I: State Information

State Information

Plan Year

Start Year:
2014

End Year:
2015

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
Julie

Last Name
Meyer

Agency Name
Division of Behavioral Health Services

Mailing Address
305 South Palm Street

City
Little Rock

Zip Code
72205

Telephone
501-265-9898

Fax
501-686-9182

Email Address
julie.meyer@arkansas.gov

State CMHS DUNS Number

Number
119841336

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 Street

City

Little Rock

Zip Code

72205-4096

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

First Name

Julie

Last Name

Meyer

Agency Name

Department of Human Services

Mailing Address

305 S. Palm Street

City

Little Rock

Zip Code

72205-4096

Telephone

501-265-9898

Fax

501-686-9182

Email Address

julie.meyer@arkansas.gov

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

From

To

IV. Date Submitted

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

Submission Date

9/3/2013 11:58:58 PM

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Julie

Last Name

Meyer

Telephone

501-265-9898

Fax

501-686-9182

Email Address

julie.meyer@arkansas.gov

Footnotes:

I: State Information

Assurance - Non-Construction Programs

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

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

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

Name	John Selig
Title	Director
Organization	Department of Human Services

Signature: _____ Date: _____

Footnotes:

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

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

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

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

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

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

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

Name	John Selig
Title	Director
Organization	Department of Human Services

Signature: _____ Date: _____

Footnotes:

I: State Information

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

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

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

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

Name of Chief Executive Officer (CEO) or Designee: John Selig

Title: Director

Signature of CEO or Designee[1]: _____ Date: _____

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

Footnotes:

STATE OF ARKANSAS
MIKE BEEBE
GOVERNOR

October 12, 2012

John Selig, Director
Arkansas Department of Human Services
Post Office Box 1437, Slot S201
Little Rock, AR 72203-1437

RE: Delegation of Authority

Dear John:

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

I hereby delegate authority to 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 the 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,

Mike Beebe

MB:jb

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

RECEIVED 10/18/12 VLW

I: State Information

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

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

Title XIX, Part B, Subpart I of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

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

Name of Chief Executive Officer (CEO) or Designee	John Selig
Title	Director

Signature of CEO or Designee[1]: _____ Date: _____

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

Footnotes:

STATE OF ARKANSAS
MIKE BEEBE
GOVERNOR

October 12, 2012

John Selig, Director
Arkansas Department of Human Services
Post Office Box 1437, Slot S201
Little Rock, AR 72203-1437

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Sincerely,

Mike Beebe

MB:jb

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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I: State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name	John Selig
Title	Director
Organization	Department of Human Services

Signature: _____ Date: _____

Footnotes:

II: 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.

Footnotes:

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 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. Additionally, DBHS provides training and research support for the system through the Research and Training Institute (RTI) operated in collaboration with the adjacent University of Arkansas for Medical Sciences (UAMS). The Research and Training Institute supports training of 4.25 general psychiatry residents, one child psychiatry fellow, two forensic psychiatry fellows, four graduate school of social work interns, three psychology interns and two forensic psychology postdoctoral fellows each year. Priority populations to be served by the public mental health system are: adjudicated individuals found not guilty by reason of mental disease or defect; individuals assessed as potentially violent; other forensic clients; adults with serious mental illness (SMI) and children/adolescents with serious emotional disturbance (SED). Additionally, to the extent that funds are available, others with mental health problems are eligible for the services of the public mental health system.

Each provider of behavioral health services (ASH, AHC, CMHCs, private providers) 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. Each provider is nationally accredited and as such are also required to assure that diversity is respected and embraced. Cultural and linguistic competency is a requirement of certification through DBHS. Sensitivity and competency is taught regarding sexual gender minorities at the local level through each specific provider. Some statewide trauma-informed care training has been completed, however, more is needed.

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 25 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.

Since the last Block Grant submission, the catchment areas that dictate funding distribution for substance abuse treatment and prevention have been consolidated from thirteen catchment areas to eight:

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 14 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 eleven 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.

DBHS in concert with the Arkansas Department of Health (ADH) has been given a mandate from the Arkansas State Legislature to implement a statewide call center to address problem gambling. As written within a memorandum of understanding (MOU) between the Arkansas Lottery Commission, ADH, and DBHS, a problem gambling helpline and related services are needed to be accessible statewide. The MOU was developed to address a clause within Act 605 of 2009 (the Arkansas Scholarship Lottery Act) which dedicates a portion of funding for the treatment of compulsive gambling disorders. Problem gambling helpline services are included within the treatment for gambling disorders.

Substance Abuse Prevention

The Arkansas Prevention System currently consists of 13 Regional Prevention Resource Centers that serve as informational hubs throughout the state. In SFY 2014 a new contract was develop to replace the Prevention Resource Centers to Regional Prevention Providers (RPP). The RPP staff will address specific needs of their communities and identify strategies to address those needs. The RPP staff will work closely with county coalitions and recruit for and provide technical assistance to these coalitions so the coalitions can address the needs identified within their counties.

Arkansas is an affiliate of the International Certification and Reciprocity Consortium (IC&RC) for Prevention Specialist Certification. Workforce development in the form of training is provided by the University of Arkansas at Little Rock (UALR) Mid-South School of Social Work, which holds an annual Mid-South Summer School to address the training needs of preventionists in varying sectors. UALR also hosts the Prevention Institute, which provides ongoing training throughout the year. DBHS also provides an outreach help-line and treatment in 10 treatment centers for problem gambling, at no cost to the individuals. Juvenile Drug Courts are also administered by DBHS. The Juvenile Drug Court program consists of 10 drug courts across the State of Arkansas. Judges in each of the drug courts refer adolescents to residential and outpatient providers in their districts for comprehensive drug screenings and substance abuse treatment.

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 Simple Point of Entry (SPOE) 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 two CMHCs providing PATH services.

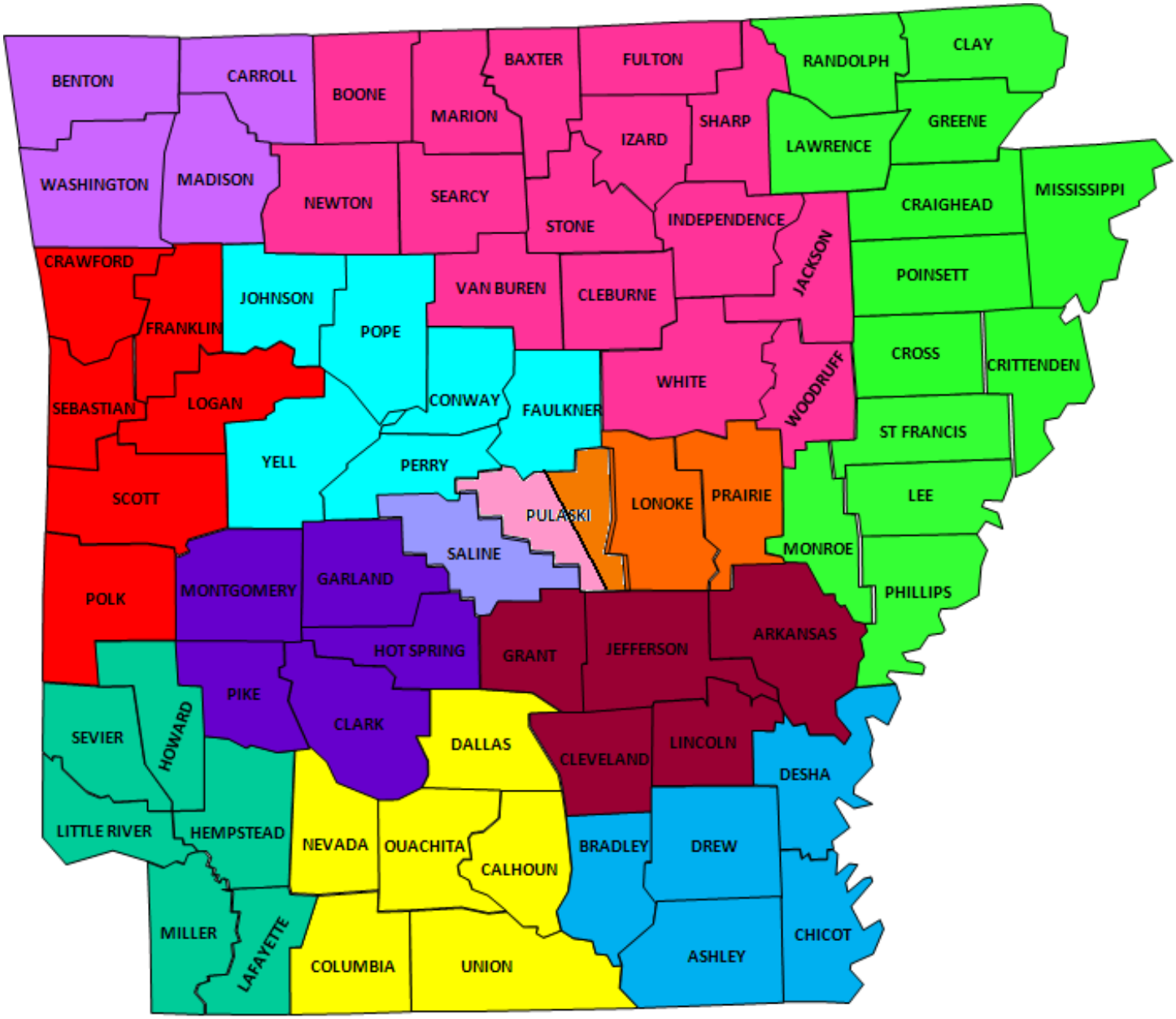
DBHS maintains the current Rehabilitative Services for Persons with Mental Illness (RSPMI) Certification Policy which includes compliance and outcome monitoring of providers. To be an eligible RSPMI provider, the agency must offer a full array of outpatient treatment services, and is eligible to bill 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 of care for individual children and adolescents with serious emotional disturbance when the current system is not adequately meeting their needs.

Community Mental Health Center (CMHC) Catchment Areas



Revised 7/06/2011

Community Mental Health Centers

Community Counseling Services, Inc.
125 Dons Way
Hot Springs, AR 71913
24-Hour Emergency Number: 501- 624-7111 or 1-800-264-2410
http://www.communitycounselingservices.org

Counseling Associates Inc.
350 Salem Road
Conway, AR 72034
24-Hour Emergency Number: 1- 800-844-2066
www.caiinc.org

Counseling Clinic Inc.
307 East Sevier Street
Benton, AR 72015
24-Hour Emergency Number: 501-315-2415
http://www.cc-inc.org

Delta Counseling Associates
790 Roberts Drive
Monticello, AR 71655
24- Hour Emergency Number: 1-800-323-2703
www.deltacounseling.org

Health Resources of Arkansas Inc.
25 Gap Road
Batesville, AR 72501
24-Hour Emergency Number: 1-800-592-9503
www.healthresourcesofarkansas.com

Little Rock Community Mental Health Center
4400 Shuffield Drive
Little Rock, AR 72205
24-Hour Emergency Number: 501-686-9300
http://lrcmhc.org

Midsouth Health Systems Inc.
2707 Browns Lane
Jonesboro, AR 72401
24-Hour Emergency Number: 1-800-356-3035
www.mshs.org

Ozark Guidance Inc.
2400 South 48th Street
Springdale, AR 72762
24-Hour Emergency Number: 479- 750-2020 or 1-800-234-7052
www.ozarkguidance.org

Professional Counseling Associates
3601 Richards Road
North Little Rock, AR 72117
24-Hour Emergency Number: 501-221-1843
www.pca-ar.org

South Arkansas Regional Health Center
715 North College
El Dorado, AR 71730
24-Hour Emergency Number: 870- 862-7921
www.sarhc.org

Southeast Arkansas Behavioral Healthcare System Inc.
2500 Rike Drive
Pine Bluff, AR 71603
24-Hour Emergency Number: 1-800-272-2008
www.sabhs.org

Southwest Arkansas Counseling and Mental Health Center
2904 Arkansas Boulevard
Texarkana, AR 71854
24-Hour Emergency Number: 1-800-652-9166

Western Arkansas Counseling & Guidance Center
3111 South 70th Street
Fort Smith, AR 72917
24-Hour Emergency Number: 1-800-542-1031
www.wacgc.org

SPECIALITY CLINICS:

Birch Tree Communities Inc.
1718 Old Hot Springs Highway
Benton, AR 72018
501-315-3344
24-Hour Emergency Number: 501-315-3344
www.birchtree.org

Centers for Youth and Families
5800 West 10th Street, Suite 101
Little Rock, AR 72225
501-666-8686
24-Hour Emergency Number: 501-666-8686 or 1-888-868-0023
www.centersforyouthandfamilies.org

GAIN Inc.
712 West 3rd Street, #100
Little Rock, AR 72201
501-379-4246
24-Hour Emergency Number: 501-258-4246 or 501-681-4246

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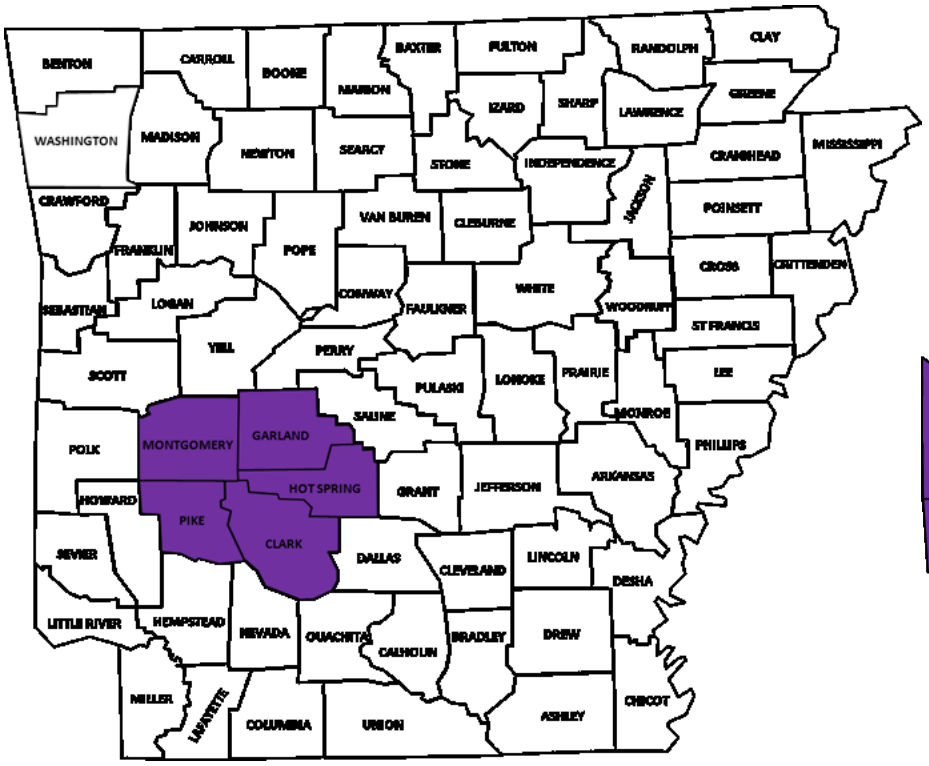
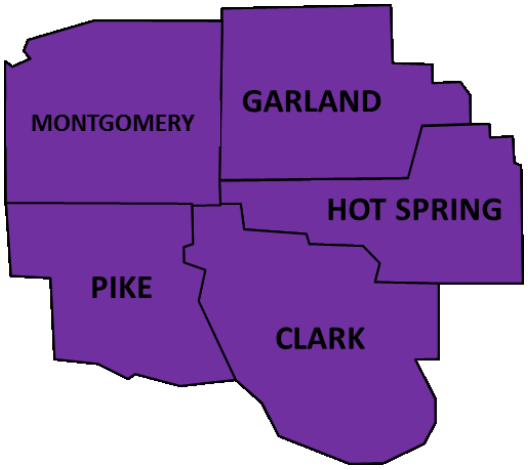




Community Mental Health Center

Community Counseling Services, Inc.: 501-624-7111

Serving Clark, Garland, Hot Spring, Montgomery and Pike Counties

Clark County

Community Counseling Services, Inc.
201 North 26th Street
Arkadelphia, AR 71923
870-246-4123

Garland County

Community Counseling Services, Inc.
505 W. Grand Avenue
Hot Springs, AR 71901
501-624-7111

Community Counseling Services, Inc.
*125 Dons Way
Hot Springs, AR 71913
501-624-7111

Hot Spring County

Community Counseling Services, Inc.
1615 Martin Luther King Boulevard
Malvern, AR 72104
501-332-5236

***Administrative Office**

Private RSPMI Providers in Counties

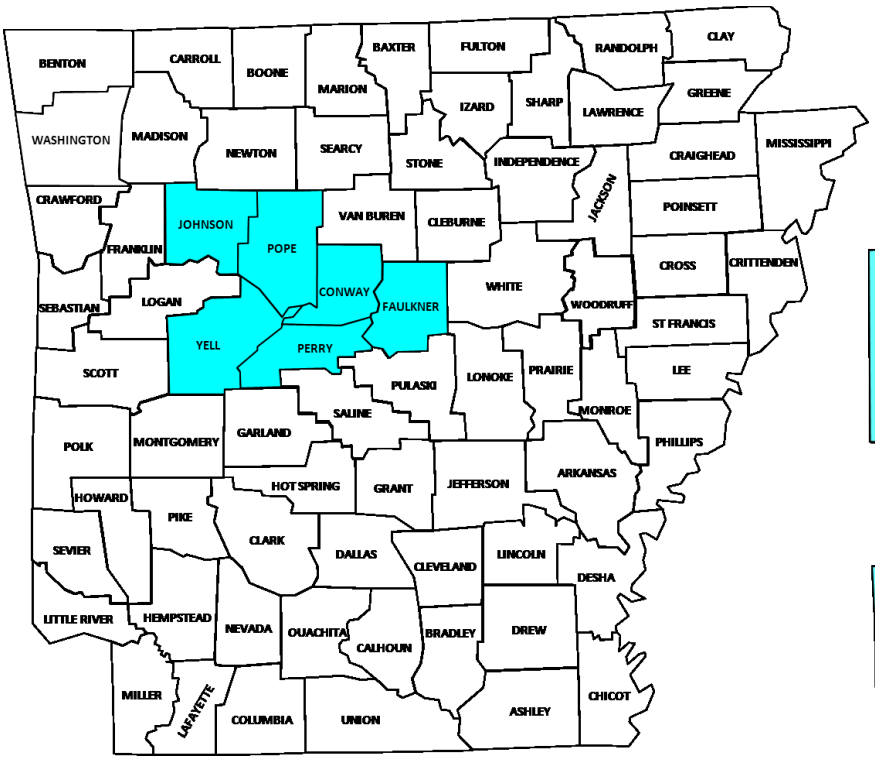
Clark County
Arkansas Counseling and Psychodiagnostics, Inc.
Ascent Acquisition Corp – PSC
Maxus
Rivendell Behavioral Health Services of Arkansas
United Methodist Behavioral Hospital

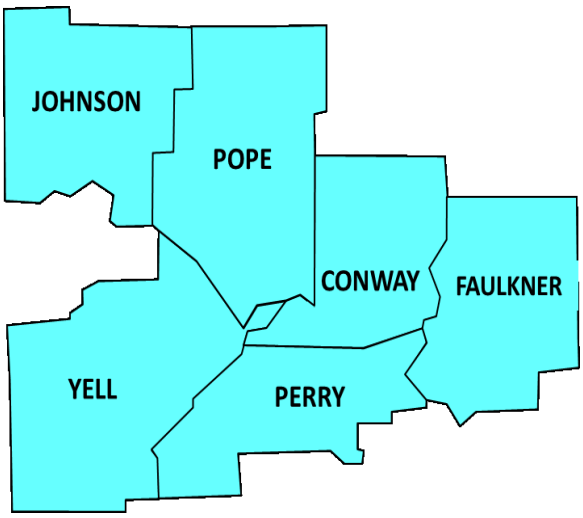
Garland County
Alternative Opportunities/ Dayspring of Arkansas
Living Hope Southeast
Pinnacle Pointe Hospital
Rivendell Behavioral Health Services of Arkansas
Therapeutic Family Services, Inc.

Hot Spring County
Alternative Opportunities/ Dayspring of Arkansas
Living Hope Southeast
Therapeutic Family Services, Inc.

Montgomery County
United Methodist Behavioral Hospital

Pike County
(None)





Community Mental Health Centers

Counseling Associates, Inc.: 501-327-4889

Serving Conway, Faulkner, Johnson, Perry, Pope, and Yell Counties

Conway County

Counseling Associates, Inc.
8 Hospital Drive
Morrilton, AR 72110
501-354-1561

Faulkner County

Counseling Associates, Inc.
1622 North Donaghey
Conway, AR 72032
501-327-7706

Counseling Associates, Inc.
*350 Salem Road, Suite 1
Conway, AR 72032
501-336-8300

Counseling Associates, Inc.
1701 Donaghey
Conway, AR 72032
501-327-1701

Johnson County

Counseling Associates, Inc.
1021 Poplar Street
Clarksville, AR 72830
501-754-8610

Pope County

Counseling Associates, Inc.
1402, and 1404 E.16th St.
Russellville, AR 72801
479-890-3045

Counseling Associates, Inc.
110 Skyline Drive
Russellville, AR 72801
479-968-1298

***Administrative Office**

Private RSPMI Providers in Counties

Conway County
Alternative Opportunities/ Dayspring of Arkansas
Conway County Community Services, Inc.

Faulkner County
Conway County Community Services, Inc.
Maxus
Pinnacle Pointe Hospital

Johnson County
Alternative Opportunities/ Dayspring of Arkansas
Conway County Community Services, Inc.
Perspectives Behavioral Health Management, LLC

Perry County
New Beginnings Behavioral Health Services, LLC

Pope County
Alternative Opportunities/ Dayspring of Arkansas
Conway County Community Services, Inc.
Perspectives Behavioral Health Management, LLC.

Yell County
Conway County Community Services, Inc.

Community Mental Health Center

Counseling Clinic, Inc.: 501-315-4224

Serving Saline County

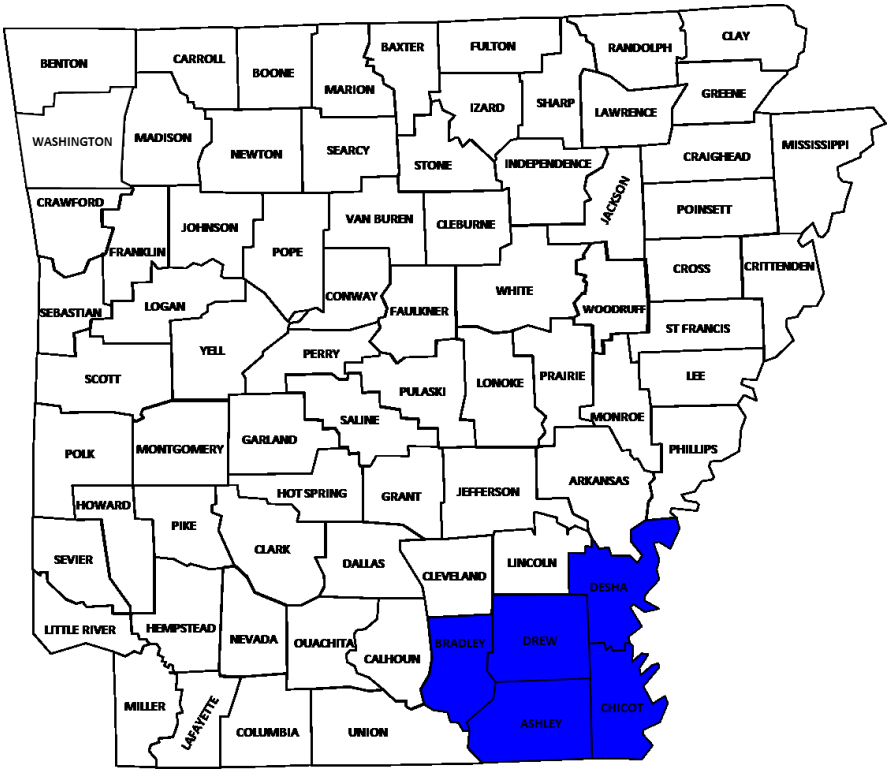
<u>Saline County</u>
Counseling Clinic, Inc.
*307 East Sevier
Benton, AR 72015
501-315-4224

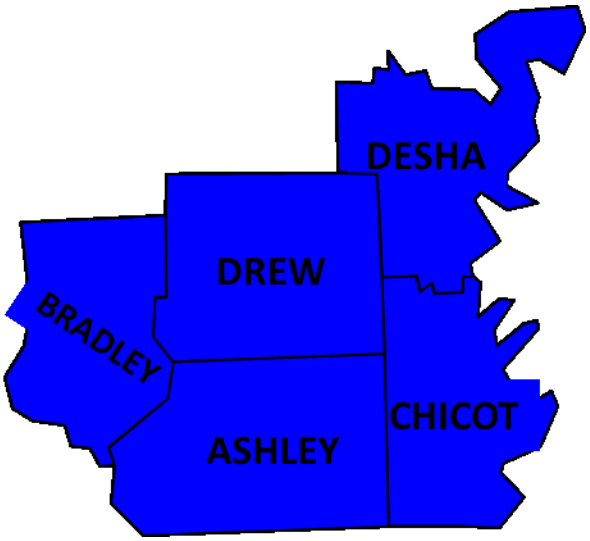
Counseling Clinic, Inc.
311 Whittington
Hot Springs, AR 71901
501-623-3477

***Administrative Office**

Private RSPMI Providers in County

Saline County
Ascent Acquisition Corp –PSC
Maxus
Rivendell Behavioral Health Services of Arkansas





Community Mental Health Center

Delta Counseling Associates: 870-367-2461

Serving Ashley, Bradley, Chicot, Desha, and Drew Counties

Ashley County

Delta Counseling Associates
1308 West 5th Avenue
Crossett, AR 71635
870-364-6471

Delta Counseling Associates
1802 Highway 82 West
Crossett, AR 71635
870-364-7248

Bradley County

Delta Counseling Associates
1404 East Church Street
Warren, AR 71671
870-226-5856

Chicot County

Delta Counseling Associates
1127 Second Street
Lake Village, AR 71653
870-265-3808

Desha County

Delta Counseling Associates
708 Highway 65 South
Dumas, AR 71639
870-382-4001

Delta Counseling Associates
2410 Highway 65 North
McGehee, AR 71654
870-222-3107

Drew County

Delta Counseling Associates
*790 Roberts Drive
Monticello, AR 71655
870-367-2461

***Administrative Office**

Private RSPMI Providers in Counties

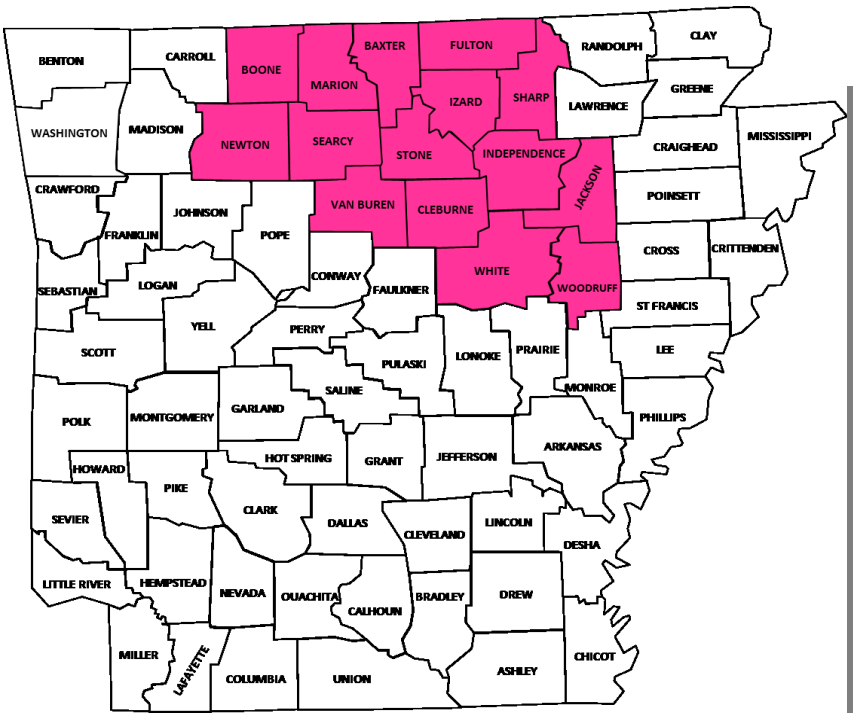
Ashley County
Perspectives Behavioral Health Management, LLC

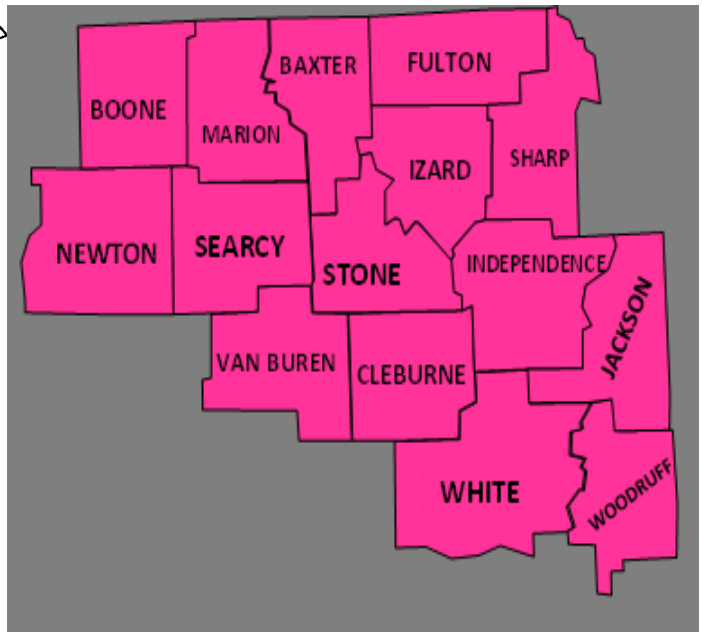
Bradley County
CMHC Only

Chicot County
Alternative Opportunities/ Dayspring of Arkansas
Maxus

Desha County
Maxus

Drew County
Alternative Opportunities/ Dayspring of Arkansas





Community Mental Health Center

Health Resources of Arkansas, Inc.: 870-793-8900

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

Baxter County
Health Resources of AR, Inc.
#8 Medical Plaza
Mountain Home, AR 72653
866-308-9923

Boone County
Health Resources of AR, Inc.
4081 Hwy 7 South
Harrison, AR 72601
866-533-1763

Cleburne County
Health Resources of AR, Inc.
1716 West Searcy Street
Heber Springs, AR 72543
866-533-1763

Fulton County
Health Resources of AR, Inc.
679 North Main Street
Salem, AR 72576
866-533-1762

Independence County
Health Resources of AR, Inc.
1800 Meyers Street
Batesville, AR 72501
870-793-8925

Health Resources of AR, Inc.
1355 East Main North
Batesville, AR 72501
870-793-8919

Health Resources of AR, Inc.
*25 Gap Road
Batesville, AR 72501
870-793-8910

***Administrative Office**

Independence County (continued)

Health Resources of AR, Inc.
1355 East Main
Batesville, AR 72501
870-793-8910

Izard County

Health Resources of AR, Inc.
1109 East Main
Melbourne, AR 72556
866-533-1760

Jackson County

Health Resources of AR, Inc.
1507 North Pecan Street
Newport, AR 72112
866-533-1758

Marion County

Health Resources of AR, Inc.
319 Highway 14 Suite #1
Yellville, AR 72687
866-308-9927

Newton County

Health Resources of AR, Inc.
504 W. Court Street, Room 110
Jasper, AR 72641
888-533-1767

Searcy County

Health Resources of AR, Inc.
200 East Main Street
Marshall, AR 72650
866-308-9928

Sharp County

Health Resources of AR, Inc.
714-A Ash Flat Drive
Ash Flat, AR 72513
866-533-1761

Stone County

Health Resources of AR, Inc.
211 Blanchard
Mountain View, AR 72560
866-533-1759

Van Buren County

Health Resources of AR, Inc.
2526 Highway 65 South
Clinton, AR 72031
866-533-1765

White County

Health Resources of AR, Inc.
931 Highway 5
Rose Bud, AR 72137
866-533-1766

Health Resources of AR, Inc.
3302 East Moore
Searcy, AR 72143
501-268-4181

Health Resources of AR, Inc.
3204 East Moore Avenue
Searcy, AR 72143
501-268-4181

Woodruff County

Health Resources of AR, Inc.
900 W. Poplar, Old Hwy 64 W.
McCrory, AR 72101
886-533-1757

Health Resources of AR, Inc.
623 North Ninth Street
Augusta, AR 72006
870-347-3254

Private RSPMI Providers in Counties

Baxter County
Alternative Opportunities/ Dayspring of Arkansas
Ascent Acquisition Corp –CYPDC
Baxter Regional Medical Center
Families Inc. of Arkansas
Maxus
Youth Bridge, Inc.

Boone County
Maxus
Vista Health
Youth Bridge, Inc.

Cleburne County
United Methodist Children's Home

Fulton County
CMHC Only

Independence County
Ascent Acquisition Corp –CYPDC
Life Strategies Counseling, Inc.
Rivendell Behavioral Health Services of Arkansas
United Methodist Behavioral Hospital

Izard County
CMHC ONLY

Jackson County
Life Strategies of Arkansas, Inc.

Marion County
CMHC Only

Newton County
CMHC Only

Searcy County
Alternative Opportunities/ Dayspring of Arkansas

Sharp County
Families Inc. of Arkansas
Hope Behavioral Healthcare
United Methodist Behavioral Hospital

Stone County
CMHC ONLY

Van Buren County
Conway County Community Service, Inc.
Maxus
Pinnacle Pointe Hospital

White County
Families Inc. of Arkansas
Maxus
Rivendell Behavioral Health Services of Arkansas
United Methodist Children's Home, Inc.

Woodruff County
CMHC Only

Community Mental Health Center

Little Rock Community Mental Health Center 501-686-9300

Serving Pulaski County (south of the Arkansas River)

<u>Pulaski County</u>
Little Rock CMHC, Inc.
*4400 Shuffield Drive
Little Rock, AR 72205
501-686-9300

Little Rock CMHC, Inc.
1020 W. Daisy L. Gatson Bates Drive
Little Rock, AR 72202
501-371-9058

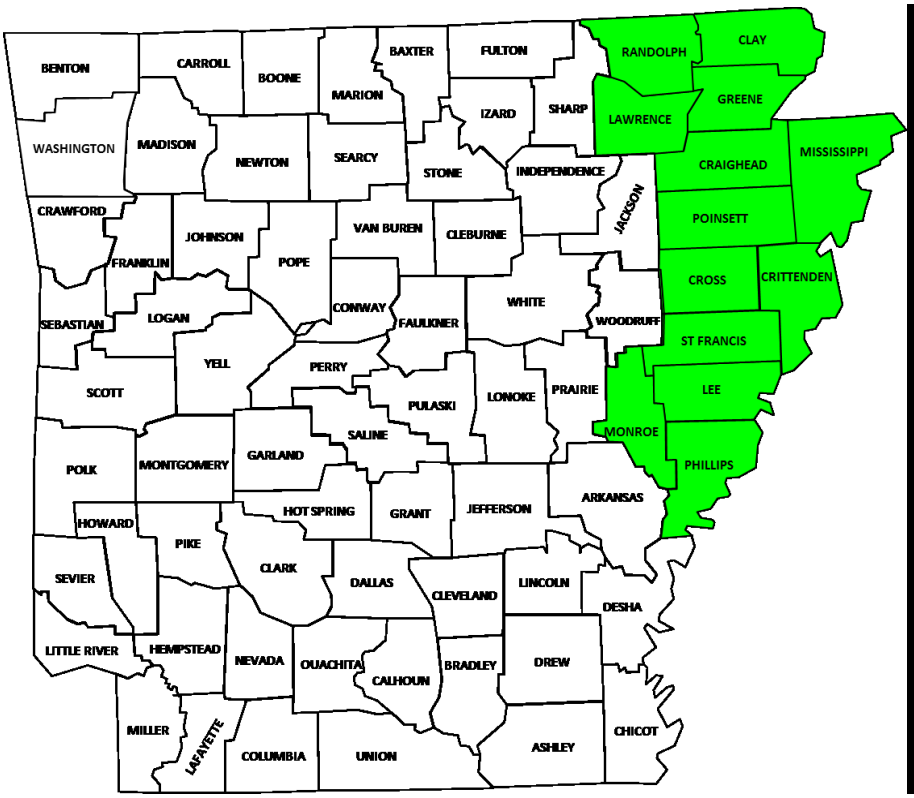
Little Rock CMHC, Inc.
4601 West Seventh Street
Little Rock, AR 72205
501-686-9380

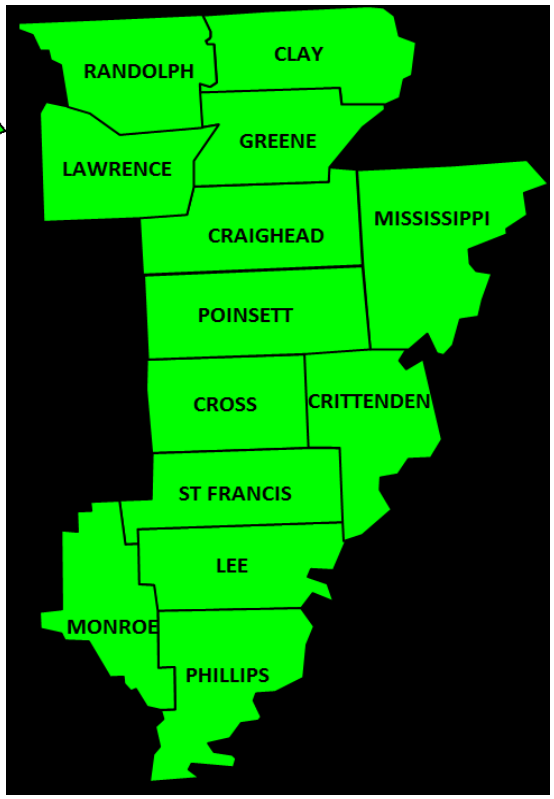
***Administrative Office**

Private RSPMI Providers in County

Pulaski County

Alternative Opportunities/ Dayspring of Arkansas
Ascent Acquisition Corp –PSC
Baptist Health Behavioral Services
Bridgeway, Inc.
Centers for Youth and Families
Families Inc. of Arkansas
Inspiration Day Treatment, Inc.
Life Strategies Counseling, Inc.
Living Hope Southeast
Maxus
Pathfinder, Inc.
Pinnacle Pointe Hospital
Rivendell Behavioral Health Services of Arkansas
Therapeutic Family Services, Inc.
Treatment Homes, Inc.
United Methodist Behavioral Hospital
United Methodist Children's Home, Inc.
University of Arkansas for Medical Sciences
Department of Psychiatry
Youth Home, Inc.





Community Mental Health Center

Mid-South Health Systems, Inc.: 870-972-4000

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

Clay County

Mid-South Health Systems, Inc.
602 David Street
Corning, AR 72422
870-857-3655

Craighead County

Mid-South Health Systems, Inc.
*2707 Browns Lane
Jonesboro, AR 72401
870-972-4050

Mid-South Health Systems, Inc.
2920 McClellan Drive NW
Jonesboro, AR 72401
870-972-4826

Crittenden County

Mid-South Health Systems, Inc.
905 North Seventh Street
West Memphis, AR 72301
870-735-5118

Cross County

Mid-South Health Systems, Inc.
661 Addison Drive
Wynne, AR 72396
870-238-1135

Mid-South Health Systems, Inc.
1201 South Falls Boulevard
Wynne, AR 72396
870-238-1135

***Administrative Office**

Greene County

Mid-South Health Systems, Inc.
1011 Morgan Street
Paragould, AR 72450
870-239-4222

Mid-South Health Systems, Inc.
28 Southpointe Drive
Paragould, AR 72450
870-236-2244

Lawrence County

Mid-South Health Systems, Inc.
102 South Larkspur
Walnut Ridge, AR 72476
870-886-7924

Lee

Mid-South Health Systems, Inc.
444 Atkins Boulevard
Marianna, AR 72360
870-295-4050

Mississippi County

Mid-South Health Systems, Inc.
209 S. Lockard
Blytheville, AR 72315
870-763-2139

Monroe County

Mid-South Health Systems, Inc.
490 Broadmore Drive
Brinkley, AR 72021
870-734-3202

Phillips County

Mid-South Health Systems, Inc.
801 Newman Drive
Helena, AR 72342
870-338-3900

Mid-South Health Systems, Inc.
507 Missouri Street
Helena, AR 72342
870-338-3434

Mid-South Health Systems, Inc.
613-615 Rightor
Helena, AR 72342
870-338-3363

Randolph County

Mid-South Health Systems, Inc.
2560 Old County Road
Pocahontas, AR 72455
870-972-4913

St. Francis County

Mid-South Health Systems, Inc.
4451 North Washington
Forrest City, AR 72335
870-630-3800

Private RSPMI Providers in Counties

Clay County
Life Strategies Counseling, Inc.

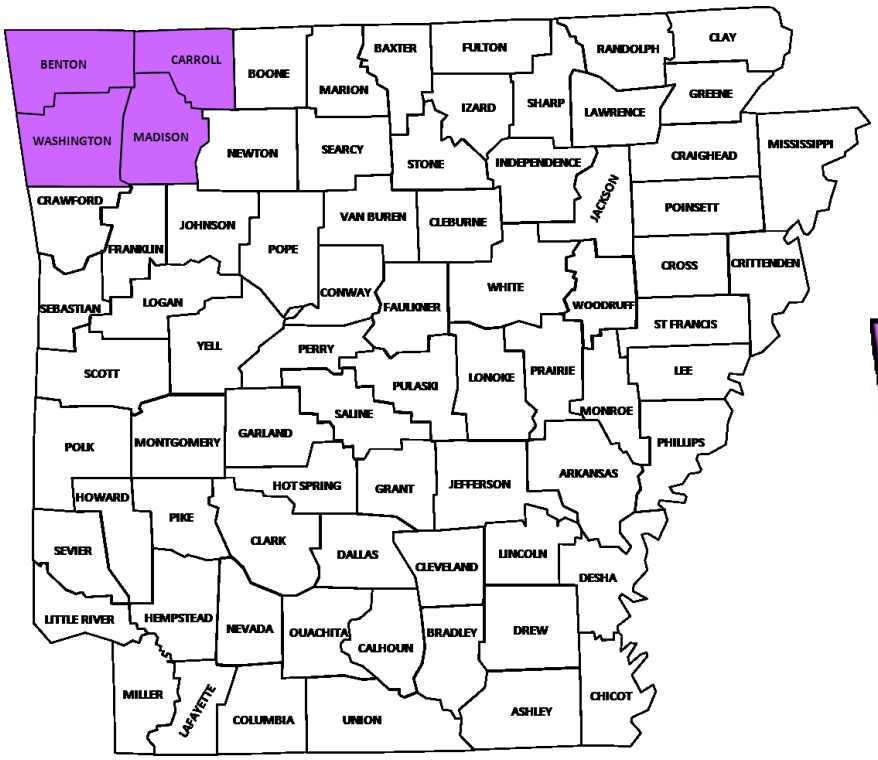
Craighead County
Alternative Opportunities/ Dayspring of Arkansas
Ascent Acquisition Corp –PSC
Families, Inc. of Arkansas
Life Strategies Counseling, Inc.
Maxus
United Methodist Behavioral Hospital

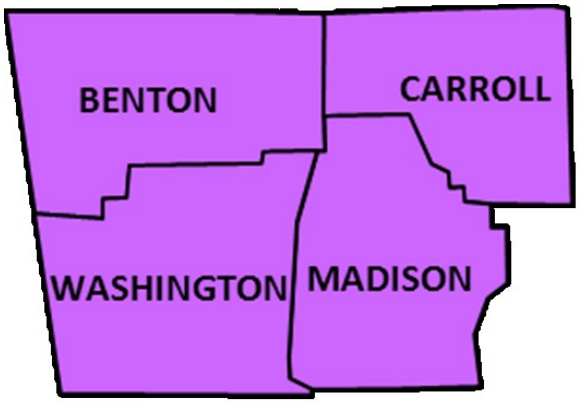
Crittenden County
Alternative Opportunities/ Dayspring of Arkansas
Ascent Acquisition Corp –PSC
Kids for the Future, Inc.
Life Strategies of Arkansas, LLC
Logan Centers, Inc.
Maxus
Rivendell Behavioral Health Services of Arkansas

Cross County
Kids for the Future, Inc.
Life Strategies of Arkansas, LLC
Logan Centers, Inc.

Greene County
Ascent Acquisition Corp – PSC
Alternative Opportunities/ Dayspring of Arkansas
Families Inc. of Arkansas
Life Strategies Counseling, Inc.
Maxus

Lawrence County
Alternative Opportunities/ Dayspring of Arkansas
Cornerstone Community Counseling Corp.





Community Mental Health Center

Ozark Guidance Center, Inc.: 479-750-2020

Serving Benton, Carroll, Madison, and Washington Counties

Benton County

Ozark Guidance Center, Inc.
710 Holly Street
Siloam Springs, AR 72761
479-524-8618

Ozark Guidance Center, Inc.
2508 SE 20th Street
Bentonville, AR 72712
479-273-9088

Ozark Guidance Center, Inc.
827 W. Harvard
Siloam Springs, AR 72761
479-524-5197

Carroll County

Ozark Guidance Center, Inc.
107 Whispering Pines
Eureka Springs, AR 72632
479-253-5665

Ozark Guidance Center, Inc.
208 Highway 62 West
Berryville, AR 72616
870-423-2758

Madison County

Ozark Guidance Center, Inc.
1104 North College
Huntsville, AR 72740
479-738-2878

Washington County

Ozark Guidance Center, Inc.
*2400 South 48th Street
Springdale, AR 72762
479-750-2020

Ozark Guidance Center, Inc.
28 West Sunbridge
Fayetteville, AR 72703
479-695-1242

***Administrative Office**

Washington County (continued)

Ozark Guidance Center, Inc.
60 West Sunbridge
Fayetteville, AR 72703
479-695-1240

Private RSPMI Providers in Counties

Benton
Alternative Opportunities/ Dayspring of Arkansas
Pathfinder, Inc.
Vista Health
Youth Bridge, Inc.

Carroll
Youth Bridge, Inc.

Madison
CMHC Only

Washington
Alternative Opportunities/ Dayspring of Arkansas
Perspectives Behavioral Health Management, LLC
United Methodist Behavioral Hospital
United Methodist Children's Home, Inc.
University of Arkansas for Medical Sciences Department of Psychiatry
Vista Health
Youth Bridge, Inc.

Community Mental Health Center

Professional Counseling Associates: 501- 221-1843

Serving Lonoke, Prairie Counties and Pulaski County (north of the Arkansas River)

Lonoke County

Professional Counseling Associates
405 North Second Street
Cabot, AR 72023
501-221-1843

Professional Counseling Associates
2nd and Depot Streets
Lonoke, AR 72086
501-676-3151

Prairie County

Professional Counseling Associates
109 North Hazen Avenue
Hazen, AR 72064
870-255-3527

Pulaski County

Professional Counseling Associates
7800 Sylvan Hills Highway
Sherwood, AR 72120
501-835-4174

Professional Counseling Associates
4354 Stockton
North Little Rock, AR 72231
501-955-7600

Professional Counseling Associates
9110 Geyer Springs Road
Little Rock, AR 72209
501-221-1843

Professional Counseling Associates
*3601 Richards Road
North Little Rock, AR 72117
501-221-1843

***Administrative Office**

Pulaski County (continued)

Professional Counseling Associates
1109 Burman
Jacksonville, AR 72076
501-982-7515

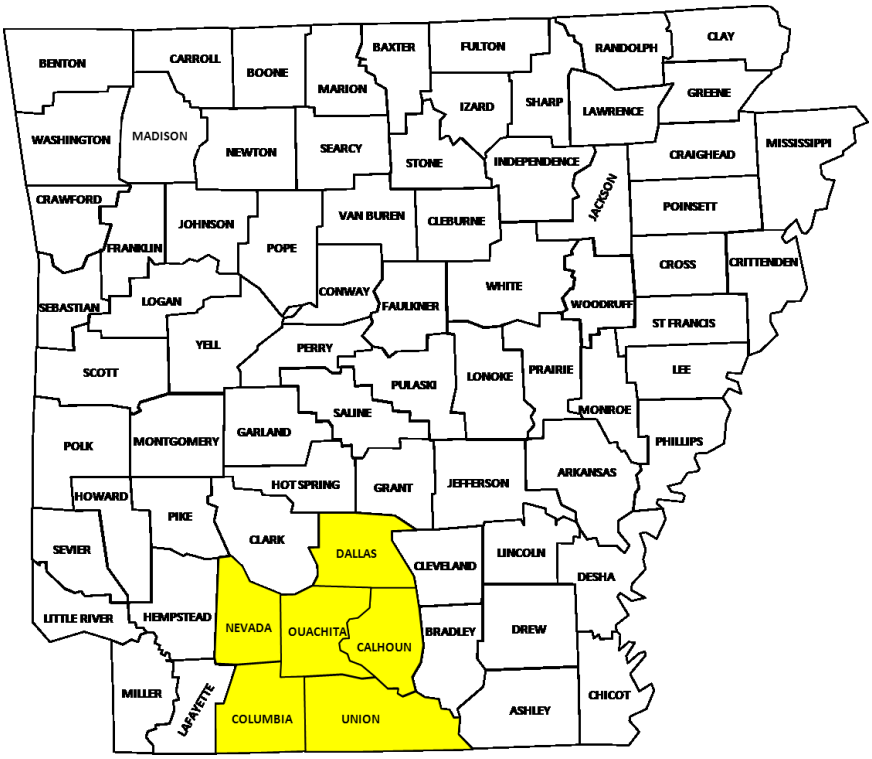
Private RSPMI Providers in Counties

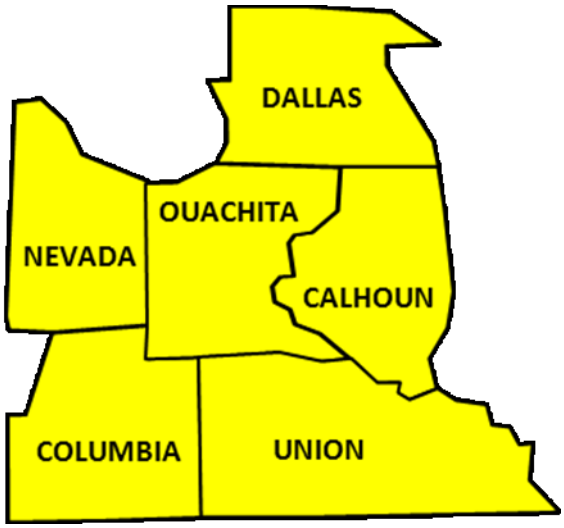
Lonoke County
Rivendell Behavioral Health Services of Arkansas

Prairie County
United Methodist Behavioral Hospital

Pulaski County
Alternative Opportunities/ Dayspring of Arkansas
Ascent Acquisition Corp –PSC
Baptist Health Behavioral Services
Bridgeway, Inc.
Centers for Youth and Families
Families Inc. of Arkansas
Inspiration Day Treatment, Inc.
Life Strategies Counseling, Inc.

Pulaski County (continued)
Living Hope Southeast
Maxus
Pathfinder, Inc.
Pinnacle Pointe Hospital
Rivendell Behavioral Health Services of Arkansas
Therapeutic Family Services, Inc.
Treatment Homes, Inc.
United Methodist Behavioral Hospital
United Methodist Children's Home, Inc.
University of Arkansas for Medical Sciences Department of Psychiatry
Youth Home, Inc.





Community Mental Health Center

South Arkansas Regional Health Center: 870-862-7921

Serving Calhoun, Columbia, Dallas, Nevada, Ouachita, Union Counties

Ouachita County

South AR Regional Health Center
412 North Vine
Magnolia, AR 71753
870-234-7500

South AR Regional Health Center
211 Jackson Street SW
Camden, AR 71701
870-836-5743

Union County

South AR Regional Health Center
710 West Grove
El Dorado, AR 71730
870-864-2471

South AR Regional Health Center
*715 North College
El Dorado, AR 71730
870-862-7921

***Administrative Office**

Private RSPMI Providers in Counties

Calhoun County
(None)

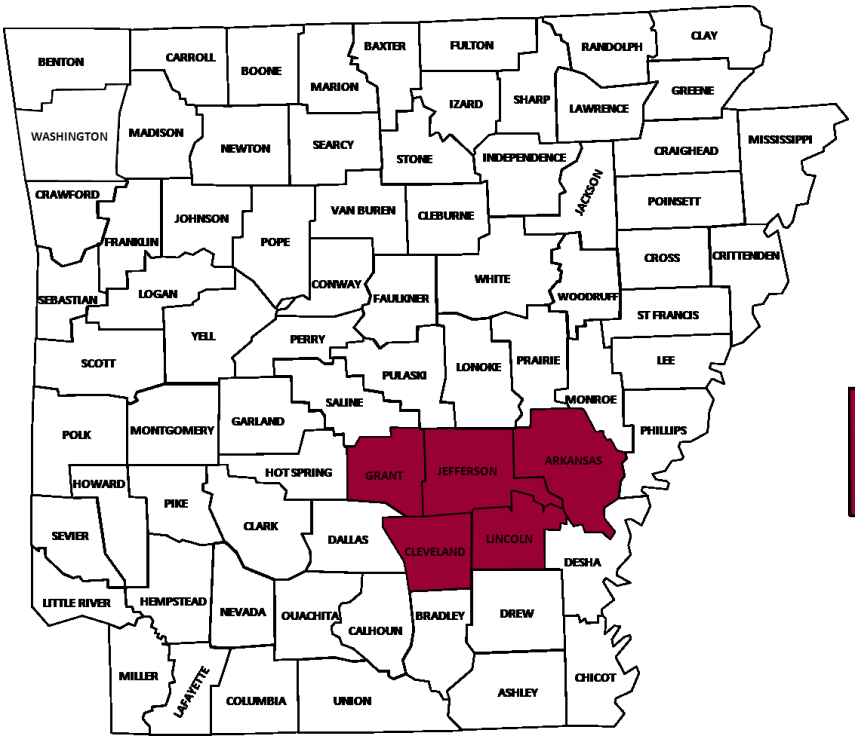
Columbia
Alternative Opportunities/ Dayspring of Arkansas
United Methodist Behavioral Hospital
United Methodist Children's Home, Inc.
South Arkansas Youth Services

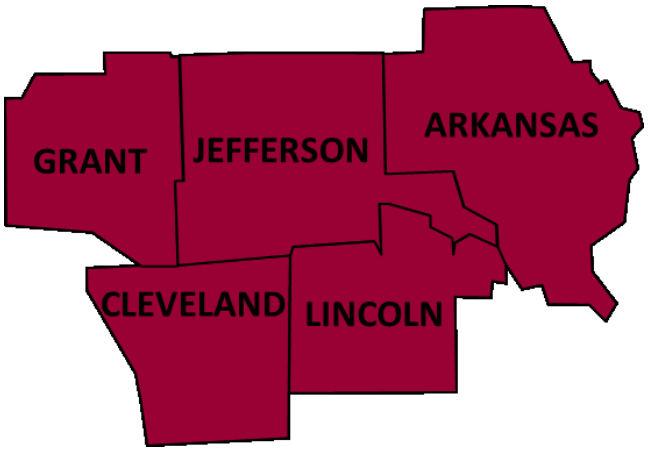
Dallas County
Rivendell Behavioral Health Services of Arkansas

Nevada County
Vista Health

Ouachita County
Alternative Opportunities/ Dayspring of Arkansas
South Arkansas Youth Services

Union County
Alternative Opportunities/ Dayspring of Arkansas
South Arkansas Youth Services





Community Mental Health Center

Southeast Arkansas Behavioral Health Care System, Inc.:870-534-1834

Serving Arkansas, Cleveland, Grant, Jefferson, and Lincoln Counties

Arkansas County

SE AR Behavioral Healthcare System, Inc.
121 Commercial Drive B
Stuttgart, AR 72160
870-673-1633

Grant County

SE AR Behavioral Healthcare System, Inc.
301 North Oak Street
Sheridan, AR 72150
870-942-5101

Jefferson County

SE AR Behavioral Healthcare System, Inc.
*2500 Rike Drive
Pine Bluff, AR 71613
870-543-1834

SE AR Behavioral Healthcare System, Inc.
3004 34th Avenue
Pine Bluff, AR 71603
870-534-1834

Lincoln County

SE AR Behavioral Healthcare System, Inc.
612 East Arkansas Street
Star City, AR 71667
870-628-4181

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***Administrative Office**

Private RSPMI Providers in Counties

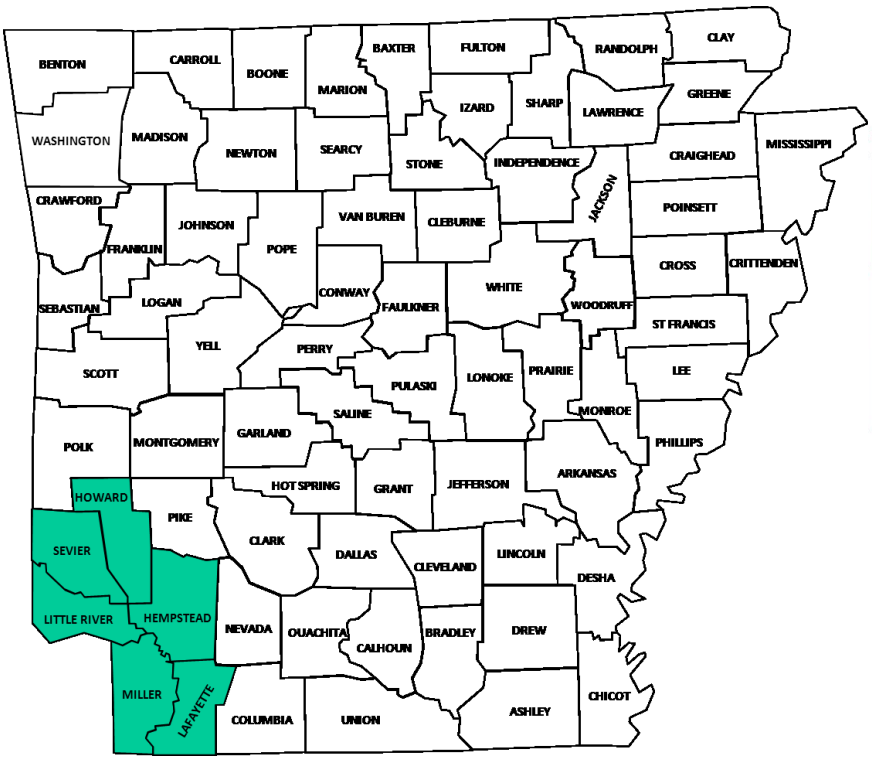
Arkansas County
Pinnacle Pointe Hospital

Cleveland County
(None)

Grant County
CMHC Only

Jefferson County
Maxus
People Advocating Transition, Inc. (The P.A.T. Center)
Rivendell Behavioral Health Services of Arkansas

Lincoln County
CMHC Only



Community Mental Health Center

Southwest Arkansas Counseling and Mental Health Center: 870-773-4655

Serving Hempstead, Howard, Lafayette, Little River, Miller, and Sevier Counties

Hempstead County

SW AR Counseling & MHC, Inc.
707 East Greenwood
Hope, AR 71801
870-777-9800

SW AR Counseling & MHC, Inc.
300 East 20th Street
Hope, AR 71802
870-777-9051

Howard County

SW AR Counseling & MHC, Inc.
508 North Second Street
Nashville, AR 71852
870-845-3110

Lafayette County

SW AR Counseling & MHC, Inc.
409 Woodruff Street
Bradley, AR 71826
870-894-3366

SW AR Counseling & MHC, Inc.
1107 Chestnut Street
Lewisville, AR 71845
870-921-5485

Little River County

SW AR Counseling & MHC, Inc.
351 North Second Street
Ashdown, AR 71822
870-898-7234

Miller County

SW AR Counseling & MHC, Inc.
*2904 Arkansas Boulevard
Texarkana, AR 71854
870-773-4655

Sevier County

SW AR Counseling & MHC, Inc.
1312 West Collin Raye Drive
DeQueen, AR 71832
870-584-7115

***Administrative Office**

Private RSPMI Providers in Counties

Hempstead County
Therapeutic Family Services, Inc.

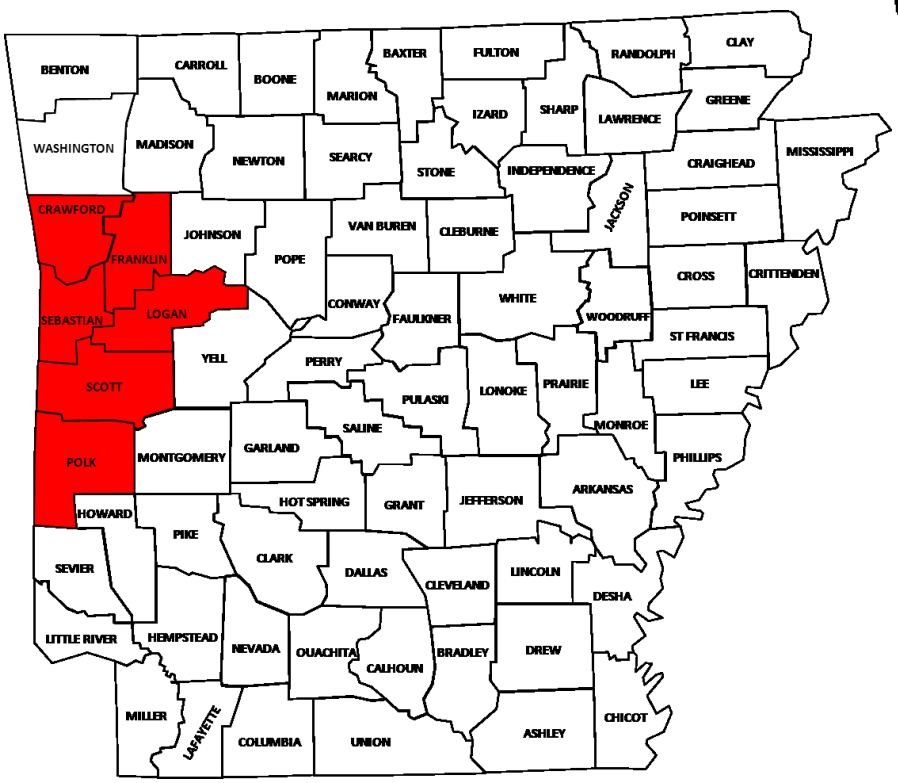
Howard County
CMHC Only

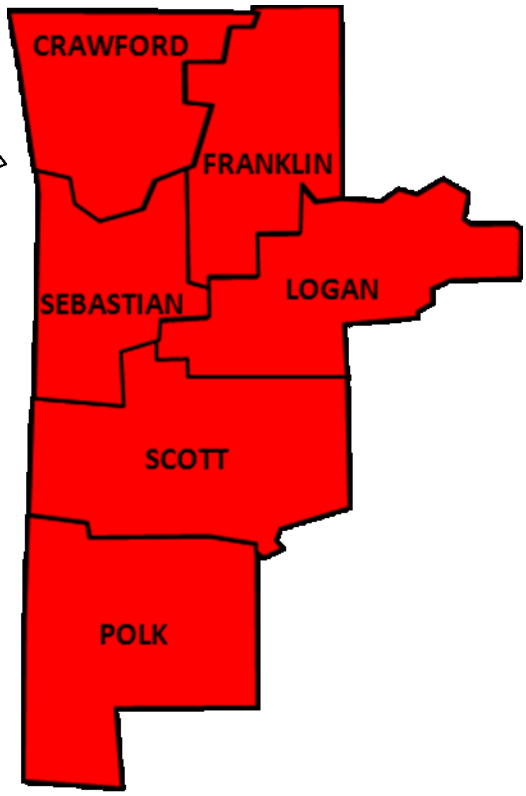
Lafayette County
Therapeutic Family Services, Inc.

Little River County
CMHC Only

Miller County
Alternative Opportunities/ Dayspring of Arkansas
South Arkansas Youth Services
Vista Health

Sevier County
CMHC Only





Community Mental Health Center

Western Arkansas Counseling and Guidance Center: 479-452-6650

Serving Crawford, Franklin, Logan, Polk, Scott, and Sebastian Counties

Crawford County

Western AR Counseling & Guidance Center
2705 Oak Lane, Suites A & B
Van Buren, AR 72956
479-474-8084

Franklin County

Western AR Counseling & Guidance Center
Highway 23 North & Airport Road
Ozark, AR 72949
479-667-2497

Logan County

Western AR Counseling & Guidance Center
415 South Sixth Street
Paris, AR 72855
479-963-2140

Western AR Counseling & Guidance Center
174 North Welsh
Booneville, AR 72927
479-675-3909

Polk County

Western AR Counseling & Guidance Center
307 South Cherry Street
Mena, AR 71953
479-394-5277

Western AR Counseling & Guidance Center
600 DeQueen Street
Mena, AR 71953
479-394-3200

Scott County
Western AR Counseling & Guidance Center
1857 Rice Street
Waldron, AR 72958
479-632-2468

Sebastian County
Western AR Counseling & Guidance Center
*3111 South 70th Street
Fort Smith, AR 72903
479-452--6650

Western AR Counseling & Guidance Center
2100 North 31st
Fort Smith, AR 72904
479-782-4991

Western AR Counseling & Guidance Center
3109 South 70th Street
Fort Smith, AR 72903
479-452-9490

Western AR Counseling & Guidance Center
3113 South 70th Street
Fort Smith, AR 72903
479-478-6664

***Administrative Office**

Private RSPMI Providers in Counties

Crawford County
Alternative Opportunities/ Dayspring of Arkansas
Perspectives Behavioral Health Management, LLC
United Methodist Behavioral Hospital

Franklin County
Conway County Community Service, Inc.

Logan County
Perspectives Behavioral Health Management, LLC

Scott County
CMHC Only

Polk County
Cedar Haven of Mena Regional Health System

Sebastian County
Bost, Inc.
Maxus

Arkansas Department of Human Services

DIVISION OF BEHAVIORAL HEALTH SERVICES

NON-FUNDED TREATMENT PROGRAMS

Location	Facility & Address	Contact Information	Services
Camden	**OUACHITA COUNTY MEDICAL CENTER** Chemical Dependency Unit P. O. Box 797 638 California (Physical) Camden, AR 71711 Website: www.ouachitamedcenter.com	Teresa Roark Director Telephone: 800-232-1289 Telephone: 870-836-1289 Fax: 870-836-1366 E-Mail: troark@ouachitamedcenter.com	Hospital Detoxification Inpatient Outpatient and Partial Day Treatment Services
Fayetteville	**VISTA HEALTH FAYETTEVILLE** 4253 N Crossover Road Fayetteville, AR 72703 Website: www.vistahealthservices.com	Connie Borengasser, CEO Lee Christenson, Administrator Telephone: 479-521-5731 E-Mail: jeanm@vistahealthservices.com	Hospital Acute Psychiatric Inpatient TX for Adults, Senior Adults, Child and Adolescent TDT & Residential Treatment School Based Counseling Out Patient Treatment Intensive Outpatient Treatment
Fayetteville & As Listed	**NORTHWEST ARKANSAS PSYCHOLOGICAL GROUP** 1706 Joyce, Suite 3 Fayetteville, AR 72703 211 North Greenwood Avenue Suite B Fort Smith, AR 72701	Richard Back, Ph.D., Executive Director Telephone: 479-442-9381 Email: back@napg.arcoxmail.com Gregory Roberts, MS, LPC, AADC Telephone: 479-478-0211 Fax: 479-782-7181 Email: Giamlistening@yahoo.com	Outpatient Treatment Outpatient Treatment
Fayetteville	**YOUTH BRIDGE** 2153 E. Joyce Blvd. Suite 201 Fayetteville, AR 72703 Website: www.youthbridge.com **YOUTH BRIDGE – Clinical** 3715 N. Business Drive, Suite 104 Fayetteville, AR 72703	Scott Linebaugh, Executive Director Telephone: 479-575-9471 Fax: 479-587-9392 Email: slinebaugh@youthbridge.com Libby Bier, Clinical Supervisor Telephone: 479-521-1532 Fax: 479-521-1532 Email: lbier@youthbridge.com	Administrative Site Only SATS
Fort Smith	**VISTA HEALTH** 10301 Mayo Road Mail Barling, AR 72923 10301 Mayo Road Physical Fort Smith, AR 72913 Website: www.vistahealthservices.com	Holli Baker, CEO Telephone: 479 494-5700 Fax: 479-494-5777 E-Mail: hollib@vistahealthservices.com	Hospitalization Acute Psychiatric Outpatient Treatment Child & Adolescent Residential & Day Treatment Gero- Psych Unit Intensive Outpatient Program

Location	Facility & Address	Contact Information	Services
Fort Smith	**RECOVERY SOLUTIONS, INC.** 501 South 18th Street Fort Smith, AR 72901	Anita Hudson Meadows, Administrator Telephone: 479-434-5566 Fax: 479-434-5568 E-Mail: ahmeadows@rsinc.arcoxmail.com	Outpatient Treatment
Fort Smith	**FORT SMITH BEHAVIORAL HEALTH, INC.** 1620 South 46th Street Fort Smith, AR 72903	Stephen Chiovoloni, CEO Lou White, Director Telephone: 479-494-7889 Fax: 479-494-7890	Outpatient Treatment
Fort Smith	**THE BRIDGE** P.O. Box 2665 4510 Towson Avenue Fort Smith, AR 72902	Sharese Bolden, Executive Director Telephone: 479-434-4681 Fax: 479-434-2224	Outpatient Treatment
Hot Springs	**C.A.T.A.R. Clinic of Hot Springs** Center for Addiction Treatment & Rehabilitation 1 Mercy Lane Suite 403 Hot Springs, AR 71913 Website: www.catarclinic.com	Miguel Casillas, MD, Director Sharon Mason, MD Russ Titsworth, Administrator Telephone: 501-463-9565 Fax: 501-463-9566 E-Mail: lr@catarclinic.com	
Jonesboro	**ST. BENARDS MEDICAL CENTER** 225 East Jackson Jonesboro, AR 72401 Website: www.sbrmc.com	Michael Givens, Administrator Telephone: 870-972-4100 Fax: 870-974-5112 E-Mail: mgivens@sbrmc.org	Hospital
Judsonia-Searcy	**CAPSTONE TREATMENT CENTER, INC.** P.O. Box 8241 Searcy, AR 72145 120 Meghan Lane (Physical) Judsonia, AR Website: http://capstonetreatmentcenter.com	Dr. Adrian Hickmon, Executive Director Telephone: 501-729-4479 Fax: 501-729-3537 E-Mail: info@capstonetreatmentcenter.com	Male Adolescent/Young A Adult Residential
Little Rock	**BAPTIST HEALTH - RECOVER** 9601 Interstate 630, Exit 7 8th Floor Little Rock, AR 72205 Website: www.baptist-health.com	Bradley Shaw, Clinical Coordinator Bob Burchfield, Nursing Supervisor Telephone: 501-202-2893 Fax: 501-202-1443 E-Mail: bradley.shaw@baptist-health.org bob.burchfield@baptist-health.org	Hospital Detoxification Adult Partial Day Intensive Outpatient Program
Little Rock & As Listed	**C.A.T.A.R. CLINIC of Little Rock** Center for Addiction Treatment & Rehabilitation 1401 S. University Little Rock, AR 72204 Website: www.catarclinic.com	Miguel Casillas, MD, Director Richard Doncer, MD Russ Titsworth, Administrator Telephone: 501-664-7833 Fax: 501-666-2366 E-Mail: hs@catarclinic.com	Opioid Treatment Program

Location	Facility & Address	Contact Information	Services
Little Rock & As Listed	**DEPT. OF COMMUNITY CORRECTION** Two Union National Plaza 105 West Capitol, 2nd Floor Little Rock, AR 72201 Website: www.dcc.arkansas.gov	David Eberhart, Director Rick Hart, Deputy Director of Residential Services Telephone: 501-682-9577 E-mail: rick.hart@arkansas.gov **Residential Services** Myra Summers-Woolfolk, Treatment Director Telephone: 501-682-9564 Fax: 501-682-9538 E-Mail: myra.summers@arkansas.gov	Criminal Justice System
	6th Judicial District Drug Court 2679 Pike Avenue North Little Rock, AR 72114	**Judicial Services** Ben Udochi, Assistant Director of Treatment Services Telephone: 501-683-2159 Fax: 501-371-1567 ben.udochi@arkansas.gov	Criminal Justice System
	Southeast Arkansas Community Correction 7301 West 13th Avenue Pine Bluff, AR 71601	Syrna Lee-Bowers, Clinical Supervisor Telephone: 870-879-0661 Fax: 870-879-1513 E-Mail: syrna.lee@arkansas.gov	Criminal Justice System
	Northwest Arkansas Community Correction Center 114 N. College Avenue Fayetteville, AR 72701	Syrna Lee-Bowers, Clinical Supervisor Telephone: 479-695-3400 E-Mail: syrna.lee@arkansas.gov	Criminal Justice System
	Northeast Arkansas Community Correction Center 1351 Cyro Road P.O. Box 487 Osceola, AR 72370	Walter Towne, Clinical Supervisor Telephone: 870-563-8330 E-Mail: walter.townne@arkansas.gov	Criminal Justice System
	Southwest Arkansas Community Correction Center 506 Walnut Street Texarkana, AR 71854	Tina Maxwell, Clinical Supervisor Telephone: 870-779-2189 Fax: 870-779-2044 E-Mail: tina.maxwell@arkansas.gov	Criminal Justice System
Little Rock	**GYST HOUSE** P.O. Box 192407 8101 Frenchman's Lane (Physical) Little Rock, AR 72219 Website: www.gysthouseinc.com	Vince Liddell, Executive Director Telephone: 501-568-1682 Fax: 501-568-1150 Stephanie Norvell E-Mail: norvellmystee@aol.com	Outpatient Treatment
Little Rock	**QUALITY LIVING CENTER** 3925 Asher Avenue Little Rock, AR 72204 Website: www.qualitylivingcenter.org	Dino Davis, Executive Director Telephone: 501-663-3490 Fax: 501-663-3446 E-Mail: QLC3925@yahoo.com	Residential Treatment Outpatient Treatment Partial Day

Location	Facility & Address	Contact Information	Services
Little Rock	**STEP UP SUPPORT CENTER** 8501 Geyer Springs Road Little Rock, AR 72209 Website: www.thestepupsupportcenter.com	Ruth Nash, Executive Director Telephone: 501-565-3579 Fax: 501-565-4932 E-Mail: Stepup1333@yahoo.com	Outpatient Treatment
Little Rock	**U.A.M.S. PROGRAM FOR ADULTS** Chemical Dependency Outpatient Program 4301 West Markham, Slot # 568 4224 Shuffield Drive, Second Floor (Physical) Little Rock, AR 72205	Michael Mancino, MD, Divisional Director Telephone: 501-526-8200 Fax: 501-526-5296 Peggy Healy, LPN, LCSW, Program Manager E- Mail: mmhealy@uams.edu	Outpatient Treatment Buprenorphine Program
Little Rock & As Listed	**UNITED FAMILY SERVICES, INC.** 1202 W. 6th Street Little Rock, AR 72201 Website: www.ufamservices.com	Levi Thomas, Executive Director Telephone: 501-244-0062 Fax: 501-244-0359 E-Mail: ufs2@ipa.net	Adolescent Outpatient Treatment
	P.O. Box 5408 1314 W. 6th Street Pine Bluff, AR 71611	Levi Thomas, Executive Director Telephone: 870-534-3386 Fax: 870-534-0350 E-Mail: ufs2@ipa.net	Outpatient Treatment
	1314 W. 6th Street Pine Bluff, AR 71601	Helen Wayne,LCSW, Clinical Coordinator E-Mail: halexander@ufs6.com Phone: 501-244-0062	Outpatient Treatment
	616 South Linden Street Pine Bluff, AR 71601	Levi Thomas, Executive Director Phone: 870-534-3386	Outpatient Treatment
	1600 S. Main Street Stuttgart, AR 72160	Telephone: 870-672-4840	Outpatient Treatment
	715 W. 2nd Street Little Rock, AR 72201	Telephone: 501-376-0111	
Little Rock	**WARDS OF SERENITY, INC.** 2020 West 3rd Street, Suite 213 Little Rock, AR 72205	Bobby Ward, LADAC, CCS Telephone: 501-372-1370 Fax: 501-372-1375 E-Mail: bobbyward01@att.net	Outpatient Treatment
Morrilton & As Listed	**COMMUNITY SERVICE, INC.** P.O. Box 679 100 South Cherokee St. (Physical) Morrilton, AR 72110 Website: http://www.communityserviceinc.com	Mike Worley, CEO Darryl Rhoda, Director of Operations Telephone: 501-354-4589 Fax: 501-354-5410 E-Mail: mworley@communityserviceinc.com drhoda@communityserviceinc.com	Adolescent Outpatient, Partial Day and Co-occurring Disorder Treatment Services
	COMMUNITY SERVICE, INC. 1505 S. Oswego Ave. Russellville, AR 72802	Kathy Gibson, Office Manager Telephone: 501-967-3370 Fax: 501-967-2775 E-Mail: kathy@communityserviceinc.com	

Location	Facility & Address	Contact Information	Services
	COMMUNITY SERVICE, INC. P. O. Box 1133 451 Ingram Street Clinton, AR 72031 **COMMUNITY SERVICE, INC.** 106 Cherokee Lane (Mailing Address) Clarksville, AR 72830 203 North 4th Street (Physical) Ozark, AR 72949 **COMMUNITY SERVICE, INC.** P.O. Box 1042 (Mailing) 730 Boston St. Danville, AR 72833 **COMMUNITY SERVICES, INC.** 106 Cherokee Lane Clarksville, AR 72830 **COMMUNITY SERVICES, INC.** 818 N Creek Drive Conway, AR 72032	Joyce Watson, Office Manager Telephone: 501-327-9788 Fax: 501-354-9843 E-mail: jwatson@communityserviceinc.com Kaethe Hoehling, Office Manager/Therapist Telephone: 479-754-7296 or 479-667-5855 Fax: 479-667-5855 E-Mail: khoehling@communityserviceinc.com Arthur Duran, Office Manager/Therapist Telephone: 479-495-5177 Fax: 479-495-5187 E-Mail: aduran@communityserviceinc.com Kaethe Hoehling, Office Manager/Therapist Telephone: 479-754-7296/479-667-5855 Fax: 479-754-8919 E-Mail: khoehling@communityserviceinc.com Joyce Watson, Office Manager Telephone: 501-327-9788 Fax: 501-327-9843 E-Mail: jwatson@communityserviceinc.com	
Rogers	**PINNACLE COUNSELING** 5500 Pinnacle Point Drive Suite 204 Rogers, AR 72758 www.PinnacleCounselingNWA.com	Sharon Nelson, Clinical Director Sharon@pinnaclecounselingnwa.com Gary Nelson, Program Director gary@pinnaclecounselingnwa.com Telephone: 479-268-4142 Fax: 888-732-7108	Outpatient Treatment for Adults and Adolescents Co-Occurring Disorders Treatment Services
Rogers	**YOUTH BRIDGE – BENTON COUNTY** 1200 W. Walnut, Suite 1500 Rogers, AR 72756 Website: www.youthbridge.com	Judy Sweet, Clinical Director Telephone: 479-636-0083 Fax: 479-636-0144 Email: jsweet@youthbridge.com	Adolescent and Co-occurring Substance Abuse and Mental Health Disorder Treatment
Springdale	**SPRINGDALE TREATMENT CENTER** 1353 East Henri De Tonti Blvd. Suite A Springdale, AR 72762 www.methadonetreatmentcenter.com	Connie Phillips, M. Ed, CADC, Program Director Telephone: 479-306-4480 Fax: 479-306-4488 Email: springdale@methadonetreatmentcenter.com	Opioid Treatment Program

Location	Facility & Address	Contact Information	Services
Springdale	**OZARK GUIDANCE CENTER** 2400 S. 48th Street (Physical Address) Springdale, AR 72766 P.O. Box 6430 (Mailing Address) Springdale, AR 72766 Website: www.ozarkguidancecenter.org	Tom Petrizzo, CEO Debbie Crews, LPC, RPT, LADC, NCG-1, CCGC, Director of Adult Behavioral & Substance Abuse Programs Telephone: 479-750-2020 Telephone: 800-234-7052 Fax: 479-750-4346 Email: brenda.hodges@ozarkguidance.org	Outpatient Treatment
Springdale & As Listed	**YOUTH BRIDGE – Residential** 3895 George Anderson Road Springdale, AR 72764 Website: www.youthbridge.com	Kathy Lott, Program Director Telephone: 479-575-9471 Fax: 479-587-9392 Email: klott@youthbridge.com	Adolescent and Co-occurring Substance Abuse and Mental Health Disorder Treatment for **Department of Youth Services Only**
	YOUTH BRIDGE – Carroll County 1004 S Main Street Berryville, AR 72616	Judy Sweet, Clinical Supervisor Telephone: 479-636-0083 Fax: 479-636-0144 Email: jsweet@youthbridge.com	Adolescent and Co-occurring Substance Abuse and Mental Health Disorder Treatment
	YOUTH BRIDGE – Boone County 107 East Crandall Avenue, Suite B Harrison, AR 72601	Judy Dunn, Clinical Supervisor Telephone: 870-741-8484 Fax: 870-741-4088 Email: jdunn@youthbridge.com	Adolescent and Co-occurring Substance Abuse and Mental Health Disorder Treatment
	YOUTH BRIDGE – Baxter County 706 South Main St. Suite #1 Mt. Home, AR 72653	Judy Dunn, Clinical Supervisor Telephone: 870-425-5644 Fax: 870-424-2201 Email: jdunn@youthbridge.com	Adolescent and Co-occurring Substance Abuse and Mental Health Disorder Treatment
Texarkana	**ARKANSAS TREATMENT SERVICES, PA** P.O. Box 23842 408 Hazel Street Texarkana, AR 71854	Andrea "Andy" Stratton, RN, CADC, Program Director Telephone: 870-774-0421 Fax: 870-774-0427 Email: andy@methadone4me.com	Opioid Treatment
Van Buren	**SERENITY COUNSELING ADVOCATES** P.O. Box 1108 Van Buren, AR 72956 3103 Alma Highway Van Buren, AR 72956	John Parker, Executive Director Gerald Rogers, Program Director Telephone: 479-410-4658 Fax: 479-410-1710 Email: johnparker8@me.com Email: gbrog7@yahoo.com	Outpatient Treatment Services Services for Adolescents and Adults

Arkansas Department of Human Services
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SUBSTANCE ABUSE TREATMENT SERVICES (SATS) PROGRAMS

LOCATION	FACILITY & ADDRESS	CONTACT INFORMATION
BENTONVILLE	ALTERNATIVE OPPORTUNITIES, INC **DECISION POINT INC.**	HELEN BALDING, Director Telephone: (479) 464-1060 Fax: (479) 464-1062 Email: hbalding@dayspringbhs.com
RUSSELLVILLE	ARVAC, INC **FREEDOM HOUSE ADTC**	GARY RHODES, Program Director Telephone: (479) 968-7086 Fax: (479) 968-7225 Email: gary.rhodes@freedomhouseadtc.org
NORTH LITTLE ROCK	**FAMILY SERVICE AGENCY, INC**	CHARLES DEVILLE, Executive Director Telephone: (501) 372-4242 Fax: (501) 372-6565 Email: cdevillejr@fsainc.org
FORT SMITH	**HARBOR HOUSE, INC.**	JOHN JOHNSON, Director Telephone: (479) 785-4083 Fax: (479) 668-2059 Email: harborhouse.hhi!gmail.com
SEARCY	HEALTH RESOURCES OF ARKANSAS **WILBUR D. MILLS CENTER**	ROB SMITH, Executive Director Telephone: (501) 268-7777 Fax: (501) 305-5009 Email: rsmith@hra-health.org
JONESBORO	NORTHEAST AR COMMUNITY MENTAL HEALTH CENTER **MID-SOUTH HEALTH SYSTEMS**	BONNIE WHITE, Executive Director Telephone: (870) 972-4063 Fax: (870) 972-4968 Email: bwhite@mshs.org
HOT SPRINGS	**QUAPAW HOUSE, INC**	CASEY BRIGHT, Executive Director Telephone: (501) 767-4456 Fax: (501) 767-4617 Email: caseybright@quapawhouseinc.org
EL DORADO	**SOUTH ARKANSAS SUBSTANCE ABUSE, INC**	PAUL MEASON, Director Telephone: (870) 881-9301 Fax: (870) 864-9934 Email: paulmeason@sasaeldo.org

PINE BLUFF	**SOUTHEAST AR BEHAVIORAL HEALTHCARE SYSTEM, INC**	KATHY HARRIS, President & CEO Telephone: (870) 534-1834 Fax: (870) 850-0942 Email: Kathy@sabhs.org
TEXARKANA	**SOUTHWEST AR COUNSELING AND MENTAL HEALTH CENTER, INC.**	DWIGHT SPERRY, Executive Director Telephone: (870) 773-4655 Fax: (870) 772-4650 Email: dsperry@swacmhc.com
LITTLE ROCK	UAMS **SUBSTANCE ABUSE TREATMENT CLINIC**	TRACY PETTY, PI Coordinator Telephone: (501) 526-8400 Fax: (501) 526-8499 Email: tpetty@uams.edu
PINE BLUFF	**UNITED FAMILY SERVICES, INC.**	LEVI THOMAS, Executive Director Telephone: (870) 534-3386 Fax: (870) 534-0350 Email: ufs2@ipa.net
FAYETTEVILLE	**YOUTH BRIDGE, INC.**	SCOTT LINEBAUGH, Executive Director Telephone: (479) 575-9471 Fax: (479) 587-9392 Email: scottlinebaugh@youthbridge.com
FORT SMITH	WESTERN AR COUNSELING & GUIDANCE CTR **HORIZON ADOLESCENT TREATMENT CENTER**	DIANE BYNUM, Director Telephone: (479) 478-6664 Fax: (479) 478-6793 Email: diane.bynum@wacgc.org

Arkansas Department of Human Services

Division of Behavioral Health Services

FUNDED TREATMENT PROGRAMS

Catchment Area 1

Benton, Carroll, Washington and Madison

ALTERNATIVE OPPORTUNITES – DECISION POINT		
Bates Campus 602 N. Walton Blvd (Physical) Bentonville, AR 72712 www.decision-point.org	Helen Balding, Director Email: hbalding@aoinc.org Site: 479-464-1060 Fax: 479-464-1062	Residential Treatment Outpatient Specialized Women's Services Detoxification Partial Day

Catchment Area 2

Boone, Marion, Baxter, Newton, Searcy

ALTERNATIVE OPPORTUNITIES - DAYSPRING BEHAVIORAL HEALTH		
315 W. 6th Street Mountain Home, AR 72653	Eddie Cooper, Regional Director Site Telephone: 870-425-8642 Fax: 870-425-8652 E-Mail: ecooper@dayspringbhs.com	Outpatient
P.O. 1175 316 Hwy 65 North Marshall, AR 72650	Eddie Cooper, Director of Field Operations Site Telephone: 870-448-4727 Fax: 870-448-4496 E-Mail: ecooper@dayspringbhs.com	Outpatient
600 S. Pine Street Suite A, Room 114 Harrison, AR 72601 www.dayspringbhs.com	Eddie Cooper, Regional Director Site Telephone: 870-425-8642 Fax: 870-425-8652 E-Mail: ecooper@dayspringbhs.com	Outpatient

OZARK MOUNTAIN ALCOHOL RESIDENTIAL TREATMENT, INC. (OMART)		
OMART P. O. Box 308 116 Snowball Drive (Physical) Gassville, AR 72635	Darlene Prine, Executive Director Telephone: 870-435-6200 Fax: 870-435-2063 E-Mail: omart-inc@suddenlinkmail.com	Residential Treatment Outpatient Partial Day Treatment Specialized Women's Services Detoxification

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Gassville Outpatient Office P. O. Box 308 116 Snowball Drive (Physical) Gassville, AR 72635	Dennis Amaral, Site Supervisor Telephone: 870-435-6300 Fax: 870-435-6063	Outpatient Treatment Partial Day Treatment
Harrison Outpatient Office 801 South Pine Street Pine Plaza, Suite #4 Harrison, AR 72601	Linda J. Higgins, Site Supervisor Telephone: 870-365-7251 Fax: 870-365-0332	Outpatient Treatment Intensive Outpatient

Catchment Area 3

Fulton, Izard, Sharp, Stone, Independence, Van Buren, Cleburne, White, Jackson, Woodruff

HEALTH RESOURCES OF ARKANSAS, INC.

P. O. Box 2578 #25 Gap Road Batesville, AR 72503 Website: www.healthresourcesofarkansas.com	Tommy Mitchum, CEO Phone: 870-793-8900 ext. 1135 Fax: 870-793-4258 E-Mail: tmitchum@hra-health.org	Administrative Location
Wilbur D. Mills Center 3204 E. Moore Street Searcy, AR 72143	Rod Smith, Director Phone: 501-268-7777 Fax: 501-305-5009 E-Mail: rsmith@hra-health.org	Residential Treatment Outpatient Treatment Specialized Women's Services Detoxification Partial Day Co-occurring Disorders
Batesville Behavioral Health 1800 Myers Batesville, AR 72501	Rod Smith, Director Phone 870-793-8900	Outpatient Treatment Partial Day Treatment Co-occurring Disorders
Mt. View Behavioral Health 211 Blanchard Avenue Mt. View AR 72560	Rod Smith, Director Phone: 866-533-1759	Outpatient Treatment Partial Day Treatment Co-occurring Disorder
Heber Springs Behavioral Health 1716 West Searcy Heber Springs, AR 72534	Rod Smith, Director Phone: 866-533-1763	Outpatient Treatment Services
Ash Flat Outpatient 714 A-Ash Flat Drive Ash Flat, AR 72513	Rod Smith, Director Phone: 866-533-1761	Outpatient Treatment Services
Salem Behavioral Health 684 Hwy Sky-VU Shopping Center Salem, AR 72576	Rod Smith, Director Phone: 866-533-1762	Outpatient Treatment Services
Melbourne Behavioral Health 1109 E. Main Melbourne, AR 72256	Rod Smith, Director Phone: 866-533-1760	Outpatient Treatment Services

Newport Behavioral Health 1507 N. Pecan Street Newport, AR 72112	Rod Smith, Director Phone: 866-533-1758	Outpatient Treatment Services
Pine Valley Behavioral Health 900 W. Popular McCroy, AR 72101	Rod Smith, Director Phone: 866-533-1757	Outpatient Treatment Services
Harrison Behavioral Health 4081 Hwy 7 South Harrison, AR 72601	Rod Smith, Director Phone: 866-308-9925	Outpatient Treatment Services
Mt. Home Behavioral Health #8 Medical Plaza Mt. Home, AR 72653	Rod Smith, Director Phone: 866-308-9923	Outpatient Treatment Services
Yellville Behavioral Health 319 Hwy 14 South #1 Yellville, AR 72687	Rod Smith, Director Phone: 866-308-9927	Outpatient Treatment Services
Augusta Behavioral Health 623 North 9th Street Augusta, AR 72006	Rod Smith, Director Phone: 870-347-3254	Outpatient Treatment Services
Marshall Behavioral Health 200 East Main Street Marshall, AR 72560	Rod Smith, Director Phone: 866-308-9928	Outpatient Treatment Services
Searcy Behavioral Health 3302 East Moore Street Searcy, AR 72143	Rod Smith, Director Phone: 501-268-4181	Outpatient Treatment Services
Clinton Behavioral Health 1303 Hwy 65 South Clinton, AR 72031	Rod Smith, Director Phone: 866-533-1765	Outpatient Treatment Services
Jasper Behavioral Health 504 West Court Street Jasper, AR 72641	Rod Smith, Director Phone: 888-533-1767	Outpatient Treatment Services

Catchment Area 4

Randolph, Clay, Greene, Lawrence, Craighead, Poinsett, Mississippi

CROWLEY'S RIDGE DEVELOPMENT COUNCIL, INC.

P. O. Box 16720 2401 Fox Meadow Lane (Physical) Jonesboro, AR 72403-1497 Website: http://www.crdcnea.com/index.html	Troy Branscum, Executive Director Phone: 870-802-7100 Fax: 870-935-0291 E-Mail: troybranscum@crdcnea.com	Administrative Site Only

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Northeast Arkansas Regional Recovery Center 6009 C. W. Post Road Jonesboro, AR 72401	Darla Tate, Director Teresa Wooten, Administrator Phone: 870-932-0228 Fax: 870-910-5689 E-Mail: dtate@crdcnea.com	Residential Treatment Outpatient Treatment Detoxification
NORTHEAST ARKANSAS COMMUNITY MENTAL HEALTH CENTER dba MID SOUTH HEALTH SYSTEMS		
2707 Browns Lane Jonesboro, AR 72401-7213 Website: http://www.mshs.org	Bonnie White, Executive Director Dr. Del Thomas, Outpatient Director Phone: 870-972-4063 Fax: 870-972-4968 E-Mail: bwhite@mshs.org Roland Irwin, PhD, Clinical Director Phone: 870-972-4000 Fax: 870-972-4968 E-Mail: rirwin@mshs.org	Community Mental Health Center Outpatient Treatment Partial Day Treatment
Bytheville Outpatient Clinic 209 Lockard Blytheville, AR 72315	Amanda Smart, Clinic Director Phone: 870-763-2139 Fax: 870-763-5056 E-Mail: asmart@mshs.org	Outpatient Treatment Partial Day Treatment
Walnut Ridge Outpatient Clinic 102 South Larkspur Walnut Ridge, AR 72476	Barbara Broadway, Clinic Director Phone: 870-886-7924 Fax: 870-886 7968 E-Mail: bbroadway@mshs.org	Outpatient Treatment
Pocahontas Outpatient Clinic 2560 Old County Road Pocahontas, AR 72455	Robbie Cline, Clinic Director Phone: 870-892-7111 Fax: 870-892-0930 E-Mail: rcline@mshs.org	Outpatient Treatment Partial Day Treatment
Paragould Outpatient Clinic 1011 Morgan Street Paragould, AR 72450	Karen Hall, Clinic Director Phone: 870-239-2244 Fax: 870-236-1616 E-Mail: khall@mshs.org	Outpatient Treatment Partial Day Treatment
Corning Outpatient Clinic 602 David Street Corning, AR 72422	Timothy Pennington, Clinic Director Phone: 870-857-3655 Fax: 870-857-3667 E-Mail tpenning@mshs.org	Outpatient Treatment

Catchment Area 5
Crawford, Franklin, Sebastian, Logan, Scott, Polk

HARBOR HOUSE, INC. dba GATEWAY AND HARBOR RECOVERY CENTERS		
P. O. Box 4207 615 North 19th Street (Physical) Fort Smith, AR 72914-72901 Website: www.recoveryhhi.org Email: info@recoveryhhi.org	John Johnson, Interim Director Phone: 479-785-4083 Fax: 479-668-2059 Email: harborhouseinc@recoveryhhi.org	
Gateway Recovery Center P.O. Box 4207 Fort Smith, AR 72914 3900 Armour Avenue Fort Smith, AR 72904	Cindy Stokes, Director of Operations Phone: 479-785-4083 Fax: 479-783-4083 E-mail: cstokes@recoveryhhi.org Sharon Turner, Clinical Director E-Mail: sturner@recoveryhhi.org	Residential Treatment Female Only Outpatient Treatment Detoxification Specialized Women's Services
Harbor Recovery Center P. O. Box 4207 615 North 19th Street (Physical) Fort Smith, AR 72914	Brad Walker, Director of Operations Phone: 479-785-4083 Fax: 479-668-2059 E-mail: bwalker@recoveryhhi.org	Residential Treatment Male Only Outpatient Treatment Detoxification
WESTERN ARKANSAS COUNSELING & GUIDANCE CENTER		
P. O. Box 11818 Fort Smith, AR 72917-1818 Website: http://www.wacgc.org	Jim West, LCSW, CEO Phone: 479-452-5847 or 800-542-1031 Fax: 479-452-5847 E-Mail: jim.west@wacgc.org	Community Mental Health Center Co-Occurring Disorders Outpatient Treatment
Horizon Adolescent Treatment Program 3113 S. 70th Street Fort Smith, AR 72903	Diane Bynum, Coordinator Phone: 479-478-6664 Fax: 479-478-6793 E-Mail: diane.bynum@wacgc.org	Adolescent Residential Treatment Adolescent Outpatient Treatment Co-occurring Disorders
P. O. Box 564 415 S. 6th Street Paris, AR 72855	Diane Bynum, Coordinator Phone: 479-963-2140 Fax: 479-478-6793	Adolescent Outpatient Treatment
P. O. Box 562 174 North Welsh (Physical) Booneville, AR 72927	Diane Bynum, Coordinator Phone: 479-675-3909	Adolescent Outpatient Treatment
1857 Rice Street Waldron, AR 72958	Diane Bynum, Coordinator Phone: 479-478-6664	Adolescent Outpatient Treatment
307 S. Cherry Street Mena, AR 71953	Diane Bynum, Coordinator Phone: 479-478-6664	Adolescent Outpatient Treatment

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Catchment Area 6
Johnson, Pope, Yell, Conway, Faulkner, Perry

ARKANSAS RIVER VALLEY AREA COUNCIL, INC. (ARVAC)		
P. O. Box 808 613 N. 5th (Physical) Dardanelle, AR 72834-3400 Website: www.arvacinc.org	Bob Adkison, Executive Director Joann Pinkney, Administrative Director Phone: 479-229-4861 Fax: 479-229-4863 E-Mail: jpinkney@centurytel.net	Administrative Site
Freedom House P. O. Box 1463 400 Lake Front Drive (Physical) Russellville, AR 72802-2206	Gary Rhodes, Interim Executive Director Email: gary.rhodes@freedomhouseadtc.org Phone: 479-968-7086 Fax: 479-968-7225	Residential & Outpatient Treatment Services Detoxification Partial Day
COUNSELING ASSOCIATES, INC.		
350 Salem Road, Suite 1 Conway, AR 72034 Website: http://www.caiinc.org	Steve Newsome, LCSW, CEO Phone: 501-327-4889 Fax: 501-327-4492 E-Mail: snewsome@caiinc.org Lou Strain, LPE, Faulkner County Program Operations Director Phone: 501-336-8300 Fax: 501-329-5508 E-Mail: lstrain@caiinc.org	Community Mental Health Center Outpatient Treatment Services Co-Occurring Disorders
110 Skyline Road Russellville, AR 72801	Dianne Skaggs, LCSW, Pope/Johnson/Yell Counties, Chief Operations Director Phone: 479-968-1298 Fax: 479-968-6053 E-Mail: dskaggs@caiinc.org	Outpatient Treatment Services
1051 Poplar Street Clarksville, AR 72830	Jimmie Wooding, LCSW, Clinical Director Phone: 479-754-8610 Fax: 479-754-8788 E-Mail: jwooding@caiinc.org	Outpatient Treatment Services
8 Hospital Drive Morrilton, AR 72110	Brynda Lilley, Conway/Perry Counties Program Operations Director Phone: 501-354-1561 Fax: 501-354-1564 E-Mail: blilley@caiinc.org	Outpatient Treatment Services

Catchment Area 7
Cross, Crittenden, St. Francis, Monroe, Lee, Phillips

HEALTH RESOURCES OF ARKANSAS, INC.		
P. O. Box 2578 #25 Gap Road (Physical) Batesville, AR 72503 Website: www.healthresourcesofarkansas.com	Tommy Mitchum, CEO Phone: 870-793-8900 Fax: 870-793-4258 tmitchum@hra-health.org	Administrative Location
Wilbur D. Mills Center 3204 E. Moore Street Searcy, AR 72143	Rod Smith, Director Phone: 501-268-7777 Fax: 501-305-5009 E-Mail: rsmith@hra-health.org	Residential and Outpatient Treatment Services Detoxification Specialized Women's Services Partial Day Co-Occurring Disorders
East Arkansas Substance Abuse Program Crittenden County 310 Mid Continental Building Suite 602 West Memphis, AR 72301	Holly Willard, Coordinator of Substance Abuse Treatment Services Phone: 870-735-2499 E-Mail: hwillard@hra-health.org	Outpatient Treatment Services
Marianna Outpatient 528 West Chestnut Marianna, AR 72360	Holly Willard, Coordinator of Substance Abuse Treatment Services Maggie Baty, LADAC Phone: 870-295-2575	Outpatient Treatment Services
Forrest City Outpatient 112 South Izard Street Forrest City, AR 72335	Holly Willard, Coordinator of Substance Abuse Treatment Services Phone: 870-639-1990	Outpatient Treatment Services
Wynne Outpatient 111 Merriman Street Wynne, AR 72396	Holly Willard, Coordinator of Substance Abuse Treatment Services Phone: 870-238-9290	Outpatient Treatment Services

Catchment Area 8
Montgomery, Garland, Hot Spring, Pike, Clark

QUAPAW HOUSE, INC.

500 Quapaw Avenue (Mailing) Hot Springs, AR 71901 812 Mountain Pine Road (Physical) Hot Springs, AR 71914 Website: www.quapawhouseinc.org	Casey Bright, Executive Director Phone: 501-767-4456 Fax: 501-767-4617 E-Mail:caseybright@quapawhouseinc.org	Residential and Outpatient Treatment Services Detoxification
500 Quapaw Avenue (Mailing) Hot Springs, AR 71901 276 Linden Street Hot Springs, AR 71901	Casey Bright, Executive Director Phone: 501-767-0051 Fax: 501-767-0059 E-Mail: caseybright@quapawhouseinc.org	Outpatient
BABIES, ADULTS, RECOVERY BASED SERVICES (BARB'S PLACE) 500 Quapaw Avenue (Mailing) Hot Springs, AR 71901 276 Linden Street (Physical) Hot Springs, AR 71901	Casey Bright, Executive Director Phone: 501-767-4456 Fax: 501-767-4456 Email: caseybright@quapawhouseinc.org	Specialized Women's Services
QUAPAW HOUSE ADOLESCENT RESIDENTIAL TREATMENT CENTER 500 Quapaw Avenue (Mailing) Hot Springs, AR 71901 812 Mountain Pine Road (Physical) Hot Springs, AR 71914 Website: www.quapawhouseinc.org	Shannon Pearce, Clinical Director Phone: 501-767-4456 Fax: 501-767-4617 E-Mail: shannonpearce@quapawhouseinc.org	Residential Adolescent Treatment Services

Catchment Area 9
Saline, Pulaski, Lonoke, Prairie

ARKANSAS CARES, INC.

United Methodist Children's Home Arkansas Cares 2002 South Fillmore Little Rock, AR 72204 Website: www.methodistfamily.org	Craig Gammon, Administrator Phone: 501-661-0720 Ext. 7104 Fax: 501-664-3702 Email:cgammon@methodistfamily.org	Specialized Women's Services

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COUNSELING CLINIC, INC.		
307 East Sevier Street Benton, AR 72015 Website: www.cc-inc.org	Jim Gregory, Executive Director E-Mail: jgregory@cc-inc.org Joyce Schimenti, Site Supervisor E-Mail: jschimenti@cc-inc.org Phone: 501-315-4224 Fax 501-776-0411	Community Mental Health Center Outpatient Treatment Services
BETTER COMMUNITY DEVELOPMENT, INC.		
HOOVER TREATMENT CENTER 3805 W. 12th Street (Mailing) 3604 W. 12th Street (Physical) Little Rock, AR 72204 Website: www.bcdinc.org	Deborah Bell, Director Richard Richardson, Clinical Supervisor Phone: 501-663-4774 Fax: 501-663-7228 E-Mail: rrichardson@bcdinc.org	Residential and Outpatient Treatment Services Partial Day
RECOVERY CENTERS OF ARKANSAS		
RIVERBEND 1201 River Road North Little Rock, AR 72114 Website: www.rcofa.org	Carole Baxter, M.S., Executive Director Phone: 501-372-4611 Fax: 501-372-1801 E-Mail: cbaxter@rcofa.org	Residential and Outpatient Treatment Services Partial Day Treatment
RCA-WILLIAMSBURG 6301 Father Tribou St., Little Rock, AR 72205-3003	Carole Baxter, M.S., Executive Director Gary Campbell, Supervisor Telephone: 501-372-4611 Fax: 501-907-7495 E-Mail: cbaxter@rcofa.org	Outpatient Treatment Services
Oasis Renewal Center 14913 Cooper Orbit Road Little Rock, AR 72223 Website: www.oasisrenewalcenter.com	Carole Baxter, M.S., Executive Director E-Mail: cbaxter@rcofa.org David Bradshaw, LCSW, Clinical Director E-Mail: dbradshaw@rcofa.org Phone: 501-376-2747 Fax: 501-372-1801	Residential and Outpatient Treatment Services
Recovery Centers of Arkansas – Cabot 302 Ritchie Road Cabot, AR 72023	Carole Baxter, M.S., Executive Director Phone: 501-372-4611 Fax: 501-907-7495 E-Mail: cbaxter@rcofa.org	Outpatient Treatment Services
SERENITY PARK, INC. & SERENITYHOME FOR WOMEN		
2801 W. Roosevelt Road Little Rock, AR 72204 Website: http://www.serenitypark.org	Larry Gaines, CEO Linda Parham, COO Phone: 501-663-7627 or 501-541-4370 Toll Free: 866-699-7627 Fax: 501-663-2859 E-Mail: lindaparham.sp@gmail.com	Residential Treatment Services for Males & Females (Gender Separate) Partial Day Outpatient (Male & Female)

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FAMILY SERVICE AGENCY, INC.

COUNSELING & EDUCATION PROGRAM 628 West Broadway, Suite 300 North Little Rock, AR 72114 Website: http://www.helpingfamiliesfirst.org	Paul McGinnis, CEO Marlo Lowe, Clinical Director Victor Werner, COO Phone: 501-372-4242 Fax: 501-372-6565 E-mail: pmcginnis@fsainc.org vwerner@fsainc.org	Outpatient Treatment Services

LITTLE ROCK COMMUNITY MENTAL HEALTH CENTER

Mid-Arkansas Substance Abuse 4601 West 7th Street Little Rock, AR 72205-5441 Website: www.lrcmhc.org	Tom Grunden, Executive Director George Weaver, Crisis Residential Services Director Flavia Smith, Program Coordinator Phone: 501-686-9380 or 501-686 9393 Fax: 501-686-9581 E-mail: george.weaver@lrcmhc.com E-mail: flavia.smith@lrcmhc.com	Detoxification Court Ordered Treatment

UAMS SUBSTANCE ABUSE TREATMENT CLINIC

4224 Schuffield Drive, 4th Floor Suite 453 (Physical) 4302 W. Markham Little Rock, AR 72205-7199 (Mailing) Website: www.uams.edu	Peggy Healy, LPN, LCSW, Program Manager E-Mail: mmhealy@uams.edu Phone: 501-526-8400 Fax: 501-526-8499	Opioid Treatment Services

Catchment Area 10

Sevier, Howard, Hempstead, Lafayette, Miller, Little River

SOUTHWEST ARKANSAS COUNSELING AND MENTAL HEALTH CENTER

P. O. Box 1987 (Mail Zip 75504) 2904 Arkansas Blvd. (Physical) Texarkana, AR 71854-2536 Website: www.swacmhs.org	Dwight Sperry, Executive Director Phone: 870-773-4655 Fax: 870-772-4650 E-Mail: dsperry@swacmhc.com	Outpatient Treatment Services
RIVER RIDGE TREATMENT CENTER P. O. Box 1987 7000 Hwy 71 N Texarkana, AR 71854	Tim Hickerson, Program Director Phone: 870-774-1315 Fax: 870-779-1317 E-Mail: thickerson@swacmhc.com	Residential Treatment Services

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HOPE CLINIC P.O Box 452 201 East 20th Hope, AR 71801	Carlotta Powell, Clinical Supervisor Phone: 870-777-9051 Fax: 870-777-3104 E-Mail: cpowell@swacmhc.com	Outpatient Treatment Services

Catchment Area 11
Dallas, Nevada, Ouachita, Calhoun, Columbia, Union

UNION COUNTY DRUG COURT

SOUTH ARKANSAS SUBSTANCE ABUSE, INC 100 Hargett Drive El Dorado, AR 71730 Website: www.southarkansasabuse.org	Barbara Biddle, Assistant Director Phone: 870-881-9301 Fax: 870-864-9934 E-mail: barbarabiddle775@yahoo.com	Residential and Outpatient Treatment Services Partial Day Treatment Detoxification

Catchment Area 12
Jefferson, Arkansas, Grant, Cleveland, Lincoln

ARKANSAS DEPARTMENT OF CORRECTIONS SUBSTANCE ABUSE TREATMENT

P. O. Box 8707 Pine Bluff, AR 71611 6814 Princeton Pike (Physical) Pine Bluff, AR 71602 Website: http://www.state.ar.us/doc/Facilities5.html#Pine	Ray Hobbs, Director Wendy Kelly, Assistant Director Phone: 870-267-6360 Roger Cameron, Administrator Phone: 870-267-6328 Fax: 870-267-6118 E-mail: roger.cameron@arkansas.gov	Criminal Justice System Residential Treatment Day Treatment

HUMAN DEVELOPMENT AND RESEARCH SERVICES, INC.

P. O. Box 8225 2106 E. 6th Street Pine Bluff, AR 71601	Donna Stewart, Administrative Director Phone: 870-535-3535 Fax: 870-535-9541 E-Mail: hdrsdonna@aol.com	Administration
WEST 13TH 6841 West 13th Street Pine Bluff, AR 71601	Joe N. Hall, Executive Director Phone: 870-879-1051 Fax: 870-879-0118 E-Mail: hdrsdonna@aol.com	Residential Treatment Services Detoxification Outpatient Treatment
GRANT/CLEVELAND COUNTY OUTPATIENT FACILITY 202 N. Oak Street, Suite C Sheridan, AR 72150	Kari Sanderson, CIT Phone: 870-942-4092 Fax: 870-942-4092	Outpatient Treatment Services

SOUTHEAST ARKANSAS BEHAVIORAL HEALTH CARE SYSTEM, INC.		
P. O. Box 1019 2500 Rike Drive (Physical) Pine Bluff, AR 71603 Website: www.sabhs.org	Kathy Harris, CEO Bessie Lancelin, Director of Clinical Services Phone: 870-534-1834 Fax: 870-534-5798 E-mail: kathy@sabhs.org	Community Mental Health Center Outpatient and Co-occurring Disorder Treatment Services
P. O. Box 971 121 Commercial Drive "B" (Physical) Stuttgart, AR 72160	Roxanne Hunter, Arkansas County Director Phone: 870-673-1633 Fax: 870-673-1253	Outpatient and Co-occurring Disorder Treatment Services
P. O. Box 8 612 East Arkansas Street (Physical) Star City, AR 71667	Cindy Slaughter, Lincoln County Director Phone: 870-628-4181 Fax: 870-628-5369 E-mail: cslaughter@sabhs.org	Outpatient and Co-occurring Disorder Treatment Services
P. O. BOX 189 301 North Oak Street (Physical) Sheridan, AR 72150	Susan Reid, Grant County Director Phone: 870-942-5101 Fax: 870-942-7123 E-mail: susanr@sabhs.org	Outpatient and Co-occurring Disorder Treatment Services

Catchment Area 13
Desha, Drew, Bradley, Ashley, Chicot

10th DISTRICT SUBSTANCE ABUSE PROGRAM dba NEW BEGINNINGS C.A.S.A.		
412 York Street Warren, AR 71671	Rita Shepherd, Executive Director Mike Knickerbocker, Clinical Director Tazua Hamaker, Administrative Support Phone: 870-226-9970 Fax: 870-226-9972 E-Mail: newbeginningscasa@sbcglobal.net	Residential and Outpatient Treatment Services Specialized Women's Services Detoxification Partial Day

FUNDED NON-TREATMENT RELATED SERVICES

ARKANSAS SUBSTANCE ABUSE CERTIFICATION BOARD
2801 S. University Avenue
Little Rock, AR 72204
Website: http://www.icraoda.org/arkansas

Mariella Barlow, Administrator
501-569-3073
Fax: 501-569-3364
E-Mail: msbarlow@midsouth.ualr.edu

MIDSOUTH ADDICTIONS TRAINING NETWORK
2801 S. University Avenue
Little Rock, AR 72204-1099
Website: http://www.midsouth.ualr.edu

John Chmielewski, Director
501-569-8446
Fax: 501-569-3364
E-Mail: jvchmielewski@midsouth.ualr.edu

GAIN, INC
712 West 3rd Street
Little Rock, AR 72201

Dennis Wells
501-379-4246
Fax: 501-379-4248
E-Mail: dmwells@gainact.com

SUBMIT CHANGES TO:

Tascha Foster
Division of Behavioral Health Services
305 South Palm
Little Rock, AR 72205
Fax: 501-686-9396
Telephone: 501-686-9953
tascha.foster@arkansas.gov

SERVICE SITES by COUNTY

Arkansas

Southeast Arkansas Behavioral Healthcare System, Inc.

121 Commercial Drive B	Stuttgart	72160	870-673-1633

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

1900 Main Street, Suite 11	Stuttgart	72160	870-674-1426

Ashley

Delta Counseling Associates

1802 Highway 82 West	Crossett	71635	870-364-7248

Perspectives Behavioral Health Management, LLC

101 South Main Street	Hamburg	71646	870-853-9293

Delta Counseling Associates

1308 West 5th. Avenue	Crossett	71635	870-364-6471

Baxter

Baxter Regional Med.Center DBA: Center for Individual & Family Dev.

7345 Highway 62 West	Gassville	72635	870-435-5511

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

315 West 6th Street	Mountain Home	72653	870-425-8642

Health Resources of Arkansas, Inc.

#8 Medical Plaza	Mountain Home	72653	866-308-9923

Families Inc. of Arkansas

700 South Main	Mountain Home	72653	870-425-1041

Maxus, dba Arkansas Counseling Associates

3348 Hwy 62 West	Mountain Home	72653	870-424-9060

Youth Bridge, Inc

706 S. Main Street, Ste 1	Mountain Home	72653	870-425-5644

Ascent Acquisition Corp - CYPDC DBA: Ascent Children's Health Services

18 County Road 458	Mountain Home	72653	870-425-5252

Benton

Vista Health

2003 SE Walton Boulevard, Suite C	Bentonville	72712	479-464-8081

Ozark Guidance Center, Inc.

1200 West Walnut Street, Suite 1400	Rogers	72756	479-695-1242

Ozark Guidance Center, Inc.

2508 SE 20th Street	Bentonville	72712	479-273-9088

Youth Bridge, Inc

1200 West Walnut St. Suite 1500	Rogers	72756	479-795-1802

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

1200 West Walnut, Suite 3100	Rogers	72756	479-631-9996

Ozark Guidance Center, Inc.

827 W. Harvard	Siloam Springs	72761	479-524-5197

Ozark Guidance Center, Inc.

710 Holly Street	Siloam Springs	72761	479-524-8618

Pathfinder, Inc.

1004 SE 5th Street	Bentonville	72712	479-254-6717

Boone

Maxus, dba Arkansas Counseling Associates

823 North Main Street	Harrison	72601	870-741-2960

Vista Health

117 Saw Grasse Point	Harrison	72601	870-741-2658

Youth Bridge, Inc

107 East Crandall, Suite B	Harrison	72601	870-741-8484

Health Resources of Arkansas, Inc.

4081 Highway 7 South	Harrison	72601	866-533-1763

Vista Health

121 Saw Grasse Point	Harrison	72601	870-391-3871

Bradley

Delta Counseling Associates

1404 East Church Street	Warren	71671	870-226-5856

Carroll

Ozark Guidance Center, Inc.

208 Highway 62 West	Berryville	72616	870-423-2758

Ozark Guidance Center, Inc.

107 Whispering Pines	Eureka Springs	72632	479-253-5665

Youth Bridge, Inc

1004 South Main Street	Berryville	72616	479-253-6062

Chicot

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

608 Highway 65-82 S. B	Lake Village	71653	870-265-3711

Maxus, dba Arkansas Counseling Associates

316 Main Street	Lake Village	71653	870-265-2186

Delta Counseling Associates

1127 Second Street	Lake Village	71653	870-265-3808

Clark

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

2749 Pine Street, Suite B	Arkadelphia	71923	870-403-0830

Arkansas Counseling & Psychodiagnostics, Inc.

2607 Caddo Street, Suite 6	Arkadelphia	71923	870-230-8217

Ouachita Regional Counseling & MHC DBA:Community Counseling Services, Inc.

201 North 26th Street	Arkadelphia	71923	870-246-4123

Ascent Acquisition Corp - PSC DBA: Ascent Children's Health Services

2410 Pine Street	Arkadelphia	71923	870-245-2210

Maxus, dba Arkansas Counseling Associates

2425 Country Club Road	Arkadelphia	71923	870-245-3888

Clay

Life Strategies Counseling, Inc.

111 South Third Street	Piggott	72450	870-236-5880

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

602 David Street	Corning	72422	870-857-3655

Cleburne

United Methodist Children's Home, Inc.

407 South 7th Street	Heber Springs	72543	501-362-5525

Health Resources of Arkansas, Inc.

1716 West Searcy Street	Heber Springs	72543	866-533-1763

Columbia

United Methodist Behavioral Hospital

617 East North	Magnolia	71753	870-234-0739

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

229 A Street	Magnolia	71753	870-234-0495

South Arkansas Youth Services

301 South Boundary	Magnolia	71753	870-234-2600

Conway

Counseling Associates, Inc.

8 Hospital Drive	Morrilton	72110	501-354-1561

Conway County Community Service, Inc.

100 South Cherokee St.	Morrilton	72110	501-354-4589

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

1300 Highway 9 South	Morrilton	72110	501-208-5911

Craighead

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

1817 Woodspring Rd, Ste G	Jonesboro	72401	870-934-9800

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

3700 Access Road	Jonesboro	72401	870-972-4826

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

2707 Browns Lane	Jonesboro	72401	870-972-4050

Maxus, dba Arkansas Counseling Associates

3009 Turman, Suite A	Jonesboro	72401	870-268-8875

Ascent Acquisition Corp - CYPDC DBA: Ascent Children's Health Services

800 South Church St., Ste. 201	Jonesboro	72401	870-935-9911

Life Strategies Counseling, Inc.

1217 Stone Street	Jonesboro	72401	866-972-1268

Families Inc. of Arkansas

1815 Pleasant Grove Road	Jonesboro	72401	870-933-6886

Ascent Acquisition Corp - CYPDC DBA: Ascent Children's Health Services

806 Glendale	Jonesboro	72401	870-933-9528

United Methodist Behavioral Hospital

2912 King Street	Jonesboro	72401	870-910-3757

Crawford

Perspectives Behavioral Health Management, LLC

949 North Main Street	Mulberry	72747	479-997-2766

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

1316 Main Street	Van Buren	72956	479-471-6892

United Methodist Behavioral Hospital

7401 Youth Ranch	Mulberry	72947	479-997-8934

Western Arkansas Counseling & Guidance Center

2705 Oak Lane, Suites A & B	Van Buren	72956	479-474-8084

Crittenden

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

1227 Highway 77, Suite 2	Marion	72364	870-739-1700

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

4001 Commercial Center Drive, Ste. 5	Marion	72364	870-735-3015

Ascent Acquisition Corp - PSC DBA: Ascent Children's Health Services

413 West Tyler Cove	West Memphis	72301	870-733-1200

Logan Centers, Inc.

835 South Woods	West Memphis	72301	870-735-2271

Kids For the Future, Inc.

252 Manor	Marion	72364	870-739-6818

Maxus, dba Arkansas Counseling Associates

4001 Commercial Center Dr, Ste 2	Marion	72364	870-735-4441

Life Strategies of Arkansas, LLC

703 Calvin Avery, Suite B	West Memphis	72301	870-735-0300

Life Strategies of Arkansas, LLC

410 South Avalon Street	West Memphis	72301	870-702-7563

Life Strategies of Arkansas, LLC

177 Bush Street, Building 76	Hughes	72348	870-339-3701

Life Strategies of Arkansas, LLC

304 North 6th. Street	West Memphis	72301	870-702-7657

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

905 North Seventh Street	West Memphis	72301	870-735-5118

Cross

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

1201 South Falls Blvd	Wynne	72396	870-238-1135

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

661 Addison Drive	Wynne	72396	870-238-1135

Kids For the Future, Inc.

750 Bridges, Suite A	Wynne	72396	870-238-3458

Life Strategies of Arkansas, LLC

1718 N. Falls Boulevard	Wynne	72396	870-238-4014

Logan Centers, Inc.

1792 Falls Blvd, Suite #5	Wynne	72396	870-208-9333

Dallas

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

1101 West 3rd Street	Fordyce	71742	870-352-5122

Desha

Delta Counseling Associates

2410 Highway 65 North	McGehee	71654	870-222-3107

Delta Counseling Associates

708 Highway 65 South	Dumas	71639	870-382-4001

Maxus, dba Arkansas Counseling Associates

105 Carlton	Dumas	71639	870-382-1680

Drew

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

583 West Gaines	Monticello	71655	870-367-2143

Delta Counseling Associates

790 Roberts Drive	Monticello	71655	870-367-2461

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

571 West Gaines	Monticello	71655	870-367-2141

Faulkner

Birch Tree Communities, Inc.

132 Lower Ridge Road	Conway	72032	501-315-3344

Counseling Associates, Inc.

1622 North Donaghey	Conway	72032	501-327-7706

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

1014 Main Street, Suite 3	Conway	72032	501-336-0511

United Methodist Behavioral Hospital

1112 Main Street	Vilonia	72173	501-803-3388

Conway County Community Service, Inc.

818 North Creek Drive	Conway	72032	501-327-9788

Maxus, dba Arkansas Counseling Associates

1100 Bob Courtway, Ste 9	Conway	72032	501-328-5525

Counseling Associates, Inc.

350 Salem Road, Suite 1	Conway	72034	501-336-8300

Counseling Associates, Inc.

1701 Donaghey	Conway	72032	501-327-1701

Conway County Community Service, Inc.

816 North Creek Drive	Conway	72032	501-327-9788

Franklin

Western Arkansas Counseling & Guidance Center

Highway 23 North & Airport Road	Ozark	72949	479-667-2497

Conway County Community Service, Inc.

203 North 4th	Ozark	72949	479-667-5855

Fulton

Health Resources of Arkansas, Inc.

679 North Main Street	Salem	72576	866-533-1762

Garland

Living Hope Southeast

3604 Central Avenue, Suite C	Hot Springs	71913	501-623-9220

Ouachita Regional Counseling & MHC DBA:Community Counseling Services, Inc.

125 Dons Way	Hot Springs	71913	501-624-7111

Ouachita Regional Counseling & MHC DBA:Community Counseling Services, Inc.

505 W. Grand Ave.	Hot Springs	71901	501-624-7111

TFS of Gurdon, Inc. DBA: Therapeutic Family Services

600 Main Street, Suite V	Hot Springs	71913	501-321-8200

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

106 Ridgeway, Suite H	Hot Springs	71901	501-609-0400

Counseling Clinic, Inc.

310 Whittington Avenue	Hot Springs	71901	501-623-3477

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

2835 Malvern Avenue	Hot Springs	71901	501-658-5222

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

5737 Central Avenue #F	Hot Springs	71913	501-321-1779

Grant

Southeast Arkansas Behavioral Healthcare System, Inc.

301 North Oak Street	Sheridan	72150	870-942-5101

Greene

Families Inc. of Arkansas

1101 West Morgan Street	Paragould	72450	870-335-9483

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

1011 Morgan Street	Paragould	72450	870-239-4222

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

1 Laubach Drive	Paragould	72451	870-240-0671

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

28 Southpointe Drive	Paragould	72450	870-236-2244

Ascent Acquisition Corp - CYPDC DBA: Ascent Children's Health Services

1910 Rector Road	Paragould	72450	870-240-8500

Life Strategies Counseling, Inc.

2420 Linwood Drive	Paragould	72450	870-236-5880

Maxus, dba Arkansas Counseling Associates

100 Rocking Chair, Ste 1,2,3	Paragould	72450	870-335-9617

Hempstead

Southwest Arkansas Counseling & Mental Health Center, Inc.

300 East 20th Street	Hope	71802	870-777-9051

Southwest Arkansas Counseling & Mental Health Center, Inc.

707 East Greenwood	Hope	71801	870-777-9800

TFS of Gurdon, Inc. DBA: Therapeutic Family Services

1420 South Main	Hope	71801	870-777-4848

Hot Spring

TFS of Gurdon, Inc. DBA: Therapeutic Family Services

829 Halbert Street	Malvern	72104	501-332-4400

Birch Tree Communities, Inc.

1628 East Page	Malvern	72104	501-303-3167

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

1519 East Paige Avenue	Malvern	72104	501-337-5600

Ouachita Regional Counseling & MHC DBA:Community Counseling Services, Inc.

1615 Martin Luther King Blvd	Malvern	72104	501-332-5236

Living Hope Southeast

3399 Finch Road	Bismarck	71929	501-865-3363

Howard

Southwest Arkansas Counseling & Mental Health Center, Inc.

508 North Second Street	Nashville	71852	870-845-3110

Independence

Health Resources of Arkansas, Inc.

1355 East Main North	Batesville	72501	870-793-8919

Health Resources of Arkansas, Inc.

1355 East Main	Batesville	72501	870-793-8910

Ascent Acquisition Corp - CYPDC DBA: Ascent Children's Health Services

2040 Fitzhugh Street	Batesville	72501	870-793-3334

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

400 Harrison St, Suite 107	Batesville	72501	870-793-6774

United Methodist Behavioral Hospital

500 East Main, Suite 310	Batesville	72501	870-793-6841

Life Strategies Counseling, Inc.

70 Batesville Boulevard	Batesville	72501	870-793-3199

Health Resources of Arkansas, Inc.

1800 Meyers Street	Batesville	72501	870-793-8925

Izard

Birch Tree Communities, Inc.

105 Highway 9	Oxford	72565	501-303-3220

Health Resources of Arkansas, Inc.

1109 East Main	Melbourne	72556	866-533-1760

Jackson

Health Resources of Arkansas, Inc.

1507 North Pecan Street	Newport	72112	866-533-1758

Life Strategies of Arkansas, LLC

2135 Malcolm Street	Newport	72112	870-523-8004

Birch Tree Communities, Inc.

210 Third Street	Newport	72112	501-315-3344

Jefferson

Southeast Arkansas Behavioral Healthcare System, Inc.

2500 Rike Drive	Pine Bluff	71603	870-543-1834

Southeast Arkansas Behavioral Healthcare System, Inc.

3004 34th Avenue	Pine Bluff	71603	870-534-1834/

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

6210 Dollarway, Suite 4	Pine Bluff	71602	870-247-3588

People Advocating Transition, Inc. (The P.A.T. Center)

620 South Laurel Street	Pine Bluff	71601	870-534-4900

Maxus, dba Arkansas Counseling Associates

204 Frankie Lane	White Hall	71602	870-247-2305

Johnson

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

1000 East Main	Lamar	72846	479-733-0400

Counseling Associates, Inc.

1021 Poplar Street	Clarksville	72830	501-754-8610

Conway County Community Service, Inc.

106 Cherokee Lane	Clarksville	72830	479-754-7296

Birch Tree Communities, Inc.

706 Brown Street	Clarksville	72830	501-303-3224

Perspectives Behavioral Health Management, LLC

311 Central Street	Clarksville	72830	479-754-0277

Birch Tree Communities, Inc.

522 Mills Road	Clarksville	72830	501-303-3174

Lafayette

Southwest Arkansas Counseling & Mental Health Center, Inc.

1117 Chestnut Street	Lewisville	71845	870-921-5485

TFS of Gurdon, Inc. DBA: Therapeutic Family Services

626 Chestnut Street	Lewisville	71845	870-921-3800

Lawrence

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

1600 Southwest Broad Street	Hoxie	72433	870-886-7200

Families Inc. of Arkansas

1425 West Main	Walnut Ridge	72476	870-886-5303

Maxus, dba Arkansas Counseling Associates

104 Elm Street	Tuckerman	72473	870-886-5250

Cornerstone Community Counseling Corp.

609 West Third Street	Imboden	72434	870-869-1500

Cornerstone Community Counseling Corp.

110 North Hendrix Street	Imboden	72434	870-869-1500

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

102 South Larkspur	Walnut Ridge	72476	870-886-7924

Hometown Behavioral Health Services of Arkansas, Inc.

503 S.E. Lindsey	Hoxie	72433	870-886-1333

Lee

Life Strategies of Arkansas, LLC

63 North Carolina St.	Marianna	72360	870-295-3300

Kids For the Future, Inc.

222 Decota Street	Marianna	72360	870-298-2424

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

444 Atkins Boulevard	Marianna	72360	870-295-4050

Lincoln

Southeast Arkansas Behavioral Healthcare System, Inc.

612 East Arkansas Street	Star City	71667	870-628-4181

Logan

Western Arkansas Counseling & Guidance Center

415 South Sixth Street	Paris	72855	479-963-2140

Western Arkansas Counseling & Guidance Center

174 North Welsh	Booneville	72927	479-675-3909

Lonoke

Professional Counseling Associates

201 West 2nd Street	Lonoke	72086	501-676-3151

Professional Counseling Associates

405 North Second Street	Cabot	72023	501-843-3503

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

203-B Westport Drive	Cabot	72023	501-843-9233

Madison

Ozark Guidance Center, Inc.

1104 North College	Huntsville	72740	479-738-2878

Marion

Health Resources of Arkansas, Inc.

319 Highway 14 S. #1	Yellville	72687	866-308-9927

Miller

Vista Health

701 Arkansas Boulevard	Texarkana	71854	870-772-5028

South Arkansas Youth Services

1202 State Line Avenue	Texarkana	71854	870-774-0920

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

4323 Jefferson Ave.	Texarkana	71854	870-773-0700

Southwest Arkansas Counseling & Mental Health Center, Inc.

2904 Arkansas Boulevard	Texarkana	71854	870-773-4655

Mississippi

Families Inc. of Arkansas

3201 W, Keiser	Osceola	72370	870-622-0592

Life Strategies Counseling, Inc.

1487 West Keiser, Suite I	Osceola	72370	870-563-4500

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

209 S. Lockard	Blytheville	72315	870-763-2139

Ascent Acquisition Corp - PSC DBA: Ascent Children's Health Services

1510 Byrum Road	Blytheville	72315	870-532-2600

Maxus, dba Arkansas Counseling Associates

634 West Main Street	Blytheville	72315	870-780-6986

Monroe

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

490 Broadmore Drive	Brinkley	72021	870-734-3202

Montgomery

United Methodist Behavioral Hospital

221 Fairgrounds Road	Mt. Ida	71957	501-765-5806

Nevada

Vista Health

1484 West 1st Street North	Prescott	71857	870-887-1078

Southwest Arkansas Counseling & Mental Health Center, Inc.

1658 Highway 371 West	Prescott	71857	870-887-3660

Newton

Health Resources of Arkansas, Inc.

504 W. Court St., Room110	Jasper	72641	888-533-1767

Ouachita

South Arkansas Youth Services

301 Washington	Camden	71701	870-836-2321

South Arkansas Regional Health Center

412 North Vine	Magnolia	71753	870-234-7500

South Arkansas Regional Health Center

211 Jackson Street SW	Camden	71701	870-836-5743

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

115 Jefferson SW	Camden	71701	870-836-8888

Phillips

Kids For the Future, Inc.

422 North Sebastian	West Helena	72342	870-572-1800

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

211 Missouri Street	Helena	72342	870-338-3363

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

801 Newman Drive	Helena	72342	870-338-3900

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

507 Missouri Street	Helena	72342	870-338-3434

Counseling & Education Center, Inc.

406 Pecan Street	Helena	72342	870-338-8447

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

1225 Martin Luther King Drive	Helena	72390	870-572-5005

Pike

Friendship Community Care, Inc. DBA: Friendship Community Care Behavioral Health Systems

200 Highway 70, Suite 2	Glenwood	71943	870-356-2012

Poinsett

Life Strategies Counseling, Inc.

809 W. Main Street, Ste C,D	Trumann	72472	870-483-0068

Families Inc. of Arkansas

1704 Highway 69	Trumann	72472	870-483-4003

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

417 West Main, Suite B	Trumann	72472	870-483-7039

Ascent Acquisition Corp - CYPDC DBA: Ascent Children's Health Services

1005 Balcom Lane	Trumann	72472	870-483-1461

Polk

Western Arkansas Counseling & Guidance Center

307 South Cherry Street	Mena	71953	479-394-5277

MHC - Cedar Haven of Mena Regional Health System

311 North Morrow	Mena	71953	479-243-2380

Western Arkansas Counseling & Guidance Center

307 South Cherry Street	Mena	71953	479-394-3200

Pope

Counseling Associates, Inc.

1402, and 1404 E.16th St.	Russellville	72801	479-967-1397

Maxus, dba Arkansas Counseling Associates

1309 North Church	Atkins	72823	501-745-8433

Counseling Associates, Inc.

110 Skyline Drive	Russellville	72801	479-968-1298

Birch Tree Communities, Inc.

210 North Shamrock	Russellville	72802	501-315-3344

Perspectives Behavioral Health Management, LLC

1305 East Main Street	Russellville	72801	479-967-5677

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

1610 S. Arkansas Street, Suite 1	Russellville	72801	479-967-4673

Conway County Community Service, Inc.

1415 South Oswego Ave	Russellville	72802	479-967-3370

Conway County Community Service, Inc.

1505 South Oswego Ave	Russellville	72802	479-967-3370

Prairie

Professional Counseling Associates

109 North Hazen Avenue	Hazen	72064	870-255-3527

Pulaski

Living Hope Southeast

100 S. University, Suite 401	Little Rock	72205	501-663-5473

Professional Counseling Associates

1109 Burman	Jacksonville	72076	501-982-7515

Professional Counseling Associates

4354 Stockton	North Little Rock	72117	501-955-7600

Professional Counseling Associates

7800 Sylvan Hills Highway	Sherwood	72120	501-835-4174

Professional Counseling Associates

9110 Geyer Springs Road	Little Rock	72209	501-568-4294

Centers for Youth & Families

5905 Forest Place	Little Rock	72207	501-666-8686

Centers for Youth & Families

6501 West 12th St., Sturgis Bldg	Little Rock	72204	501-666-9424

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

1405 North Pierce, Suite 101	Little Rock	72207	501-603-2147

Ascent Acquisition Corp - PSC DBA: Ascent Children's Health Services

4107 Richards Road	North Little Rock	72117	501-955-2220

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

6100 Patterson Road	Little Rock	72209	501-663-6771

Life Strategies Counseling, Inc.

5918 Lee Avenue	Little Rock	72205	501-663-2199

Little Rock Community Mental Health Center, Inc.

4601 West Seventh Street	Little Rock	72205	501-686-9380

Little Rock Community Mental Health Center, Inc.

4400 Shuffield Drive	Little Rock	72205	501-686-9300

Little Rock Community Mental Health Center, Inc.

1020 W. Daisy L. Gatson Bates Dr.	Little Rock	72202	501-371-9058

Bridgeway, Inc.

21 Bridgeway Road	North Little Rock	72113	501-771-1500

Youth Home, Inc.

10 Corporate Hill Drive, Suite 330	Little Rock	72205	501-954-7470

University of Arkansas for Medical Sciences Department of Psychiatry

4701 Fairway Avenue	North Little Rock	72116	501-771-8261

United Methodist Children's Home, Inc.

2002 South Filmore, Building 14	Little Rock	72204	501-661-0720

University of Arkansas for Medical Sciences Department of Psychiatry

11 Children's Way	Little Rock	72202	501-364-5150

University of Arkansas for Medical Sciences Department of Psychiatry

4224 Shuffield Drive	Little Rock	72205	501-526-8250

New Beginnings Behavioral Health Services, LLC

7107 West 12th Street, Suite 201	Little Rock	72204	501-663-1837

Centers for Youth & Families

200 West 20th	North Little Rock	72114	501-771-5511

University of Arkansas for Medical Sciences Department of Psychiatry

4224 Shuffield Drive	Little Rock	72205	501-526-8250

Maxus, dba Arkansas Counseling Associates

1901 Main Street	North Little Rock	72214	501-955-2674

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

1405 N. Pierce Street, Suite 101	Little Rock	72202

GAIN, Inc.

712 West 3rd. Street #100	Little Rock	72201	501-379-4246

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

9914 I-30	Little Rock	72209	501-565-8501

Baptist Health Behavioral Services

11401 Interstate 30	Little Rock	72209	501-202-6470

United Methodist Behavioral Hospital

1600 Aldersgate Road	Little Rock	72205	501-661-0720

Families Inc. of Arkansas

1200 James Street	Jacksonville	72076	501-982-5000

Treatment Homes, Inc.

700 West Fourth Street	Little Rock	72203	501-372-5039

Pathfinder, Inc.

2520 West Main Street	Jacksonville	72076	501-982-5402

TFS of Gurdon, Inc. DBA: Therapeutic Family Services

4620 W. Commercial Drive, Suite C	North Little Rock	72116	501-753-8400

Inspiration Day Treatment, Inc.

1014 Autumn Road Suite 3	Little Rock	72211	501-221-1941

Randolph

Families Inc. of Arkansas

2305 Old County Road	Pocahontas	72455	870-892-1005

Maxus, dba Arkansas Counseling Associates

1878 Highway 62 W	Pocahontas	72455	870-892-5000

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

2560 Old County Road	Pocahontas	72455	870-972-4913

Saline

Ascent Acquisition Corp - PSC DBA: Ascent Children's Health Services

3214 Winchester Drive	Benton	72015	501-326-6160

Birch Tree Communities, Inc.

1502 Mary Kay	Benton	72015	501-303-3163

Birch Tree Communities, Inc.

718 Alcoa Road	Benton	72015	501-315-3344

Birch Tree Communities, Inc.

6701 Highway 67, Bldg 70	Benton	72015	501-303-3150

Birch Tree Communities, Inc.

6701 Highway 67, Bldg 4	Benton	72015	501-315-3344

Counseling Clinic, Inc.

307 East Sevier	Benton	72015	501-315-4224

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

22461 I-30 South, Building 1000	Bryant	72022	501-847-0081

Maxus, dba Arkansas Counseling Associates

109 West South Street	Benton	72015	501-776-1191

Scott

Western Arkansas Counseling & Guidance Center

1857 Rice Street	Waldron	72958	479-637-2468

Searcy

Health Resources of Arkansas, Inc.

200 East Main Street	Marshall	72650	866-308-9928

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

316 Highway 65 North	Marshall	72650	870-448-4727

Sebastian

Perspectives Behavioral Health Management, LLC

1200 West Center	Greenwood	72936	479-996-1494

Western Arkansas Counseling & Guidance Center

3113 South 70th Street	Fort Smith	72903	479-478-6664

Western Arkansas Counseling & Guidance Center

3111 South 70th Street	Fort Smith	72903	479-452-6650

Western Arkansas Counseling & Guidance Center

3109 South 70th Street	Fort Smith	72903	479-452-9490

Vista Health

815 A Fort Street	Barling	72923	479-494-5700

Perspectives Behavioral Health Management, LLC

1340 South Waldron Road	Fort Smith	72903	479-783-5353

Maxus, dba Arkansas Counseling Associates

100 Towson Avenue	Fort Smith	72901	479-784-9801

Perspectives Behavioral Health Management, LLC

1340 South Waldron, Road	Fort Smith	72855	479-963-1448

Bost, Inc.

7701 South Zero Street	Fort Smith	72903	479-478-5596

Sevier

Southwest Arkansas Counseling & Mental Health Center, Inc.

1312 West Collin Raye Drive	DeQueen	71832	870-584-7115

Sharp

Health Resources of Arkansas, Inc.

714-A Ash Flat Drive	Ash Flat	72513	866-533-1761

United Methodist Behavioral Hospital

35 Choctaw Trace	Cherokee Village	72529	870-257-3249

Hope Behavioral Healthcare

#4 E. Cherokee Village Mall	Cherokee Village	72529	870-257-3336

Families Inc. of Arkansas

75 Highway 62-412 Suite J	Ash Flat	72513	870-994-7060

St. Francis

Kids For the Future, Inc.

1825 East Broadway	Forrest City	72335	870-630-2328

Life Strategies of Arkansas, LLC

320 Lee Street	Earle	72331	870-792-7769

Logan Centers, Inc.

1800 Lindauer Road	Forrest City	72335	870-494-4600

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

1521 North Washington	Forrest City	72335	870-633-8092

Northeast Arkansas Community Mental Health Center DBA: Mid-South Health Systems, Inc.

4451 North Washington	Forrest City	72335	870-630-3800

Stone

Birch Tree Communities, Inc.

218 Dogwood Hollow	Mountain View	72560	501-315-3344

Health Resources of Arkansas, Inc.

211 Blanchard	Mountain View	72560	866-533-1759

Union

South Arkansas Youth Services

514 West Faulkner	El Dorado	71730	870-863-5153

South Arkansas Regional Health Center

715 North College	El Dorado	71730	870-862-7921

South Arkansas Regional Health Center

710 West Grove	El Dorado	71730	870-864-2471

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

412 North Washington St.	El Dorado	71730	870-863-4611

Van Buren

Health Resources of Arkansas, Inc.

2526 Highway 65 South	Clinton	72031	866-533-1765

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

1303 Highway 655 South #6	Clinton	72031	501-908-6963

Birch Tree Communities, Inc.

242 Shake Rag Road	Clinton	72031	501-315-3344

Conway County Community Service, Inc.

451 Ingram Street	Clinton	72031	501-745-2956

Washington

United Methodist Behavioral Hospital

74 West Sunbridge	Fayetteville	72703	479-582-5565

Youth Bridge, Inc

3715 Business Drive, Suite 104	Fayetteville	72703	479-575-9471

Vista Health

4253 North Crossover Road	Fayetteville	72703	479-521-4731

University of Arkansas for Medical Sciences Department of Psychiatry

601 W. Maple, Suite 403	Springdale	72764	479-750-2742

Ozark Guidance Center, Inc.

2400 South 48th Street	Springdale	72762	479-750-2020

Perspectives Behavioral Health Management, LLC

202 West Meadow Street	Fayetteville	72701	479-442-2125

Ozark Guidance Center, Inc.

60 West Sunbridge	Fayetteville	72703	479-695-1240

Alternative Opportunities, Inc. DBA: Dayspring Behavioral Health Services

750 Mathias Drive	Springdale	72762	479-750-1272

White

Health Resources of Arkansas, Inc.

3302 East Moore	Searcy	72143	501-268-4181

Health Resources of Arkansas, Inc.

3204 East Moore Ave	Searcy	72143	501-268-4181

BHC Pinnacle Pointe Hospital, DBA: The Pointe Outpatient Behavioral Health Services

403 Poplar, Suite A	Searcy	72143	501-279-9220

Health Resources of Arkansas, Inc.

931 Highway 5	Rose Bud	72137	866-533-1766

Families Inc. of Arkansas

400 Llama Drive	Searcy	72143	501-305-2359

Maxus, dba Arkansas Counseling Associates

106 South Spring Street	Searcy	72143	501-268-2812

Woodruff

Health Resources of Arkansas, Inc.

623 North Ninth St.	Augusta	72006	870-347-3254

Health Resources of Arkansas, Inc.

900 W. Poplar, Old Hwy 64 W.	McCrory	72101	886-533-1757

Yell

Conway County Community Service, Inc.

730 Boston Street	Danville	72833	479-495-5177

II: Planning Steps

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

Narrative Question:

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

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

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

Footnotes:

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

The Division of Behavioral Health Services (DBHS) utilizes multiple data sets to inform the decision making process. DBHS recognizes the need to improve the data collection system and move to a fully integrated system to further inform the planning and decision making process.

Below is a list of the data systems utilized by the Division:

- 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. Minimum Data Set (MDS) is maintained by Kit Solutions and SSA employees. The stakeholders for prevention enter their services that were provided in the communities.

- **Web Infrastructure for Treatment Services (WITS)** is maintained by FEi, and is operated for the Access to Recovery (ATR) program. Client level data is collected by participation from Access to Recovery episodes.

- 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 Youth Outcomes Questionnaire (YOQ), implemented statewide for all Medicaid funded Rehabilitative Services for Persons with Mental Illness (RSPMI) providers, is a standardized instrument to track the progress of children and youth while they are in treatment and facilitate the State's ability to track treatment effectiveness. Client-level demographic and YOQ overall and

six subscale scores are available to DBHS. This data is used to assess provider instrument utilization compliance and treatment outcomes as measured by intake and discharge YOQ scores.

- 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 2012 86,424 students from 216 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. DBHS is planning to extend to the survey to mental health clients served by all the private providers.

- DBHS created and maintains an Excel data base to capture various aspects of the state **System of Care (SOC)** program for 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. DBHS is developing a web-based data infrastructure application that will automate data capture from the 17 providers of the SOC program. The application will collect demographic and treatment outcomes 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. Currently, the YOQ data is being migrated to the system. In the near future the substance abuse treatment data from ADMIS will be migrated into the EDW system.

- DBHS is currently partnering 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 to transform the Medicaid funded behavioral health system through the implementation of Episodes of Care, Behavioral Health Homes, and 1915i services. 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. This effort is extensively driven by **Medicaid Claims** data.

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

Priority #: 1

Priority Area: Substance Abuse Treatment

Priority Type: SAT

Population (s): PWWDC, IVDUs, HIV EIS, TB

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.

Strategies to attain the goal:

- 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: 10,255

First-year target/outcome measurement: 10,563

Second-year target/outcome measurement:

Data Source:

ADMIS

Description of Data:

The First Year Target is based on a projected 3% increase in individuals served.

Data issues/caveats that affect outcome measures::

The Baseline Measurement is the number of unduplicated individuals served from July 1, 2012 to June 30, 2013.

The Second Year Target will be determined at a later date after analysis of data from the implementation of Medicaid Transformation, Private Option, and the Health Insurance Marketplace.

Indicator #:	2
Indicator:	Units of services provided
Baseline Measurement:	Total Units for Residential Treatment = 83,639 / Total Units for Outpatient Treatment = 313,746 / Total Detoxification Units = 7,982
First-year target/outcome measurement:	Total Units for Residential Treatment = 86,148 / Total Units for Outpatient Treatment = 323,158 / Total Detoxification Units = 8,221
Second-year target/outcome measurement:	

Data Source:

ADMIS

Description of Data:

First year target is based on a 3% projected increase in units provided

Data issues/caveats that affect outcome measures::

The Baseline Measurement is based on data from July 1, 2012 to June 30, 2013.

The Second Year Target will be determined at a later date after analysis of data from the implementation of Medicaid Transformation, Private Option, and the Health Insurance Marketplace.

Indicator #:	3
Indicator:	Array of services provided
Baseline Measurement:	10 services
First-year target/outcome measurement:	
Second-year target/outcome measurement:	
Data Source:	

Description of Data:

Through contracts with Substance Abuse Providers, DBHS currently reimburses for the following services:

Intake and Assessment for Substance Abuse
Medical Detoxification
Observational Detoxification
Outpatient Service - Family
Outpatient Service - Group
Outpatient Service - Individual
Partial Day Treatment
Residential
Residential Services for Adolescents - Comprehensive
Specialized Women's Services

Data issues/caveats that affect outcome measures::

The Second Year Target will be determined at a later date after analysis of data from the implementation of Medicaid Transformation, Private Option, and the Health Insurance Marketplace.

Indicator #:	4
Indicator:	Reduction in waiting list
Baseline Measurement:	140
First-year target/outcome	135

measurement:

Second-year target/outcome measurement:

Data Source:

ADMIS

Description of Data:

The First Year Target is based on a projected 3% decrease.

Data issues/caveats that affect outcome measures::

The Baseline Measurement is the average number of individuals on the waiting list for substance abuse treatment from July 1, 2012 to June 30, 2013

With the advent of Medicaid Transformation, the Health Insurance Marketplace, and the Medicaid Expansion through the Private Option, it is difficult to project the average waiting list for the coming year.

Priority #: 2

Priority Area: Mental Health Treatment

Priority Type: MHS

Population (s): SMI, SED

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of unduplicated individuals served
Baseline Measurement:	72,351
First-year target/outcome measurement:	74,521
Second-year target/outcome measurement:	

Data Source:

SPQM

Description of Data:

The First Year Target is based on a projected 3% increase in individuals served.

Data issues/caveats that affect outcome measures::

Contracts to provide mental health services are sole sourced by law to Community Mental Health Centers in Arkansas. Due to the Medicaid funded mental health system and the State General Revenue received by Community Mental Health Centers, the Mental Health Block Grant funding is primarily utilized by Community Mental Health Centers for program support.

The Second Year Target will be determined at a later date after analysis of data from the implementation of Medicaid Transformation, Private Option, and the Health Insurance Marketplace.

Indicator #:	2
Indicator:	Array of services provided
Baseline Measurement:	18 services
First-year target/outcome measurement:	N/A
Second-year target/outcome measurement:	N/A

Data Source:

SPQM

Description of Data:

Currently the Community Mental Health Centers provide the following services through contracts with the Division of Behavioral Health Services:

Collateral Intervention
Crisis Services
Day Services
Group Psychotherapy
Individual/Family Therapy
Intake/Assessment/Diagnosis
Medication Maintenance
Nurse Medication Related
Offsite Mental Health Professional
Offsite Mental Health Paraprofessional
Onsite Mental Health Professional
Onsite Mental Health Paraprofessional
Physical Examination
Psychological Testing/Evaluation
Residential Bed Day
Inpatient Bed Day
Treatment Planning/Review

Data issues/caveats that affect outcome measures::

Contracts to provide mental health services are sole sourced by law to Community Mental Health Centers in Arkansas. Due to the Medicaid funded mental health system and the State General Revenue received by Community Mental Health Centers, the Mental Health Block Grant funding is primarily utilized by Community Mental Health Centers for program support.

With the system changes being implemented in the coming year, DBHS, with input from stakeholders, will assess the services being funded through contracts with the Community Mental Health Centers.

Priority #: 3

Priority Area: Medicaid System Transformation

Priority Type: SAP, SAT, MHP, MHS

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

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.

Strategies to attain the goal:

- 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 Episodes of Care, Behavioral Health Homes, and 1915i services. 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. The transformation, along with Medicaid Expansion and the Arkansas Health Insurance Marketplace, will drastically change the population DBHS is responsible for the services purchased for this population by the Division.

- Develop agency provider and performing provider qualifications, certification processes, and standards to reflect the new Medicaid funding streams that will be an outcome of the Payment Improvement Initiative.

- 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 Behavioral Health Homes

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::

The Division of Medical Services (DMS) and the Division of Behavioral Health Services (DBHS) are currently working to transform the Medicaid funded behavioral health system through submitting a Health Homes State Plan Amendment (SPA) and a 1915i SPA. After approval from the State Legislature and the Centers for Medicare and Medicaid Services (CMS), new services will be implemented. The comprehensive list of services has not been finalized. The draft includes:

Care Coordination
Supported Housing
Supported Employment
Peer Support
Wraparound Facilitation

At this time, it is difficult to project how many evidence based practices will be adopt. DBHS will update this information after the SPAs are approved.

Indicator #:	2
Indicator:	Number of individuals receiving care coordination through the Behavioral Health Home
Baseline Measurement:	0
First-year target/outcome measurement:	
Second-year target/outcome measurement:	20,000

Data Source:

Medicaid claims

Description of Data:

It is projected that 20,000 individuals within the current Medicaid system will become eligible for care coordination services through Behavioral Health Homes.

Data issues/caveats that affect outcome measures::

The Division of Medical Services (DMS) and the Division of Behavioral Health Services (DBHS) are currently working to transform the Medicaid funded behavioral health system through submitting a Health Homes State Plan Amendment (SPA) and a 1915i SPA. After approval from the State Legislature and the Centers for Medicare and Medicaid Services (CMS), new services will be implemented. Health Homes will be responsible for care coordination.

A First Year Target was not provided as the timeline for implementation has not been solidified.

Indicator #:	3
Indicator:	Number of individuals receiving home and community based treatment
Baseline Measurement:	0
First-year target/outcome measurement:	
Second-year target/outcome measurement:	20,000

Data Source:

Medicaid claims

Description of Data:

It is projected that 20,000 individuals within the current Medicaid system will be eligible for home and community based services through the 1915i SPA.

Data issues/caveats that affect outcome measures::

The Division of Medical Services (DMS) and the Division of Behavioral Health Services (DBHS) are currently working to transform the Medicaid funded behavioral health system through submitting a Health Homes State Plan Amendment (SPA) and a 1915i SPA. After approval from the State Legislature and the Centers for Medicare and Medicaid Services (CMS), new services will be implemented, including home and community based treatment through the 1915i SPA.

Indicator #:	4
Indicator:	Completion and promulgation of new performing and agency provider certifications
Baseline Measurement:	N/A
First-year target/outcome measurement:	Completion of the development of the certification processes
Second-year target/outcome measurement:	Completion of promulgation of certifications

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

The Division of Medical Services (DMS) and the Division of Behavioral Health Services (DBHS) are currently working to transform the Medicaid funded behavioral health system through submitting a Health Homes State Plan Amendment (SPA) and a 1915i SPA.

This will require new agency provider and performing provider certifications, including, but not limited to:

1915i Provider
Behavioral Health Home
Peer Support Specialist

Indicator #:	5
Indicator:	Number of individuals received supportive services
Baseline Measurement:	
First-year target/outcome measurement:	

Second-year target/outcome measurement: 20,000

Data Source:

Medicaid Claims Data

Description of Data:

It is projected that 20,000 indivuduals within the current Medicaid system will be eligible for support services through the 1915i SPA.

Data issues/caveats that affect outcome measures::

The Division of Medical Services (DMS) and the Division of Behavioral Health Services (DBHS) are currently working to transform the Medicaid funded behavioral health system through submitting a Health Homes State Plan Amendment (SPA) and a 1915i SPA. After approval from the State Legislature and the Centers for Medicare and Medicaid Services (CMS), new services will be implemented, including supportive services through the 1915i SPA.

Priority #: 4

Priority Area: Supplement Healthcare Reform

Priority Type: SAP, SAT, MHP, MHS

Population (s): SMI, SED, PWWDC, IVDUs, HIV EIS, TB, Other (Adolescents w/SA and/or MH, Students in College, LGBTQ, Rural, Military Families, Criminal/Juvenile Justice, Persons with Disablities, Children/Youth at Risk for BH Disorder, Homeless, Asian, Native Hawaiian/Other Pacific Islanders, Underserved Racial and Ethnic Minorities)

Goal of the priority area:

Assess and plan to provide care for the uninsured population and cover unavailable services after the implementation of the Health Insurance Marketplace, Medicaid Expansion, and Medicaid Transformation in January 2014.

Strategies to attain the goal:

- Analyze available data and current contracts to determine current population being served

- Adjust contracts to ensure providers are providing services to individuals without a payment option beyond January 2014

- Assess current workforce capacity to serve newly insured population

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Completion of service needs and gaps analysis
Baseline Measurement:	0
First-year target/outcome measurement:	N/A
Second-year target/outcome measurement:	Completion of analysis

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #:	2
Indicator:	Completion of a capacity development plan addressing current versus needed resources
Baseline Measurement:	0
First-year target/outcome measurement:	
Second-year target/outcome measurement:	Completion of plan

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Completion of workforce development assessment and enhancement/expansion plan

Baseline Measurement: 0

First-year target/outcome measurement: Completion of assessment

Second-year target/outcome measurement: Completion of plan

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 4

Indicator: Number of uninsured individuals served

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

SPQM
ADMIS
MDS

Description of Data:

Data issues/caveats that affect outcome measures::

With the implementation of Medicaid Expansion through a Private Option and the implementation of the Health Insurance Marketplace, DBHS will continue to monitor the clients served through contracted providers. DBHS will need to adjust the data needs from providers to ensure DBHS is collecting information regarding the effect of Private Option and Health Insurance Marketplace implementation.

DBHS will also need to examine provider practices surrounding financial and insurance screenings.

Priority #: 5

Priority Area: Criminal Justice Involved

Priority Type: SAP, SAT, MHP, MHS

Population (s): SMI, Other (Criminal/Juvenile Justice)

Goal of the priority area:

To develop a multi-system statewide action plan to enhance jail diversion and mental health services for individuals with a behavioral health condition involved in the criminal justice system including forensic evaluations, aftercare and transition from incarceration to community re-entry.

Strategies to attain the goal:

- Convene workgroup of external stakeholders to develop a statewide action plan based on the Sequential Intercept Model

- Identify and implement law enforcement training to raise awareness of mental health and substance abuse

- Examine issues around utilization, payment accessibility and accuracy of forensic evaluations.

- Identify an efficient and effective mental health screen that will aid in the early identification of severe mental illnesses and other acute psychiatric problems during the jail intake process

- Develop a plan for behavioral health care in the transition period for re-entering offenders between time of release and enrollment in third-

party payment options

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Completion of statewide action plan for improving the Forensics System
Baseline Measurement:	0
First-year target/outcome measurement:	Completion of statewide action plan
Second-year target/outcome measurement:	Implementation of plan

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #:	2
Indicator:	Number of trainings held regarding behavioral health and criminal justice
Baseline Measurement:	0
First-year target/outcome measurement:	Number of trainings held based on statewide action plan
Second-year target/outcome measurement:	Number of trainings held based on statewide action plan

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

The First Year Target and Second Year Target will be established in the statewide action plan

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Indicator #: 3

Indicator: Implementation of a mental health screen for jails

Baseline Measurement: 0

First-year target/outcome measurement: Selection of screening instrument/Plan for implementation

Second-year target/outcome measurement: Number of jails utilizing mental health screen

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Priority #: 6

Priority Area: Children's System of Care

Priority Type: MHS

Population (s): SED, Other (Adolescents w/SA and/or MH)

Goal of the priority area:

To expand and improve the Children's System of Care

Strategies to attain the goal:

This initiative will take a multi-aspect approach to plan for a statewide family-driven and youth-guided Children's System of Care 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. These three areas will be addressed by work groups that will include not only state staff, but also youth, families, local and state child serving agencies and others that will make this a highly inclusive project with widespread input and support.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Identify and customize a statewide data tracking system that identify success of the intensive care coordination services for the target population in Wraparound
Baseline Measurement:	0
First-year target/outcome measurement:	
Second-year target/outcome measurement:	Completion of statewide data tracking system

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #:	2
Indicator:	Identify training needs and develop plan for implementation of identified trainings
Baseline Measurement:	
First-year target/outcome measurement:	Training needs assessment complete

Second-year target/outcome measurement: Completion of implementation plan

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 3

Indicator: Identify and customize curriculum and standards for ongoing training and certification for Wraparound Specialists, Family Support Partners, and Youth Support Specialists.

Baseline Measurement: Completed curriculum and trainings for Wraparound Specialists and Family Support Partners

First-year target/outcome measurement:

Second-year target/outcome measurement: Completion of all curriculum and standards

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Priority #: 7

Priority Area: Integrated Data System

Priority Type: SAP, SAT, MHP, MHS

Population (s):

Goal of the priority area:

Develop an integrated behavioral health data collection and processing system that facilitates data-driven decisions and efficiency-oriented utilization and improvement of behavioral health resources and treatment.

Strategies to attain the goal:

Develop a plan to enhance the data processing system, to report outcomes, and to collect data relevant to Medicaid transformation, Medicaid Expansion, and Health Insurance Marketplace.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Completion of Capacity Assessment Matrix of existing data infrastructure

Baseline Measurement: 0

First-year target/outcome measurement: Completion of Capacity Assessment Matrix

Second-year target/outcome measurement: N/A

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #:	2
Indicator:	Completion of implementation plan for enhancing data process.
Baseline Measurement:	0
First-year target/outcome measurement:	N/A
Second-year target/outcome measurement:	Completion of implementation plan

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #:	3
Indicator:	Accessible dashboard for reporting outcomes.
Baseline Measurement:	0
First-year target/outcome measurement:	N/A
Second-year target/outcome measurement:	Availability of dashboard

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Priority #: 8

Priority Area: Trauma Informed Care

Priority Type: SAT, MHS

Population (s): SMI, SED, PWWDC, IVDUs, HIV EIS, TB, Other

Goal of the priority area:

Build capacity to implement trauma-informed care throughout the behavioral health care system.

Strategies to attain the goal:

DBHS will develop training to provider organizations on trauma-informed care.

DBHS will assist providers and the service system in development of trauma sensitive policies.

Train providers and state staff on in trauma informed

Assess the state's capacity to implement fidelity scales.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Provider policy development to address a trauma sensitive environment

Baseline Measurement:

First-year target/outcome measurement: 50% of contracted providers have implemented policies regarding trauma sensitive enviroment

Second-year target/outcome measurement: 90% of contracted providers have implemented policies regarding trauma sensitive enviroment

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 2

Indicator: Number of provider training based on the utilization of trauma sensitive screening tools and inclusion of trauma related issues addressed during intake process

Baseline Measurement: 0

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Indicator #: 3

Indicator: Number of trauma-informed care trainings to all provider staff, behavioral health leaders/champions, and service systems.

Baseline Measurement: 0

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

N/A

Description of Data:

N/A

Data issues/caveats that affect outcome measures::

N/A

Priority #: 9

Priority Area: Recovery

Priority Type: SAT, MHS

Population (s): SMI, SED, Other

Goal of the priority area:

Integration of recovery oriented care and treatment approaches across all service lines.

Strategies to attain the goal:

DBHS will implement training with an emphasis on recovery oriented care and treatment approaches.

Work with ABHPAC and other stakeholder groups

Take advantage of the BRSS TACS grant awarded to DBHS to promote and incorporate recovery oriented care

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Formulate a working definition of recovery oriented care for the State of Arkansas

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Number of stakeholder meetings held to develop State working definition with representation from mental and substance use services consumers

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Indicator #: 3

Indicator: Number of trainings held for providers around the inclusion of the definition of recovery in

service plan development

Baseline Measurement:

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 10

Priority Area: Lower alcohol usage

Priority Type: SAP

Population (s):

Goal of the priority area:

Lower the reported 30 day alcohol usage rate according to the Arkansas Prevention Needs Assessment from 16.3% in 2011 to 13.3% by 2016.

Strategies to attain the goal:

Training and Technical Assistance:
- 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.
- 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.
- Increase collaboration with Alcohol Beverage Control including coordinated merchant trainings and increase board responsiveness to communities desires surrounding private club permits.
- 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 Love and Logic, Guiding Good Choices, and Strengthening Families to

Regional Prevention Representatives who will provide training in communities.

Coordination of Services:
- 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.
- Initiate connection with the Arkansas Retail Beverage Association to solicit involvement by their merchant members in a social host law awareness campaign.
- Re-establish of the Arkansas Underage Drinking Prevention Taskforce to serve as an advocacy group.
- Develop a network of support providers focused on the LGBTQ population to enhance support network through consistent and strategic statewide services for LGBTQ concerns such as suicide and increased risk of substance abuse.
- Coordinate services for veterans, families, and other impacted by war to determine and fill gaps based on issues, geography, age, and gender.
- 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.
- Through MOUs, common terminology, and shared goals, design and implement leveraged funding with a common application process.

Data:
- Develop survey about ATOD use among LGBTQ to be analyzed by DBHS Outcome and Performance section which can be administered through the LGBTQ consortium.
- Enhance or expand data being collected by veteran serving organization for ATOD usage.
- Analyze information collected during DASEP screenings to create aggregate data about adult usage risk factors.

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

Priority #: 11

Priority Area: Lower smokeless tobacco usage

Priority Type: SAP

Population (s):

Goal of the priority area:

Lower the reported 30 day smokeless tobacco usage rate according to the Arkansas Prevention Needs Assessment from 5.6% in 2011 to 3.6% by 2016 and the cigarette usage rate from 8.8% in 2011 to 6.8% in 2016.

Data:
- Develop survey about ATOD use among LGBTQ to be analyzed by DBHS Outcome and Performance section which can be administered

through the LGBTQ consortium.
- Enhance or expand data being collected by veteran serving organization for ATOD usage.
- Combine the Arkansas Prevention Needs Assessment and Youth Tobacco Survey.

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

Strategies to attain the goal:

Coordination of Services:
- Enhance coordination with Arkansas Dept. of Health Tobacco Prevention and Cessation and Arkansas Tobacco Control Board to coordinate trainings to create more community responsiveness.
- Initiate coordination with Arkansas Chapter of American Lung Association and the American Cancer Society to solidify coordinated efforts to reduce tobacco use.
- 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.
- 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.
- Through MOUs, common terminology, and shared goals, design and implement leveraged funding with a common application process

Training and Technical Assistance:
- Coordinate efforts between Arkansas Tobacco Control Board, Arkansas Beverage Control, and DBHS for joint merchant education.
- Coordinate efforts around awareness campaign about law against smoking in cars with young children.
- 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 Love and Logic, Guiding Good Choices, and Strengthening Families to Regional Prevention Representatives who will provide training in communities.

Priority #: 12

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 according to the Arkansas Prevention Needs Assessment from 4.4% in 2011 to 2.1%

by 2016.

Strategies to attain the goal:

Coordination of Services:
- 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.
- Develop a network of support providers focused on the LGBTQ population to enhance support network through consistent and strategic statewide services for LGBTQ concerns such as suicide and increased risk of substance abuse.
- Coordinate services for veterans, families, and other impacted by war to determine and fill gaps based on issues, geography, age, and gender.
- 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.
- Through MOUs, common terminology, and shared goals, design and implement leveraged funding with a common application process

Training and Technical Assistance:
- 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.
- Provide training about prevention to law enforcement, especially school resource officers, for better understanding of youth drug trends, behaviors, and appropriate environmental prevention strategies.
- 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.
- Work with addiction studies graduate students and Arkansas Dept. of Education to publish and make trainings about prevention available to all teachers so that they have a better understanding of the science of addiction and how to work with individuals from substance addicted home.
- 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.
- 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 Love and Logic, Guiding Good Choices, and Strengthening Families to Regional Prevention Representatives who will provide training in communities.

Data:
- Develop survey about ATOD use among LGBTQ to be analyzed by DBHS Outcome and Performance section which can be administered through the LGBTQ consortium.
- Enhance or expand data being collected by veteran serving organization for ATOD usage.
- Coordinate with the Arkansas Health Department to review data collected about prescribing trends through the Prescription Drug Monitoring Program.

Evaluation:

- Implement standardized collection processes and expected measures for process and outcome data.

Priority #: 13

Priority Area: Lower the number of attempted suicides

Priority Type: MHP

Population (s):

Goal of the priority area:

Lower the number of attempted suicide reported by the Arkansas Department of Health Injury Prevention from the 2010 rate of 1692 to 1400 by 2016.

Strategies to attain the goal:

Training and Technical Assistance:
- Collaborate with Army One Source to provide training to social services providers, faith-based organizations and veterans support organizations about effects on veterans, families, and other impacted by war for better understanding of the behavioral health care needs of this special population.
- Provide training on suicide screenings to community providers and promote awareness of suicide as a preventable health issue by developing a better understanding the relationship between self-harm and mental health and substance abuse issues.
- 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 Love and Logic, Guiding Good Choices, and Strengthening Families to Regional Prevention Representatives who will provide training in communities.
- Train and provide technical assistance to the Arkansas Behavioral Health Policy Advisory Council to help this consumer advisory committee understand prevention and promotion of wellness.

Coordination of Services:
- Develop a network of support providers focused on the LGBTQ population to enhance support network through consistent and strategic statewide services for LGBTQ concerns such as suicide and increased risk of substance abuse.
- Coordinate services for veterans, families, and other impacted by war to determine and fill gaps based on issues, geography, age, and gender.
- 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.
- Through MOUs, common terminology, and shared goals, design and implement leveraged funding with a common application process

Data:
- Coordinate data about suicide attempts collected by the Arkansas Department of Health, crisis call placed to the Arkansas Crisis Center and

cause of death data collected by the Arkansas State Crime Lab.

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

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [SA]

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

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment	$9,900,000		$200,000	$	$2,700,000	$	$
a. Pregnant Women and Women with Dependent Children*	$ 1,410,000		$ 100,000	$	$	$	$
b. All Other	$ 8,490,000		$ 100,000	$	$ 2,700,000	$	$
2. Substance Abuse Primary Prevention	$ 2,640,000		$	$	$	$	$
3. Tuberculosis Services	$		$	$	$	$	$
4. HIV Early Intervention Services	$		$	$	$	$	$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non -24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	$ 660,000		$	$	$	$	$
11. Total	$13,200,000	$	$200,000	$	$2,700,000	$	$

* Prevention other than primary prevention

Footnotes:

Column C: The Substance Abuse Treatment Services (SATS) program was created to provide services to two Medicaid eligible populations: children and youth up to 21 years of age; and pregnant and post-partum women. Enrollment began in March 2011, and services began in July 2011. Approximately $50,000 was billed through the SATS program in SFY2013.

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

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

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$	$	$	$	$
6. Other 24 Hour Care		$	$	$	$ 11,300,000	$	$
7. Ambulatory/Community Non -24 Hour Care		$ 3,487,500	$	$	$ 20,592,000	$	$
8. Mental Health Primary Prevention		$	$	$	$	$	$
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)		$ 187,500	$	$	$	$	$
10. Administration (Excluding Program and Provider Level)		$ 75,000	$	$	$ 474,000	$	$
11. Total	$	$3,750,000	$	$	$32,366,000	$	$

* Prevention other than primary prevention

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

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

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			$	$
Specialized Outpatient Medical Services	1539		$	$
Acute Primary Care			$	$
General Health Screens, Tests and Immunizations			$	$
Comprehensive Care Management			$	$
Care coordination and Health Promotion			$	$
Comprehensive Transitional Care			$	$
Individual and Family Support			$	$
Referral to Community Services Dissemination			$	$
Prevention (Including Promotion)			$	$
Screening, Brief Intervention and Referral to Treatment			$	$

Brief Motivational Interviews			$	$
Screening and Brief Intervention for Tobacco Cessation			$	$
Parent Training			$	$
Facilitated Referrals			$	$
Relapse Prevention/Wellness Recovery Support			$	$
Warm Line			$	$
Substance Abuse (Primary Prevention)			$	$
Classroom and/or small group sessions (Education)	10		$	$
Media campaigns (Information Dissemination)	1106		$	$
Systematic Planning/Coalition and Community Team Building(Community Based Process)	2081		$	$
Parenting and family management (Education)	16		$	$
Education programs for youth groups (Education)	4		$	$
Community Service Activities (Alternatives)	134		$	$
Student Assistance Programs (Problem Identification and Referral)	98		$	$
Employee Assistance programs (Problem Identification and Referral)	11		$	$

Community Team Building (Community Based Process)	248		$	$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)	353		$	$
Engagement Services			$	$
Assessment	11012		$	$
Specialized Evaluations (Psychological and Neurological)	536		$	$
Service Planning (including crisis planning)			$	$
Consumer/Family Education			$	$
Outreach			$	$
Outpatient Services			$	$
Evidenced-based Therapies	9035		$	$
Group Therapy	2541		$	$
Family Therapy			$	$
Multi-family Therapy			$	$
Consultation to Caregivers	987		$	$
Medication Services			$	$

Medication Management	7138		$	$
Pharmacotherapy (including MAT)			$	$
Laboratory services			$	$
Community Support (Rehabilitative)			$	$
Parent/Caregiver Support			$	$
Skill Building (social, daily living, cognitive)			$	$
Case Management			$	$
Behavior Management			$	$
Supported Employment	109		$	$
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)	400		$	$
Partial Hospital			$	$

Assertive Community Treatment	281		$	$
Intensive Home-based Services			$	$
Multi-systemic Therapy	933		$	$
Intensive Case Management	6377		$	$
Out-of-Home Residential Services			$	$
Children's Mental Health Residential Services			$	$
Crisis Residential/Stabilization			$	$
Clinically Managed 24 Hour Care (SA)			$	$
Clinically Managed Medium Intensity Care (SA)			$	$
Adult Mental Health Residential	1671		$	$
Youth Substance Abuse Residential Services	220		$	$
Therapeutic Foster Care	352		$	$
Acute Intensive Services			$	$
Mobile Crisis	4070		$	$
Peer-based Crisis Services			$	$

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

Footnotes:

Three different databases were utilized to report this information.

The Director of Quality of Assurance, Dr. Kazi Ahmed, has utilized this information to identify the gaps in the Division's database capacity.

The Division's need to integrate data systems, along with improve the data elemnts collected, is noted in the Block Grant Application Priorities.

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

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

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$9,900,000	
2 . Substance Abuse Primary Prevention	$2,640,000	
3 . Tuberculosis Services		
4 . HIV Early Intervention Services**		
5 . Administration (SSA Level Only)	$660,000	
6. Total	$13,200,000	

* Prevention other than primary prevention

** HIV Early Intervention Services

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

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

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal		
	Selective		
	Indicated		
	Unspecified	$414,830	
	Total	$414,830	
Education	Universal		
	Selective		
	Indicated		
	Unspecified	$303,655	
	Total	$303,655	
Alternatives	Universal		
	Selective		
	Indicated		
	Unspecified	$213,731	
	Total	$213,731	
Problem Identification and Referral	Universal		
	Selective		
	Indicated		
	Unspecified	$58,099	

	Total	$58,099	
Community-Based Process	Universal		
	Selective		
	Indicated		
	Unspecified	$842,434	
	Total	$842,434	
Environmental	Universal		
	Selective		
	Indicated		
	Unspecified	$154,391	
	Total	$154,391	
Section 1926 Tobacco	Universal		
	Selective		
	Indicated		
	Unspecified	$90,360	
	Total	$90,360	
Other	Universal		
	Selective		
	Indicated		
	Unspecified	$562,500	
	Total	$562,500	
Total Prevention Expenditures	$2,640,000		
Total SABG Award*	$13,200,000		
Planned Primary Prevention Percentage	20.00 %		

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

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

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

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	$1,601,250	
Universal Indirect	$1,038,750	
Selective		
Indicated		
Column Total	$2,640,000	
Total SABG Award*	$13,200,000	
Planned Primary Prevention Percentage	20.00 %	

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

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

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

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

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

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$13,000		$137,000	$150,000				
2. Quality Assurance	$150,000			$150,000				
3. Training (Post-Employment)	$159,000			$159,000				
4. Education (Pre-Employment)	$12,000			$12,000				
5. Program Development	$75,000			$75,000				
6. Research and Evaluation								
7. Information Systems								
8. Enrollment and Provider Business Practices (3 percent of BG award)			$396,000	$396,000				
9. Total	$409,000		$533,000	$942,000				

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

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

Service	Block Grant
MHA Technical Assistance Activities	$
MHA Planning Council Activities	$ 25,000
MHA Administration	$ 25,000
MHA Data Collection/Reporting	$
Enrollment and Provider Business Practices (3 percent of total award)	$ 112,500
MHA Activities Other Than Those Above	$
Total Non-Direct Services	$162500

Comments on Data:

The total administration expenditures reported on Table 2 include MHA Planning Council Activities in addition to MHA Administration Activities

Footnotes:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

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

Please answer the following questions:

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

Footnotes:

PRELIMINARY DRAFT

Building a healthier future for all Arkansans

Behavioral Health Transformation

August 2013

PRELIMINARY WORKING DRAFT, SUBJECT TO CHANGE

Agenda

- Introduction
- Health home model
- New behavioral health services

Page 161 of 642

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

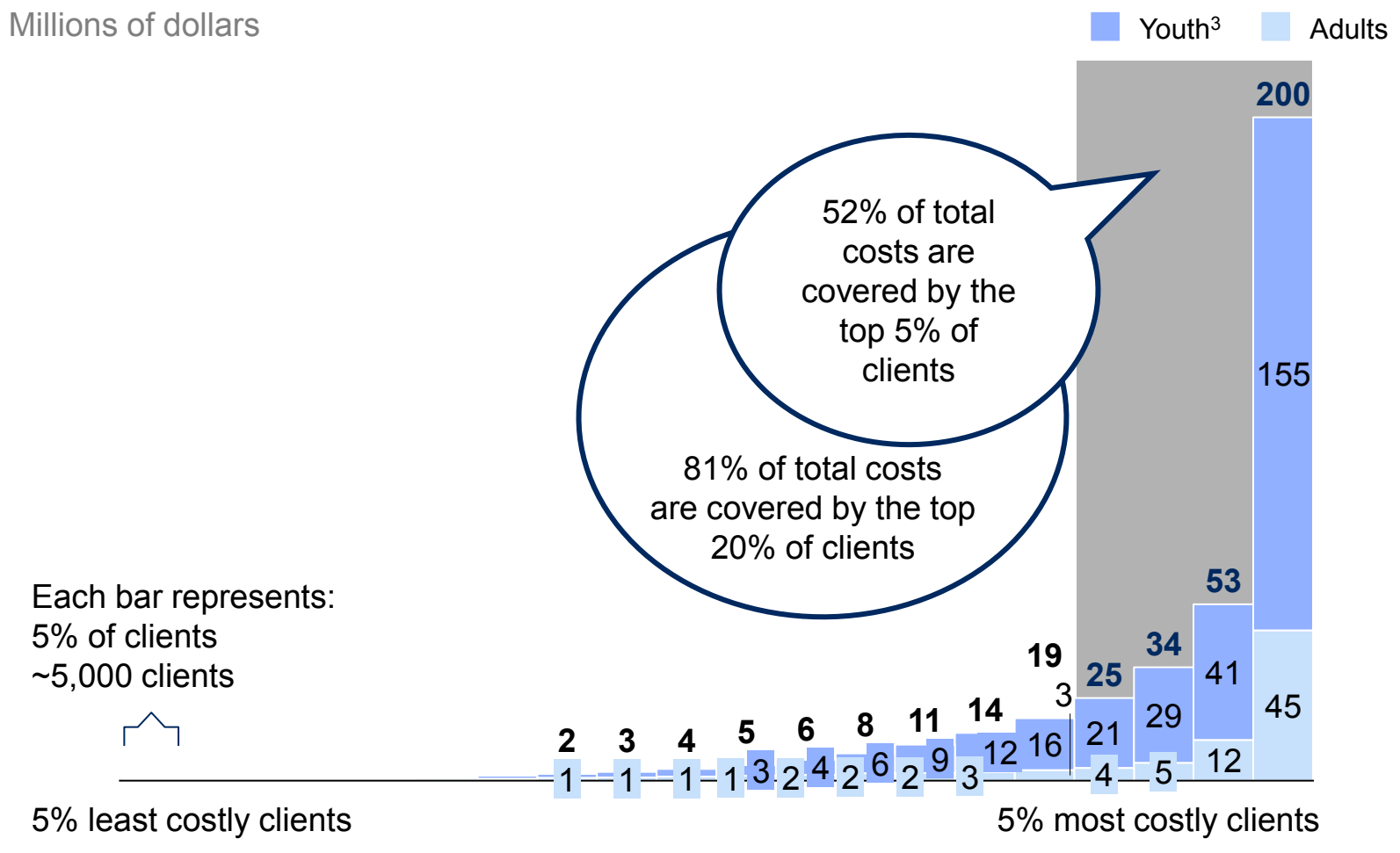
NOTE: Does not include those funded solely from state general revenue. Analysis underway to incorporate broader behavioral health programs

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

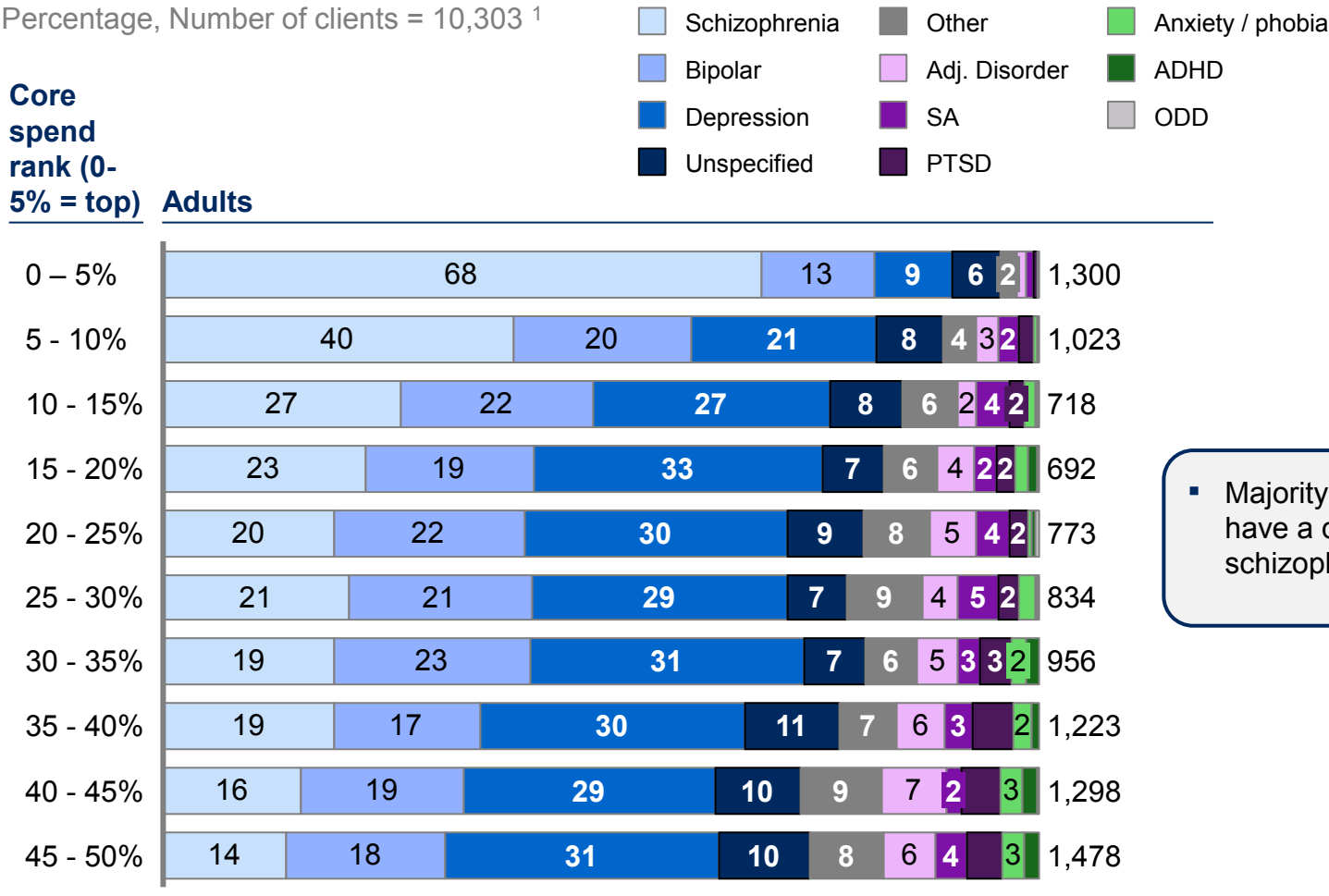


1 Includes all clients with at least one core related claim
2 Excludes clients with DD and LTSS because this group is likely to have multiple health home options
3 Youths are clients<21 years of age; Adults are clients ≥ 21 years of age

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

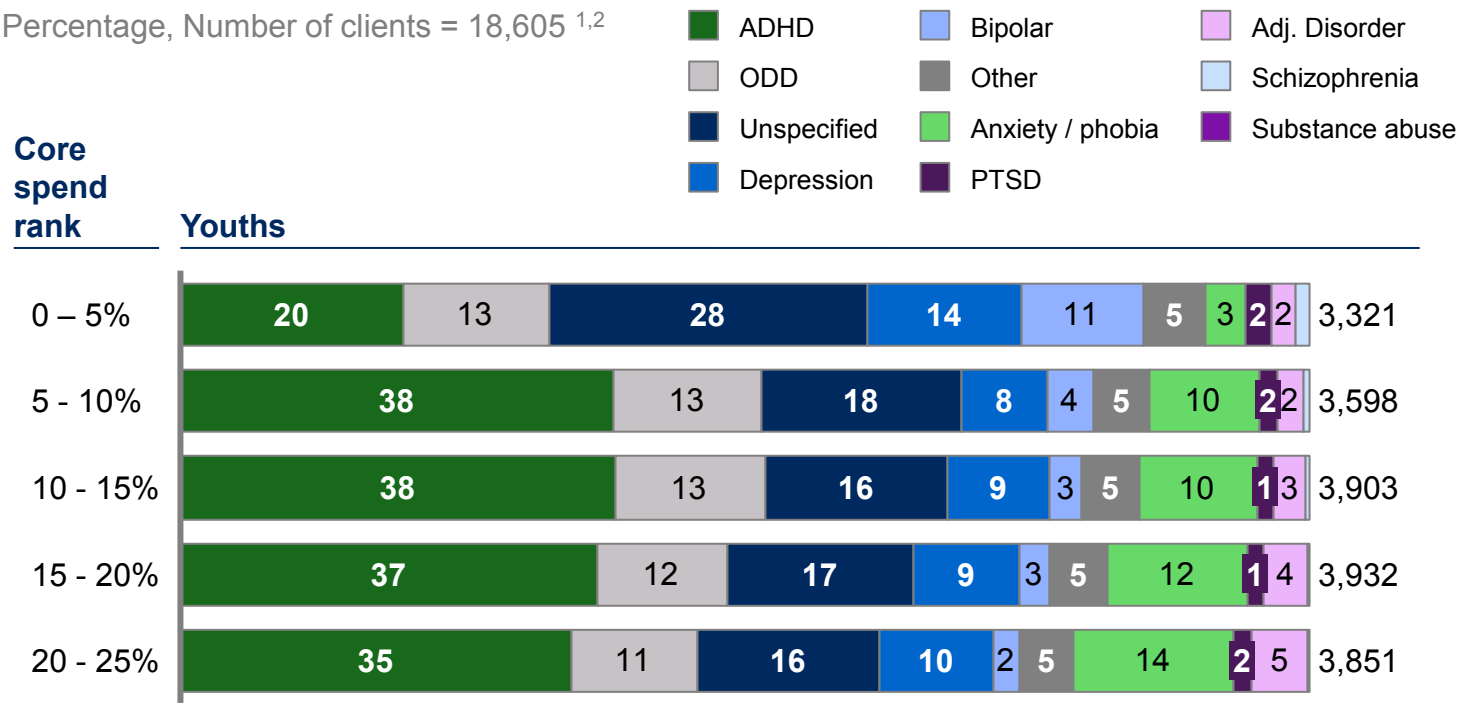
1 Excludes clients with DD and LTSS because this group is likely to have multiple health home options

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]



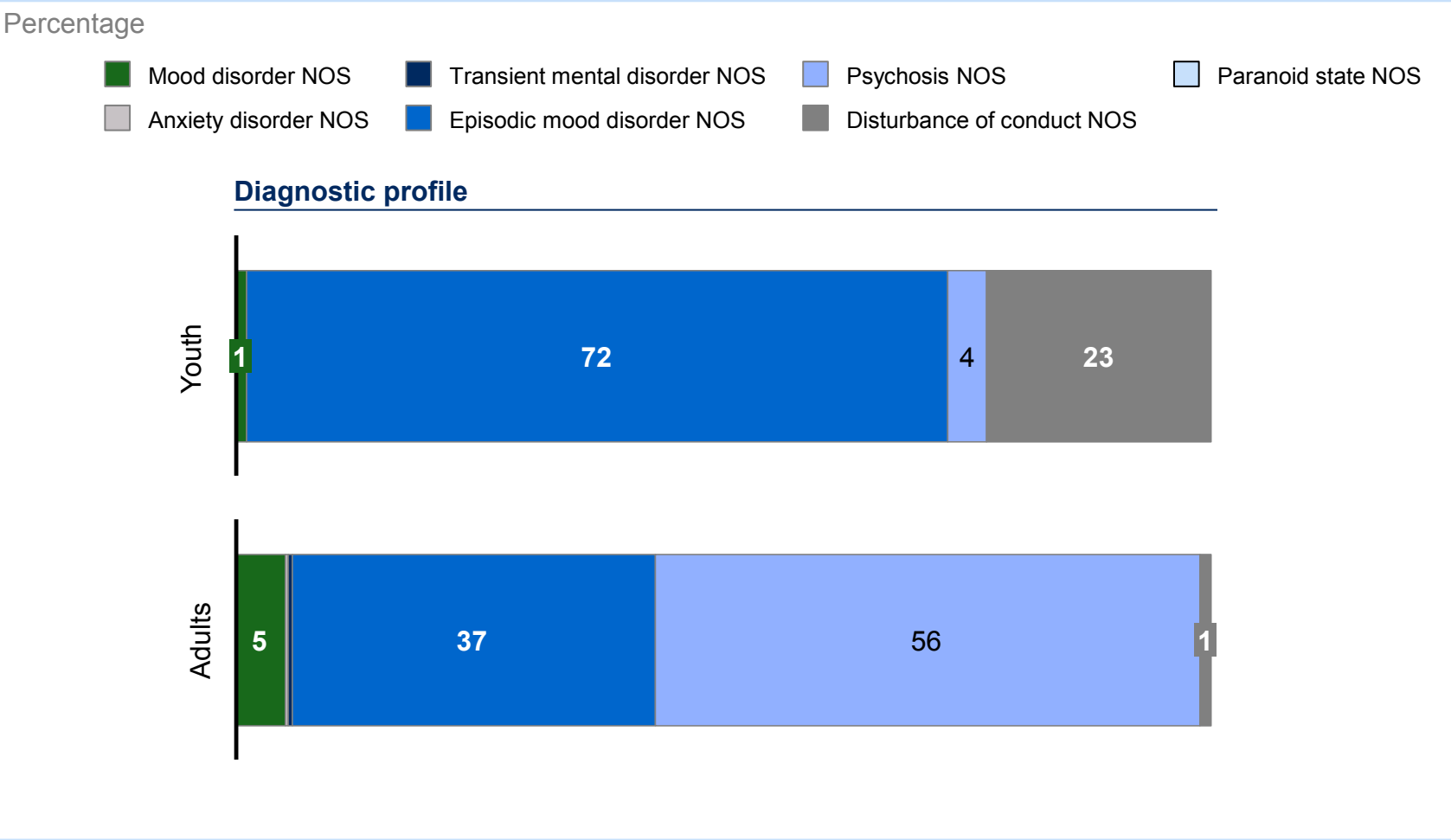
- Both ADHD and ODD will be covered by episodes
- Over 1,000 clients in top 5% of spend are diagnosed with ADHD or ODD

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

OMB No. 0930-0168 Approved: 05/21/2013 Expires: 05/31/2016

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

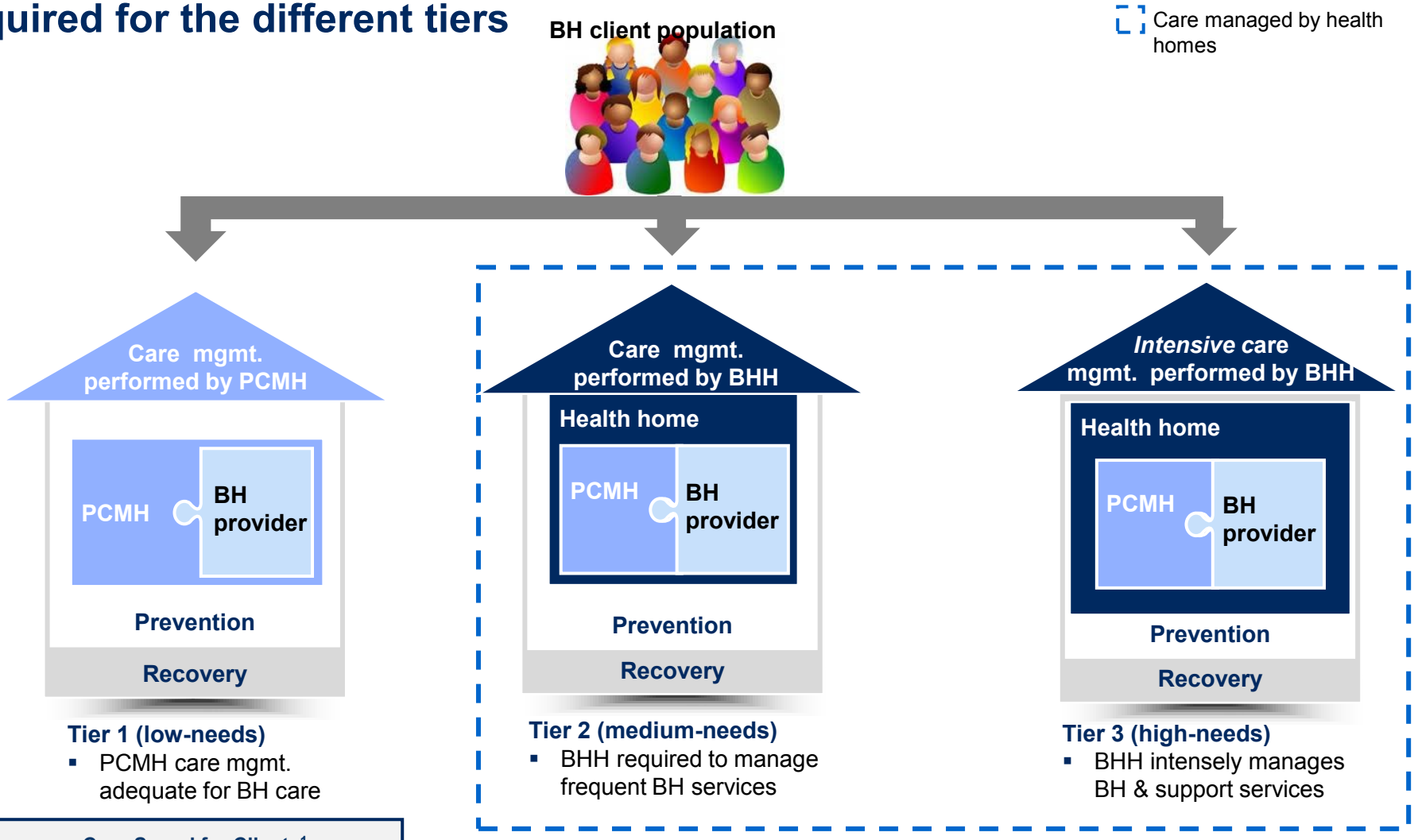
- Health homes must address **comprehensive needs of individuals** by utilizing a “whole person” and “person centered” approach while ensuring personal choice assurances through service planning and delivery
- Health homes will provide services that address issues of **access to care, accountability, 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



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

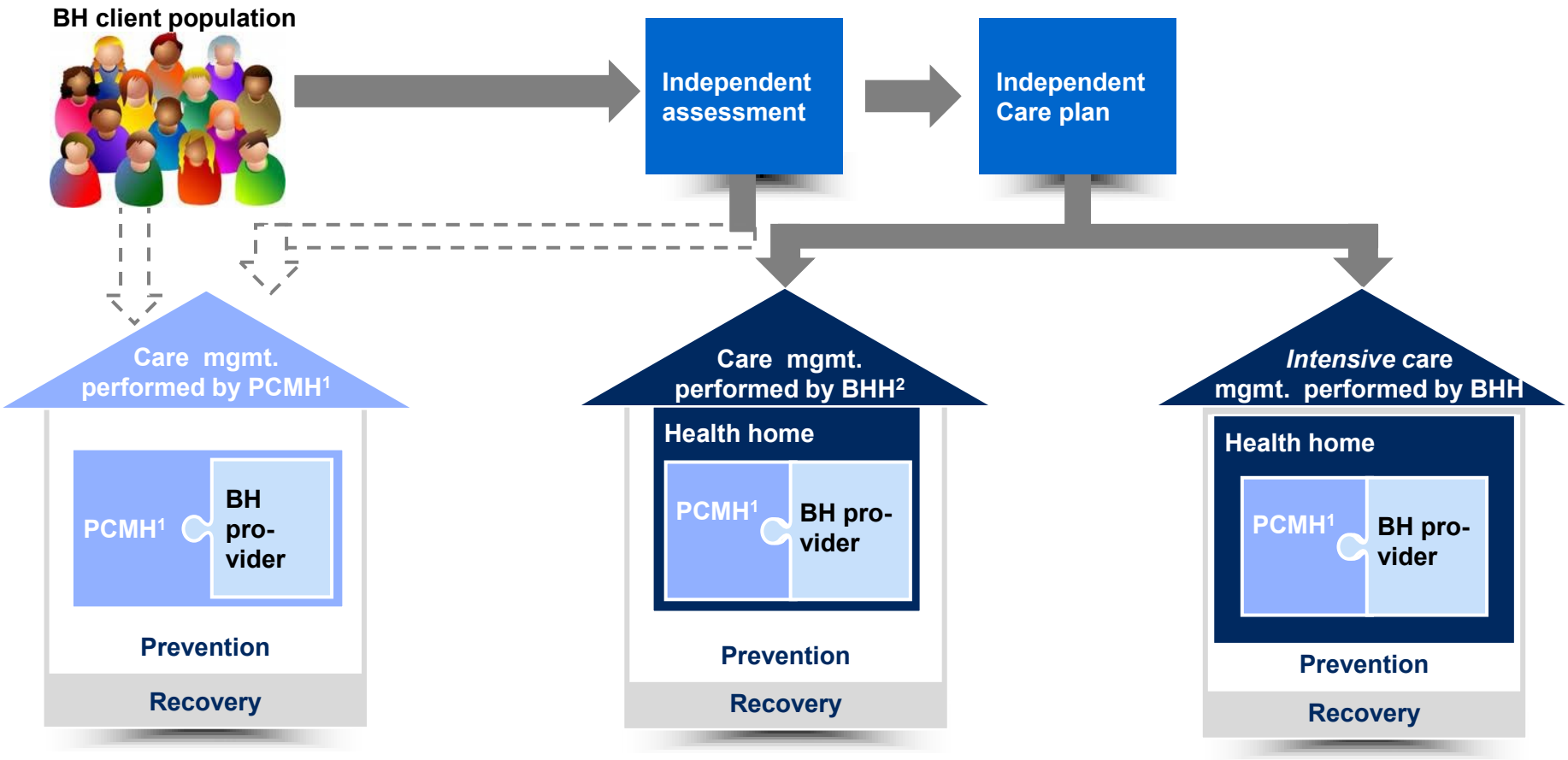
1 This Federal state plan option allows states to offer Home and Community Based Services under a Medicaid state plan to individuals who are Medicaid-eligible.

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



Tier 1 (~90,000 clients)
- PCMH[1] care mgmt. adequate for BH care

Tier 2 (~10-15,000 clients)
- BHH[2] required to manage frequent BH services

Tier 3 (~5,000 clients)
- BHH[2] intensely manages BH & support services

Care management and behavioral health services will be available in appropriate tiers

1 Patient centered medical home
2 Arkansas

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*
- *Family psychoeducation*
- *Mental health diagnosis*
- *Interpretation of diagnosis*
- *Substance abuse assessment*
- *Psychological evaluation*
- *Psychiatric assessment*
- *Physician tobacco cessation program*
- 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

C. Coverage for M/SUD Services

The services that will be included in the QHPs has not been determined, yet the services available on each plan should be announced within the month. This decision falls under the periphery of the Arkansas Insurance Department. Yet the Department of Human Services is working with the Insurance Department regarding the QHPs and the implementation of the Medicaid Expansion through the Private Option. Therefore, the Department and the Division will be aware of the services available on the QHPs and the performing providers eligible to provide those services.

Due to the changes in insurance coverage and Medicaid services in Arkansas, the Division will compare the populations being served and the services available to amended current contracts with substance abuse and mental health providers to ensure enrollment, service, and populations gaps are covered.

The SMHA and/or SSA will not be involved in reviewing complaints or possible violations of MHPAEA, this will be handled by the Insurance Department. As part of establishing the Health Insurance Exchange in Arkansas, the Arkansas Insurance Department is facilitating the Arkansas Consumer Assistance Program. This program will assist consumers with complaints regarding insurance companies and inquiries regarding insurance. Additionally, funding is available for organizations to apply to be Marketplace Navigators and In-Person Assistors. Both will provide in-person assistance to individuals applying for coverage through the Exchange. These programs and funding will greatly assist individuals with a behavioral health disorder navigate a potentially complicated system and gain access to needed services.

DBHS is a close partner with the State Medicaid agency. Therefore, DBHS is and will continue to be involved in the transformation of the Medicaid supported behavioral health system to include evidence based and recovery oriented services. While the Department of Human Services is currently working to transform the Medicaid system, which will include the addition of many behavioral health services, this will not be in effect as of January 1, 2014.

The following behavioral health services are currently provided by Medicaid:

Rehabilitative Option Services

- Mental Health Evaluation/Diagnosis
- Psychiatric Diagnostic Assessment
- Group Outpatient – Group Psychotherapy
- Individual Psychotherapy
- Pharmacologic Management
- Medication Administration
- Master Treatment Plan
- Periodic review of Master Tx Plan
- Group Outpatient – Pharmacologic Management by a Physician
- Therapeutic Day/Acute Day Tx
- Interpretation of Diagnosis
- Psychological Evaluation

- Physical Exam--Physician
- Crisis Intervention
- Marital/Family Psychotherapy – Beneficiary is present
- Marital/Family Psychotherapy – Beneficiary is not present
- Routine Venipuncture for Collection of Specimen
- Collateral Intervention
- Crisis Stabilization Intervention
- Intervention
- Rehabilitative Day Service

Substance Abuse Treatment Services – Available to Pregnant/Post-Partum Women and Adolescents

- Addiction Assessment
- Group Counseling
- Individual Counseling
- Medication Management
- Treatment Planning
- Care Coordination
- Marital/Family Counseling
- Multi-Person (Family) Group Counseling

Licensed Mental Health Practitioners Program – Available to Children, Youth, and Adolescents

- Diagnosis
- Diagnosis – Psychological Test/Evaluation
- Diagnosis – Psychological Testing – Battery
- Interpretation of Diagnosis
- Crisis Management Visit
- Individual Outpatient – Therapy Session
- Marital/Family Therapy
- Marital/Family Therapy without patient present
- Individual Outpatient – Collateral Services
- Group Outpatient – Group Therapy

As mentioned, the Department of Human Services is in the midst of transforming the Medicaid funded behavioral health system. While it is still in the development stages and pending Legislative and Federal approval, the Department plans to fund the following services through the Medicaid system, utilizing the Rehabilitative Option, 1915i, and Health Homes, beginning in March 2014:

- Individual behavioral health counseling (to include substance abuse, mental health, and tobacco cessation)

- Group behavioral health counseling (to include substance abuse, mental health, and tobacco cessation)
- 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
- 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
- Psychiatric diagnostic assessment
- Individual life skills development
- Group life skills development
- Child and youth support services
- Individual recovery support
- Group recovery support
- Planned respite
- Residential treatment unit and center
- Crisis residential treatment
- Therapeutic communities
- Acute psychiatric hospitalization
- Mobile response and crisis stabilization
- Acute crisis units
- Substance abuse detoxification
- Care management
- Intensive care management
- Wraparound facilitation

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

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

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

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?

2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?

3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?

4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?

5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.

6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.

7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.

8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

The Arkansas Insurance Department has authority over the Health Insurance Marketplace in Arkansas.

The state is still awaiting many decisions regarding the Health Insurance Marketplace, including the QHPs and Provider Qualifications.

ARKANSAS DRAFT 1115 WAIVER FOR PUBLIC COMMENT

This draft 1115 Demonstration waiver request supports implementation of Arkansas's Health Care Independence Act of 2013, which was signed into law by Governor Beebe on April 23, 2013. The Act clearly articulates the context, goals, and objectives for the Demonstration.

Arkansas is uniquely situated to serve as a laboratory of comprehensive and innovative healthcare reform that can reduce the state and federal obligations to entitlement spending. Arkansas has historically addressed state-specific needs to achieve personal responsibility and affordable health care for its citizens through initiatives such as the ARHealthNetworks partnership between the state and small businesses. The State has also initiated nationally recognized and transformative changes in the healthcare delivery system through alignment of payment incentives, health care delivery system improvements, enhanced rural health care access, initiatives to reduce waste, fraud and abuse, policies and plan structures to encourage the proper utilization of the healthcare system, and policies to advance disease prevention and health promotion.

The Health Care Independence Act calls on the Arkansas Department of Human Services to explore design options that reform the Medicaid Program so that it is a fiscally sustainable, cost-effective, personally responsible, and opportunity-driven program utilizing competitive and value-based purchasing to:
(1) Maximize the available service options;
(2) Promote accountability, personal responsibility, and transparency;
(3) Encourage and reward healthy outcomes and responsible choices; and
(4) Promote efficiencies that will deliver value to the taxpayers.

The Act determines that the State of Arkansas shall take an integrated and market-based approach to covering low-income Arkansans through offering new coverage opportunities, stimulating market competition, and offering alternatives to the existing Medicaid program. The specific purposes of the novel approach to coverage established in the HCIA are to:

(1) Improve access to quality health care;
(2) Attract insurance carriers and enhance competition in the Arkansas insurance Marketplace;
(3) Promote individually-owned health insurance;
(4) Strengthen personal responsibility through cost-sharing;
(5) Improve continuity of coverage;
(6) Reduce the size of the state-administered Medicaid program;
(7) Encourage appropriate care, including early intervention, prevention, and wellness;
(8) Increase quality and delivery system efficiencies;
(9) Facilitate Arkansas's continued payment innovation, delivery system reform, and market-driven improvements;
(10) Discourage over-utilization; and
(11) Reduce waste, fraud, and abuse.

The Demonstration program described below in this Draft 1115 waiver application is specifically designed to meet the requirements of the Health Care Independence Act of 2013.

Section I - Program Description

1) Provide a summary of the proposed Demonstration program, and how it will further the objectives of title XIX and/or title XXI of the Social Security Act (the Act).

Under the Demonstration, the State will use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Arkansas insurance Marketplace for individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes at or below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or (2) parents between the ages of 19 and 65 with incomes between 17 and 138% FPL who are not enrolled in Medicare (collectively "Private Option beneficiaries"). Private Option beneficiaries will receive the Alternative Benefit Plan (ABP) through a QHP that they select and have cost sharing obligations consistent with both the State Plan and with the cost-sharing rules applicable to individuals with comparable incomes in the Marketplace. The Demonstration will further the objectives of Title XIX by promoting continuity of coverage for individuals (and in the longer run, families), improving access to providers, smoothing the "seams" across the continuum of coverage, and furthering quality improvement and delivery system reform initiatives. Ultimately, the Demonstration will provide truly integrated coverage for low-income Arkansans, leveraging the efficiencies of the private market to improve continuity, access, and quality for Private Option beneficiaries. Additionally, by nearly doubling the size of the population enrolling in QHPs offered through the Marketplace, the Demonstration is expected to drive structural health care system reform and more competitive premium pricing for all individuals purchasing coverage through the insurance Marketplace.

In the coming year, the State anticipates revising the waiver to include parents with incomes below 17% FPL and children. In addition, the State anticipates developing a pilot project to create health savings accounts to promote cost-effective use of the health care system.

2) Include the rationale for the Demonstration

Expanding Medicaid to nearly all individuals with incomes at or below 138% FPL, as set out in the Affordable Care Act, would present several challenges for Arkansas. First, the new adults are likely to have frequent income fluctuations that lead to changes in eligibility. In fact, studies indicate that more than 35% of adults will experience a change in eligibility within six months of their eligibility determination.[1] Without carefully crafted policy and operational interventions, these frequent changes in eligibility could lead to (1) coverage gaps during which individuals lack any health coverage, even though they are eligible for coverage under Title XIX or Advanced Premium Tax Credits (collectively, along with CHIP, "Insurance Affordability Programs" or "IAPs") and/or (2) disruptive changes in benefits, provider networks, premiums,

[1] Health Affairs, "Frequent Churning Predicted Between Medicaid and Exchanges," February 2011.

and cost-sharing as individuals transition from one IAP to another. In addition, by expanding Medicaid to include all individuals with incomes at or below 138% FPL, Arkansas would be increasing its Medicaid program by nearly 40%. The State's existing network of fee-for-service Medicaid providers is at capacity; as a result, Arkansas would be faced with the challenge of increasing providers' capacity to serve Medicaid beneficiaries to ensure adequate access to care. In short, absent the Demonstration, Arkansas's Medicaid expansion would rely on the existing Medicaid delivery system and perpetuate an inefficient, underfunded and inadequately coordinated approach to patient care. While reforms associated with Arkansas's Payment Improvement Initiative are designed to address the quality and cost of care, these reforms do not include increased payment rates needed to expand provider access for the 250,000 new adults that will enroll through the expansion.

The Demonstration is crafted to address these problems. By using premium assistance to purchase QHPs offered in the Marketplace, Arkansas will promote continuity of coverage and expand provider access, while improving efficiency and accelerating multi-payer cost-containment and quality improvement efforts.

- **Continuity of coverage** – For households with members eligible for coverage under Title XIX and Marketplace coverage as well as those who have income fluctuations that cause their eligibility to change year-to-year, the Demonstration will create continuity of health plans and provider networks. Households can stay enrolled in the same plan regardless of whether their coverage is subsidized through Medicaid, CHIP (after year one), or Advanced Premium Tax Credits.

- **Rational provider reimbursement and improved provider access** – Arkansas Medicaid provides rates of reimbursement lower than Medicare or commercial payers, causing some providers to forego participation in the program and others to "cross subsidize" their Medicaid patients by charging more to private insurers. The Demonstration will rationalize provider reimbursement across payers, expanding provider access and eliminating the need for providers to cross-subsidize.

- **Integration and efficiency** – Arkansas is taking an integrated and market-based approach to covering uninsured Arkansans, rather than relying on a system for insuring lower income families that is separate and duplicative. This transition to private markets is a more efficient way of covering Arkansans.

- **"All payer" health care reform** – Arkansas is at the forefront of payment innovation and delivery system reform, and the Demonstration will accelerate and leverage its Arkansas Health Care Payment Improvement Initiative (AHCPII) by increasing the number of carriers participating in the effort, and the number of privately insured Arkansans who benefit from a direct application of these reforms.

3) Describe the hypotheses that will be tested/evaluated during the Demonstration's approval period and the plan by which the State will use to test them.

The Demonstration will authorize the delivery of health insurance benefits to a new group of low-income adults through a novel alternative to traditional Medicaid programs and will test the following hypotheses during the approval period:

Hypothesis	Evaluation Approach	Data Sources[2]
***Provider Access**:* Private Option beneficiaries will have greater provider access than newly eligible adults would otherwise have in a traditional fee-for-service system. Private Option beneficiaries will have provider access comparable to other individuals insured in the private market. Private Option beneficiaries will have more consistent access to preventive care services compared to Medicaid beneficiaries in non-Premium Assistance expansions nationally Private Option beneficiaries will have lower non-emergent use of emergency room services as compared to Medicaid beneficiaries in non-Premium Assistance expansions nationally.	• Compare traditional Medicaid and Private Option provider networks for primary and specialty care • % of individuals who reported how often they get care quickly • % of persons with hospital emergency department as usual source of care • % of individuals with a usual primary care provider • % of individuals with an ambulatory or preventive care visit in the past year • Compare denied Emergency Room claims in QHPs v. Fee- for-Service claims for non-emergency services provided in the Emergency Room	Arkansas Health Data Initiative Physician masterfile State claims databases Hospital Discharge Data Medical Expenditure Panel Survey from AHRQ (MEPS) NCQA HEDIS CAHPS CDC- Behavioral Risk Factor Surveillance System
***Churning**:* Private Option Beneficiaries will have fewer gaps in insurance coverage than Medicaid beneficiaries in non-Premium Assistance expansions nationally.	• Compare churn rates between Private Option and evidence in literature/other states experiences with traditional expansion	Enrollment data from Arkansas and other states MEPS

[2] Subject to availability.

Hypothesis	Evaluation Approach	Data Sources[2]
	• % of individuals with any period of uninsurance during the year	
***Churning**:* Private Option beneficiaries will maintain continuous access to the same health plans and/or providers at higher rates than under a traditional Medicaid expansion.	• Analysis of Marketplace subsidy-eligible and Private Option beneficiary changes in premium contributions to measure the % of Private Option/subsidy-eligible QHP enrollees that would have otherwise had to change coverage and/or providers	Marketplace/Private Option enrollment data
***Churning**:* Reduction in churning for Private Option Beneficiaries will lead to reduced administrative costs.	• Comparison of administrative costs per capita expended between traditional Medicaid and Private Option expansions	Enrollment/Administrative costs data from Arkansas and other states
***Cost**:* Over the life of the demonstration, the cost for covering Private Option beneficiaries will be comparable to what the costs would have been for covering the same expansion group in Arkansas Medicaid fee-for-service, assuming adjustments to fee-for-service reimbursement to achieve access in the fee-for-service model.	TBD	
***Quality Improvement**:* Private Option enrollees will have lower rates of potentially preventable admissions than enrollees in	Analysis of hospital discharge data	Arkansas Department of Health data Arkansas Health Data

Hypothesis	Evaluation Approach	Data Sources[2]
Arkansas's Medicaid fee for service program.		Initiative
Cost in the Arkansas Marketplace: The Private Option will drive down overall premium costs in the Marketplace and will result in better quality than would otherwise have occurred absent the Private Option.	Actuarial analysis of the impact of increased volume and competitive pricing requirements for plans offered to Private Option beneficiaries	Claims data
Quality in the Arkansas Marketplace*:* The Private Option, inclusive of its requirement to participate in the Arkansas Payment Improvement Initiative (APII), will produce improved quality over time than would otherwise have occurred absent the Private Option	Analysis of APII PCMH quality metrics for preventive care and chronic disease management	Claims and clinical information
Uncompensated Care*:* Uncompensated care costs will be driven down as a result of higher levels of provider reimbursement and fewer numbers of uninsured.	Analysis of Disproportionate Share Hospital Payments	CMS data

4) Describe where the Demonstration will operate, i.e., statewide, or in specific regions within the State. If the Demonstration will not operate statewide, please indicate the geographic areas/regions of the State where the Demonstration will operate

The Demonstration will operate statewide.

5) Include the proposed timeframe for the Demonstration

The Demonstration will operate during calendar years 2014, 2015, and 2016.

6) Describe whether the Demonstration will affect and/or modify other components of the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost sharing or delivery systems

No. The demonstration will not modify the State's current Medicaid and CHIP programs outside of eligibility, benefits, cost-sharing or delivery systems.

Section II – Demonstration Eligibility

1) Include a chart identifying any populations whose eligibility will be affected by the Demonstration (an example is provided below; note that populations whose eligibility is not proposed to be changed by the Demonstration do not need to be included).

Please refer to Medicaid Eligibility Groups: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-Eligibility-Groups.pdf when describing Medicaid State plan populations, and for an expansion eligibility group, please provide the state name for the groups that is sufficiently descriptive to explain the groups to the public.

The Demonstration will not affect any of the eligibility categories or criteria that are set forth in the State Plan.

Participation in the Demonstration, however, will be mandatory for Private Option-eligible individuals. Individuals who qualify for the Private Option will be required to receive coverage through QHPs, and those who decline coverage through QHPs will not be permitted to receive benefits through the State Plan.

Eligibility Chart

Mandatory State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Optional State Plan Groups

Eligibility Group Name	Social Security and CFR Sections	Income Level

Expansion Populations

Eligibility Group Name	N/A	Income Level

2) Describe the standards and methodologies the state will use to determine eligibility for any populations whose eligibility is changed under the Demonstration, to the extent those standards or methodologies differ from the State plan.

When determining whether an individual is eligible for the Private Option, Arkansas will apply the same eligibility standards and methodologies as those articulated in the State Plan.

3) Specify any enrollment limits that apply for expansion populations under the Demonstration.

There are no caps on enrollment in the Demonstration. To be eligible to participate in the Demonstration an individual must: (1) be a childless adult between 19 (including age 19) and 65 (excluding age 65) years of age, with an income at or below 138% of the federal poverty level who is not enrolled in Medicare **or** be a parent between 19 and 65 years of age, with an income between 17-138% FPL who is not enrolled in Medicare and (2) be a United States citizen or a documented, qualified alien. However, individuals determined to be medically frail/ having exceptional medical needs for which coverage through the Marketplace is determined to be impractical, overly complex, or would undermine continuity or effectiveness of care will not be eligible for the Demonstration.

Description	Income	Age	Exceptions
Adults in Section VIII Group	*Childless Adults:* 0-138% FPL *Parents:* 17-138% FPL	19-65	▪ Dual Eligibles ▪ Individuals who are medically frail/have exceptional medical needs. ▪

4) Provide the projected number of individuals who would be eligible for the Demonstration, and indicate if the projections are based on current state programs (i.e., Medicaid State plan, or populations covered using other waiver authority, such as 1915(c)). If applicable, please specify the size of the populations currently served in those programs.

Approximately 225,000 individuals will be eligible for the Demonstration. Currently, the State estimates that approximately 250,000 individuals will be newly eligible for or newly enrolled in Medicaid in Arkansas beginning in 2014. It is projected that 90% of newly eligible Medicaid beneficiaries will also be eligible for the Demonstration, with the remaining 10% of the newly eligibles receiving ABP or standard coverage under the State Plan.

5) To the extent that long term services and supports are furnished (either in institutions or the community), describe how the Demonstration will address post-eligibility treatment of income, if applicable. In addition, indicate whether the Demonstration will utilize spousal

impoverishment rules under section 1924, or will utilize regular post-eligibility rules under 42 CFR 435.726 (SSI State and section 1634) or under 42 CFR 435.735 (209b State)

N/A. Long-term services and supports will not be provided through the Demonstration, since the ABP, as set forth in the State Plan, does not cover long-term services and supports.

6) Describe any changes in eligibility procedures the state will use for populations under the Demonstration, including any eligibility simplifications that require 1115 authority (such as continuous eligibility or express lane eligibility for adults or express lane eligibility for children after 2013).

The State proposes to institute 12-month continuous eligibility for all newly eligible adults whose income is assessed on a modified adjusted gross income basis. Applying 12-month continuous eligibility to the adult population will reduce churning.

7) If applicable, describe any eligibility changes that the state is seeking to undertake for the purposes of transitioning Medicaid or CHIP eligibility standards to the methodologies or standards applicable in 2014 (such as financial methodologies for determining eligibility based on modified adjusted gross income), or in light of other changes in 2014.

N/A

Section III – Demonstration Benefits and Cost Sharing Requirements

1) Indicate whether the benefits provided under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

____ Yes __X__ No (if no, please skip questions 3 – 7)

2) Indicate whether the cost sharing requirements under the Demonstration differ from those provided under the Medicaid and/or CHIP State plan:

____ Yes __X_ No (if no, please skip questions 8 - 11)

Cost-sharing requirements for ABP will be the same regardless of whether the benefits are delivered under the State Plan or the Demonstration.

3) If changes are proposed, or if different benefit packages will apply to different eligibility groups affected by the Demonstration, please include a chart specifying the benefit package that each eligibility group will receive under the Demonstration (an example is provided):

Benefit Package Chart

Eligibility Group	Benefit Package

4) If electing benchmark-equivalent coverage for a population, please indicate which standard is being used:

___ Federal Employees Health Benefit Package
___ State Employee Coverage
___ Commercial Health Maintenance Organization
_X_ Secretary Approved

Since individuals in the new adult group are required to receive coverage through the Alternative Benefit Plan ("ABP"), the State is not electing ABP-equivalent coverage for a population; instead, the State is providing the statutorily required benefit package. Arkansas's State Plan Amendment (SPA) will outline its selection of a Secretary-approved ABP.

5) In addition to the Benefit Specifications and Qualifications form: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Benefit-Specifications-and-Provider-Qualifications.pdf, please complete the following chart if the Demonstration will provide benefits that differ from the Medicaid or CHIP State plan, (an example is provided).

N/A. Benefits are the same under the Demonstration and the State Plan.

Benefit Chart

Benefit	Description of Amount, Duration, and Scope	Reference

Benefits Not Provided

Benefit	Description of Amount, Duration, and Scope	Reference

Although the benefits in the ABP will be identical across the State Plan and the Demonstration, the appeals process relating to coverage determinations will differ. Under the Demonstration, Private Option beneficiaries will use their QHP appeals process. All QHPs must comply with federal standards governing internal insurance coverage appeals. Additionally, all QHPs must

comply with state standards governing external review of insurance coverage appeals, which in turn are approved as meeting the requirements imposed under the Affordable Care Act. Private Option beneficiaries will have access to the following two levels of appeals:

Internal Review

Each QHP must provide all enrollees with:

1) Notice identifying the claim or claims being denied;

2) A description of the reason for the denial;

3) Copies of the guidelines used to deny the claim; and

4) Notice that the recipient may request more explanation of the reason for the denial.

Any enrollee whose claim for health care is denied or is not acted upon with reasonable promptness may:

1) Appeal to the QHP; and

2) Present evidence and testimony to support the claim.

The QHP must render a decision regarding an internal appeal within:

1) 72 hours for denial of a claim for urgent care;

2) 30 days for non-urgent care that has not yet been delivered; and

3) 60 days for denials of services already delivered.

External Review

If the QHP does not render a decision within the timeframe specified above, or affirms the denial in whole or in part, the enrollee may request review, and in some cases expedited review, by a Qualified Independent Review Organization (QIRO) that has been selected by the Arkansas Insurance Department. Each QIRO must use qualified and impartial clinical reviewers who are experts in the treatment of the enrollee's medical condition and have recent or current actual clinical experience treating patients similar to the enrollee. Additionally, the enrollee is permitted to submit a statement in writing to support his or her claim. The QIRO will render its decision in 45 days, or within 72 hours in the case of an expedited review.

In addition to, and separate from the safeguards provided above, Arkansas enrollees may sue the QHP directly in state court for breach of contract.

6) Indicate whether Long Term Services and Supports will be provided.

___ Yes (if yes, please check the services that are being offered) _X_ No

In addition, please complete the: http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/List-of-LTSS-Benefits.pdf, and the:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Long-Term-Services-Benefit-Specifications-and-Provider-Qualifications.pdf.)

- ☐ **Homemaker**
- ☐ **Case Management**
- ☐ **Adult Day Health Services**
- ☐ **Habilitation – Supported Employment**
- ☐ **Habilitation – Day Habilitation**
- ☐ **Habilitation – Other Habilitative**
- ☐ **Respite**
- ☐ **Psychosocial Rehabilitation**
- ☐ **Environmental Modifications (Home Accessibility Adaptations)**
- ☐ **Non-Medical Transportation**
- ☐ **Home Delivered Meals Personal**
- ☐ **Emergency Response**
- ☐ **Community Transition Services**
- ☐ **Day Supports (non-habilitative)**
- ☐ **Supported Living Arrangements**
- ☐ **Assisted Living**
- ☐ **Home Health Aide**
- ☐ **Personal Care Services**
- ☐ **Habilitation – Residential Habilitation**
- ☐ **Habilitation – Pre-Vocational**
- ☐ **Habilitation – Education (non-IDEA Services)**
- ☐ **Day Treatment (mental health service)**
- ☐ **Clinic Services**
- ☐ **Vehicle Modifications**
- ☐ **Special Medical Equipment (minor assistive devices)**
- ☐ **Assistive Technology**
- ☐ **Nursing Services**
- ☐ **Adult Foster Care**
- ☐ **Supported Employment**
- ☐ **Private Duty Nursing**
- ☐ **Adult Companion Services**
- ☐ **Supports for Consumer Direction/Participant Directed Goods and Services**
- ☐ **Other (please describe)**

7) Indicate whether premium assistance for employer sponsored coverage will be available through the Demonstration.

___ Yes (if yes, please address the questions below)
_X_ No (if no, please skip this question)

a) Describe whether the state currently operates a premium assistance program and under which authority, and whether the state is modifying its existing program or creating a new program.

N/A

b) Include the minimum employer contribution amount.

N/A

c) Describe whether the Demonstration will provide wrap-around benefits and cost-sharing.

N/A

d) Indicate how the cost-effectiveness test will be met.

N/A

8) If different from the State plan, provide the premium amounts by eligibility group and income level.

There are no premiums under the Demonstration.

9) Include a table if the Demonstration will require copayments, coinsurance and/or deductibles that differ from the Medicaid State plan (an example is provided):

Arkansas will be submitting a SPA in addition to the submission of waiver requests for this Demonstration which includes eligibility limits for the newly covered population, updated cost-sharing requirements and the state's selection of an ABP. Consumer cost-sharing obligations under the Demonstration will be identical to those under the State Plan for all individuals receiving the ABP. The SPA describing the ABP will include the cost-sharing design for all individuals receiving the ABP. As will be described in the SPA, Private Option beneficiaries with incomes below 100% FPL will not have cost-sharing obligations in year one of the Demonstration; Arkansas plans to submit amendments to the waiver to implement cost-sharing for Demonstration participants with incomes from 50-100% FPL to be effective in years two and three of the Demonstration. Individuals with incomes of 100-138% FPL will be responsible for cost-sharing in amounts consistent with both the State Plan and with the cost-sharing rules applicable to individuals with comparable incomes in the Marketplace. . For individuals with income between 100-138% FPL, aggregate annual cost-sharing will be capped at 5% of 100% FPL ($604 for 2014). Providers will collect all applicable co-payments at the point of care. QHPs will monitor Private Option beneficiaries' aggregate amount of co-payments to ensure that they do not exceed the annual limit.

Arkansas will pay QHP issuers advance monthly cost-sharing reduction (CSR) payments to cover the costs associated with the reduced cost-sharing for Private Option beneficiaries. The advance monthly CSR payments will be calculated in the same way for individuals between 138 and 250% of the federal poverty level (FPL) who are eligible for federal CSRs and for individuals at or below 138% FPL enrolled in the Private Option; the only difference will be that HHS will make the federal CSR payments and Arkansas Medicaid will make the Private Option CSR payments. Under this method, issuers would, before each benefit year, estimate monthly allowed claims for essential health benefits for each standard silver plan and report this information to the Marketplace (for APTC/CSR eligible enrollees) and Arkansas Medicaid (for Private Option enrollees). For the zero cost sharing plan variation, HHS or Medicaid will multiply this estimate by 1.12 to reflect induced utilization for the higher AV and then multiply that product by the difference between zero cost sharing plan variation AV and standard silver plan AV (i.e. 0.3). The same formula is used for the high-value silver plan variant, using the same induced demand factor of 1.12 and substituting 0.24 for 0.3 for the AV factor. Issuers will receive per member per month payments during the benefit year on the basis of this formula. These payments will be subject to reconciliation at the conclusion of the benefit year based on actual CSRs that are utilized. If an issuer's actuary determines during the benefit year that the estimated advance CSR payments are significantly different than the CSR payments the issuer will be entitled to at reconciliation, the issuer may ask HHS or Arkansas Medicaid to adjust the advance payments. *See* 45 C.F.R. § 156.430; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410, 15487-88, 15494-95 (Mar. 11, 2013).

At the conclusion of the benefit year, each QHP issuer will report actual cost-sharing reduction amounts to HHS (for members receiving APTCs/CSRs) and Arkansas Medicaid (for members enrolled in the Private Option) to reconcile CSR amounts with the advance payments. The Arkansas Medicaid process for such reconciliations will be modeled on the HHS process. HHS has announced that issuers may choose one of two methods to calculate the actual cost sharing reductions. The standard method requires the issuer to adjudicate each claim and determine the plan's liability twice: first calculating plan liability using the standard silver plan cost sharing and a second time with reduced cost sharing under the silver plan variant. The CSR payment the issuer is entitled to is the difference between the second number and the first. The simplified methodology does not require readjudication of claims. Instead, issuers will enter certain basic cost sharing parameters of its silver plans into a formula that will model the amount of CSR payments, based on total incurred claims. Issuers may choose either method, but a single issuer must apply the same method to all its plans. Furthermore, if an issuer selects the standard method in 2014, it may not select the simplified method in future years. 45 C.F.R. § 156.430(c).

Copayment Chart

Eligibility Group	Benefit	Copayment Amount

10) Indicate if there are any exemptions from the proposed cost sharing.

Yes. All individuals who are statutorily required to be exempt from cost sharing will be exempt from cost sharing under the Demonstration.

Section IV – Delivery System and Payment Rates for Services

1) Indicate whether the delivery system used to provide benefits to Demonstration participants will differ from the Medicaid and/or CHIP State plan:

_X_ Yes
___ No (if no, please skip questions 2 – 7 and the applicable payment rate questions)

2) Describe the delivery system reforms that will occur as a result of the Demonstration, and if applicable, how they will support the broader goals for improving quality and value in the health care system. Specifically, include information on the proposed Demonstration's expected impact on quality, access, cost of care and potential to improve the health status of the populations covered by the Demonstration. Also include information on which populations and geographic areas will be affected by the reforms.

By leveraging premium assistance to purchase private coverage for Private Option beneficiaries, the Demonstration will improve quality and value in the healthcare system for all Arkansans. First, as a result of provisions included in the Arkansas Healthcare Independence Act which establishes the Private Option, all carriers offering QHPs in the Marketplace will be required to participate in the AHCPII—an innovative, multi-payer initiative to improve quality and reduce costs statewide. Because the Demonstration will add approximately 225,000 individuals to these carriers' enrollment rosters, the Demonstration dramatically expands the number of patients for whom providers are held accountable for the cost and quality of care.

Second, the Demonstration will improve access to care for Private Option beneficiaries by expanding the number of in-network providers. Because reimbursement rates in Medicaid have historically been lower than Medicare or commercial rates, many providers in Arkansas accept only limited numbers of Medicaid patients and expansion of the Medicaid network to absorb an expansion population would not succeed without meaningful increases in provider reimbursement. Private Option beneficiaries will have access to the full provider networks of their QHPs, which include many providers who do not currently participate in Medicaid. Moreover, had Arkansas expanded Medicaid without leveraging QHPs the number of Medicaid beneficiaries accessing care through the existing Medicaid fee-for-service network would increase by 40% creating access problems for all Medicaid beneficiaries.

Finally, by nearly doubling the number of individuals who will enroll in QHPs through the Marketplace, the Demonstration is expected to encourage carrier entry, expanded service

areas, and competitive pricing in the Marketplace, thereby enabling QHP carriers to better leverage economies of scale to drive pricing down even further.

Taken together, the three factors described above will improve quality, promote access, and reduce costs statewide. All Arkansans, regardless of the underlying subsidy for their health insurance, will benefit from improved quality and reduced costs spurred by the Demonstration. And all Medicaid beneficiaries, including those served through fee-for-service Medicaid will benefit from spreading the growing Medicaid population across a broader network of providers.

3) Indicate the delivery system that will be used in the Demonstration by checking one or more of the following boxes:

- ☐ **Managed care**
  - ☐ **Managed Care Organization (MCO)**
  - ☐ **Prepaid Inpatient Health Plans (PIHP)**
  - ☐ **Prepaid Ambulatory Health Plans (PAHP)**
- ☐ **Fee-for-service (including Integrated Care Models) Primary Care Case Management (PCCM)**
- ☐ **Health Homes**
- ☒ **Other (please describe)**

The Demonstration will use premium assistance to purchase QHP coverage for Private Option beneficiaries. Each Private Option beneficiary will have the option to choose between at least two high-value silver plans offered in the individual market through the Marketplace. The State will pay the full cost of QHP premiums; all cost-sharing in the high-value silver plans will comply with Medicaid requirements. Additionally, the State will provide through its fee-for-service Medicaid program wrap-around benefits that are required for the ABP but not covered by qualified health plans—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment services for individuals participating in the Demonstration who are under age 21 (to the extent such services are not covered under the QHP). EPSDT services are relevant to the Private Option only because the Affordable Care Act defines 19 and 20 year olds as children for purposes of service benefit requirements, but adults for purposes of eligibility. If family planning services are accessed at out-of-network providers, the State's fee-for-service Medicaid program will cover those services, as required under federal Medicaid law. Because of Arkansas's Any Willing Provider Law, few, if any, such providers are expected to be outside of private insurance carrier networks.

4) If multiple delivery systems will be used, please include a table that depicts the delivery system that will be utilized in the Demonstration for each eligibility group that participates in the Demonstration (an example is provided). Please also include the appropriate authority if the Demonstration will use a delivery system (or is currently seeking one) that is currently authorized under the State plan, section 1915(a) option, section 1915(b) or section 1932 option:

Delivery System Chart

Eligibility Group	Delivery System	Authority

5) If the Demonstration will utilize a managed care delivery system:

The Demonstration is utilizing premium assistance to purchase QHPs in the individual market, and not Medicaid managed care plans, to deliver benefits. Although the Medicaid managed care regulations do not apply to the proposed premium assistance model, the State responds to the questions below to provide additional detail and context for its proposal to leverage qualified health plans as the delivery system for the Demonstration.

a) Indicate whether enrollment be voluntary or mandatory. If mandatory, is the state proposing to exempt and/or exclude populations?

For individuals who are eligible for the Private Option, enrollment in a QHP will be mandatory. Individuals who are determined to be medically frail/have exceptional medical needs are not eligible for the Private Option and such individuals will be excluded from enrolling in QHPs. Individuals excluded from enrolling in QHPs through the Private Option as a result of medical frailty/exceptional medical needs will be eligible for coverage under Title XIX and will have the option of receiving either the ABP or the standard Medicaid benefit package through the State Plan.

Arkansas will institute a process to determine whether an individual is medically frail/has exceptional medical needs—such as individuals who would benefit from long-term services and supports and targeted outreach and care coordination through the State's emerging plans to establish health homes and to provide services through the Community First Choice state plan option.

Arkansas has engaged consultants from the University of Michigan to develop a questionnaire with fifteen to twenty questions to assess whether an individual may be medically frail/have exceptional medical needs ("the Screening Tool"). The Screening Tool will be conducted online (unless an individual requests a paper copy) and will consist of yes/no answers to a short series of questions that focus on a person's use of long term supports and services and mental health resources, and presence of complex medical conditions. Responses will be entered into software that will calculate whether the person meets the medically frail/exceptional medical needs criteria. Downstream refinements to the questionnaire algorithm will occur as data accumulates and individual screening results are compared with actual utilization patterns.

The medical frailty/exceptional medical needs screening process is meant to be prospective at the time of enrollment and will be conducted annually by Arkansas Medicaid. Self-attestation to the questions in the Screening Tool will be accepted in year one. In the case of false negatives and for individuals with emerging medical needs that lead to a predictable and significant need for additional benefits during the plan year, Medicaid will develop a process for making mid-year transitions to traditional Medicaid. The State may also develop a process to monitor claims experience to identify individuals who were initially identified as medically frail/having exceptional medical needs but no longer appear to meet those criteria.

The exact details of the process will differ slightly depending on whether an individual applies for the Private Option through the federally facilitated Marketplace (FFM) or through the State's eligibility system.

- *Individuals Applying Through FFM:* After the FFM determines that an individual is eligible for Medicaid, the State will send a notice informing the individual that he/she appears to be eligible for the Private Option. The notice will, among other things, direct individuals who appear Private Option eligible to the State portal where they will first see the Screening Tool described above. If the answers on the Screening Tool indicate that the individual is not medically frail/has exceptional medical needs, the individual will move on to shopping and enrollment through the State's eligibility and enrollment system. If the results of the Screening Tool indicate that the individual is medically frail/has exceptional medical needs, instead of advancing to the shopping and enrollment pages, the individual will be given the option of receiving either standard Medicaid benefits or the ABP through fee-for-service Medicaid.

- *Individuals Applying Through the State's Eligibility System:* Immediately after an individual is determined to be Medicaid-eligible, the individual will be asked to complete the Screening Tool. Once the individual completes the Screening Tool, the individual will be directed to shopping and enrollment, if not determined to be medically frail/have exceptional medical needs, or will be given the option of receiving either standard Medicaid benefits or the ABP through fee-for-service Medicaid.

The State will comply with all requirements set forth in Section 1937 of the Social Security Act, including, but not limited to, ensuring that all individuals determined to be medically frail, as well as individuals in other ABP-exempt populations identified in Section 1937 of the Social Security Act, will be given the option to receive through fee-for-service Medicaid either the ABP or the standard Medicaid benefit package.

b) Indicate whether managed care will be statewide, or will operate in specific areas of the state.

The Demonstration will be statewide.

c) Indicate whether there will be a phased-in rollout of managed care (if managed care is not currently in operation or in specific geographic areas of the state).

There will not be a phased-in rollout. The Demonstration will begin statewide on January 1, 2014.

d) Describe how the state will assure choice of MCOs, access to care and provider network adequacy.

Through AID's plan management process, the State will assure that Private Option beneficiaries will be able to choose from at least two high-value silver plans in each service/rating area of the State. Private Option beneficiaries will be permitted to choose among all high-value silver plans offered in their geographic area, and thus all Private Option beneficiaries will have a choice of at least two qualified health plans. Additionally, AID will evaluate network adequacy, including QHP compliance with Essential Community Provider network requirements, as part of the qualified health plan certification process. As a result, Private Option beneficiaries will have access to the same networks as individuals who purchase coverage in the individual market, ensuring compliance with the requirement found in Section 1902(a)(30)(A) of the Social Security Act that Medicaid beneficiaries have access to care comparable to the access the general population in the geographic area has.

The State expects to implement policies over time that will further ensure cost-effective QHP purchasing. Given the expansion of health insurance coverage associated with the Private Option, uncompensated care is expected to decline significantly in 2014 and beyond, reducing the need for providers to "cost-shift", i.e., raise their contractual prices with private health insurance plans to make up for losses incurred by serving uninsured (or under-insured) patients. Also, the Private Option will result in the enrollment of a large number of Medicaid beneficiaries into QHPs, resulting in increased payments to providers for existing uninsured patients.

In sum, the Private Option helps transform and significantly expand the private insurance Marketplace, and this new Marketplace will establish competitive price points for provider reimbursement. As a result of these large shifts in payment and compensation for providers, actuaries projecting the expected costs of Arkansas's Private Option for DHS estimated that contractual rates of reimbursement for providers participating in QHPs that serve Private Option participants would be, on average, at least 5% less than existing provider contracts with commercial insurers today due to the reduced need for cost-shifting. To help ensure cost-effective use of taxpayer funds, the Private Option is employing a purchasing standard consistent with a transition to more competitive insurance markets during Plan Year 2014, and in future Plan Years expects to develop and adopt additional strategies to ensure the purchase of both competitively-priced and cost-effective plans.

e) Describe how the managed care providers will be selected/procured

Qualified health plans will be selected through AID's QHP certification process. As noted above, Private Option beneficiaries will be able to choose among high-value silver plans available in their geographic region. Products with proposed premiums that the AID determines are outliers will not be certified to be offered on the Marketplace, ensuring that Private Option beneficiaries choose among only cost-effective QHPs. In the second and third years of the Demonstration, the State will review carrier competition and premiums and may establish more selective criteria for QHP eligibility for the Private Option to ensure both beneficiary choice and cost-effective purchasing that meets the terms and conditions of this waiver.

6) Indicate whether any services will not be included under the proposed delivery system and the rationale for the exclusion.

Wrap-Around Benefits

All services will be provided through QHPs, except for two services that are not fully covered under the QHP benefit package but that must be included in the ABP. Specifically, the State will provide a fee-for-service wrap around benefit for: (1) non-emergency medical transportation; and (2) Early Periodic Screening Diagnosis and Treatment for individuals under age 21 (to the extent the service is not otherwise included in the QHP benefit). In addition, if a Private Option beneficiary accesses family planning services through an out-of-network provider, those services will be covered through fee-for-service Medicaid, consistent with federal law.

Retroactive Coverage

Arkansas will also use the fee-for-service delivery system to provide retroactive coverage for the three months prior to the month in which an individual is determined eligible for Medicaid.

Coverage Prior To QHP Enrollment

The State will provide coverage through fee-for-service Medicaid from the date an individual is determined eligible for Medicaid until the individual's enrollment in the QHP becomes effective. For individuals who select (or are auto-assigned) to a QHP between the first and fifteenth day of a month, QHP coverage will become effective as of the first day of the month following QHP selection (or auto-assignment). For individuals who select (or are auto-assigned) to a QHP between the sixteenth and last day of a month, QHP coverage will become effective no later than the first day of the second month following QHP selection (or auto-assignment).

7) If the Demonstration will provide personal care and/or long term services and supports, please indicate whether self-direction opportunities are available under the Demonstration. If yes, please describe the opportunities that will be available, and also provide additional information with respect to the person-centered services in the Demonstration and any financial management services that will be provided under the Demonstration

___ Yes
_X_ No

The Demonstration will not provide long-term services and supports or personal care.

8) If fee-for-service payment will be made for any services, specify any deviation from State plan provider payment rates. If the services are not otherwise covered under the State plan, please specify the rate methodology.

Providers will be reimbursed for care provided to Private Option beneficiaries at the rates the providers have negotiated with the QHP. The State anticipates that provider payment rates under QHPs will be at least as high as provider payment rates offered under the State Plan.

9) If payment is being made through managed care entities on a capitated basis, specify the methodology for setting capitation rates, and any deviations from the payment and contracting requirements under 42 CFR Part 438.

N/A

10) If quality-based supplemental payments are being made to any providers or class of providers, please describe the methodologies, including the quality markers that will be measured and the data that will be collected.

Arkansas Medicaid will not make supplemental payments directly to providers through the Demonstration. All QHP carriers, however, will be required to participate in the AHCPII by assigning enrollees a primary care physician, supporting patient-centered medical homes, and accessing clinical performance data for providers, and thus providers caring for Private Option beneficiaries will be eligible to receive payments under applicable components of the AHCPII.

The AHCPII is intended to shift the delivery system in Arkansas from one that primarily rewards volume to one that rewards quality and affordability. This statewide, multi-payer initiative is designed to be practical and data-driven in its approach to promoting patient-centered, clinically appropriate care. The AHCPII comprises four related, but distinct, components. The four components, described below, will be phased-in over the next several years.

- ***Episode-Based Care Delivery: Retrospective Risk Sharing.*** For specified medical episodes, such as episodes of congestive heart failure or total joint replacement, participating payers have established comprehensive retrospective episode-based payment. Each payer designates one or more providers as the Principal Accountable Provider (PAP) for the episode of care. The PAP is responsible for the overall quality and cost effectiveness of all care included in the episode. Payers then calculate each PAP's average costs and quality across all of episodes delivered during the year. Payers compare the average costs and quality against performance thresholds specifically set by each payer. If a PAP achieves an average episode cost below a "commendable"

threshold and meets quality requirements, the PAP is eligible to receive a portion of the savings. Conversely, if a PAP's performance reflects an average cost in excess of the "acceptable" threshold, the PAP is responsible for a share of costs in excess of the threshold. PAPs not meeting quality targets are not eligible for shared savings.

- ***Episodes-Based Care Delivery: Assessment-Based Episodes***. Payment for episodes for special populations with developmental disabilities and long-term services and supports will be based on individual assessments of support and health care needs. The assessment will result in the determination of a "level of need" for each person. This level of need will be matched to a dollar amount to be paid for services. The lead provider, selected in consultation with the patient and the patient's family, would be responsible for ensuring that services across all the individuals for whom they are leads are delivered within the total budget and according to each individual's plan of care.

- ***Medical homes***. Payers participating in the AHCPII will support primary care transformation in the form of patient-centered medical homes through care coordination fees and shared savings. Medical homes will be paid care coordination fees on a per member per month (PMPM) basis. The PMPM fees will be linked to demonstrated practice transformation, based on outcomes used in the Comprehensive Primary Care initiative and eventually expanded to include nationally recognized metrics (*e.g.*, AHRQ) for pediatric care. The AHCPII will also measure the value created by a provider, on a risk-adjusted basis, based on both (a) absolute performance and (b) performance improvement, and reward the provider based on the greater of the two amounts.

- ***Health homes***. Health home payment will cover the full range of health home responsibilities and will include a PMPM fee. A portion of the PMPM will be at risk based on process and outcome metrics and only paid when these metrics show that an acceptable level of care management and coordination has been delivered. PMPM payments will be risk adjusted based on the results of a universal assessment of a person's level of developmental disability, long-term services and supports, or behavioral health needs and their medical complexity. In addition, episode-based payments will be made for care of specific conditions.

Through each of these four programs, the AHCPII aims redesign the payment and delivery system to promote quality improvement and affordability. Providers who can successfully provide high-quality care while controlling costs will be eligible to receive payments in excess of their ordinary reimbursement.

Section V – Implementation of Demonstration

1) Describe the implementation schedule. If implementation is a phase-in approach, please specify the phases, including starting and completion dates by major component/milestone.

Applications for the Medicaid expansion population will begin on October 1, 2013 for Private Option QHP enrollment effective January 1, 2014. A proposed implementation timeframe is included below:

Milestone	Timeframe
Issue public notice of waiver	June 24, 2013
Accept comments on waiver	June 24 – July 24, 2013
Hold public hearings on waiver	July 2 – 9, 2013
Submit waiver application to CMS	By August 2, 2013
Receive waiver approval	By October 1, 2013
Open enrollment period	October 1, 2013 – March 31, 2014
Post medically frail/exceptional medical needs screening tool on website	October 2013
Launch shopping and enrollment function on State's Eligibility/Enrollment System	October 2013
Coverage under Private Option becomes effective	January 1, 2014

2) Describe how potential Demonstration participants will be notified/enrolled into the Demonstration.

Notices

Upon enrollment in Medicaid, Private Option beneficiaries will receive a notice from Arkansas Medicaid advising them of the following:

- *QHP Plan Selection.* The notice will include, among other things, information regarding how Private Option beneficiaries can select a QHP, including advice on selecting the plan that will best address their health needs and information on the State's auto-enrollment process in the event that the beneficiary does not select a plan.

- *Access To Services Until QHP Enrollment is Effective.* The notice will include the Medicaid client identification number (CIN) and information on how beneficiaries can use the CIN number to access services until their QHP enrollment is effective.

- *Wrapped Benefits.* The notice will also include information on how beneficiaries can use the CIN number to access wrapped benefits. The notice will include specific information regarding wrapped benefits, including what services are covered directly through fee-for-

service Medicaid, what phone numbers to call or websites to visit to access wrapped services, and any cost-sharing for wrapped services.

- *Appeals.* The notice will also include information regarding the grievance and appeals process. Specifically, the notice will inform Private Option beneficiaries that, for all services covered by the QHP, the beneficiary should begin by filing a grievance or appeal pursuant to the QHP's grievance and appeals process.

- *Exemption from the Alternative Benefit Plan.* The notice will include information describing how Private Option beneficiaries who believe they may be exempt from the ABP, including pregnant women and the medically frail, can request a determination of whether they are exempt from the ABP and, if they are exempt, choose between receiving coverage through the standard Medicaid benefit package or the ABP. The notice will include information on the difference in benefits under the ABP as compared to the standard (State Plan) benefit package. The exemption process is described in Section IV.5.a.

Enrollment

Individuals eligible for QHP enrollment through the Private Option will begin to enroll during the open enrollment period (October 1, 2013 –March 31, 2014) through the following process:

- Individuals will submit a single application for insurance affordability programs—Medicaid, CHIP and Advanced Premium Tax Credits/Cost Sharing Reductions—electronically, via phone, by mail, or in-person.
- An eligibility determination will be made either through the FFM or the Arkansas Eligibility & Enrollment Framework (EEF).
- Once individuals have been determined eligible for coverage under Title XIX, they will enter the State's web-based portal. They will then have an opportunity to complete the Medical Frailty/Exceptional Medical Needs Screening Tool.
- Individuals who are determined eligible to receive coverage through the Private Option will enter the State's eligibility/enrollment system to shop among QHPs available to Private Option eligible individuals and to select a QHP.
- The MMIS will capture their plan selection information and will transmit the 834 enrollment transactions to the carriers.
- Carriers will issue insurance cards to Private Option enrollees.
- MMIS will pay premiums on behalf of beneficiaries directly to the carriers.
- MMIS premium payments will continue until the individual is determined to no longer be eligible; the individual selects an alternative plan during the next open enrollment period; or the individual is determined to be more effectively treated due to complexity of need through the fee-for-service Medicaid program.
- In the event that an individual is determined eligible for coverage through the Private Option, but does not select a plan, the State will auto-assign the enrollee to one of the available QHPs in the beneficiary's county.

Auto-assignment

The State's goal is to minimize the number of Private Option participants who do not complete the QHP selection process, and therefore need to be auto-assigned. However, particularly in 2014, operational aspects of the enrollment process may result in a significant number of individuals being auto-assigned.

The State anticipates that the majority of Private Option eligible individuals who apply for Medicaid directly through the state's eligibility/enrollment system (EEF) will complete the eligibility and enrollment process, including QHP selection.

Importantly, due to the inability of the FFM to support shopping and enrollment of Arkansas Private Option eligible individuals who apply for coverage through the FFM portal, the State must rely on the EEF to effectuate QHP selection and enrollment. As a result of this disjointed consumer experience, significantly higher levels of auto-assignment are expected for those Private Option beneficiaries who apply for coverage through the FFM. For Private Option beneficiaries who do not select a QHP, the eligible individual will be assigned a QHP and will be notified of the effective date of his or her QHP enrollment.

In Plan Year 2014, Private Option auto-assignments will be distributed among issuers offering silver-level QHPs certified by AID with the aim of achieving a target minimum market share of Private Option enrollees for each issuer in a service/rating region. Specifically, the target minimum market share for an Issuer offering a high-value silver QHP in a service/rating region will vary based on the number of competing issuers as follows:

- Two issuers: 33% of Private Option participants in that region.
- Three issuers: 25% of Private Option participants in that region.
- Four issuers: 20% of Private Option participants in that region.
- More than four issuers: 10% of Private Option participants in that region.

AID and Arkansas Medicaid will collaborate to refine and revise the auto-assignment methodology for Plan Years 2015 and 2016, based on factors including QHP premium costs, quality and performance experience.

Individuals who are auto-assigned will be notified of their assignment and will be given a thirty-day period to request enrollment in another plan, consistent with the timeframes for changing coverage that are currently found in Arkansas's commercial market.

Access To Wrap Around Benefits

In addition to receiving an insurance card from the applicable QHP carrier, Private Option beneficiaries will have a Medicaid client identification number (CIN) through which providers may bill Medicaid for wrap-around benefits. The notice containing the CIN will include information about which services Private Option beneficiaries may receive through fee-for-service Medicaid and how to access those services. Similar information will be provided on Arkansas Medicaid's website. Staff at the Arkansas Medicaid beneficiary call centers be trained to provide information regarding the scope of wrap-around benefits and how to access them.

Finally, Arkansas Medicaid will work closely with carriers to ensure that the carriers' call center staff is aware that Private Option beneficiaries have access to certain services outside of the QHP and that carrier's staff can direct the Private Option beneficiaries to the appropriate resources to learn more about wrap-around services.

3) If applicable, describe how the state will contract with managed care organizations to provide Demonstration benefits, including whether the state needs to conduct a procurement action.

No procurement action is needed.

Arkansas Medicaid will not contract directly with the QHPs. Instead, Arkansas Medicaid will enter into a memorandum of understanding (MOU) with the plans to outline the process for verifying plan enrollment and paying premiums. Under the terms of the MOU, the QHP will provide a roster of its enrollees who are Private Option beneficiaries. The State will verify that the individuals listed on the roster are Private Option beneficiaries. The MMIS will then transmit payment for premiums to the QHP.

Section VI – Demonstration Financing and Budget Neutrality

Please complete the Demonstration financing and budget neutrality forms, respectively, and include with the narrative discussion. The Financing Form: http://www.medicaid.gov/Medicaid- CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Demo-Financing-Form.pdf includes a set of standard financing questions typically raised in new section 1115 demonstrations; not all will be applicable to every demonstration application. The Budget Neutrality form and spreadsheet: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Downloads/Interim1115-Budget-Neutrality-Form.pdf includes a set of questions with respect to historical expenditure data as well as projected Demonstration expenditures.

The Budget Neutrality approach recognizes that the population covered by this Demonstration, known as "Private Option beneficiaries", represents a hypothetical population for Budget Neutrality purposes. Hypothetical populations are individuals that otherwise could have been made eligible for Medicaid under: 1) section 1902(r)(2), 2) 1931(b), or 3) 1902(a)(10)(A)(i)(VIII)) (as modified by Section 2001 of the ACA), via a SPA . Because they could have been made eligible without a waiver, savings are not available. As a result, the projected enrollment and costs for the Private Option Beneficiaries are shown as identical in the without waiver and with waiver scenarios.

Specifically, this waiver will cover individuals eligible for coverage under Title XIX of the Social Security Act who are either (1) childless adults between the ages of 19 and 65 with incomes at or below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or (2) parents between the ages of 19 and 65 with incomes between 17 and 138% FPL who are not enrolled in Medicare. The State of Arkansas intends to use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the Marketplace. These Private Option beneficiaries will receive the Alternative Benefit Plan (ABP) and have cost sharing obligations consistent with the State Plan. To determine the hypothetical enrollment associated with the Private Option Beneficiaries, the State's actuaries, Optumas, reviewed estimates for uninsured populations by income band (corresponding the income eligibility for the Medicaid expansion by Federal Poverty Level) provided by the Arkansas Center for Health Improvement and then adjusted them for overlap with current Arkansas Medicaid eligibility categories and the resulting woodwork effect expected as a result of the ACA. Optumas then projected the costs for this hypothetical population by reviewing the access and quality of care standards required under 1902(a)(30)(a) and determining that the most appropriate benchmark for network access and quality of care would be the commercial reimbursement anticipated to be used on the Marketplace. Using 2 years of Arkansas Medicaid data for utilization, Optumas applied the commercial reimbursement anticipated to be used on the Marketplace to the projected utilization, adjusted for approved cost-sharing, trend, comprehensive private market care coordination, reinsurance, and non-medical load (administration and profit/risk/contingencies) to determine the estimated premium for the Private Option beneficiaries. Combining the projected enrollment with the expected premium yielded the projected costs for the hypothetical population in both the without and with waiver scenarios.

Section VII – List of Proposed Waivers and Expenditure Authorities

1) Provide a list of proposed waivers and expenditure authorities.

- § 1902(a)(14): To enable the State to apply the 5% cap on cost-sharing on an annual, rather than quarterly, basis.
- § 1902(a)(15): To permit the State to limit reimbursement for federally qualified health centers (FQHC) and rural health centers (RHC) to the amount the FQHC/RHC negotiated with the QHP carrier, rather than the amount established under the prospective payment system.
- § 1902(a)(17): To permit the State to provide different delivery systems for different populations of Medicaid beneficiaries. The State is not requesting a waiver of comparability with respect to benefits, eligibility, or cost-sharing.
- § 1902(a)(23): To make premium assistance for QHPs in the Marketplace mandatory for Private Option beneficiaries and to permit the State to limit beneficiaries' freedom of

choice among providers to the providers participating in the network of the Private Option beneficiary's QHP.

- § 1902(a)(54): To permit the State to limit a Private Option beneficiary to receiving coverage for drugs on the formulary of the Private Option beneficiary's QHP.
- § 1902(a)(54): To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.

2) Describe why the state is requesting the waiver or expenditure authority, and how it will be used.

Waiver Authority	Use for Waiver	Reason for Waiver Request
§ 1902(a)(14)	To enable the State to apply the 5% cap on cost-sharing on an annual, rather than quarterly, basis.	This waiver authority will allow the State to align with how carriers will apply the annual cost-sharing limit for commercial coverage in the individual market.
§ 1902(a)(15)	To permit the State to limit reimbursement for federally qualified health centers (FQHC) and rural health centers (RHC) to the amount the FQHC/RHC negotiated with the QHP carrier, rather than the amount established under the prospective payment system.	This waiver authority will allow the State to limit its financial exposure and align reimbursement to FQHCs/RHCs for Private Option beneficiaries with QHPs' contracted rates.
§ 1902(a)(17)	To permit the State to provide coverage through different delivery systems for different populations of Medicaid beneficiaries. Specifically, to permit the State to provide coverage for Private Option eligible Medicaid beneficiaries through QHPs offered in the individual market. The State is not requesting a waiver of comparability with respect to benefits, eligibility, or cost-sharing.	This waiver authority will allow the State to test using premium assistance to provide coverage for QHPs offered in the individual market through the Marketplace or a subset of Medicaid beneficiaries.
§ 1902(a)(23)	To make premium assistance for QHPs in the Marketplace mandatory for Private Option beneficiaries and to permit the State to limit beneficiaries' freedom of choice among providers to the providers participating in the	This waiver authority will allow the State to require that Private Option eligible beneficiaries receive coverage through the Demonstration, and not through the State Plan. This waiver authority will also allow the state to

Waiver Authority	Use for Waiver	Reason for Waiver Request
	network of the Private Option beneficiary's QHP.	align the network available to Private Option beneficiaries with the network offered to QHP enrollees who are not Medicaid beneficiaries.
§ 1902(a)(54)	To permit the State to limit a Private Option beneficiary to receiving coverage for drugs on the formulary of the Private Option beneficiary's QHP.	This waiver authority will allow the State to align the prescription drug benefit for Private Option beneficiaries with the prescription drug benefit offered to QHP enrollees who are not Medicaid beneficiaries.
§ 1902(a)(54)	To permit the State to require that requests for prior authorization for drugs be addressed within 72 hours, rather than 24 hours. A 72-hour supply of the requested medication will be provided in the event of an emergency.	This waiver authority will allow the State to align prior authorization standards for Private Option beneficiaries with standards in the commercial market.

Section VIII – Public Notice

1) Start and end dates of the state's public comment period.

The State's comment period is June 24, 2013 to July 24, 2013.

2) Certification that the state provided public notice of the application, along with a link to the state's web site and a notice in the state's Administrative Record or newspaper of widest circulation 30 days prior to submitting the application to CMS.

3) Certification that the state convened at least 2 public hearings, of which one hearing included teleconferencing and/or web capability, 20 days prior to submitting the application to CMS, including dates and a brief description of the hearings conducted.

4) Certification that the state used an electronic mailing list or similar mechanism to notify the public. (If not an electronic mailing list, please describe the mechanism that was used.)

5) Comments received by the state during the 30-day public notice period.

6) Summary of the state's responses to submitted comments, and whether or how the state incorporated them into the final application.

7) Certification that the state conducted tribal consultation in accordance with the consultation process outlined in the state's approved Medicaid State plan, or at least 60 days

prior to submitting this Demonstration application if the Demonstration has or would have a direct effect on Indians, tribes, on Indian health programs, or on urban Indian health organizations, including dates and method of consultation.

Section IX – Demonstration Administration

Please provide the contact information for the state's point of contact for the Demonstration application.

Name and Title: Andy Allison, Director, Division of Medical Services, Arkansas Department of Human Services
Telephone Number: (501) 683-4997
Email Address: Andy.Allison@arkansas.gov

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D. Affordable Insurance Exchange

The Arkansas Insurance Department is responsible for outreach, eligibility determination, enrollment, and re-enrollment in the Exchange.

Arkansas is still awaiting a decision regarding the services available on the QHPs.

The Arkansas Insurance Department is responsible for this function and has established multiple means to insure consumer protection within the Exchange:

- **In-Person Assisters:** Arkansas has developed a comprehensive In-Person-Assister (IPA) program that will assist consumers gain coverage. The state will use a contract process to distribute planning grant funds to entities that will employ trained IPAs to do outreach, education, and enrollment.
- **Consumer Assistance Advisory Committee:** Tasked with overseeing the development of the In-Person-Assistance program, outreach and education efforts, and consumer complaints resolution process.

Multiple behavioral health providers have been awarded the contract to be In-person Assisters, including nine Community Mental Health Centers.

While the Division of Behavioral Health Services (DBHS) acknowledges the importance of ensuring providers are screening for Medicaid and Exchange eligibility, this process has not been determined.

Provider qualifications and eligibility for the Exchange have not been determined yet. Once this is determined, DBHS will work closely with our providers to assist in business model transformation. DBHS has begun an assessment of current licensed mental health professionals in the state.

DBHS does not have the ability to determine the number of individuals served through the MHBG and SABG who are currently uninsured or who will remain uninsured in the coming year.

All providers funded through the MHBG are Medicaid providers. While fourteen of the 25 substance abuse providers funded through the SABG are Medicaid providers. DBHS is responsible for certifying all Medicaid providers providing services through the Rehabilitative Services for Persons with Mental Illness (RSPMI) and Substance Abuse Treatment Services (SATS) Medicaid programs.

State of Arkansas

Consumer Assistance Advisory Committee

Enrollment Assister Program:

Training Requirements

July 13, 2012

www.pcghealth.com

Agenda | Topics of Discussion

I.	Welcome and Reintroductions	*1:00-1:10*
II.	June Steering Committee	*1:10-1:20*
III.	"Navigators" and "Enrollment Assisters"	*1:20-1:50*
IV.	Training Intro - context	*1:50-2:00*
V.	Core Competency Discussions	*2:00-4:00*

Steering Committee | June Decision

Consumer Assistance Advisory Committee

Recommendations

FFE Partnership Steering Committee

Recommendations

AID Commissioner

Decision

Implement

PCG Health

Public Focus. Proven Results.™

OMB No. 0930-0168 Approved: 05/21/2013 Expires: 05/31/2016

Name Change | Explanation

Original	Updated
Navigator Program	**In-Person Assister (IPA)**
Navigators	Navigators
	Enrollment Assisters
Brokers and Agents	Brokers and Agents

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OMB No. 0930-0168 Approved: 05/21/2013 Expires: 05/31/2016

Roadmap | Topic #3

May	Navigator Eligibility
June	Certification Standards
July	Training Requirements
August	Grant Application Process
September	Funding Options
October	Performance Measurement
November	On-Going Navigator Monitoring

- Training topics to be discussed are many and require deep knowledge;
- Unlikely that one individual will be well-versed in all topics;
- Goal is to identify all topics needed in order to best serve Arkansans

PCG Health
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OMB No. 0930-0168 Approved: 05/21/2013 Expires: 05/31/2016

Training | CAAC Recommendations

The Consumer Assistance Advisory Committee will today be making recommendations to the Steering Committee regarding these main questions:

- **What are the appropriate training competencies to be acquired by individual Enrollment Assisters?**
- **What is the training frequency?**
- **What are the appropriate methods of delivery to provide initial and ongoing training?**

Core Competency I | FFE Understanding

Understanding of…

- FFE Partnership Model adopted by the state of Arkansas;
- Exchange Marketplace concepts
- Federal regulations governing the Exchange;
- Enrollment Assister program and the state's rules concerning its operation;
- Program eligibility guidelines specific to the consumer's income, including Medicaid, ARKids First, and the exchange;
- Concepts of cost sharing and premiums for applicable groups;
- Application components and how to apply for each program including on line
- How technology will be used to support Enrollment Assister duties.
- Basic computer skills
- Public and FFE applications

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Core Competency 2 | Privacy and Confidentiality

Understanding of…

- What is considered personal health information (PHI);
- How to protect a consumer's PHI especially when interacting in public places;
- HIPAA rules and regulations;
- Ethics;
- Arkansas privacy and confidentiality rules and regs;
- The definition of conflict of interest and how to avoid it;
- Understanding of professional ethical standards.

Core Competency 3 | QHP Understanding

Understanding of…

- Key terminology ("out-of-pocket expense" and "non-covered services," for examples)
- Program requirements and service coverage for health plans in the exchange including dental and optical plans for children;
- Federal tax credits/subsidies;
- Facilitating enrollment in plans and plan renewal or during coverage transitions that arise when income or other life circumstances change;
- Rating systems for qualified health plans and their importance on the quality of care the member will receive in the plan.

Core Competency 4 | Medicaid and ARKids

Understanding of…

- Understanding of Program requirements and service coverage for Medicaid and ARKids First;
- Income calculation(s) for determining eligibility for public programs, cost sharing and premiums based on income level;
- Expertise in facilitating enrollment during coverage transitions that arise when income or other life circumstances change.

Core Competency 5 | Understanding Audience

Understanding of…

- How to vary your presentation to meet the needs of all groups that you may encounter while performing Enrollment Assister duties whether it be one or all (examples may include but are not limited to):
  - consumers with disabilities;
  - limited English proficiency;
  - limited literacy skills;
  - Individuals of different ethnicities;
  - low-income individuals and families;
  - individuals with special health care needs;
  - Small businesses;
  - Socio economic status;
  - Cultural competency

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Core Competency 5 | Understanding Audience

Understanding of how to…

- Provide consumers information in a fair, accurate, and impartial and does not favor one insurance over another;
- Use Enrollment Assister tools and functions for individuals with disabilities;
- Assess the likelihood of the consumer to enroll in a plan on their own versus a consumer that will need further assistance;
- Provide information in a culturally and linguistically appropriate manner;
- Resolve conflicts with consumers;
- Communicate, both inter-personal communication and public speaking

Core Competency 6 | Post Enrollment Support

Understanding of…

- The Enrollment Assister role and the importance of post-enrollment support;
- How post enrollment support helps consumers stay insured;
- All processes for complaints and grievances (state, federal, and each QHP);
- Next steps if a consumer's complaint is not resolved.

Training | Initial Training

- Should initial training be provided in person, via web, ITV or a combination of all three?
- Should on-site training be provided in Little Rock, with opportunity to participate by ITV? Should the state consider providing training in more than one location?
- For those who are unable to participate in live training, should web based training be made available?
- Should training be scored with a passing grade for achieving certification or should certification be granted based on completion of training?
- Should training be provided by the state to entities and the entities be responsible to train individual enrollment assisters associated with each entity?

Training | On-Going Updates

- Should changes to the HBE be communicated via email blasts and be posted on web site page specific to individual enrollment assisters and entities?
- Should enrollment assister entities be responsible for updating their employees based on information that the state provides?
- Should only entities be provided information and they would be held responsible for providing new information to individuals associated with the entity?

Training | On-Going Updates

- How frequently should refresher training be provided by the state, (e.g. 6 months, 1 year)?
- Should refresher training be provided by the state to entities and the entities be made responsible to train individual enrollment assisters associated with each entity?
- What method should be used to provide refresher training? (web based, in person, combination of both)
- Other ideas?

Enrollment Assister | Next Steps

- Finalize CAAC recommendations and present to the Steering Committee
- Continue Enrollment Assister outreach and education work group
- Complete Enrollment Assister Grant Application

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OMB No. 0930-0168 Approved: 05/21/2013 Expires: 05/31/2016

Roadmap | Topic #4

May	Navigator Eligibility
June	Certification Standards
July	Training Requirements
August	Grant Application Process
September	Funding Options
October	Performance Measurement
November	On-Going Navigator Monitoring

The Committee will make recommendations related to:

a) Features of the application to ensure quality control and integrity.

b) Application processes and policies.

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OMB No. 0930-0168 Approved: 05/21/2013 Expires: 05/31/2016

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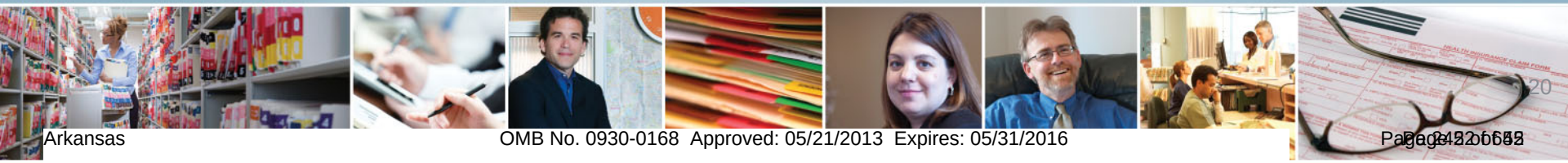

IV: Narrative Plan

E. Program Integrity

Narrative Question:

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

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

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

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

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

Footnotes:

E. Program Integrity

DBHS has established a Quality Assurance Office (QA) to oversee a program improvement plan for Division sponsored and supported 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, review provider resource plans, and measures for program deliverables.

DBHS has designated Dr. Kazi Ahmed as Director of the Office of Quality Assurance. He serves in an Assistant Director position to the Director of the division. In addition to Dr. Ahmed's oversight, the finance office serves as the tracking unit for expenditures of funds and contract compliance. Ms. Julie Carpenter is the Finance Director.

Block Grant funded providers submit their Annual Plans to DBHS for review. The plans include accounts for the services they provide and the money they spent. However, the expenditures are not broken down by clients served. These plans are reviewed by Programs staff at DBHS. Additionally, the Contract Support Office of the Department of the Human Services also conducts annual audits of all the funded providers.

The substance abuse treatment providers send in their 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 offers 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 more 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 perform service to billing 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 standard of care and service guidelines as articulated 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 expenditures are captured in the ADMIS data base for substance abuse treatment, 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.

Quality Assurance office offers 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 more closely with the finance office.

Mental Health Block Grant allocations to providers have been 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, RFPs are issued to select providers. As 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 invoice 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 in 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 education that include regulation, 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.

Additionally, 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.

DBHS contract guidelines include a formula that offers a mechanism to qualify for "indigent funds" for uninsured clients. DBHS' Substance Abuse and Mental Health data bases (ADMIS and SPQM) also track funding expended by payor type. According to the Payor Study, conducted by DBHS in 2010, the 13 Community Mental Health Centers reported that 19% of the their total bill was paid for by the Mental Health Block Grant and State General Revenue funds used exclusively to pay for services to indigent clients.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

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

1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?

2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?

   a) What information did you use?

   b) What information was most useful?

3) How have you used information regarding evidence-based practices?

   a) Educating State Medicaid agencies and other purchasers regarding this information?

   b) Making decisions about what you buy with funds that are under your control?

Footnotes:

F. Use of Evidence in Purchasing Decisions

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 evidence based approaches. The state's policymakers and stakeholders are educated on evidence based approaches and made aware of the importance of utilizing these approaches to result in better health outcomes for individuals and the general population.

The state's program managers are responsible for tracking and disseminating information regarding evidence-based or promising practices and approaches that have been selected and being utilized by providers. Tracking is done mostly through site visits and progress reports. Disseminating information is primarily done through fact sheets, newsletters, and trainings.

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. The performance deliverables and indicators are outlined in the procurement document: Request for Proposal, Request for Qualifications, Sole Source, and Request for Application. Outlining this information regarding evidence-based and promising practices in contracts has ensured the use of these practices statewide.

With the Payment Improvement Initiative, DBHS has had the opportunity to work alongside Medicaid to include evidence based practices in to the transformed Medicaid funded behavioral health system.

IV: Narrative Plan

G. Quality

Narrative Question:

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

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

1) What additional measures will your state focus on in developing your State BG Plan (up to three)?

2) Please provide information on any additional measures identified outside of the core measures and state barometer.

3) What are your states specific priority areas to address the issues identified by the data?

4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

G. Quality

In addition to the data elements included in the SAMHSA Behavioral Health Barometer, the Division of Behavioral Health Services (DBHS) will track the following data elements:

- Percentages of youth reporting binge drinking in the past 30-days
- Percentages of youth reporting being arrested in the past 12-months
- Percentages of adults receiving mental health services reporting spending time in jail/prison in the past 12-months
- Mental health consumers satisfaction with outcomes (control over life, dealing with crisis, social situations, symptoms) by demographic categories (race, age, gender, living condition)

IV: Narrative Plan

H. Trauma

Narrative Question:

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

Please answer the following questions:

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

Footnotes:

H. Trauma

The state does not have any policies directing providers to screen clients for a personal history of trauma.

The state does not have policies designed to connect individuals with trauma histories to trauma-focused therapy.

At this time, the state does not have any policies that promote the provision of trauma-informed care. However, the SSA has explored bringing in people who self-identify as consumer/survivors and are consultants from the National Center for Trauma-Informed Care (NCTIC) to begin state-wide training for Trauma-Informed Care. The SSA is in the very early planning stages of developing and planning this training. The training will be designed to focus on the Principles of Trauma-Informed Care as set forth by Harris and Fallot and measured through the Community Connections (Version 1.4), Trauma-Informed Program Self-Assessment Scale (Fallot and Harris,) and the Trauma-Informed Organizational Toolkit Secton I: Trauma-Informed Organizational Self-Assessment (Guarino, Soares, Konnath, Clervil and Bassuk, 2009) for fidelity.

At this time, the state does not have any evidence-based trauma-specific interventions. However, as indicated in the state priorities, the state will focus on moving towards a trauma-informed care approach. As policies and procedures are developed, evidence-based trauma specific interventions will be researched and adopted for the state of Arkansas.

At this time, the state does not provide any training to increase the capacity of providers to deliver trauma-specific interventions. However, as indicated in the state priorities, the state will focus on developing a trauma-informed care approach. During the assessment and planning phases, appropriate trainings for trauma-informed care will be researched, identified and adopted for the state of Arkansas for increasing the capacity of providers to deliver and implement trauma-specific interventions.

IV: Narrative Plan

I. Justice

Narrative Question:

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

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

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

Please answer the following questions:

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

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

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

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

Footnotes:

Drug and Alcohol Safety Education Program(DASEP)

Contract Guidelines

ARKANSAS DEPARTMENT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES

10/12/2012

This document should be used in conjunction with the licensure standards and Rules of Practice and Procedure of the Division of Behavioral Health Services' Office of Alcohol and Drug Abuse Prevention. The guidelines set forth are intended to provide general information and guidance for current and (or) potential DASEP providers. Contract Guidelines were established to ensure program obligations are met; it should not be relied on as a substitute for a binding agreement; and may be modified or altered from time to time.

BACKGROUND

DASEP was established to implement legislative mandates relevant to the illegal operation of a motor vehicle while under the influence of alcohol and (or) other drugs (*see* Arkansas Criminal Code § 5-65-104, § 5-65-109, and § 5-65-115). Through investigation, assessment, referral, and educational services, the program aims to reduce the number of injuries and fatalities caused by alcohol and other drug impaired drivers.

The DASEP is for persons who have plead guilty, nolo contendere; or have been found guilty of Driving While Intoxicated (DWI), Driving Under the Influence (DUI), Boating While Intoxication (BWI) and other alcohol and drug offenses as ordered by the court.

This program provides an investigation, screening/assessment, referral to treatment, and (or) 12-15 contact hours of education. Completion of an educational program is required to have the offender's driver's license reinstated.

All DASEP programs must be approved by the administration and authority of DBHS as provided under Ark. Code Ann. §5-65-104 (b) (1) (A). The Division of Behavioral Health Services (DBHS) contracts with various organizations throughout the state for this purpose.

SCOPE

Contract Guidelines were established to ensure program obligations are met. No provision or procedure in this guidelines' manual creates a binding agreement, guarantee, implied or expressed contract. The guidelines set forth are intended to provide general information and guidance for DASEP providers; and may be modified by DBHS from time to time.

CONTRACT GUIDELINES

Pursuant to Ark. Code Ann. §19-11-1010, DASEP contractors must comply with performance based standards. The following are provisions of the DASEP contract and the performance based standards with which the contractor must comply for acceptable performance to occur under the contract:

1.1 Providers will comply with all statutes, regulations, codes, ordinances, licensure, or certification requirements applicable to the provider or to the provider's agents and employees; and to the subject matter of the contract.

GUIDELINE: DASEP has been established to implement those portions of the law requiring presentence screening reports, education ,and (or) treatment requirements. DASEP providers are not officers of the court and shall not give legal advice or opinions. Services provided by staff must meet DBHS certification requirements.

1.2 Each DASEP provider will make recommendations to the court, as required by law, to assist the court in determining whether an individual upon adjudication of guilt should receive DWI/DUI education or be referred to a state approved treatment program. DASEP providers must be present in each court whenever DWI/DUI cases are presented for arraignment.

GUIDELINE: Providers conducting Presentence Screening Reports (PSSR) must be acquainted with each court in their service area. This includes, but is not limited to, judges, court clerks, prosecutors, probation and police officers. DASEP providers are not officers of the court and shall not give legal advice or opinions.

1.3 Providers will use a DBHS approved presentencing screening instrument and protocol to screen each DWI/DUI offender who is referred for screening prior to sentencing.

GUIDELINE: Factors to be considered in determining an appropriate recommendation Include, but are not limited to (SSI-SA score, prior DWI/DUI or related offenses, blood alcohol content, history of drug and alcohol use, previous involvement in drug and alcohol education or treatment; and concurrent charges relative to drug use or possession. The presiding judge weighs this recommendation and issues a final court order.

1.4 Providers will present the court with recommendations based on the result of the PSSR, a client interview, a DBHS approved screening tool.

GUIDELINE: The DBHS approved screening tool is Simple Screening Instrument for Substance Abuse (SSI-SA). Instructions for the administration of this instrument can be found at http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_138738.pdf

1.5 DASEP will provide education services for all individuals who are charged with the offense of DWI/DUI. Educational materials must be from DBHS approved curriculum. Each DASEP provider will collect program fees and shall remit fees to Department of Human Services DBHS as prescribed by Ark. Code Ann. §5-65-115.

GUIDELINE: DBHS' approved curriculum is an *Interactive Journal* and can be found at http://ww.changecompanies.net

GUIDELINE: The allowed program fee and administrative fee will be collected for each enrollee in a DASEP education course. The allowed administrative fee will be collected for each person completing a DBHS licensed treatment program and (or) approved out-of-state DWI program. All fees shall be remitted to DBHS within 60 days of collection and without regard to program completion (e.g., a course enrollee who fails to attend and/ or forfeits fee payment).

1.6 Providers shall submit a monthly report of fees collected, course enrollees' pre and post test scores, and certificates issued.

GUIDELINE: Monthly reports will be submitted on DBHS approved forms. Please refer to DBHS website for applicable forms. A DASEP certificate will be prepared for persons completing a DASEP education program, a DBHS licensed treatment program, and (or) approved out-of-state DWI programs. Certificates must include client name, date issued, client name, and certificate type (e.g., BWI, DWI, DUI, treatment, or duplicate).

1.7 Providers will disseminate education and awareness information to the local community regarding DWI/DUI laws, consequences, and current initiatives. This list is not exhaustive.

GUIDELINE: DASEP providers will hold at least one annual event in which law enforcement, local schools, civic groups, or other interested groups may attend. The intended purpose is to help inform the community of the importance of responsible alcohol use. Providers must keep local media outlets and publications informed of Alcohol Awareness Month.

1.8 DASEP employees providing direct services must attend annual training and professional development opportunities with DWI/DUI education and treatment emphasis.

GUIDELINE: Annual conferences, training and education should provide the most current methods and techniques in DWI/DUI field. Participants must sign an attendance roster and (or) receive a certificate indicating participation.

PERFORMANCE

Acceptable performance of DASEP program obligations will be determined at the sole discretion of the DHS Division of Behavioral Health Services. DBHS will notify DASEP providers of unacceptable performance. The remedies for unacceptable performance include: implementation of an acceptable corrective action plan, payment delays, reductions, withholding, or recoupment, contract termination; and all other remedies available by law or equity.

CREATING AND RESTORING HEALTHY FAMILIES

PARTNERS IN PREVENTION

Arkansas Department of Human Services

Division of Youth Services

COMPREHENSIVE PLAN 2009 - 2014

PREVENTING JUVENILE DELINQUENCY

STRENGTH-BASED FAMILY SYSTEMS

POSITIVE OUTCOMES FOR YOUTH

ARKANSAS DIVISION OF YOUTH SERVICES

Comprehensive Juvenile Justice Reform Plan 2009 - 2014

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Special thanks to
Stacy Moak and Lisa Hutchinson
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Planning process completed in collaboration with the National Center for Youth Law with support from the JEHT Foundation and the Public Welfare Foundation

ARKANSAS DEPARTMENT OF HUMAN SERVICES

The Division of Youth Services offers thanks to the following individuals who contributed significantly to the planning process:

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Cassondra Williams
Judge Wiley Branton
Scott LInebaugh
Scott Tanner
Connie Tanner
Dana McClain
Paul Kelly
Lisa Hutchinson
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Graphic design and layout by Larry J. Rhodes
UALR Institute of Government

The Division of Youth Services has developed a five-year comprehensive strategic plan that will revolutionize the juvenile justice system in Arkansas. The chