division of Drug Court Programs~~ Specialty Court Progam

Advisory Committee based upon the nature of the drug court program and the nature of the participants.

(B) The follow-up contacts with and reviews of former drug court participants are not extensions of the drug court's jurisdiction over the drug court participants.

(d) For purposes of standardized measurement of success of drug court programs across the state, ~~the Division of Drug Court Programs in consultation with other state agencies and subject to the review of the Drug~~ Specialty Court Advisory Committee shall adopt an operational definition of terms such as "recidivism", "retention", "relapses", "restarts", "sanctions imposed", and "incentives given" to be used in any evaluation and report of drug court programs.

(e) Each drug court program shall provide to the ~~Division of Drug Court Programs~~ Specialty Court Program Advisory Committee all information requested by the Division of Drug Court Programs.

(f) The Division of Drug Court Programs, the Department of Community Correction, the ~~Office of Alcohol and Drug Abuse Prevention~~ Division of Behavioral Health Services, and the Arkansas Crime Information Center shall work together to share and make available data to provide a comprehensive data management system for the state's drug court programs.

(g)~~(1)~~ The Administrative Office of the Courts shall~~:~~

~~(A) Develop a statewide evaluation model to be reviewed by the Drug Court Advisory Committee; and~~ collect monthly data reports submitted by approved drug courts and provide the monthly data reports to the Specialty Court Program Advisory Committee.

~~(B) Conduct ongoing evaluations of the effectiveness and efficiency of all drug court programs.~~

(h) The Specialty Court Program Advisory Committee shall:

(1) Submit a report by July 1 of each year summarizing the data collected and outcomes achieved by all approved drug courts; and

(2) Contract with a third-party evaluator every three (3) years to conduct an evaluation on the effectiveness of the drug court program in complying with the key components of § 16-98-302(b).

~~(2) A report of the evaluations of the Administrative Office of the Courts shall be submitted to the General Assembly by July 1 of each year.~~

SECTION 41. Arkansas Code § 16-98-307 is repealed.

~~*16-98-307. Drug Court Advisory Committee — Creation.*~~

~~*(a) There is created a Drug Court Advisory Committee.*~~

~~*(b) The Drug Court Advisory Committee shall consist of the following members:*~~

~~*(1) The Chief Justice of the Supreme Court or the Chief Justice's designee who shall serve as chair;*~~

~~*(2) The Director of the Administrative Office of the Courts or the director's designee;*~~

~~*(3) A judge to be appointed by the Arkansas Judicial Council;*~~

~~*(4) The Director of the Department of Community Correction or the director's designee;*~~

~~*(5) The Director of the Department of Human Services or the director's designee;*~~

~~*(6) The Director of the Division of Behavioral Health Services or the director's designee;*~~

~~*(7) A prosecutor appointed by the Prosecutor Coordinator;*~~

~~*(8) A public defender appointed by the Executive Director of the Arkansas Public Defender Commission;*~~

~~*(9) A member of the Senate appointed by the President Pro Tempore of the Senate;*~~

~~*(10) A member of the House of Representatives appointed by the Speaker of the House of Representatives;*~~

~~*(11) The Arkansas Drug Director or the director's designee;*~~

~~*(12) The Chair of the Board of Corrections or the chair's designee; and*~~

~~*(13) The Chair of the Parole Board or the chair's designee.*~~

~~*(c) The chair or the chair's designee shall promptly call the first meeting after April 4, 2007.*~~

~~*(d)(1) The committee shall conduct its meetings at the State Capitol or at any place designated by the chair or the chair's designee.*~~

~~*(2) Meetings shall be held at least one (1) time every three (3) months but may occur more often at the call of the chair.*~~

~~*(e) If any vacancy occurs on the committee, the vacancy shall be filled by the same process as the original appointment.*~~

~~*(f) The committee shall establish rules and procedures for conducting*~~

~~*its business.*~~

~~*(g) Members of the committee shall serve without compensation.*~~

~~*(h) A majority of the members of the committee shall constitute a quorum for transacting any business of the committee.*~~

~~*(i)(1) The committee is established to promote collaboration and provide recommendations on issues involving drug courts.*~~

~~*(2) The committee may provide advice and review on at least the following:*~~

~~*(A) Provisions to identify data to be collected for evaluation; and*~~

~~*(B) Provisions to ensure uniform data collection.*~~

SECTION *42*. Arkansas Code Title 19, Chapter 5, Subchapter 11, is amended to add an additional section to read as follows:

19-5-1142. Social Innovation Fund.

(a) There is created on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a trust fund to be known as the "Social Innovation Fund".

(b) The fund shall consist of:

(1) Any loans, investments, or other amounts received by the Department of Community Correction under the Pay-for-Success Act, § 12-27-201 et seq.;

(2) Grants made by any person or federal government agency; and

(3) Any other funds authorized or provided by law.

(c) The fund shall be used by the department to make any payments required under the Pay-for-Success Act, § 12-27-201 et seq.

SECTION 43. Arkansas Code Title 19, Chapter 5, Subchapter 11, is amended to add an additional section to read as follows:

19-5-1143. Accountability Court Fund.

(a) There is created on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a trust fund to be known as the "Accountability Court Fund".

(b) The fund shall consist of:

(1) Grants made by any person or federal government agency; and

(2) Any other funds authorized or provided by law.

(c) The fund shall be used by the Department of Community Correction for adult and juvenile specialty court programs as defined under § 16-10-139, based upon a formula to be developed by the Arkansas Judicial Council, reviewed by the Specialty Courts Advisory Committee, and approved by the Legislative Council.

SECTION 44. Arkansas Code § 19-6-301(216), concerning special revenue funds, is amended to read as follows:

(216) Drug court program user fees, ~~§§~~ 16-98-304 and ~~19-6-489~~ specialty court program user fees, § 16-10-701;

SECTION 45. Arkansas Code § 19-6-489 is amended to read as follows:

19-6-489. ~~MAGNUM Drug~~ Specialty Court Program Fund.

~~(a) A drug court judge may order an offender to pay:~~

~~(1) Court costs;~~

~~(2) Treatment costs;~~

~~(3) Drug testing costs;~~

~~(4) A program user fee not to exceed twenty dollars ($20.00) per month; and~~

~~(5) Necessary supervision fees, including any applicable residential treatment fees.~~

~~(b)(1) A drug court judge shall establish a schedule for the payment of costs and fees.~~

~~(2) The cost for treatment, drug testing, and supervision shall be set by the treatment and supervision providers respectively and made part of the order of the drug court judge for payment.~~

~~(3) User fees shall be set by the drug court judge within the maximum amount authorized by this subsection and payable directly to the court clerk for the benefit and administration of the drug court program.~~

~~(4) Treatment, drug testing, and supervision costs shall be paid to the respective providers.~~

~~(5) The court clerk or the designee of the drug court judge shall collect all other costs and fees ordered.~~

~~(6)(A) The remaining user fees shall be remitted to the Treasurer of State by the court clerk for deposit in the MAGNUM Drug Court Fund, which is a special revenue fund created and established on the books of~~

~~the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State.~~

~~(B) The MACNUM Drug Court Fund shall consist of user fees and any other moneys provided by law.~~

~~(7) Court orders for costs and fees shall remain an obligation of the offender with court monitoring until fully paid.~~

(a) There is created on the books of the Treasurer of State, the Auditor of State, and the Chief Fiscal Officer of the State a special revenue fund to be known as the "Specialty Court Program Fund".

(b) The Specialty Court Program Fund shall consist of the specialty court program user fees under § 16-10-701 and any other moneys provided by law.

(c) The fund shall be used exclusively for:

(1) Treatment services provided by the Department of Community Correction as defined by and distributed under § 16-98-305(1)(E);

(2) Treatment services provided by the Department of Human Services as defined by and distributed under § 16-98-305(2)(C);

(3) The cost of the evaluation of specialty court programs by the Specialty Court Advisory Committee as required under § 16-10-139; and

(4) Drug and mental health crisis intervention centers."

SECTION 46. Arkansas Code § 27-16-801, concerning the issuance of a driver's license, is amended to add an additional subsection to read as follows:

(i)(1) As used in this subsection, "eligible inmate" means a person who is within one hundred twenty (120) days of release from custody by the Department of Correction or the Department of Community Correction.

(2)(A) The office shall issue an identification card to an eligible inmate who has previously been issued an:

(i) Arkansas identification card; or

(ii) Arkansas driver's license and the driving privileges of the eligible inmate are suspended or revoked.

(B) The office shall issue a driver's license to an eligible inmate who has previously been issued an Arkansas driver's license if the driving privileges of the eligible inmate are:

(i) Not suspended or revoked; or

(ii) Suspended or revoked solely as a result of an outstanding driver's license reinstatement fee imposed under the laws of this state.

(3) The Department of Correction and the Department of Community Correction shall identify eligible inmates to apply for a replacement or renewal driver's license or identification card.

(4) Any fees for a replacement identification card under § 27-16-805 shall be waived for an eligible inmate.

(5) If the office issues a driver's license to an eligible inmate under subdivision (i)(2)(B)(ii) of this section, the office shall waive the reinstatement fee.

SECTION 47. Arkansas Code § 27-16-1105(a)(3)(A), concerning minimum issuance standards for driver's licenses, is amended to read as follows:

(3)(A)(i) The office may establish by rule a written and defined exceptions process for a person who is unable to present all the necessary documents for a driver's license or identification card and who must rely upon alternate documents.

(ii) The office shall accept alternate documents only to establish identity or date of birth of the person.

(iii)(a) An eligible inmate as defined under § 27-16-801(i)(1)(A) may satisfy the identity document requirement under this section by submitting a sentencing order to the Office of Driver Services before his or her release from incarceration.

(b) The exception to the identity document requirement under subdivision (a)(3)(A)(iii)(a) of this section shall not be applicable to a first-time issuance of a driver's license or identification card nor may it be used to waive any documentation requirements for non-United States citizens.

SECTION 48. DO NOT CODIFY. Effective dates.

(a) Sections 11, 12, 13, and 20 of this act are effective on and after September 1, 2015.

(b) Sections 46 and 47 of this act are effective on and after January 1, 2016.

SECTION 49. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that prison overcrowding is one of the largest problems currently burdening the state both from a public safety and budgetary standpoint; that safe and effective measures are needed to immediately combat this problem; and that this act is immediately necessary because in the interests of public safety and the state budget the Department of Correction, Department of Community Correction, Department of Human Services, and the Parole Board should be allowed to immediately implement these new measures. Therefore, an emergency is declared to exist, and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

/s/J. Hutchinson

APPROVED: 04/01/2015

12. Criminal and Juvenile Justice

Juvenile Justice

Department of Human Services Systems of Care has a pilot project in which they are working with the Division of Youth Services targeting youth who have a Family In Need of Services (FINS) or are on probation. They are also including the Division of Youth Services community-based providers. Evidenced-based Trainings are provided to improve outcomes of treatment to lessen involvement with the juvenile justice system and improve overall functioning. Trainings consisted of Collaborative Problem Solving and Cultural and Linguistic Competency. Trauma-focused Cognitive Behavioral Therapy certification is on-going as well as Team Up for Your Child-road Map to Services, and coaching process for wraparound service providers. A Trauma-Informed Care workgroup is ongoing and continues to work on bringing together Department of Human Services divisions to ensure commitment to being a trauma-informed organization.

Juvenile Drug Court services are available in ten different judicial districts. Services are provided by contracted licensed substance abuse providers. These contracts are awarded via bid process. Juveniles admitted to the Juvenile Drug Court program are provided a number of services including outpatient therapy, case management, and urine analysis

The Arkansas Supreme Court Commission on Children, Youth and Families adopted Core Principles for Reducing Recidivism and Improving Outcomes for Youth in Juvenile Justice System. The Division of Behavioral Health Services has partnered with the Administrative Office of the Courts to support this initiative.

Criminal Justice

Arkansas utilizes a Forensic Outpatient Restoration Program. Here, when there is concern that an individual is unfit to proceed within the legal system due to a possible mental health deficit, the individual is referred to the court where a judge orders a Forensic Evaluation. The evaluation is completed by a Psychologist trained in Forensics. If the individual is determined to be "unfit to proceed," a report is presented to the court with this information and the individual is then ordered to proceed in the Forensic Outpatient Restoration Program. The time frame for the Restoration is ten (10) months and the individual is referred to his/her local community mental health center for a maximum duration of six months in order to complete the restoration process. The individual, to be restored, may either be in the county jail or on bond during the outpatient restoration process. Sixty-percent of individuals reside in jail while approximately forty-percent are on bond. At any point, the process can be terminated for one of two reasons. Either the individual is restored by a passing score of 70% or higher on an educational exam or the individual appears to not be restorable due to malingering, lack of cooperation or the individual's mental health condition has elevated to the point that inpatient services are necessary. In either case, the individual is referred to the Arkansas State Hospital where they are re-evaluated. This evaluation is utilized to determine if the individual needs further inpatient restoration in a more structured environment or to determine if the individual is ready to proceed through the legal system due to restoration. If found not restored but capable of restoration, the individual may be referred back to the CMHC for continuation of services. If the time-line is close to the sixth month window, the individual will in most cases remain at ASH for continued restoration services until the completion of the tenth month duration. The end result is that a report is sent to

the courts declaring the individual as being: competent/responsible, competent/not responsible or In-competent (unfit to proceed) as determined by the evaluator. The implementation of the Outpatient Restoration has drastically reduced the waitlist at the state hospital and has allowed for treatment to be provided in the least restrictive setting and in a more expedient timeframe.

There has been training for law enforcement within the state. More importantly, this is a continued goal of organizations such as the Sheriff's Association, County Associations, and the Community Mental Health Centers. Further, the Arkansas Community Corrections Department now has 35 trainers to provide Mental Health First Aid state-wide training to their staff. Also, Community Corrections is assisting parolees with signing up for insurance. They report that this has been successful with assisting with recidivism due to treatment

Behavioral Health Treatment Access Task Force

Arkansas' Behavioral Health Treatment Access Legislative Task Force was created as part of Act 895, known as the Criminal Justice Reform Act in the latest legislative session. The panel is comprised of lawmakers, advocates and agency heads, which are focusing on behavioral health services instead of longer sentences as an answer to keeping prison recidivism rates down in the Natural State. The overall responsibility and ultimate goal of the task force is responsible for ensuring that persons in the criminal justice system who have a demonstrated need for behavioral health treatment have access to treatment. The panel will work to keep former inmates from ending up back behind prison walls. Instead of looking at longer sentences, one of the main focuses of the task force is that individuals with treatment needs have access to healthcare, specifically substance abuse and mental health, which could be a key piece to curbing the incarceration puzzle.

According to an Arkansas Community Correction report, there are 53,000 parolees and probationers at any given time for oversight. Approximately 80 percent of them suffer substance abuse issues and of those 42,000 people, another 20 to 30 percent also have mental health needs. The budget currently set for these types of services and to provide both mental health and substance abuse treatment is only $1.5 million. A way to adequately pay for services and competition for treatment slots that are available are described as fierce by some who provide services. At this point, the task force has its work cut out for it, if it intends to make treatment the tactic to keep felons from ending up back behind bars.

The task force has a deadline of December 2015 to produce an official report of its findings and recommendations.

Specialty Courts

Act 895 also amended the statute outlining the drug court system in the state. The amendment expanded the definition of specialty court to include other specialty courts, such as HOPE court, Veterans Court, juvenile drug court, and etc.

All specialty court programs operated by a circuit court or district court must be approved by the Supreme Court in the administrative plan submitted under Supreme Court Administrative Order No.14. The Administrative Office of the Courts shall evaluate and make finding with respect to all specialty court programs operated by a circuit court or district court in this state and refer the

findings to the Supreme Court. An evaluation under this section shall reflect nationally recognized and peer-reviewed standards for each particular type of specialty court program. The office shall also establish, implement, and operate a uniform specialty court program evaluation process to ensure specialty court program resources are uniformly directed to high-risk and medium-risk offenders and that specialty court programs provide effective and proven practices that reduce recidivism, as well as other factors such as substance dependency, among participants. They should also establish an evaluation process that ensures that any new and existing specialty court program that is a drug court meets standards for drug court operation and promulgate rules to be approved by the Supreme Court to carry out the evaluation process under this section.

A specialty court program shall be evaluated under the following schedule. (1) A specialty court program application submitted on or after the effective date of this act shall require evaluation of the specialty court program based on the proposed specialty court program plan; (2) A specialty court program established on or after the effective date of this act shall be evaluated after its second year of funded operation; (3) A specialty court program in existence on the effective date of this act shall be evaluated under the requirements of this section prior to expending resources budgeted for fiscal year 2017; and (4) A specialty court program shall be reevaluated every two years after the initial evaluation. All of these "specialty courts" are utilized the asses, screen and provide services to individuals with both mental health and/or substance abuse use disorders prior to adjudication.

Affordable Care Act

The Department of Human Services has worked closely with Arkansas Community Corrections and the Department of Corrections to assist in the enrollment of individuals transitioning out of prison on the state's Medicaid Expansion program, Private Option. With process tweaks, the agencies have been able to get individuals private insurance that reimburses for behavioral health services.

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:

13. State Parity Efforts

The Division of Behavioral Health Services (DBHS) does not dedicate fiscal resources towards education or awareness of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). DBHS is acutely aware of the applicability to the Health Insurance Marketplace and other private plan.

Currently, Arkansas Medicaid reimbursed behavioral health services are not a part of managed care.

While not part of a formalized plan, Division staff has and will continue to have dialogues and provide presentations regarding the implication of the Patient Protection and Affordable Care Act, including the extension of MHPAEA. DBHS staff have also made multiple presentations to stakeholders regarding the transformation in the Medicaid funded behavioral health services. This transformation includes the expansion of Medicaid funded substance abuse services.

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 40[85], 43[86], 45[87], and 49[88]. 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:

14. Medication Assisted Treatment

Arkansas has a contract with Mid-South Training Academy and is in the process of implementing Medication Assisted Treatment Continuing Education trainings throughout the state to educate and raise awareness to substance abuse providers/programs of the effectiveness of this evidenced based practice.

Currently all licensed providers are required to document their outreach activities to judges, prosecuting attorneys, law enforcement personnel, community service providers, other substance abuse treatment providers and the public. A more concentrated effort could be made to target these specialized groups. Also, as stated above, continuing education is being developed to assist with reaching appropriate and relevant audiences to improve access which will assist with this process. Additionally, the Specialized Women Services Manager provides assistance to individual cases to ensure that pregnant women are provided the necessary and appropriate services.

Arkansas' State Opiod Authority performs site inspections and holds providers to the federal and state guidelines. Arkansas currently supports a state-wide Medical Detoxification Program and also funding to an Opiod Treatment Facility with current plans to continue to fund these programs. A State Plan was created to include peer support and payment for substance abuse disorders when accompanied with a mental health disorder. That plan has been placed on hold and a task force created which is gathering information and plans to make recommendations.

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.

[89]Practice 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:

15. Crisis Services

Crisis Services provided under the auspices of the Division of Behavioral Health Services are primarily delivered through the state's thirteen Community Mental Health Centers (CMHCs), two Community Mental Clinic specialty providers, and eight Substance Abuse Provider Agencies. These services are supplemented by a Division supported information telephone line provided through NAMI-Arkansas. Calls to this line are frequently regarding crisis situations and NAMI-Arkansas responds to these and provides an appropriate referral to the caller to services.

The Division's contracts with CMHCs require that they provide crisis services, including providing face-to-face contact with a mental health professional within two hours of being made aware of a crisis situation. As part of their crisis services all CMHCs have 24 hour crisis lines which provide access to a mental health professional within 15 minutes. All clients of CMHCs are made aware of this crisis line phone number and it is published to the community. Much of the work of CMHCs, however, is devoted to preventing or mitigating crises. Efforts in this vein include use of Wellness Recover Action Plan (WRAP) Crisis Planning, Psychiatric Advance Directives, Safety Planning and Family Engagement. Centers (and the state's two certified "clinics" which provide specialty care to severe and persistently mentally ill adults, including Assertive Community Treatment) provide a variety of responses to crises that do develop. These efforts include Assessment and Triage, Crisis Intervention Teams, Mobile Crisis Outreach, and extensive collaboration with Hospital Emergency Departments.

By contract CMHCs serve as the Single-Point-Of-Access to publicly funded inpatient psychiatric care at either the Arkansas State Hospital or, more frequently, in a local psychiatric inpatient unit. In this role CMHCs perform approximately 14,000 crisis assessments and interventions per year, typically involving acute psychosis and/or suicidality, and frequently occurring in hospital emergency units. A primary focus of these assessments and interventions is providing effective crisis intervention in the least restrictive environment. CMHCs are able to effectively intervene in and prevent an inpatient hospitalization in over half of these crisis situations. In most of these diversions from inpatient the CMHC is providing immediate crisis intervention and counseling and follow-up outreach and support, including connection to care coordination and follow-up clinical care for individuals in crisis. When an inpatient hospitalization is necessary the CMHCs maintain contact with the person hospitalized and are required by contract to schedule the individual for follow up contact within two week of hospital discharge. Another area of focus of crisis services by CMHCs is contact with the criminal justice system, in particular, intervention efforts at jail diversion, many of which involve crisis situations. Some Centers have highly developed jail diversion programs while others are just in the planning stage.

In addition to the services provided by the CMHCs, DBHS contracts with eight substance abuse providers across the state who are responsible for providing a continuum of substance abuse treatment to those in need. The following services are available statewide for individuals experience a substance abuse crisis:

> **Observation Detoxification**- Includes monitoring on a 24-hours per day basis of a client who is undergoing mild withdrawals in a residential/live setting Monitoring will consist of taking the client's vital signs. Vital signs will be taken by a staff member trained and certified by DBHS, a medical doctor, registered nurse, licensed psychiatric technical nurse or licensed practical nurse. The facility shall establish approved emergency medical

procedures. These services shall be available should the client's condition deteriorate and emergency procedures by required.

Medical Detoxification follows all the protocols for Observation Detoxification but once a person has become dependent (they will have withdrawal symptoms if they stop taking the drug) or addicted (they are taking the drug or drinking alcohol primarily for the way it makes them feel), they are going to experience mild to severe discomfort and pain when they attempt to stop taking the drug or drinking alcohol. Medical Detoxification provides up t*o* three days detoxification services and aftercare plan. A medical detox means that the detoxification process is done under medical supervision with medications.

Specialized Women's Services for pregnant women and women with their children are given priority admittance. Treatment will include intensive primary treatment and clients must participate in at least thirty hours of therapeutic services per week, including substance abuse group counseling, education, parenting, family reunification and child development services.

Intravenous drug use The IDU user is given priority care with getting them into medical detoxification and medical personnel developing medication management and aftercare plans which would include residential treatment and or outpatients treatment.

Medicaid also reimburses for a range of crisis services. The Rehabilitative Services for Persons with Mental Illness (RSPMI) Arkansas Medicaid program provides reimbursement for the following crisis services: (1) Crisis Intervention, (2) Crisis Stabilization Intervention, Mental Health Professional, and (3) Crisis Stabilization Intervention, Mental Health Paraprofessional. A Crisis Intervention is an unscheduled, immediate, short-term treatment provided to a Medicaid beneficiary who is experiencing a psychiatric or behavioral crisis. A Crisis Stabilization Intervention is a scheduled face-to-face treatment activity provided to a Medicaid beneficiary who has recently experienced a psychiatric or behavioral crisis that is expected to further stabilize, prevent deterioration and serve as an alternative to 24-hour inpatient care. A Crisis Stabilization Intervention, Mental Health Professional, can be provided via telemedicine to adults. These services are not included in the eight (8) hour maximum daily amount of RSPMI services allowed by Arkansas Medicaid. All RSPMI sites, which are certified by the Division of Behavioral Health Services, must provide a 24-hour emergency telephone number to all beneficiaries served, as well as post the 24-hour emergency number on all public entries to each site. Each site must also provide direct access to a Mental Health Professional within fifteen (15) minutes of an emergency/crisis call and face-to-face crisis assessment within two (2) hours.

The Division of Behavioral Health Services worked closely with the State Medicaid Authority to propose changes to the current Medicaid system. The Payment Improvement Initiative Behavioral Health Transformation proposed the addition of the following crisis services: (1) Acute Crisis Units, (2) Substance Abuse Detoxification, and (3) Mobile Crisis Units. While never reviewed by the appropriate Arkansas Legislative Committees or filed final to the Arkansas Secretary of State as a rule to implement, the plan was to release a request for proposal (RFP) for a single, statewide crisis entity to be responsible for ensuring the coordination of mobile crisis response and stabilization, monitoring mobile crisis response and stabilization, training providers on how to handle behavioral health crises, contracting with regional mobile

crisis response entities, collecting and reporting key indicators, and supporting a centralized access call center. The goal of mobile crisis units would be to alleviate the need for admittance into a psychiatric facility or hospital. Psychiatric and hospital based crisis units would also be reimbursed by Medicaid for clients who were in need of that level of care.

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

employment

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:

16. Recovery

The Division of Behavioral Health Services (DBHS) seeks to improve the quality of life for Arkansans by providing a comprehensive, recovery-based and consumer-driven behavioral health system of care utilizing evidence-based or promising practices which include trauma-informed care principles. We value the strengths and assets of consumers and their families and believe these should be recognized and utilized as an essential perspective of treatment to support a self-determined life.

DBHS has adopted Substance Abuse and Mental Health Service Administration's (SAMHSA) definition for Recovery in Arkansas:

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

Through the Recovery Support Strategic Initiative, SAMHSA has delineated four major dimensions that support a life in recovery:

- Health: overcoming or managing one's disease(s) or symptoms—for example, abstaining from use of alcohol, illicit drugs, and non-prescribed medications if one has an addiction problem—and for everyone in recovery, making informed, healthy choices that support physical and emotional wellbeing.
- Home: a stable and safe place to live;
- Purpose: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society; and
- Community: relationships and social networks that provide support, friendship, love, and hope.

Stakeholders and consumer/family groups were asked to participate in open forums to identify Guiding Principles that best reflect ways Arkansas programs and services can promote a recovery oriented system and guide system development efforts.

As part of the Payment Improvement Initiative with Medicaid, DBHS has developed a 1915i and Health Home State Plan Amendment to include recovery based services, including peer support. Submission of those State Plan Amendment is on hold as DBHS is awaiting recommendations for a legislative task force that has been convened to look at all aspects of healthcare, Medicaid, and funding streams.

As stated, peer support services are still in the planning stages. Therefore, at this time, the state does not have an accreditation or certification program for peer support specialists o peer-run services although this topic was in development previously.

The state team leader for SOAR and PATH is housed at DBHS so that recovery supports are available to individuals at-risk or experiencing homelessness. Technical assistance and training in coalition development is provided by staff to organizations around the state addressing the re-entry of individuals returning from incarceration so that recovery and behavioral health is specifically addressed.

The Arkansas Behavioral Health Planning and Advisory Council is a group composed on individuals in recovery, family members, and professionals in the behavioral health field. This group reviews the block grant and its outcomes each year. It provides input on concerns and planning of behavioral health administration.

Individuals also have input to the system through local consumer councils. These organizations are operated by community mental health centers but come together as an umbrella of the Mental Health Council of Arkansas.

The system of care includes community stakeholder councils comprised of youth and family members accessing the system. While serving as a method for the families to connect and provide recovery support to each other, the councils also gives them opportunities to provide input and address concerns. In a similar vein, the 15 chapters of YouthMove, a national organization, allows youth to have say in planning.

Technical assistance and encouragement is given to the statewide Personal Empowerment Recovery Coalition, a body originally convened under a BRSS TACs grant awarded to the state. This group has developed the ability to function on its own and receives much of its technical advice from the National Empowerment Center.

Some community-based providers have developed supportive employment programs for individuals. Others assist individuals in enrolling in programs through the state vocational rehabilitation program which is administered by a different state agency.

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:

17. Community Living and the Implementation of Olmstead

The state's Olmstead plan was written in 2003. One of the priorities identified, at that time, was the issue of parity between behavioral health care and physical health care. This parity was established with the federal Mental Health Parity and Addiction Equity Act of 2008.

DBHS has developed two State Plan Amendments, which are inclusive of peer support services and supportive housing, and other home and community based services. DBHs is awaiting recommendations from a Legislative Health Care Reform Task Force who is analyzing the entire Medicaid system to move forward with the implementation of the developed 1915i and 2703 State Plan Amendments. In the meantime, DBHs continue to build momentum towards the implementation of these evidence based practices.

In 2013, the state implemented a Forensic Outpatient Restoration Program. This program has encouraged timely forensic evaluation and outpatients services, which has lowered the demand for inpatient forensic beds in the state hospital. This change has allowed some individuals to receive services in the community where they are on bond or incarcerated.

Families with children in the Systems of Care program have access to family support partners, community care councils, and community service coordinators. These individuals and entities serve as support and a bridge between families so that they do not feel individually isolated as they navigate the system for their child's best interest.

Some of the state's addiction treatment centers provide limited transitional housing for those in outpatient and having completed substance abuse treatment. With continued access to counselors and peers, this allows individuals to gradually return to community function. Some of the community mental health centers provide day treatment centers which individuals who have graduated from active treatment can return for additional supports and as peer volunteers.

The discharge planning with specific goals and outcomes begins at the time of an individual's admission to the state hospital. After treatment goals are met, a discharge summary is provided to the individual's home community mental health center which develops a treatment including follow-up services. The treatment is strictly between the individual and their mental health provider and the state does not provide any impact beyond information about inpatient care.

As part of the PASRR process, individuals with serious mental illnesses who make application for care in Medicaid eligible nursing facilities are reviewed by a staff member of the Division of Behavioral Health Services to assure that placement is the least restrictive environment. Alternative placement is recommended should nursing facility be found to be too restrictive.

At this time, complete data about congregate versus integrated housing is not available. Given the rural nature of the state, many individuals live within the community at large but the precise number is not known at this time. The same can be said about competitive wage earners.

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 care[95]:

- 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.

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[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:

18. Children and Adolescent Behavioral Health Services

The Division of Behavioral Health Services (DBHS) ensures mental and behavioral health care is available to children and youth throughout the state. Outpatient mental health services are available through certified community providers and as such, must comply with State requirements that meet nationally accepted standards for delivering services.

ACT 1593 of 2007 a follow up to ACT 2209 of 2005, is legislation that established the principles of a System of Care (SOC) for behavioral health care services for children and youth as the public policy of the State. It addressed improvement of the effectiveness of behavioral health and related services to children, youth and their families and ensured better utilization and coordination of the State's behavioral health care resources devoted to serving children, youth and their families. The legislation also required a twenty person, Governor appointed Arkansas Children's Behavioral Health Care Commission to provide advice and guidance to DHS/DBHS and other state agencies providing behavioral health care services on the most effective methods for establishing a SOC approach. The DBHS SOC staff report activities to the Commission members in quarterly meetings as well as providing ongoing updates on the Commission website. The DBHS SOC staff includes a Children's Services Coordinator, SOC Clinician, Family Support Partner (FSP) Coordinator and a Project Director for the SAMHSA SOC Implementation and Expansion Grant. A Youth Support Partner Coordinator, a new positions will be hired during the state fiscal year of 2016.

The purpose of the Arkansas System of Care (AR SOC) Wraparound Demonstration project has been to facilitate the development of local systems of care and to provide funding for demonstrating the effectiveness of wraparound funds. Since 2010, the project has been funded by Requests for Applications (RFAs) from 14 mental health agencies covering all of the 75 counties in Arkansas. Since then, DHS has continued the development of local systems of care with the addition of three funded staff positions. The Community Care Director is charged with building a local infrastructure and Care Coordinating Council (CCC) composed of families, local behavioral health agencies, faith-based organizations, community leaders as well as representatives from child welfare, juvenile justice, intellectual disabilities, and prevention services. A Wraparound Facilitator is located in each of the 14 demonstration project sites as well as 11 FSPs. DBHS SOC staff provides ongoing trainings, annual site visits, and monthly technical assistance in all regions, invoice analysis, monthly reports and outcome measures.

This has led to a dramatic increase in availability and fidelity to wraparound and an increase in community access to non-traditional services and supports. In 2014, the 14 sites have served 1581 children and youth who met the Wraparound criteria. This project has demonstrated that children and youth that were enrolled in the program decreased psychiatric inpatient services, decreased arrest and juvenile justice involvement, reduced custody in the Division of Children and Family Services (foster care) and reduced school suspensions/expulsions thereby increasing family stability.

FSPs are employed, contracted or supported by agencies committed to family driven, culturally competent and individualized care. FSP training and certification is provided by DBHS SOC staff. Three of the FSPs received the National Certification for Parent Support Professionals.

DBHS also provided oversight for the Child Adolescent Services Systems Program (CASSP) which was established in Arkansas by ACT 945 of 1991 and in 2001 through ACT 1517. There are 14 CASSP sites located in each of the Community Mental Health Centers. CASSP utilizes state general revenue and block grant funds to provide services to children and families. These groups coordinate services and in many areas have combined with the CCCs.

The development of a State Youth Organization began at Mid-South Health Systems through an Arkansas SAMHSA funded *ACTION for Kids* (AFK) in 2007. They worked with National Youth MOVE to develop an Arkansas chapter. DBHS has continued to provide support and funding for Youth MOVE Arkansas (YMA) to maintain a state office and a full time coordinator position, recruit new chapters across Arkansas and provide trainings and leadership to youth with a focus on resiliency and recovery. YMA currently has 13 chapters. The 5th Annual Youth MOVE Summer Conference was held in June of this year with over 270 youth and family members attending.

The AR SOC Wraparound Demonstration Project continues to explore and expand wraparound services to a larger population. DHS SOC staff is working with the Division of Youth Services (DYS) on a pilot project to work with youth who have a *Family in Need of Services* (FINS) or on probation and their DYS community-based providers.

Individual care plans are required by all providers of Medicaid services. The RSPMI program has rules regarding this provision of service and contractors that monitor through annual Inspection of Care Audits as well as review at the time of the certification of the services requested.

The AR SOC Wraparound Demonstration Project provides individualized care plans to applicants diagnosed with a severe emotional disturbance (SED), involvement with multiple child serving agencies and at risk of out of home placement. Many of the wraparound youth have a secondary diagnosis of substance abuse.

Therapy services are supported through the Medicaid Rehabilitation Services for Persons with Mental Illness (RSPMI) for the under 21 age population. There are 53 providers and 302 RSPMI certified sites across the state. All but three of the providers serve children and youth. There are approximately 70,000 children and youth served through this program per year. The therapy services can be provided in a clinic, home or school setting. Over 5,000 children per year are provided services in a psychiatric residential treatment setting.

Juvenile Drug Court services are available in ten different judicial districts. Services are provided by contracted licensed substance abuse providers. These contracts are awarded via bid process. Juveniles admitted to the Juvenile Drug Court program are provided a number of services including outpatient therapy, case management, and urine analysis.

The Substance Abuse Treatment Services (SATS) Program was created to provide services for two Medicaid eligible populations: 1) children and youth up to 21 years of age; and 2) pregnant and post-partum women. The program began enrolling providers in March 2011 and offering services in July 2011. The services available within the SATS Program include: Addiction

Assessments, treatment planning, care coordination, martial/family group counseling, multi-person/family group counseling, individual counseling, and medication management. There are 15 DBHS SATS Medicaid Providers across the state.

Collaboration is essential to DBHS in working with other child serving agencies. Most of our children and youth access services in more than one child serving agency. DBHS SOC staff are initiating a pilot project with the Division of Youth Services (DYS) and three of their community based provider sites to facilitate wraparound and family support partner services to youth who have a Family in Need of Services (FINS) or who are on probation. These targeted youth must have a behavioral health diagnosis. In addition to DYS involvement, DBHS SOC staff are key stakeholders at the DCFS Interdivisional weekly staffings. These staffings are a collaborative process with other DHS divisions and additional child serving agencies to strategize placement options for youth with complex behavioral health care needs.

The DBHS leads a monthly meeting with DHS's child serving divisions including: Division of Children and Family Services (DCFS), Division of Youth Services (DYS), Division of Medical Services (DMS), Division of Developmental Disability Services (DDS), and the Division of Child Care and Early Childhood Education (DCCECE). In addition to this meeting, DBHS staff work on various projects with each division. Some examples of the activities include:

- DHS Trauma Informed work group
- Early Childhood and Child Care Medical Home work group,
- Arkansas Infant Mental Health Association
- Project LAUNCH State Council
- DCFS Psychotropic Medication for Foster Children work group,
- DCFS Parent Partner work group
- Safe Babies Court Team Council with DCFS
- Child and Adolescent Service System Program (CASSP)
- Youth MOVE Advisory Board
- National Alliance for Mental Illness (NAMI)

Focus on evidenced-based trainings within behavioral health services has for many years included Wraparound Academy 101 and Family Support Partner Training both of which are conducted by the DBHS SOC Staff. The University of Arkansas for Medical Sciences ARBEST (Arkansas Building Effective Services for Trauma) conducts ongoing training which includes follow-up coaching for certification in trauma-focused cognitive behavioral therapy. Within the last year, through a sub-grant with UALR MidSOUTH Training Academy, the Team Up for Your Child-Road Map to Services was initiated. Additionally, last year through a SOC sub grant with MidSOUTH Dr. Ross Green was brought to the state to provide three trainings in Collaborative Problem Solving and Dr. Vivian Jackson presented three trainings on Cultural and Linguistic Competency. These trainings were offered in three different areas of the state as well as streamed to numerous sites to increase availability to participants. A survey was conducted for behavioral health clinicians to help identify future evidence-based trainings that would be beneficial as these practices expand across the state. In the next year we plan to utilize SAMHSA grant funding to continue the Road Map training, provide continued evidence-based training to our behavioral health service providers as well as implement a coaching process for the Wraparound service providers. The Trauma-Informed Care Workgroup is ongoing and has been

provided with the task of bringing together DHS divisions and insuring that DHS is committed to being a trauma-informed organization. This process includes insuring that trauma and trauma symptoms are understood, trauma screens and assessments are administered, agency wide trainings regarding trauma-informed care are conducted, providers and contractors are trained, and trauma-informed care outcome measures are in place.

SPQM data is received from the Community Mental Health Centers across Arkansas. It is compiled by DBHS staff and shared with Planning Councils and other stakeholders.

DBHS, along with the Division of Medical Services (DMS) monitors service utilization among all RSPMI providers. Outcomes are monitored utilizing the Youth Outcome Questionnaire (Y-OQ®). The Y-OQ® was implemented after passage of ACT 1593 in 2007 and promulgated into policy and monitored for compliance until 2015. The Y-OQ® was used to track individual and aggregate outcomes of treatment to better measure quality of services to RSPMI beneficiaries. It was given to children and youth at intake and at least every 90-days, providing a measure of progress throughout the course of treatment and a measure of effectiveness after a client has completed treatment. The Arkansas Indicators was another outcome tool administered with the Y-OQ®. ACT 161 repealed the outcome measures within DBHS resulting in a committee being formed to select an alternative tool no later than September 30, 2015 to be utilized in its place. This committee is ongoing.

The DBHS SOC staff utilizes a data system to monitor and track wraparound clients and services rendered. Wraparound sites are required to complete an outcome tool called the Arkansas Youth Information Form on all participants. The sites post wraparound "success stories" on the data system and many of these are shared in the quarterly reports to the Arkansas Children's Behavioral Health Care Commission. There are yearly on-site reviews, monthly technical assistants available in each region, invoice analysis, monthly reporting and outcome measures.

The Arkansas SOC Wraparound Demonstration Project provides youth services to youth up their 21st birthday. Each wraparound plan is individualized to meet the youth and family's cultural needs.

Youth MOVE Arkansas provides support and leadership to youth up to age 26. After that, youth are considered adult allies and encouraged to remain involved in their chapter.

DCFS employs Transitional Youth workers for the youth in foster care. The coordinator of this project is called an Independent Living Coordinator and is a youth. DCFS also has a Youth Advisory Board (YAB) that meets regularly and provides an annual youth conference.

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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:

19. Pregnant Women and Women with Dependent Children

Pursuant to SAPT Block Grant-Funded Programs, all funded substance abuse treatment providers in Arkansas must give preference in admission to pregnant women who seek treatment services. All treatment programs are instructed to give priority admission preference in the following order:

1. Pregnant Injecting Drug Users
2. Pregnant Substance Abusers
3. Injecting Drug Users
4. Clients with the greatest clinical need
5. Clients from the Catchment area as specified by OADAP
6. Clients from the State of Arkansas
7. Clients from other states.

These priorities are listed in the Division of Behavioral Health, Substance Abuse Treatment "Rules of Practice (2009), Section III, Page 11, Paragraph 9.

It is also stated in the Substance Abuse Treatment Licensure Standards, Section on Specialized Women's Services: 3.03.04 "The Program shall give admission priority to pregnant women".

All residential treatment programs are required to a post this priority list where it can be seen by the public.

Programs are also required to do outreach to advertise their services for pregnant and parenting women with dependent children. The Licensure standards state:

1.07.01.07 The program has policies and procedures that describe and govern outreach and referral activities necessary to educate judges, prosecuting attorneys, law enforcement personnel, community service providers, substance abuse treatment programs, and the public as to the operations of the program.

This standard is monitored during licensure reviews. A program is required to show documentation of advertising, presentations to public or judges, etc., Written Articles, TV or radio commercials that have been completed during the years of the current licensure term.

The Treatment Request for proposal states: …"Treatment programs shall provide treatment services within forty-eight (48) hours for pregnant women who request admission. For IDU's who cannot be placed in comprehensive treatment within 14 days from the date of the request for admission, or pregnant women within 48 hours from the date of request, "interim services" will be provided within 48 hours of the request, until the time of admission to treatment." The provider must address this in their response.

The DBHS staff monitoring program compliance with the Contracts will review the program policy and procedure manuals to assure that this criterion is addressed. They will also review waiting lists and interim services documentation as well as client records to discover, if in fact, this admission criteria is being upheld and acted upon.

Staff from the Division of Behavioral Health Services, Adult Services, are responsible for monitoring these requirement.

There are 8 catchment areas and 8 funded primary contractors serving the entire state for Substance Abuse Treatment. These contractors offer residential, intensive outpatient, and outpatient services. The 8 contracted providers are responsible for ensuring specialized women's services in their catchment area. None are hospital based. None offer MAT.

There are no treatment centers offering services for pregnant and/or parenting women in the Southwest or Northeast areas in the state. Those in Texarkana must travel to Little Rock (145 miles), Fort Smith (191 miles) or Warren (137 miles). Women in Paragould must travel to Gassville (138 miles) or Searcy (103 miles). From West Memphis the nearest program is in Searcy 100 miles away.

Program landscape:

- There are a total of six facilities in the state of Arkansas that directly offer specialized services for pregnant women and women with their children.
- Of the Eight (8) primary contractors, only three (3) serve pregnant women and their infants. The other five (5) subcontract with non-funded substance abuse treatment programs to provide these services. There are three non-funded subcontractors who participate and offer services for pregnant women and mothers and their infants.
- Three programs offer children's services in the IOP setting.
- All 8 funded providers offer out-patient services to pregnant women but do not offer services to their infants and children but all will refer out to mental health clinics in services are needed.
- None of the funded substance abuse providers in Arkansas offer medically assisted treatment for pregnant women.

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:

Arkansas Strategy for Suicide Prevention

I. Awareness

Goal 1: Promote awareness that suicide is a public health problem and that many suicides are preventable.

Objective 1.1 Develop and implement public information campaigns designed to increase the knowledge of all Arkansans regarding suicide prevention and the role of risk and protective factors in prevention.

Objective 1.2 Establish and host regularly scheduled suicide prevention conferences designed to foster collaboration with stakeholders regarding prevention strategies and to inform communities.

Objective 1.3 Increase the number of Arkansas institutions (public and private) active in suicide prevention who deliver accurate and culturally sensitive information through the internet.

Goal 2: Develop broad-based support for suicide prevention.

Objective 2.1 Increase the number of people in Arkansas actively involved in some aspect of suicide prevention.

Objective 2.2 Increase the number of local communities in actively working to implement the Arkansas Suicide Prevention Plan.

Objective 2.3 Include suicide prevention education in ongoing programs and activities carried out by prevention organizations, professional, volunteer and other groups in all areas of the state.

Objective 2.4 Increase the number of faith-based communities and organizations adopting policies and procedures promoting suicide prevention and resiliency.

Objective 2.6 Develop an “Advisory Committee” to provide advice and support for implementation and to assure that the diversity of Arkansas citizens is recognized and addressed through the Suicide Prevention Plan.

Goal 3: Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services.

Objective 3.1 Increase the proportion of Arkansans who view mental health as an integral part of overall health and well-being.

Objective 3.2 Increase the proportion of Arkansans who view mental illness as medical conditions that respond to specific treatments, supports, and holistic practices.

II. Intervention

Goal 4: Develop and implement suicide prevention programs.

Objective 4.1 Demonstrate collaboration between government agencies and public/private partners in implementing the Arkansas Suicide Prevention Plan at the state, regional, and local levels.

Objective 4.2 Establish institutional policies and procedures for referral of persons at-risk for suicide and for crisis response situations.

Objective 4.3 Increase the number of school districts with evidence-based programs designed to identify youth in behavioral health distress and prevent suicide.

Objective 4.4 Increase the number of colleges and universities providing evidence-based programs addressing transitional-age young adult behavioral health distress and suicide prevention.

Objective 4.5 Increase the number of employers in Arkansas who offer assistance through evidence-based practices for their employees in emotional distress and at-risk for suicide.

Objective 4.6 Improve suicide prevention programs for adult and juvenile offenders in correctional facilities, jails, and detention centers in Arkansas.

Objective 4.7 Increase the number of evidence-based suicide prevention programs offered to the older adult population in Arkansas, particularly through service organizations targeting that population.

Objective 4.8 Increase the number of family, youth and community service organizations and providers in Arkansas offering evidence-based suicide prevention programs.

Objective 4.9 Improve, coordinate, and advertise crisis help line services throughout Arkansas.

Goal 5: Promote efforts to reduce access to lethal means and methods of self-harm for persons at high risk.

Objective 5.1 Increase the proportion of primary care physicians, health and safety officers, and other physical and behavioral health care providers who routinely ask about the presence of lethal means of self-harm in the home of individuals at high risk for suicide.

Objective 5.2 Develop and distribute materials to educate about actions to reduce the accessibility of lethal means of self-harm for those at high risk.

Goal 6: Implement training for recognition of at-risk behavior and delivery of effective treatment.

Objective 6.1 Provide continuing education for primary care physicians/staff on recognizing the signs of persons at-risk for suicide and in accessing community resources for treatment/prevention programs.

Objective 6.2 Incorporate suicide prevention materials in training programs for health care professionals including physicians, physician assistants, nurse practitioners, registered nurses, licensed practical nurses, certified nursing assistants, paramedics, and emergency medical technicians. Training should incorporate screening for at-risk indicators, identification of protective factors, promotion of resiliency, and local referral options when needed.

Objective 6.3 Incorporate suicide prevention materials in training programs for mental health and substance abuse professionals including psychologists, social workers, and counselors. Training should incorporate screening for at-risk indicators, identification of protective factors, promotion of resiliency, and local referral options when needed.

Objective 6.4 Incorporate suicide prevention materials in training programs for individuals providing in-home and community outreach and first responders including firefighters, police, poison control center personnel, 911 operators, home visitation program providers, hospice personnel, and case managers. Training should incorporate screening for at-risk indicators, identification of protective factors, promotion of resiliency, and local referral options when needed.

Objective 6.5 Increase the number of faith-based community providers trained in the identification of individuals at-risk for suicide, including the differentiation between mental health crisis and faith crisis.

Objective 6.6 Incorporate suicide prevention materials in training programs for educational faculty and youth development staff working outside school settings. Training should incorporate screening for at-risk indicators, identification of protective factors, promotion of resiliency, and local referral options when needed.

Objective 6.7 Incorporate suicide prevention materials in training programs for individuals working in juvenile justice, corrections, and public safety. Training should incorporate screening for at-risk indicators, identification of protective factors, promotion of resiliency, and local referral options when needed.

Objective 6.8 Increase the number of community helpers, such as mail carriers, hairdressers, nail salon attendants, Meals on Wheels volunteers, and senior citizen volunteers who are trained to recognize the warning signs of suicide and are aware of community referral options for help.

Objective 6.9 Improve education programs and support services available to family members and others in close relationships with individuals at-risk for suicide and also for survivors of suicide.

Goal 7: Develop and promote effective clinical and professional practices.

Objective 7.1 Increase the proportion of individuals treated in hospital emergency departments who follow up with recommended behavioral health treatment/intervention.

Objective 7.2 Promote the incorporation of screening for at-risk factors and protection factors (including resiliency) into primary health care settings, emergency departments, and specialty clinics.

Objective 7.3 Consult with mental health and substance abuse providers throughout Arkansas to assure that appropriate suicide prevention policies, procedures and evaluation programs are incorporated into their programs and followed accordingly.

Objective 7.4 Enhance screening for depression, substance abuse and suicide risk as a basic standard of care for all state-supported health care programs in Arkansas.

Objective 7.5 Promote guidelines for aftercare treatment and follow up for individuals treated in an inpatient setting for suicidal behavior.

Objective 7.6 Assure first responders and individuals in key roles providing services to suicide survivors (emergency medical personnel, public safety officers, funeral directors, and clergy) are trained in the unique needs of this population and utilize a trauma-informed care perspective.

Objective 7.7 Increase the availability and completion of evidence-based treatment for mental health and substance abuse issues throughout Arkansas. Incorporate trauma-informed care throughout the system to increase effectiveness and satisfaction with programs.

Objective 7.8 Increase the number of hospital emergency departments providing, or accessing, immediate post-trauma mental health support/education for all individuals experiencing sexual assault and/or physical abuse.

Objective 7.9 Develop guidelines to assure that family members and significant others of individuals receiving treatment for a mental illness or substance abuse are provided with education on suicide risk factors, protective factors (including resiliency), and community resources.

Objective 7.10 Improve and expand comprehensive support services for survivors of suicide.

Goal 8: Increase access to, and community linkage with, mental health and substance abuse services.

Objective 8.1 Compile and update a guide to suicide prevention resources and services throughout Arkansas. Provide linkages to appropriate local and national resources.

Objective 8.2 Work closely with the Arkansas Insurance Commission to assure that mental health and substance abuse services are covered at the same level as physical health services.

Objective 8.3 Increase the number of counties in Arkansas providing outreach programs for at-risk populations.

Objective 8.4 Support guidelines and resources for mental health and substance abuse screening and referral procedures for students in schools, colleges and university.

Objective 8.5 Support consistent use of screening for at-risk populations in correctional facilities, detention centers, crisis centers, family planning clinics, recreation centers, youth organizations, homeless shelters, employee assistance offices, and treatment programs.

Objective 8.6 Support the development and utilization of clinical “best practice” guidelines regarding response to suicidal behavior and/or risk factors. Encourage implementation in health insurance programs throughout the state.

Goal 9: Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.

Objective 9.1 Coordinate efforts with consumer and advocacy groups (NAMI-Arkansas, Mental Health Council of Arkansas, ASPN, Elliott Foundation, Alex Blackwood Foundation, and others) to include media practices toward accurate and responsible representation of suicidal behavioral and mental illnesses and informed media coverage of suicide prevention.

Objective 9.2 Increase the proportion of entertainment and news programs and print coverage in Arkansas reflecting accurate and responsible portrayal of suicidal behavior and mental illness

Objective 9.3 Encourage Arkansas journalism programs to include guidance in their course of study on the portrayal and reporting of mental illness, substance use disorders, suicide, and suicidal behaviors.

III. Methodology

Goal 10: Promote and support research on suicide and suicide prevention.

Objective 10.1 Increase public and private funding for suicide prevention research and evaluation conducted in Arkansas.

Objective 10.2 Support the development of, and access to, a registry of prevention activities with demonstrated effectiveness (evidence-based or best practice) for preventing suicide and suicidal behaviors.

Objective 10.3 Provide training and technical assistance on evaluation of suicide prevention programs in Arkansas.

Goal 11: Improve and expand surveillance systems.

Objective 11.1 Develop and refine standard procedures for death scene investigations, and implement throughout Arkansas.

Objective 11.2 Develop and test a protocol to assist Arkansas hospitals in collecting uniform and reliable data on suicidal behaviors by coding external causes of injury and determining associated costs.

Objective 11.3 Implement a violent death reporting system that includes suicides and collects information not consistently from death certificates.

Objective 11.4 Compile and distribute reports on suicide and suicide attempts in Arkansas integrating data from all available sources.

Objective 11.5 Develop a set of community-level indicators for progress in suicide prevention to signal achievement of results.

State of Arkansas *As Engrossed: H3/17/15*
90th General Assembly **A Bill**
Regular Session, 2015 HOUSE BILL 1887

By: Representatives Lemons, *Baltz, Bentley, Bragg, Copeland, Cozart, Davis, D. Ferguson, C. Fite, L. Fite, Gates, Gossage, M. Gray, Hammer, Harris, Henderson, Jean, Jett, Johnson, Love, Lowery, Magie, Richey, Richmond, Rushing, Shepherd, B. Smith, Sorvillo, Speaks, Sturch, Tosh, Vines*
By: Senator E. Williams

For An Act To Be Entitled

AN ACT TO AMEND THE LAW CONCERNING SUICIDE PREVENTION; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND THE LAW CONCERNING SUICIDE PREVENTION.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 45, is amended to add an additional subchapter to read as follows:

Subchapter 3 -- Arkansas Suicide Prevention Council

20-45-301. Findings and intent.

(a) The General Assembly finds that:

(1) Five hundred sixteen (516) Arkansans died by suicide in 2013, making suicide the leading cause of injury death in Arkansas and that suicide is an urgent and serious public health and welfare problem in the state;

(2) Arkansas needs a comprehensive and coordinated approach to prevent suicide across all age and demographic groups in all areas of the state and to ensure that suicide prevention becomes a shared priority for all citizens;

(3) Statewide coordination of suicide prevention efforts is necessary to ensure high levels of collaborative leadership, effectiveness, and continuous improvement;

(4) An effective, evidence-based strategy is necessary to increase knowledge about and access to suicide prevention, intervention, and postintervention resources for all Arkansans;

(5) Intentional leadership, survivor input, and capacity-building, policy development, and alignment of services for high-risk sectors are needed;

(6) A seamless system of support and follow-up coordination for suicide attempt survivors and situationally high-risk individuals is needed;

(7) The rate of suicide in Arkansas is presently out-pacing the nation and increasing year to year; and

(8) The absence of a suicide prevention program authority in Arkansas is a major threat to public health and welfare.

(b) It is the intent of the General Assembly that the Injury Prevention Division of the Department of Health be designated the program authority to receive and solicit funding as appropriate to provide adequate funding in support of an effective and staffed statewide suicide prevention program.

20-45-302. Creation and purpose.

(a) There is established the "Arkansas Suicide Prevention Council".

(b) The purpose of the council is to serve as a central body on suicide prevention efforts across the state, including without limitation:

(1) Setting priorities for statewide, data-driven, evidence-based, and clinically-informed suicide prevention in Arkansas;

(2) Providing a public forum to examine the current status of suicide prevention and intervention policies, priorities, and practices;

(3) Identifying interested parties, community, state, and national prevention providers and stakeholders for collaboration and devising a system of gathering data and other information to ensure coordination of suicide prevention resources and services throughout Arkansas;

(4) Assisting private, nonprofit, and faith-based entities, including without limitation coalitions, foundations, initiatives, churches, veterans groups, substance abuse recovery groups, senior adult organizations,

grief support groups, injury prevention groups, and other groups to enhance suicide prevention and survivor support efforts; and

(5) Aiding in the development of evaluation tools and data collection for use in reporting suicide prevention efforts to the public.

(c) Within sixty (60) days of the effective date of this act, there shall be appointed to the council no more than twenty-three (23) members, including:

(1) A representative of the Office of the Attorney General, to be designated by the Attorney General;

(2) A representative of the Division of Behavioral Health Services of the Department of Health, to be designated by the head of the Division of Behavioral Health Services;

(3) A representative of the Department of Education, to be designated by the Director of the Department of Education;

(4) A representative of the Division of Youth Services of the Department of Health, to be designated by the head of the Division of Youth Services;

(5) A representative of Arkansas Children's Hospital, to be designated by the Director of Arkansas Children's Hospital;

(6) A representative of law enforcement, to be designated by Director of the Department of Arkansas State Police;

(7) A representative from higher education, to be designated by the Director of the Department of Higher Education;

(8) A representative from kindergarten through grade twelve (K-12) education, to be designated by the Arkansas Education Association;

(9) A representative from an employee assistance program or human resources in the private sector, to be designated by the Governor;

(10) A licensed mental health professional, to be designated by the Governor;

(11) A representative of substance-abuse treatment providers, to be designated by the Governor;

(12) A representative of primary medical care providers, to be designated by the Governor;

(13) A representative of first responders, to be designated by the Governor;

(14) A representative from a hospital with an on-site emergency

department, to be designated by the Governor;

(15) A hospital-based social worker, to be designated by the Governor;

(16) An elected coroner, to be designated by the Governor;

(17) An active member or veteran of any branch of the United States military, to be designated by the Governor;

(18) A family member of a person who died by suicide, to be designated by the Governor;

(19) A person who has attempted suicide, recovered, and is now thriving, to be designated by the Governor;

(20) A representative of the suicide prevention nonprofit community, to be designated by the Governor;

(21) A representative of the Arkansas Prevention Network, to be designated by the Director of the Arkansas Prevention Network;

(22) A representative from an interfaith organization, to be designated by the Governor; and

(23) The Chair of the Arkansas Youth Suicide Prevention Task Force, or his or her designee.

(d) The council shall elect annually two (2) cochairs, a vice chair, and a secretary who will serve as an executive board.

(e)(1) The council shall establish a charter and bylaws within ninety (90) days of the first meeting.

(2) A quorum for conducting business is one-half (1/2) of the appointed members.

(f)(1) The council shall meet at least four (4) times each year.

(2) The council shall meet at times and places that the co-chairs deem necessary, but no meeting shall be held outside the state.

(3) Special meetings may be held at the call of the co-chairs, as needed.

(g)(1) The appointed members of the council shall serve staggered terms of four (4) years with no more than two (2) contiguous terms.

(2) If a vacancy occurs in an appointed position, the vacancy shall be filled for the unexpired term by an appointment made in the same manner as the original appointment.

(h) Appointments shall:

(1) Represent persons of different ethnic backgrounds;

(2) Include members from each of Arkansas's four (4) congressional districts; and

(3) Include members with expertise from groups associated with high suicide rates and suicide attempts.

(i)(1) The members of the council shall serve without compensation but may seek reimbursement for travel expenses to and from meetings of the council.

(2) The expense reimbursement shall be paid by the Department of Health from moneys available for that purpose.

(j) The Department of Health shall provide staff and programmatic support for the council to the extent that funding is available.

(k) The Department of Health is the designated agency for the purposes of suicide prevention and related state and federal programmatic and funding applications.

(l) Within the first year of its creation, the council shall make recommendations to the General Assembly on staffing and funding needs to implement an effective statewide suicide prevention program.

/s/Lemons

APPROVED: 04/04/2015

20. Suicide Prevention

During the last legislative session, Arkansas State Legislators passed House Bill 1887 to establish the Arkansas Suicide Prevention Council. This action reflects that state officials recognize that suicide is a leading cause of injury and a serious public health problem in our state. This act (Act 1067) is attached. The legislatively created council represents a comprehensive and coordinated approach to prevent death by suicide in Arkansas. The council will engage in statewide coordination to ensure high levels of collaborative leadership. The council will set "priorities for statewide, data driven, evidenced based and clinically informed suicide prevention in Arkansas." The work of this council will mirror the National Strategy for Suicide Prevention focus of attention in "coordinating resources…at all levels... (U.S. Public Health, 2001) A representative from the Division of Behavioral Health Services will serve on this council. DBHS will work in collaboration with members from this council to update the state plan and incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).

In 2014, the Arkansas Department of Health was awarded the Garrett Lee Smith Grant through SAMSHA. DBHS staff members will collaborate with grant staff members to implement suicide prevention activities funded through the grant.

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:

21. Support of State Partners

Department of Human Services, Division of Medical Services
The Division of Medical Services (DMS) is the Arkansas Medicaid agency. DMS is within the same umbrella agency as the Division of Behavioral Health Services (DBHS), the Department of Human Services (DHS). Medicaid is currently under an entire system transformation coined the Payment Improvement Initiative. The Medicaid funded behavioral health system is undergoing dramatic change and the Division of Behavioral Health Services (DBHS) has partnered with DMS to develop Behavioral Health Homes and develop a 1915i State Plan Amendment. This initiative will fill the tremendous gaps that currently exists in the system by implementing care coordination, recovery based services, and crisis services.

Department of Human Services, Division of Youth Services
The Division of Youth Services (DYS) is responsible for the Arkansas juvenile justice system. Since 2009, the Division has been working to transform in to a system that prevents and diverts youth from the justice system and that provides community based services. As a part of this transformation, one of the objectives addressed in DYS' Comprehensive Plan is to "Expand and strengthen alcohol and substance abuse programs". Access to mental health services through DBHS funded Community Mental Health Centers and Medicaid funded services is also listed in this plan. Additionally, DYS is an important partner within the Arkansas Children's System of Care and Juvenile Drug Court system.

In 2012, DBHS collaborated with DYS to apply for the Improving Diversion Policies and Programs for Justice Involved Youth with Co-occurring Mental Health and Substance Abuse Disorders: An Integrated Policy Academy grant through the National Center for Mental Health and Juvenile Justice. DYS was awarded the grant and DBHS has been and will continue to be an active participant in the grant. The team selected a pilot community to improve diversion activities through the implementation of a behavioral health screen prior to intake. After implementation and analysis, the plan is to identify sustainable funding to roll out a screening tool statewide.

Recently, DYS appointed a DBHS staff person to the Youth Justice Reform board, which is tasked with guiding juvenile justice reform in Arkansas.

The DBHS System of Care team is currently working on a project with DYS to pilot three Community based provider sites to provide Wraparound and Family Support services to kids with a FINS petition or on probation.

Administrative Office of the Court
The Administrative Offices of the Court (AOC) supports the information technology, training, juvenile support services, language, and advocate services of the Arkansas court system. Specifically relating to DBHS, the AOC is an essential partner in the successful implementation and sustainability of the juvenile and adult drug courts. A representative from DBHS sits on the Specialty Court Task Force. Additionally, a DBHS staff person sits on the Supreme Court Subcommittee on Juvenile Justice Reform Risk Assessment and Behavioral Health Screening grant Implementation, which are facilitated by AOC

Department of Human Services, Division of Children and Family Services
As a sister agency within the Department of Human Services (DHS), the Division of Behavioral Health Services (DBHS) works closely with the child welfare agency, Division of Children and Family Services (DCFS). There is a representative from DCFS on the Arkansas Behavioral Health Commission, which has oversight over the Arkansas Children's System of Care. Additionally, DCFS is a partnering agency in the Children's System of Care initiative. The two agencies have also partnered with the Division of Medical Services (DMS) to monitor and reduce the prescription of psychotropic medication in foster children. DBHS and DCFS staff also participate in interdivisional staffings to assist in difficult placements.

Department of Education
DBHS will continue to work with the Department of Education in regards to the implementation of Mental Health Services in schools. They have provided consultation to DBHS and the Division of Medical Services (DMS) regarding this topic and how it will be affected by the Payment Improvement Initiative. As it stands, Medicaid funded mental health services will still be allowed to be provided in a school setting.

Arkansas Community Corrections
DBHS meet on a regular basis with Arkansas Community Corrections (ACC), the agency responsible for probation and parole, to ensure treatment is available for their clients. Much progress has been made in signing up individuals recently released from prison for private insurance through the Private Option. This has increased their access to needed behavioral health services.

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]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There 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:

BYLAWS OF THE
ARKANSAS BEHAVIORAL HEALTH PLANNING
AND ADVISORY COUNCIL

Article I
Name

The name of the organization is the "Arkansas Behavioral Health Planning and Advisory Council" (ABHPAC). Collectively, all persons who are appointed as members comprise the ABHPAC.

Definition: Throughout these Bylaws, the term, "Council" means a State Behavioral Health Planning Council. The "State Mental Health Planning Council" for Arkansas is named the "Arkansas Behavioral Health Planning and Advisory Council" to be known as the Behavioral Health PAC.

Article II
Duties

As mandated in Public Law 102-321, cited from Section 1914, "(a) ...the State involved will establish and maintain a State mental health planning council in accordance with the conditions described in this section. (b) ...the duties: (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans; (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State."

Article III
Responsibilities

The ABHPAC responsibilities to improve the service delivery in the public mental health and substance abuse systems have been identified as:

- To act on concerns that are paramount commonalities in each Region, as identified during a series of mental health forums that target consumers and families;
- To identify and assist in the design of pilot programs for specialized services, including prevention services, within their respective Region;

- To present position papers to the Division of Behavioral Health Services ("the Division") regarding recommendations for implementation of such specialized programs and/or services;
- To assist the Division to design a system of care to meet the needs of the consumers by matching resources and choices to maximize the consumers' health and quality of life;
- To build a more comprehensive and appropriate network for future needs;
- To plan and advise on policies, procedures, mandates, and regulations set forth by the Division and the Department of Human Services.
- To advocate for the provision of behavioral health services to persons of all ages with serious mental illness, substance abuse issues, and other needs, particularly as it relates to managed care and the imminent changes in national behavioral health systems;
- To network with local communities (i.e., municipal leagues, chambers of commerce, church groups, volunteer agencies, etc.) to help assure the accessibility of services for clients of the behavioral health system throughout the state; and
- To promote the use of appropriate evidence based programs and strategies in the behavioral health field.

Article IV
Membership and General Structure

Composition

As mandated in Public Law 102-321, cited from Section 1914 C Membership -- "(1) In General (2) The Council [will] be composed of residents of the State, including representatives of –

(A) The principal State agencies with respect to -- (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and (ii) the development of the plan submitted pursuant to the Title XIX of the Social Security Act [42 U.S.C.1396 et seq];
(B) Public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) Adults with serious mental illnesses who are receiving (or have received) behavioral health services; and
(D) The families of such adults or families of children with emotional disturbance."

As mandated by the same Public Law, "(a) the ratio of children in the deliberations of the Council; and (b) not less than fifty percent of the members of the Council shall be individuals who are not State employees and not providers of mental health services."

As suggested by block grant guidance (2011) the Behavioral Health PAC is expanding membership to include (a) clients of substance abuse services and their families (b) providers of substance abuse services.

New Membership

Nominations of prospective members shall be submitted by the Chair, who will ensure that the application is forwarded to the Director of the Division of Behavioral Health Services. The Director of the Division (or their designee) is responsible for authorizing appointments to the Council.

Active Membership

Active membership is defined by the guidelines for the Division Supported Conference Attendance, as follows: The member must have attended four meeting during a year not including the meeting held at the Annual Institute. Those four meetings can be all of or a combination of state and committee meetings.

Active participation is monitored by the signatures' on the ABHPAC sign-in sheets.

A member is considered inactive when one calendar year has passed without attendance as monitored by the sign-in sheets. Any member considered inactive on January 1st of each year will receive a letter notifying them of their change in status. An inactive member that doesn't respond to the change in status letter within 30 days will be considered resigned. Any member who has resigned may reapply by filling out a new application.

Resignation of Membership

A member may resign by sending a written notice to the Chair. The Chair will notify the Director of the Division. The current roster is available upon request.

Voting

During election of officers all members of the Behavioral Health PAC in active status will have equal voting power. Paper ballots will be used for the election of officers. Any officer running for reelection cannot be called upon to break a tie that pertains to their office. The election of officers will use a simple majority vote of individuals in the room to determine the results.

During general business of a regular state meeting vote all members of PAC in active status will have equal voting power. Current State Chair is only allowed a vote in the event of a tie. In the event that the Chair is not present Vice Chair acting as chair in that meeting is only allowed a vote in the event of a tie.

In the event that a member does not attend the meeting the member has forfeited that vote. **NOTE**: Exceptions to this rule will be allowed for Federally Mandated State Agency members (mental health, criminal justice, education, housing, vocational rehabilitation, social service, and Medicaid) who may send a proxy to represent their agency.

In the election of Chair, the current Vice Chair will assume Chair assume Chair duties and is not allowed to vote unless there is a tie.

Membership Meetings

The ABHPAC membership will meet a minimum of four times per year, or as needed, for purposes such as: member education, systems planning, development of policies and procedures, and other such purposes as benefit from the participation of the entire group. These meetings are open to the public. Two weeks' written notice will be sent from the Division to all Council members before such a meeting. The council meets as follows: January, May, and September every third Saturday; March, July, and November every third Thursday. There is also an annual council retreat held in August to coincide the Arkansas Behavioral Health Institute.

Article V
Election of Officers

Officers

Chair. A chair of the ABHPAC will be elected from among the current members in active status. Nominations may be offered from the floor or by petition, except that no person's name may appear on the ballot until that individual has accepted the nomination. Candidates shall have the opportunity to present statements to the membership, and an election shall be held with each member present casting one vote.

The term of the Chair will be two years, and two consecutive terms may be served. The election shall be held at the March meeting. The term shall begin July 1 of each odd-numbered year and end June 30 of each odd-numbered year.

Vice Chairs. Two Vice-Chairs of the ABHPAC will be elected during one voting session from among the current member's active status. A first Vice Chair will be designated as

decided by the highest number of votes. The second Vice Chair will be the runner up for Vice Chair. Nominations may be offered from the floor or by petition, except that no person's name may appear on the ballot until that individual has accepted the nomination. Candidates shall have the opportunity to present statements to the membership, and an election shall be held with each member present casting one vote.

The term of the Vice-Chairs will be two years, and two consecutive terms may be served. The election shall be held at the March meeting. The term shall begin July 1 of each odd-numbered year and end June 30 of each odd-numbered year.

The Vice-Chair will fulfill any duties of Chair as requested by the Chair or the Director of the Division.

Parliamentarian. The Parliamentarian of the ABHPAC will be elected from among the current member's active status. Nominations may be offered from the floor or by petition, except that no person's name may appear on the ballot until that individual has accepted the nomination. Candidates shall have the opportunity to present statements to the membership, and an election shall be held with each member present casting one vote.

The term of the Parliamentarian will be two years, and two consecutive terms may be served. The term shall begin July 1 of each odd-numbered year and end June 30 of each odd-numbered year.

The parliamentarian will advise the Chair and gives his/her opinion when asked or when he/she believes that the issue at hand is not in compliance with current Bylaws. The Parliamentarian only advises. The Chair maintains sole responsibility for ruling on a point of order or answering a parliamentary inquiry.

Article VII
Amendments to Bylaws

The Chair shall ensure that the Bylaws are reviewed yearly. The State Chair shall appoint an ad hoc committee to review the entire Bylaws and to recommend changes. The ad hoc committee shall prepare a description of changes being proposed, along with a list of all persons who participated in the review and revision. Amendments to these Bylaws must be proposed at a State meeting. This shall be mailed to all ABHPAC members, along with a notice of date, time, and place that the State Council will vote on the revisions. This notice shall be mailed no less than 30 days before the State meeting.

A two-thirds affirmative vote of the members present shall be necessary to approve the proposed changes to the existing bylaws. The revised Bylaws shall be immediately forwarded to the Director of the Division, within 30 days for final approval. **NOTE**: Exceptions to this rule will be allowed for Federally Mandated State Agency members (mental health, criminal justice, education, housing, vocational rehabilitation, social service, substance abuse, and Medicaid) who may send a proxy to represent their agency.

Article VII
Committees

The Council shall have the power to abolish or create committees by a two-thirds vote of members present. Persons who are not members of the Council may serve on committees.

The Block Grant Committee is a standing committee.

The Executive Committee is made up of the current officers and the Current Past Chair. As Ex-Officio. This committee meets as needed or requested by the Director of the Division. The Executive Committee will decide the Behavioral Health PAC Member of the Year and make any emergency decisions needed

Article VIII
Removal

Elected officers at the State or Region level and members of the Council can be recommended for removal by a two-thirds vote of members in active status and present in the room and the approval of the Director. **NOTE**: Exceptions to this rule will be allowed for Federally Mandated State Agency members (mental health, criminal justice, education, housing, vocational rehabilitation, social service, substance abuse, and Medicaid) who may send a proxy to represent their agency.

Article IX
Parliamentary Authority

In all procedural matters not governed by these Bylaws, the ABHPAC shall be bound by the provisions of *Robert's Rules of Order* [*tenth edition*].

Article X

Adoption and Review of Bylaws

The Arkansas Behavioral Health Planning Advisory Council Governing Bylaws were presented and adopted this 15th day of February, 2012.

Section 11.01

APPROVED:
This 15th day of February, 2012.

APPROVED:
This 15th day of February, 2012.

State Chair, Arkansas Behavioral Health Planning Advisory Council

Director of the Division of Behavioral Health Services

Recommendations:

- That in FY16, DBHS pull the $213,633 (5% set aside for FEP) and develop 2 pilot sires (one urban and one rural). During the pilot, with DBHS technical assistance develop policies and procedures, action steps, developing and reporting on measurable outcomes and referral criterion:
    - ABHPAC was surprised and disappointed that DBHS staff didn't confer with ABHPAC before making a decision.
    - Ensure appropriate multi-disciplinary teams (consider using existing wraparound/SOC teams)
    - Training and mandated use of fidelity scales for evidence based practice delivery be written into contracts
    - 5 Centers have no EBP in their continuum of services. They are Area #1 CCS ($13,395.00), Area #2 CAI ($16,081.00), Area #5 DCA ($8,461.00), Area #11 SoARHC ($9,532) and Area #13 SwACMH ($9,826.00). It seems that these Centers with no EBP (even at less than fidelity) will have a hard time delivering services under RAISE or NAVIGATE model descriptions.
    - What is the plan on finding these young people after the first episode of psychosis?
    - It is the planning councils understanding that the DBHS has written the FEP into the CMHC's contract and that they are developing a plan on implementing the FSP. ABHPAC would like to see these plans from the Centers.
    - And last, GAIN and NAMI were given a piece of the 5% set aside. GAIN doesn't service individuals under the age of 21 and they have criterion that limits who can actually use their services – a first break isn't going to qualify to receive services at GAIN – what will their funds ($3,902.00) be used for? NAMI-Arkansas doesn't provide services, what will they use their funds ($4,846.00) for?
- That similar data to the SPQM data that is collected from CMHC's be collected from the Private RSPMI providers.
- Page 2 of the Special Services document states that the EBP's reported have defined practice guidelines and "in an ideal situation there is an independent assessment". ABHPAC recommends that the ideal situation be found, that fidelity scales are used by DBHS staff to assure fidelity.

- Transformation based, consumer led/driven services need to be funded and develop, possibly in pilot sites, to show effectiveness and develop baseline data, then moved statewide. We are talking about services delivered by individuals who get it, believe in it and are trained with fidelity.
- That person first language is used in our block grants. (Children identified as SED not SED children; or Individuals identified as SMI not SMI adults)
- Huge lack of services for those individuals under the age of 21 who are identified as intellectual disability and mentally ill and who are still not on the waiver list. Many of these children/youth are not allowed back in school and a significant number of the caregivers have not filled out the waiver packet and those young people are not yet on the waiting list. These children/youth are not getting the services that they need to reach their full potential, schools are to educate our children not be responsible for the services that aren't provided by DDS for this population. The parents/caregivers only option many times is HDC placement – which in the opinion of the members of the block grant committee flies directly in the face of Olmstead.
- Substance Abuse prevention funds should be used in more efficient ways to decrease risk factors, increase protective factors and address trauma issues at the community level.
- High risk youth and our frequent flyers need: programs that help families and communities to increase protective factors; decrease risk factors; and focus on specific trauma issues – where they live, - what they're exposed to and what community issues are present.
- Certain populations have ongoing evolving needs that must be addressed:
    - Military families (particularly the reserve and guard)
    - Youth with just substance abuse issues
    - Individuals with trauma histories
    - Focus of community approaches and highlight community strengths to increase success.
- No attention being paid to developing adult peer specialist as a part of our workforce. Suggest an 'environmental scan' to survey providers on their attitudes about putting peers to work in the mental health field.

- The treatment plans (for adults and children/youth) should include non-diagnostic treatment goals that help support an individual's recovery journey. The members of the committee felt that more diversity was needed in treatment plan goals; if an individual is to truly move into and/or beyond recovery then the system must treat the whole person; addressing mental illness symptoms, mental health conditions, substance abuse needs, physical health needs, trauma experience and the development of social capital by truly integrating the individual into the community.
- Field training for RSPMI service providers on ways to improve valuing the service recipient (and in the case of children & youth their families), developing a process for individuals accessing services to drive those services, cultural competent recovery principles, person centered planning and hearing the voice of the service recipient.
- DBHS needs to do strategic planning. It appears that the pattern is going from crisis to crisis without any long range planning.

Questions:

- The number of individuals identified as indigent in December 2013, which now have either Private Option coverage or have been deemed 'medical necessity' and have been shifted to traditional Medicaid?
- Special Service report (page 6) states that 9,509 children identified as SED receive school-based mental health services at the school. How many of those children getting those services are also receiving family therapy?
- Looking for and didn't find information about trauma informed care, complex-trauma or those individuals that mimic refractory issues? Research shows that individuals with numerous trauma experiences are misdiagnosed with mental illness when it is actually trauma and not a refractory issue. Experiences of ABHPAC members is that trauma issues are not adequately address across the state. One member of the block grant committee has specific issues with the training currently being implemented across the state.
- Table # 10: shows 399 children/youth receiving substance abuse treatment from CMHC's. Were these SAT services? Or was the SA block grant funds used to reimburse for services?

- Table # 4: WACGC had a 275% increase in the number of clients receiving integrated treatment for co-occurring disorders (160/600). Any information captured for this huge increase?
- Services delivered in a manner that focuses on recovery from mental illnesses, mental health conditions and/or substance abuse services are basically non-existing. They should include person-centered planning, increased safe and affordable housing, mainstream employment opportunities, higher educational opportunities and social/natural supports in the community of their choice. In addition, include non-traditional services/supports that are driven by the person's self-determined goals.
- Are the substance abuse providers being trained in trauma informed care?
- CMHC's served 20,686 children are all those children deemed SED?
- The population served by the private RSPMI providers should be included in the MHSIP data collection process.
- Recovery Coach training that the BRSS TACS funded training individuals on care coordination for adults. How many of those individuals trained are we using in the system?
- How does a professional work with an individual whose life goals don't match treatment plan goals?
-

Concerns:

- Arkansas' mental health system, is a system driven by funding, not by needs, not by planning and additionally the EBP's that CMHC's report on for the Special Services Program Report have not been assessed by a fidelity scale to determine if actually an practice.
- SPQM data that is collected is not outcomes data. Page #3 of the Service Process Quality Management (SPQM) states that this data includes client level demographic, diagnostic, outcome and service data. The DBHS should change this part of the report to accurately reflect what is captured.
- Special Service report (page 6) states that 9,509 children identified as SED receive school-based mental health services at the school. Of those, 2,608 of those children receive special education services through the school. That's 27% of that population also receiving special education support – ABHPAC is interested in focusing in on this

population. The remaining 6901 children identified as SED are they doing well with grades, etc. with this service and truly don't need special education supports?

- Data (SPQM) reports that 13,622 guardians/caregivers signed their child's POC (treatment plan), but 20,686 children and youth were served by CMHC's. So, 7064 children and youths POC weren't signed, but services were provided without parent consent and/or involvement in developing the plan of care for their child. Unappropriated and possibly illegal!
- A very small number of individuals who benefit from EBP (DBHS doesn't access the fidelity of any EBP): What can DBHS do to increase the number of individuals receiving EBP's, while assuring fidelity?
    - 307/47,922 adults receive ACT services - .6%
    - 53/47,922 adults receive Supported Employment - .1%
    - 930/47,922 adults receiving Supported Housing – 1.9%
    - 78/47,922 adults receiving Family Psycho-education - .16%
    - 1748/47,922 adults receive Co-occurring treatment (MI/SA) – 3.6%
    - 1849/47,922 adults receive Illness Self-management – 3.8%
    - 680/47,922 adults receive Medication Management – 1.4%
    - 339/20,686 children/youth (in state custody) received TFC – 1.6%
- Table #10 and page 6 of the Special Services Report (SPQM) that of the 20,686 children identified as SED, of those 9,509 Children received school-based services (46% of population served). 843 children/youth involved in juvenile justice (4%), 674 had FINS filed (3.2%) and 720 had DYS involvement (3.4%). Also reported was that 1,905 children/youth were in some type of out of home placement (9.2%). 7064 caregivers didn't sign the treatment plan for their children (34%)
- Single Point of Entry Screenings:
    - SoARHC (El Dorado) 563 screenings for those under the age of 18 in 2014 versus 24 in 2013? (4.3% increase). Seems to be a huge jump in the number of children/youth receiving a SPOE. Was a reason given?
- 9,509 children/youth received school-based services. How many of those children received family therapy service in 2014. Of those 9,509, how many had a signed treatment plan?

- Table #9: when looking across the three fields how many children appear in more than one column? Or is there no duplication across fields – which would mean that 2,237 children receiving services from the CMHC's were touched by the court systems.
- The FY16 & FY17 application states that SAMHSA expects the block grant dollars to support reduction in disparities related to access, service use and outcomes associated with those individuals that have limited English proficiency. It appears to the members of the block grant committee that this issue is not being addressed. There is also a concern by the committee that those individuals who are illiterate or functionally illiterate are experiencing disparities in access for this population also. This is a cultural competency issue not addressed in the block grant.
- 25% of Arkansans have a disability or impairment. This is a huge segment of our population, with much diversity of level of functioning and economic stability and access for many is a major issue.
- 52% of those individuals (listed in bullet above) identified as having a disability are dual-eligible, meaning they have both Medicaid and Medicare coverage. These individuals with dual-eligible status account for 39% of Medicaid billing. Does Medicare not reimburse for mental health services?
- Where and when will Arkansas begin to deal with Olmstead mandates?
-

Strengths, Weaknesses, Opportunities, Threats

2015 ABHPAC SWOT

Strengths:

- AMHPAC members 'lived experience' tells the story of their recovery journey.
- Representatives from both SA and MH service silos presently part of ABHPAC membership
- Peers (individuals accessing services) are more excepted in the SA services system than in mental health
- Beginning structure in place for a U-21 system of care
- To date, DBHS has strived to partner with ABHPAC and listens to our voice
- NAMI warm line in place
- Some Consumer Councils are doing 'stop smoking' curriculums. (2 votes)
- 2 Recovery Coaches working
- CIT training will be held in Central Arkansas by the end of September (2 votes)
- Consumer Councils at each CMHC. (3 votes)
- PERC has received training in Trauma Informed Care
- DRA is in the process of doing a survey for Consumer Councils at CMHC's to see what is happening, what they need, what they want etc.

Weaknesses:

- Lack of awareness across the state of the Affordable Care Act (Arkansas Private Option)
- Providers unwillingness to embrace transformation
- Providers/professionals try to present themselves as the experts and discount 'lived experience' as valuable
- ABHPAC membership influx, not a lot of people doing the work.
- DHS/DBHS has a lack of insight on how to undertake transformation of the behavioral health system
- Substance abuse providers aren't active on planning council
- A lack of providers that accept Medicaid, even fewer mental health providers take Medicare; uneven distribution of providers, lack of transportation leads to many access issues. (3 votes)
- Cultural Competence should extent to those with lived experience. Those individuals many times have a unique culture resulting from their lived experience
- A lack of structure of an adult system of care, no recovery services in place (1 vote)

- Implementing 'true parity' for behavioral health services compared with physical health services across the state
- Integration of community support and follow up support from hospitals back to community (2 votes)
- Concern about DBHS organizational culture or readiness to lead a transformation in Behavioral Health (1 vote)
- A lack of behavioral health services at the criminal justice facilities in Arkansas for adults and children/youth (3 votes)
- A lack of access to trauma informed services (1 vote)
- Individuals identified as dually-diagnosed (MI/ID) not yet on the waiver have no services (except those provided at school) – if they are still in school. Included in this are those individuals with extreme physical disabilities. (1 vote)

Opportunities:

- Self-determination is not an option to those receiving services
- ABHPAC representative on the Medicaid Advisory Committee
- SAMHSA/CMS building support for transformation into other initiatives.
- ABHPAC can contact other organizations for new members
- Seek out opportunities to fund peer specialist training and utilize the Recovery Coaches already trained. (4 votes)
- Consumer Councils at each CMHC (2 votes)
- Behavioral health issues (and funding) 'going on' in other agencies; it's not coordinated and there is a lack of collaboration – DBHS staff are not at these meetings. (1 vote)
- A lack of communication among DHS divisions on those individuals that are receiving services who cut across the varies divisions. (1 vote)
- True co-occurring services (SA/MH) services are not happening
- It seems Division of Medical Services moving forward with plans for a Medicaid managed Care Carve out without the other division have input; and without the various stakeholders (consumers, families and providers) having any input to process. (4 votes)
- No self-determination choices offered to those receiving treatment. (6 votes)
- Parity Legislation could be a window of opportunity for input.
- Bringing peers into the behavioral health workforce would enhance the quality of services available and improve outcomes. (peers, family support and youth support included)
- Behavioral Health prevention in primary care – with dollars for healthy supports
- Reimbursement of non-traditional services/supports across the systems

- Medicaid services: at the National level work is being done to use Medicaid to pay for non-medical model services
- Managed care carve-out
- To find funding and build structure for alternative choices (non-traditional services) offered at all levels.

Threats:

- Providers/professionals that are arrogant and paternalistic
- Private option sunsets December 2016
- Those individuals with lived experiences that have developed empowered voices are many times seen as a threat by the professionals
- Not enough discussions about values and belief concepts about recovery, behavioral health transformation and prevention
- Collaboration threatens the power of people who are in positions of power
- Planning for managed care implementation without stakeholder involvement. (6 votes)

Top Votes

- Planning for managed care implementation without stakeholder involvement. (6 votes). It seems Division of Medical Services moving forward with plans for a Medicaid managed Care Carve out without the other division have input; and without the various stakeholders (consumers, families and providers) having any input to process. (4 votes)
- No self-determination choices offered to those receiving treatment. (6 votes)
- Seek out opportunities to fund peer specialist training and utilize the Recovery Coaches already trained. (4 votes)

2015 ABHPAC Strategic Plan

Problem/Need	Action Step	Responsible Person	Completion Date	Outcome/Product	Comments
#1. Lack of ABHPAC involvement in planning, decision making, implementation & outcomes of managed care in Arkansas.	1a. Write letter to Dr. Green explaining what ABHPAC is, explaining that we would like to be involved in the process, asking for his guidance on how to proceed with getting involved.	Executive Committee, Angie Lassiter, chair, Linda Northern	No later than August 14th, 2015	We hope that Dr. Green is receptive and allows us to move forward, possibly even forwarding the letter or communicating our agenda to DMS and DHS.	
	1b. Develop a document with major talking points in implementing managed care in Arkansas.	Division individuals responsible for work in BH transformatio n and health homes (Joyce S. & Linda N).	By Sept. 1st emailed to group; presented to entire council on Sept. 19th.	Approval of the presented fact sheet by council at the meeting.	Will use PASSR data, CMS language, and transformati on documents to build the document. To make sure issues will be covered- supported employment svcs, etc.
	1c. Choose a diverse sub-	Entire Council-	Sept. 19th ABHPAC	We will have a diverse and state	

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	committee that consists of family members, consumers, older adults, dually-diagnosed (developmental disabilities & mental illness), co-occurring (SA/MI) to ensure team can identify talking points	subcommittee chosen on a volunteer basis	Meeting	represented sub-committee chosen.	
#2. Self Determination (SD) choices are not always offered to those receiving Behavioral Health Services.	2a. To provide information, including an explanation of assumptions and principals about self-determination (SD) in Behavioral Health agencies.	ABHPAC	July 1, 2017	Self-determination language will be provided in block grant contracts	
	2b. By making a recommendation to DBHS Director about inserting SD Language into Block Grant Funded contracts	Chair will meet with DBHS director	8/15	Approval and support for SD language recommendation	
	2c. SD Language will be drafted by ABHPAC Sub-	ABHPAC sub-committee	Volunteers for sub-committee	1. Sub-committee will complete task by March	Additional assistance can be found

	committee		selected Sept. 19, 2015 (next State meeting) and committee work done Jan 16, 2016 (state meeting date)	17, 2016 (state meeting) 2. Language sent to DBHS to follow procurement process	at: • TA Center • NAMI Star Center
	2d. Increasing SD awareness among youth, consumers and families			Fact Sheet explaining 'return on investment' for this recovery-based service.	
	2e. By ABHPAC incorporating SD language in its mission, vision and values statements.	ABHPAC	May 2016		*These task are to be in concert with overall action step.
	2f. By disseminating educational material on Facebook and other social media. Flyers and other one pagers to Consumer Councils	Executive Committee	After May 16, 2016	Individuals will learn SD language and become knowledgeable about rights	Also send information to NAMI, CASSP, PERC and Youth MOVE
	2g. Inquire into whether SD	Angie	July 1, 2017	SD language inserted into Bill of	

2015 ABHPAC Strategic Plan

	language can be included in agencies Bill of Rights?			Rights	
#3. Lack of funding for Peer Specialist Training	3a. Select ABHPAC members to create sub-committee. Members will include consumers, professionals, stakeholders, ABHPAC members	Eddie, Georgia	August/Sept 2015	Peer Specialist Funding Search Committee	
	3b. Create/develop data collection form (use form that was developed for the tour of 3 state programs) • Plug in information from the 3 state visits to form with additional data • Request copy of TTI proposal that wasn't funded	Committee members	October 2015	Develop tool/form to gather data and make sure are areas are covered. Fact Sheet explaining 'return on investment' for this recovery-based service.	

	• VA documents/ outcomes of their peer specialist • Info on youth peer specialist curriculum; benefits and cost, include return on investment information .				
	3c. create a report of all findings including but not limited to benefits of peer specialists, return on investment, curriculums, certification	Committee will vote on individual to take over this task	January 2016	Final Report	
	3d. Report is given to the ABHPAC leadership (Executive Committee)	ABHPAC review and vote on document	January 2016 state meeting will be on agenda for state vote	Approval and one step closer to having peer specialist (both youth and adults) in	

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	• After full committee approval forward to Director of DBHS • Post report on social media sites and hard copies sent to Consumer Councils.			AR being trained and hired	
#4. Under-utilized the previously trained Recovery Coaches providing services in the Behavioral Health System	4a. Select ABHPAC members to create sub-committee: members include consumers, professionals and other stakeholders	Eddie and Georgia	August/Sept 2015		
	4b. Committee will come together and create document with needs identified for these services	Committee members	October 2015	Fact Sheet explaining 'return on investment' for this recovery-based service.	
	4c. Compose a 'proposed' budget	Committee members	October 2015		
	4d. Report/Budget presented to ABHPAC Executive	Executive Team	On January 2016 agenda for state		

2015 ABHPAC Strategic Plan

	4e. Committee for changes and approval • After ABHPAC state body approval send to DBHS director. • Post report on social media sites and hard copies sent to Consumer Councils.		meeting		

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

The Arkansas Alcohol and Drug Abuse Coordinating Council (AADACC) has the legislative mandated responsibility of "overseeing all planning, budgeting, and implementation of expenditures of state and federal funds allocated for alcohol and drug education, prevention, treatment, and law enforcement."

The Coordinating Council has the following functions, powers, and duties:

(a) All federal money received by the State of Arkansas for drug law enforcement, treatment, education, or prevention shall be reviewed by the Coordinating Council for disbursement, accountability and evaluation;

(b) The Coordinating Council reviews and coordinates all school based drug education, prevention, and awareness programs and efforts funded by the State.

The Coordinating Council has the authority to develop its rules of procedure to include the establishment of a committee structure for the approval of funding and other purposes. Committees include, but are not limited to:

(a) prevention, education and treatment committee

(b) a law enforcement committee.

The members of the AADACC are appointed by the Governor. The Arkansas Drug Director serves as the chairperson of the Coordinating Council. The position of the Arkansas Drug Director is placed within the Department of Human Services (DHS) Division of Behavioral Health Services (DBHS) and serves at the pleasure of the Governor. A representative from the DBHS is a member of AADACC and attends a quarterly meeting. Additionally, the Coordinating Council has a Treatment and Prevention Subcommittee that makes recommendations to the full council regarding substance abuse treatment and prevention. A representative from DBHS chairs the Treatment and Prevention Subcommittee.

While the Arkansas Behavioral Health Planning and Advisory Council (ABHPAC) were not directly involved in the development of the block grant, the ABHPAC Block Grant committee (made up of 9 ABHPAC members) went through a lengthy analysis and review of the combined block grant application, existing block grants, and data that is included in developing the block grant. From there, the block grant committee developed a document with recommendations and questions to DBHS, which was referenced and utilized by DBHS staff in the development of the block grant. ABHPAC also participated in a SWOT exercise at one of our state meetings, which provided guidance and content for the Planning Steps of the application. From that SWOT ABHPAC then developed ABHPAC's strategic plan.

The integration of substance abuse prevention and treatment of ABHPAC is ongoing. In 2014 and 2015 ABHPAC was successful in recruiting six individuals who identify as substance abuse treatment providers, advocators, or persons in recovery for the Council. ABHPAC currently has one consumer/family representative from the Arkansas Alcohol and Drug Abuse Coordinating Council and presently serves as 1st Vice-Chair of ABHPAC. ABHPAC and DBHS recognize that the Planning Council in order to continually be a successful, effective, integrated Council, recruitment efforts with Substance Abuse stakeholders is ongoing but are encouraged by the strides the Planning Council has made. Important to note, the newly elected ABHPAC Chair,

Angie Lassiter identifies as a person in recovery, a parent of SED and an advocator for Substance Abuse services.

The ABHPAC Bylaws and the AADACC Rules of Procedure are included in this application to better illustrate the roles and responsibilities of both councils.

Arkansas Alcohol and Drug Abuse Coordinating Council
Rules of Procedure

ARTICLE 1. MISSION STATEMENT

The Arkansas Alcohol and Drug Abuse Coordinating Council oversees the planning and budgeting of education, prevention, treatment and law enforcement services and programs to efficiently and effectively combat the abuse of alcohol and drugs in the state of Arkansas.

ARTICLE 2. BACKGROUND

In 1989, the Arkansas Legislature created the position of Arkansas Drug Director ("the Drug Director") within the Office of the Governor. In addition, the legislature created the Council, specifying that the Drug Director shall serve as the chairman of the Council. In 1995, the legislature reconstituted the Council and transferred both the Highway Safety Program Advisory Council (created by Ark. Code Ann. § 12-6-101) to the Arkansas Alcohol and Drug Abuse Authority (created by Ark. Code Ann. § 20-64-604) to the Council pursuant to a type 3 Transfer as defined in Ark. Code Ann. § 25-2-106. As a result of these transfers, the Council possesses all of the powers and duties of these entities as set forth in these rules. In 2005, the legislature reorganized the Council according to Act 1453.

ARTICLE 3. RESPONSIBILITIES

The Council oversees the spending of state and federal funds on alcohol and drug education, prevention, treatment, and law enforcement. Striving to effectively combat the dangers associated with alcohol and drug abuse, the Council provides the framework for ensuring that federal and state funds are expended in a manner that meets the needs of the local community while consistent with efforts conducted state-wide. The Council awards funding each year to local schools, police departments, treatment and prevention centers, and drug task forces, as well as other entities, in an effort to confront the problem of drug and alcohol abuse from every angle; through programs designed to prevent the spread of substance abuse and educate children about the dangers of substance abuse; through programs aimed at treating those with substance abuse problems; and through funds spent to eradicate controlled substances through the work of law enforcement agencies.

ARTICLE 4. MEMBERSHIP

The Council is composed of twenty-seven members, thirteen (13) of whom are administrative officers or their designees, including the Drug Director, the Director of the Office of Alcohol and Drug Abuse Prevention (OADAP) of the Department of Human Services, the Director of the Arkansas State Police, the Director of the Department of Education, the Director of the Arkansas State Highway and Transportation Department, the Director of the Department of Correction, the Director of the Department of Finance and Administration, the Adjutant General of the Arkansas National Guard, the Attorney General for the State of Arkansas, the Director of the State Crime Laboratory, the Director of the Administrative Office of the Courts, the Director of the Department of Community Correction, and the chief administrative officer of the Office of Alcohol Testing of the Department of Health. Other members include one police chief, one county sheriff, one drug court judge, one prosecuting attorney, a private citizen not employed by the state or federal government, a director of a publicly funded alcohol and drug abuse treatment program, a school drug counselor, a director of a drug abuse prevention program, a director of a driving while intoxicated program, a health professional, and four members from the state at large who have demonstrated knowledge of or an interest in alcohol and drug abuse prevention, at least two of whom shall be recovering persons. Ref: Ark. Code Ann. § 20-64-1002.

ARTICLE 5. STRUCTURE

Four standing committees have been established to assist in carrying out the responsibilities of the Council as prescribed by law and any other matters referred to them by the Council. They are a Prevention, Education, and Treatment Committee, chaired by the Director of the Office of Alcohol and Drug Abuse Prevention, a Law Enforcement Committee, a Joint Action Committee, and a Policies and Procedures Committee. Other committees may be established by the Drug Director as needed. Each committee is comprised of Council members assigned to the committee by the Drug Director, who may, at her or his discretion, restructure the membership of each committee on an annual basis. The Drug Director serves on each committee as a non-voting member. In addition, the chairperson of each committee may not vote on a matter before the committee except in cases of a tie, in which case the chairperson shall cast the deciding vote. A simple majority of committee members constitutes a quorum. When a vote is taken, a simple majority of the members present is sufficient for the committee to act on the matter before it. Recommendations by the respective committees will be forwarded to the Council for action consistent with these rules.

A. Prevention, Education, and Treatment Committee

(1) **Responsibilities.** The Prevention, Education, and Treatment Committee is responsible for recommending awards of state and federal funding to state and local agencies, schools, and private non-profit groups in the areas of prevention, education, and treatment of alcohol and drug abuse.

(2) **Procedures.** All applications considered for funding by the Prevention, Education, and Treatment Committee are available through OADAP and are to be submitted in accordance with OADAP's rules and regulations, while funding consideration of competitive contract proposals must abide by state procurement procedures. OADAP shall not forward a competitive grant/contract and/or continuation request to the Committee unless it has met (1) technical review to assure compliance with grant/contract requirements and (2) program review to assure the proposed project is sound and appropriate to the OADAP strategic plan. Upon receipt of the forwarded applications, the Prevention, Education, and Treatment Committee will review the applications and interview all applicants to determine which applications will be recommended for further funding consideration by the Council. Upon receipt of the committee's recommendation, the Council may take any action it deems necessary with respect to the recommendation, including, but not limited to, voting to accept all of the committee's recommendations, requesting additional information, or delaying a decision until such time as the Council determines to be appropriate.

(3) **Unused or returned funds.** All funds awarded but not used by a grantee/contractor returned to OADAP shall be available for redistribution in accordance with the Procedures stated in A. (2) above, providing that such reissue fits within the time limitation of the original funding source.

B. Law Enforcement Committee

(1) **Responsibilities.** The primary responsibilities of the Law Enforcement Committee are developing funding strategies and overseeing awards of the Edward J. Byrne Memorial Justice Assistance Grant (JAG) Program from the U.S. Department of Justice. In addition, the committee reviews requests from units of state and local government including cities, counties, state, agencies, prosecuting attorneys, circuit judges, and various law enforcement agencies, municipalities, and drug task forces for funding from recovered grant funds administered by the Council. The Law Enforcement Committee is also responsible for providing recommendations to the Council for the awarding of state and federal funds for drug interdiction, eradication, education, rehabilitation, and drug courts.

(2) **Procedures.** Edward J. Byrne Memorial Justice Assistance Grant (JAG) Program. In each state, the Governor or other Chief Executive Officer designates a state agency (State Administering Agency, or SAA) to apply for and administer these funds. The SAA for Arkansas is the Department of Finance and Administration Office of Intergovernmental Services (IGS). As the SAA for Arkansas, IGS is responsible for:

- Coordination of JAG funds among state and local justice initiatives.
- Preparation and submission of the state JAG application.
- Administration of JAG funds including establishing funding priorities; distributing funds, monitoring subrecipients' compliance with all JAG special conditions and provisions; and providing ongoing assistance to subrecipients.
- Submission of financial reports, programmatic reports, performance measures, and subgrant information.

After receipt of award from the U.S. Department of Justice that the state is eligible to apply for funding under the Edward J. Byrne (JAG) Grant Program, a Notice of Funds Available will be sent by the Office of Intergovernmental Services, Department of Finance and Administration to the Drug Director, all mayors, chiefs of police, county judges, sheriffs, circuit, district, and municipal judges, prosecutors, and all state agencies that have a law enforcement function. The Notice will contain a due date for submission of applications. If the due date falls on a weekend, the due date will be the Friday before the due date, unless that Friday is a State or Federal holiday, in which case the due date will be the Thursday before the original due date. All applications must be received by the close of business, 4:30 PM, on the due date in order to be considered for funding. In the event of extraordinary circumstances, a late filing may be accepted by approval of the Administrator of IGS upon showing by the applicant that unexpected circumstances beyond the control of the applicant agency prevent a timely filing.

Upon receipt, IGS will review all applications and make recommendations based on funding priorities, availability of funds, grant program restrictions, and federal grant management regulations. The individual project descriptions, budgets, budget narratives, the IGS funding recommendations, and overall grant program budget will be sent by IGS to the Law Enforcement Committee for review by each of the committee members and then by the committee as a whole. The applying law enforcement agency, upon request by the Law Enforcement Committee or the Council, may be required to appear before the Law Enforcement Committee or the Council to support its application. Federal grant management issues of supplanting, unallowable costs to federal funding, unavailability of federal funding or impermissible federal program uses are to be determined by the State Administering Agency, IGS. The committee will forward its recommendations for funding to the Council. Upon receipt of the

committee's recommendations, the Council may take any action it deems appropriate with respect to the recommendations, including, but not limited to, voting to accept the committee's recommendations, requesting additional information, or delaying a decision until such time as the Council determines to be appropriate. IGS will notify applicants of the Council's decision, as well as any right to seek reconsideration. Any applicant who has been denied funding by the Council must notify the Drug Director and the Office of Intergovernmental Services, Arkansas Department of Finance and Administration, in writing of the intent to seek reconsideration no later than ten (10) business days of receiving notification. The party requesting reconsideration will submit written materials supporting the request. Parties desiring reconsideration may request the opportunity to present oral arguments before the Council. After the request for reconsideration has been presented, the Council may either refer the request back to the committee for reconsideration or take any other action it deems necessary, including not to reconsider the request for funding. Should the applicant be referred back to committee, the request for reconsideration will be reviewed and resubmitted to the Council for final decision.

(3) Unused or Recovered Funds. When the Office of Intergovernmental Services, Department of Finance and Administration, determines that unused or recovered funds are available, they shall notify the Council of the availability of such funds, the approximate amount available, and the deadline for applying for such funds. All grant funds which are not used by the grantees or which are returned by the grantees shall be awarded in accordance with the Procedures state in B. (2) above.

C. Joint Committee Action.

The Prevention, Education, and Treatment Committee and the Law Enforcement Committee shall meet jointly on matters including, but not limited to, the Residential Substance Abuse Treatment for State Prisoners Program, and shall make recommendations for funding to the Council which shall make the final funding decision.

D. Policies and Procedures Committee.

The Policies and Procedures Committee reviews and recommends, as needed, revisions to the rules of procedure that govern the operations of the Council. Any recommendations by the committee will be forwarded to the Council, and any action taken by the Council will be consistent with the provisions of the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201, et seq.

ARTICLE 6. MEETINGS

A. Schedule**.** The Council meets monthly or at such time(s) as the Drug Director deems necessary. An agenda including the location of the meeting will be provided to each member of the Council prior to the meeting. Dates, times, and locations of all meetings will be posted on www.arkansas.gov in accordance with Act 1302 of 2009.

B. Attendance. The Council will adhere to Ark. Code Ann. § 25-16-804 regarding member absences.

C. Agenda**.** The Drug Director or her/his designee presides over each meeting and determines the business to be conducted at the meeting, including any reports or recommendations from the respective committees, appeals, and any other business pertinent to the Council.

D. Quorum and Voting. A simple majority of Council members constitutes a quorum. When a vote is taken, a simple majority of the members present is sufficient for the Council to act on the matter before it. The Drug Director shall not vote except in cases of a tie, in which case the Drug Director shall cast the deciding vote. The thirteen state administrative officers of the Council may designate one voting designee. Should they choose to exercise this option, written notification will be sent to the Drug Director.

E. Conflicts of Interest. No member may cast a vote, either in committee or in a meeting of the Council or both, with respect to any item of business in which the member has a conflict of interest. A conflict of interest includes, but is not limited to, situations in which a member has either a financial interest in or holds any position of control of any organization, public or private, that is seeking funding from the Council. In the event a conflict of interest exists, the member with the conflict must abstain from discussion and voting on the matter involving the conflict, but the member may respond to any factual question posed by another member of the Council.

F. Appeals from OADAP action.

In addition to its other business, the Council shall also serve as a board of review for action taken by OADAP with respect to matters including, but not limited to, the licensing of alcohol and/or drug abuse treatment programs. Appeals taken from adverse action by OADAP must comply with the policies and procedures of OADAP. Once such an action by OADAP is appealed to the Council, the Council may act on the matter, or it may refer the matter to the Prevention, Education, and Treatment Committee for its recommendation. The director of OADAP shall abstain from

discussion and voting, either in committee or in a meeting of the Council or both, with respect to any such action, but the director may respond to any factual questions posed by another member of the Council. If the matter is referred to the Prevention, Education, and Treatment Committee, the committee shall consider the matter and shall forward its recommendation to the Council. Upon receipt of the recommendation, the Council shall act on the recommendation in accordance with the provisions of this Article.

ARTICLE 7. APPEALS FROM ACTION BY THE COUNCIL

Decisions by the Council are final. Federal grant management issues of supplanting, unallowable costs to federal funding, unavailability of federal funding or impermissible federal program uses are to be determined by the State Administering Agency. These determinations shall be reported to the Council. Those decisions that meet the definition of "adjudication" under the Arkansas Administrative Procedure Act, Ark. Code Ann. § 25-15-201, et seq., may be appealed in accordance with the Arkansas Administrative Procedure Act.

ARTICLE 8. GENERAL INFORMATION

Any questions concerning the Council should be directed to the attention of the Office of the Drug Director in care of the Governor's Office. Petitions for declaratory orders as to the applicability of any rule, statute, or order enforced by the Council shall be directed to the Office of the Drug Director and shall be considered at the next meeting of the Council following receipt of such petition. All funds awarded by the Council are subject to evaluation and review by the Council within its discretion to ensure that all funds awarded are spent in a manner consistent with the mission of the Council as set forth herein.

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*** received from the Arkansas Code Revision Commission through ***
*** August 1, 2012. ***

Title 20 Public Health And Welfare
Subtitle 4. Food, Drugs, And Cosmetics
Chapter 64 **Alcohol** And Drug Abuse
Subchapter 10 -- **Alcohol** and Drug Abuse Coordinating Council

A.C.A. § 20-64-1002 (2012)

20-64-1002. Arkansas Alcohol and Drug Abuse Coordinating Council -- Creation.

(a) There is hereby established the Arkansas **Alcohol** and Drug Abuse Coordinating Council, hereafter referred to in this subchapter as the coordinating council.

(b) The coordinating council shall be composed of twenty-seven (27) members as follows:

(1) Thirteen (13) members of the coordinating council shall be administrative officers of the following agencies, or their appropriate designees, confirmed by gubernatorial appointment:

(A) The Arkansas Drug Director, who shall serve as chair of the coordinating council;

(B) The Director of the Office of **Alcohol** and Drug Abuse Prevention;

(C) The Director of the Department of Arkansas State Police;

(D) The Commissioner of Education;

(E) The Director of the Arkansas State Highway and Transportation Department;

(F) The Director of the Department of Correction;

(G) The Director of the Department of Finance and Administration;

(H) The Adjutant General of the Arkansas National Guard;

(I) The Attorney General of Arkansas;

(J) The Director of the State Crime Laboratory;

(K) The Director of the Office of **Alcohol** Testing of the Department of Health;

(L) The Director of the Administrative Office of the Courts; and

(M) The Director of the Department of Community Correction.

(2) The following persons shall be appointed by the Governor for three-year terms and will not serve more than two (2) consecutive terms:

(A) One (1) police chief, one (1) county sheriff, and one (1) drug court judge;

(B) A prosecuting attorney;

(C) A private citizen not employed by the state or federal government;

(D) A director of a publicly funded **alcohol** and drug abuse treatment program;

(E) A school drug counselor;

(F) A director of a drug abuse prevention program;

(G) A director of a driving while intoxicated program;

(H) A health professional; and

(I) Four (4) members from the state at large who have demonstrated knowledge of or interest in **alcohol** and drug abuse prevention, at least two (2) of whom shall be recovering persons.

(c) The coordinating council members may receive expense reimbursement and stipends in accordance with § 25-16-901 et seq.

(d) The coordinating council may appoint noncouncil members for PEER review of grants, and the PEER Review Committee members shall be entitled to reimbursement for actual expenses and mileage to be paid by the Office of **Alcohol** and Drug Abuse Prevention from funds appropriated for its maintenance and operation.

(e) The United States Attorney for Arkansas or his or her designee shall serve on the council in an advisory capacity.

HISTORY: Acts 1989, No. 855, §§ 2, 5; 1995, No. 551, § 1; 1997, No. 250, § 203; 2005, No. 1453, § 1.

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*** August 1, 2012. ***

Title 20 Public Health And Welfare
Subtitle 4. Food, Drugs, And Cosmetics
Chapter 64 **Alcohol** And Drug Abuse
Subchapter 10 -- **Alcohol** and Drug Abuse Coordinating Council

A.C.A. § 20-64-1003 (2012)

20-64-1003. Arkansas Alcohol and Drug Abuse Coordinating Council -- Functions, powers, and duties.

(a) The Arkansas **Alcohol** and Drug Abuse Coordinating Council shall have the responsibility for overseeing all planning, budgeting, and implementation of expenditures of state and federal funds allocated for **alcohol** and drug education, prevention, treatment, and law enforcement.

(b) The coordinating council shall have the following functions, powers, and duties:

(1) All federal money received by the State of Arkansas for drug law enforcement, education, or prevention shall be reviewed by the coordinating council for disbursement, accountability, and evaluation;

(2) The coordinating council shall review and coordinate all school-based drug education, prevention, and awareness programs and efforts funded by the state.

(c) The coordinating council shall assist community-based prevention councils in planning and coordinating prevention activities, promoting innovative programs, developing stable funding sources, and disseminating current information. These local councils should be racially balanced and shall include at least one (1) representative from each of the following groups:

(1) One (1) law enforcement officer;

(2) One (1) school board member;

(3) One (1) school administrator;

(4) One (1) school teacher;

(5) One (1) parent;

(6) One (1) student;

(7) One (1) **alcohol** and drug abuse program director; and

(8) One (1) health professional.

(d) The coordinating council shall develop training and education programs for criminal justice personnel in drug-related matters in conjunction with the Arkansas Law Enforcement Training Academy.

(e) (1) The coordinating council shall have authority to develop its rules of procedure to include the establishment of a committee structure for the approval of funding and other purposes.

(2) Committees shall include, but not be limited to, a prevention, education, and treatment committee chaired by the Director of the Bureau of **Alcohol** and Drug Abuse Prevention, and a law enforcement committee.

(f) The coordinating council shall establish advocacy groups among the business community and youth population of this state.

(g) The coordinating council shall work with all federal, state, county, and local law enforcement agencies to ensure an integrated system of enforcement activities.

(h) The coordinating council shall perform other functions as may be necessary to carry out the functions, powers, and duties as set forth in this subchapter.

HISTORY: Acts 1989, No. 855, §§ 3, 4; 1995, No. 551, §§ 2, 3.

Coordinating Council Membership

CATEGORY	MEMBER	CONTACT INFORMATION
Arkansas Drug Director	Denny Altes, Council Chair	#1 State Police Plaza Drive Little Rock, AR 72209 O: (501) 618-8690 F: (501) 618-8841 E-mail: denny.altes@asp.arkansas.gov
Director, Alcohol and Drug Abuse Prevention	Pam Dodson	305 South Palm Street Little Rock, AR 72205 O: (501) 686-9875 F: (501) 686-9396 Email: pamela.dodson@dhs.arkansas.gov
Director, Arkansas State Police	Bill Bryant	#1 State Police Plaza Drive Little Rock, AR 72209 O: (501) 618-8299 F: (501) 618-8222
		Alternate: Sgt Stuart Woodward O: (501) 618-8413 C: (501) 944-8017 F: (501) 618-8859 E-mail: stuart.woodward@asp.arkansas.gov
Commissioner, Department of Education	Johnny Key	#4 Capitol Mall, Room 202A Little Rock, AR 72201-1071 Main (501) 682-4203
		Alternate: Don Kaminar O: (501) 683-5188 F: (501) 682-7693 E-mail: john.kaminar@arkansas.gov
Director, Highway and Transportation Department	Scott Bennett	10324 Interstate 30 Little Rock, AR 72209
		Alternate: Chief Ronald Burks Arkansas Highway Police P.O. Box 2779 Little Rock, AR 72203-2779 O: (501) 569-2421 C: (501) 425-7821 F: (501) 569-2963 E-mail: ron.burks@arkansashighways.com
Director, Department of Corrections	Wendy Kelley	P. O. Box 8707 Pine Bluff, AR 71611
		Alternate: Robert Parker O: (870) 267-6325 C: (870) 543-0119 F: (870) 267-6327 E-mail: bob.parker@arkansas.gov
Director, Department of Finance & Administration	Larry Walther	1509 West 7th Street Little Rock, AR 72201
		Alternate: Doris Smith O: (501) 682-5242 F: (501) 682-5206 E-mail: doris.smith@dfa.arkansas.gov

Coordinating Council Membership

CATEGORY	MEMBER	CONTACT INFORMATION
Adjutant General Arkansas National Guard	Brigadier General Mark Berry	Camp Joe T. Robinson, Box 16 North Little Rock AR 72199-9600 O: (501) 212-5001 F: (501) 212-5009
		Alternate: Lt. Col. Clement Papineau Camp Joe T. Robinson CD-DOMS Building #16412 North Little Rock, AR 72199 O: (501) 212-5494 E-mail: clement.j.papineau.mil@mail.mil
Attorney General	Leslie Rutledge	323 Center Street, Suite 200 Little Rock, AR 72201 O: (501) 682-2007 F: (501) 682-2591
		Alternate: Jake Jones O: (501) 682-8131 C: (501) 765-1465 E-mail: jake.jones@arkansasag.gov
Director, State Crime Laboratory	Kermit Channell	#3 Natural Resources Drive Little Rock, AR 72205 O: (501) 227-5747 F: (501) 227-5936 E-mail: kermit.channell@crimelab.arkansas.gov
		Alternate: Rick Gallagher O: (501) 683-6150 C: (501) 920-3470 F: (501) 227-0713 E-mail: rick.gallagher@crimelab.arkansas.gov
Chief Administrative Officer (Director) of the Blood Alcohol Testing Program, Department of Health	Laura Bailey	Department of Health 4815 West Markham, Slot 4 Little Rock, AR 72205 O: (501) 661-2287 F: (501) 661-2258 E-mail: laura.bailey2@arkansas.gov
Director, Department of Community Correction	Sheila Sharp	Two Union National Plaza, 2nd Floor Little Rock, AR 72201 O: (501) 682-9566 F: (501) 682-9539 E-mail: sheila.sharp@arkansas.gov
		Alternate: Dan Roberts O: (501) 682-9566 F: (501) 682-9539 E-mail: dan.roberts@arkansas.gov
		Alternate: Ben Udochi O: (501) 682-9510 Email: ben.udochi@arkansas.gov

Coordinating Council Membership

CATEGORY	MEMBER	CONTACT INFORMATION
Director, Administrative Office of the Courts	J. D. Gingerich	625 Marshall Street Little Rock, AR 72201 O: (501) 682-9400 F: (501) 682-9410 E-mail: jd.gingerich@arkansas.gov
		Alternate: Kari Powers O: (501) 682-9400 C: (501) 218-3708 F: (501) 682-9410 E-mail: kari.powers@arkansas.gov
Police Chief	Chief Everett Cox	Dumas Police Department 149 East Waterman Dumas, AR 71639 O: (870) 382-5511 C: (870) 377-0489 F: (870) 382-5667 E-mail: ecox901@yahoo.com
County Sheriff	Sheriff Tate Lawrence	Izard County Sheriff's Office P.O. Box 370 Melbourne, AR 72556 O: (870) 368-4203 F: (870) 368-5226 E-mail: tatelawrence@yahoo.com
Drug Court Judge	Judge Steve Tabor	12th Judicial Circuit Sebastian County Courts Building 901 South B Street Fort Smith, AR 72901 O: (479) 782-4715 F: (479) 784-1527 Email: stabor@co.sebastian.ar.us
Prosecuting Attorney	Scott Ellington	Second Judicial District Prosecuting Attorney Post Office Box 1736 Jonesboro, AR 72403 O: (870) 932-1513 C: (870) 219-1763 F: (870) 336-4011 E-mail: ellington@yourprosecutor.org
Private Citizen Not Employed by the State or Federal Government	Dr. Rob Covington	10412 Stoneleige Street Fort Smith, AR 72908 P: (479) 769-4339 E-mail: rcovington823@yahoo.com
Director of a Publicly- Funded Alcohol and Drug Abuse Treatment Program	George Weaver	5308 Cypress Drive Jacksonville, Arkansas 72076 O: (501) 686-9393 C: (501) 413-7843 F: (501) 686-9581 E-mail: georgeweaver@sbcglobal.net Email2: georgeweaver@quapawhouseinc.org

Coordinating Council Membership

CATEGORY	MEMBER	CONTACT INFORMATION
School Drug Counselor	Gail Stith	1705 Utah St. Pine Bluff, AR 71607 O: (870) 897-2838 C: (870) 872-3899 E-mail: prieststith@yahoo.com
Director of a Drug Abuse Prevention Program	Tonna Butzlaff	Community Service, Inc. 201 Daffodil #A1 Hot Springs, AR. 71913 O: (501) 624-5636 C: (501) 580-1253 F: (501) 624-5363 E-mail: butz@aristotle.net
Director of a DWI Program	Paul Dottley	Delta Counseling, Inc. P.O. Box 175 Monticello, AR 71657 O: (870) 367-1701 C: (870) 723-2555 F: (870) 367-3637 E-mail: p.dottley@deltacounseling.org
Health Professional	Charlotte Denton	2718 Bradley 16 Banks, AR 71656 O: (870) 465-2589 C: (870) 820-1422 E-mail: denton@uamont.edu
Four members from the state at large, two of which shall be recovering persons	Kimberly Brown	2408 Duncan Rd. Jonesboro, AR 72401 O: (870) 972-4989 C: (870) 243-7219 H: (870) 972-9950 E-mail: k2brown@mshs.org
	Erin Gildner	1619 Waldron CV Bryant, AR 72022 C: (501) 920-1432 E-mail: emgildner@sbcglobal.net
	Kathy Lewison	Pulaski County Quorum Court 201 South Broadway, Suite 401 Little Rock, AR 72201 O: (501) 224-5724 E-mail: kslewison@aol.com
	L. J. Bryant	361 Southwest Drive #137 Jonesboro, AR 72401 O: (870) 910-5900 C: (501) 412-3930 F: (888) 521-1729 E-mail: lj@ljbryant.com

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Junie "Sissy" Cumblidge	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Arkansas Behavioral Health Planning and Advisory Council	11001 Donnie Drive Shannon Hills, AR 72103 PH: 501-455-2174	tomandsissy777@msn.com
Georgia Rucker	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Arkansas Behavioral Health Planning and Advisory Council	P.O. Box 45402 Little Rock, AR 72214 PH: 501-681-5186	mgrucker@sbcglobal.net
Angie Lassiter	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Behavioral Health Advisory Council-1st Vice Chair	714 Acklin Gap Rd Conway, AR 72032 PH: 501-450-7218	angie.lassiter@ymail.com
Linda Donovan	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	DHS/Division of Behavioral Health	PH: 501-683-0387	linda.donovan@arkansas.gov
William "Bill" Shumaker	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Member of Leadership Academy for Consumer Councils	811 N. Spruce St. Little Rock, AR 72205 PH: 501-412-9460	williamshumaker@gmail.com
Joyce Soularie	State Employees	DHS/Division of Behavioral Health Services-Family Support Partner Coordinator	305 South Palm Street Little Rock, AR 72205 PH: 501-683-0312 FAX: 501-686-9182	joyce.soularie@arkansas.gov
Jo Thompson	State Employees	AR Division of Children and Family Services - Social Services Represenative	700 Main Street, Slot S570 Little Rock, AR 72203 PH: 501-682-2067	jo.thompson@arkansas.gov
Latrese Atkins	State Employees	DHS/Division of Behavioral Health Services-SA Certification	4800 West 7th Street Little Rock, AR 72205 PH: 501-683-0387	
Linda Nelson	Family Members of Individuals in Recovery (to include family members of adults with SMI)		5416 B Street Little Rock, AR 72205 PH: 501-258-3989	lindanelson1006@gmail.com
Lonnie Phillips	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Arkansas Behavioral Health Planning and Advisory Council	1400 Cumberland Street #401 Little Rock, AR 72202 PH: 501-398-2154	coconigeria29@yahoo.com
Lynn Kell	State Employees	DHS/Division of Behavioral Health	5 Virginia Lane Little Rock, AR 72207 PH: 501-258-5948	lynn.kell@arkansas.gov
Patricia Brannin	State Employees	DHS/Division of Behavioral Health Services-Olmstead Coordinator/PASRR	1708 South Harrison Little Rock, AR 72204 PH: 501-859-5633	patricia.brannin@arkansas.gov
Therthenia Lewis	Family Members of Individuals in Recovery (to include family members of adults with SMI)		12 King Richard Cove Pine Bluff, AR 71603 PH: 870-535-4335	lewist@uapb.edu
Tammy Alexander	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Veteran Affairs-Arkansas	29 Rosewood Dr. Beebe, AR 72012 PH: 501-288-7208	Tammy.Alexander2@va.gov

Casey Bright	Providers	Quapaw House		CaseyBright@quapawhouseinc.org
Eddie Smith	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Arkansas Department Of Veterans Affairs		
Billie Denny	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Arkansas Behavioral Health Planning and Advisory Council	PH: 501-278-1450	
Sharron Mims	State Employees	DHS/Division of Behavioral Health		Sharron.Mims@dhs.arkansas.gov
Roger Isbell	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Arkansas State Hospital		
Linda Northern	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Arkansas Department of Human Services, Division of Behavioral Health Services		
LaTosha Taylor	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	PERC		
Sarah Stack	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Arkansas Behavioral Health Planning and Advisory Council	PH: 501-487-8162	
Erin Gildner	Providers	Arkansas Behavioral Health Planning and Advisory Council	1619 Waldron Cv. Bryant, AR 72022 PH: 501-920-1432	emgildner@sbcglobal.com
Denise Ennett	Parents of children with SED			
Jessica Sanchez	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Shirley Morris	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Arkansas Behavioral Health Planning and Advisory Council	9201 Kanis Rd., Apt. 12L Little Rock, AR 72205	shirley_morris49@yahoo.com
Ben Udochi	State Employees	Arkansas Department of Community Corrections		
Bob Parker	State Employees	Criminal Justice - Ark Dept of Corrections	PH: 870-267-6325	
Elisabeth Brooks	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Arkansas Behavioral Health Planning and Advisory Council	6115 W. Markham St.. Apt. 4C Little Rock, AR 72205 PH: 501-257-0208	
Noelle Stimach	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	AR Department of Human Services, Division of Behavioral Health Services	2111Countryview Loop Jonesboro, AR 72404 PH: 870-917-5066	nhapers@msh.org
Pat Warner	Parents of children with SED	YouthMOVE	1409 E. Moore St. Searcy, AR 72143 PH: 501-230-1793	patwarner1@yahoo.com
Ray Warner	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	YouthMOVE	1409 E. Moore St. Searcy, AR 72143 PH: 501-230-8533	raydog1322@gmail.com
John Jones	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Disability Rights of Arkansas	3805 Dunkled Dr. N. Little Rock, AR 72116 PH: 501-680-5821	johnebjones@yahoo.com

Kwashunda Watson	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Veteran Affairs-Arkansas	5615 Green Valley Ave N. Little Rock, AR 72118 PH: 501-831-7127	
Alan McClain	State Employees	Vocational Rehabilitation	PH: 501-296-1616	alan.mcclain@arkansas.gov
Angela Smith	Family Members of Individuals in Recovery (to include family members of adults with SMI)	PERC	21 Dellwood Dr. Little Rock, AR 72209 PH: 501-541-4087	angela.smith@lrsd.org
Dr. Keith Noble	Providers	Arkansas Behavioral Health Planning and Advisory Council	111 S. Glenstone, Ste 300 Springfield, MO 65804 PH: 417-869-8911	knoble@aoinc.org
Kim Dean	State Employees	Arkansas Department of Human Services	700 Main St. Little Rock, AR 72203	michomebiz@yahoo.com
Diane Skaggs	Others (Not State employees or providers)	Arkansas Behavioral Health Planning and Advisory Council	501 S. Woodlane, Ste. 104 Little Rock, AR 72201 PH: 501-372-7062	dskaggs@mhca.org
Janie Cotton	Providers	Professional Counseling Associates	PH: 501-221-2376	
Elizabeth Kindell, Ed. D	State Employees	AR Department of Education	PH: 501-580-6827	
Kim Arnold	Providers	NAMI	PH: 501-661-1548	
Kim Weser, LMSW	Providers	Arkansas Behavioral Health Planning and Advisory Council	PH: 501-200-0170	

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	43	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	12	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	11	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	0	
Others (Not State employees or providers)	1	
Total Individuals in Recovery, Family Members & Others	26	60.47%
State Employees	11	
Providers	6	
Federally Recognized Tribe Representatives	0	
Vacancies	0	
Total State Employees & Providers	17	39.53%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	5	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	7	
Persons in recovery from or providing treatment for or advocating for substance abuse services	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:

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

JUL 6 2015

Mr. Albert Wall
State of Alaska Health &
Social Services
P.O Box 110620
Juneau, AK 99811-0620

Dear Mr. Wall:

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.

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,

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Ms.Stacy Toner
Ms. Brenda Moore

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory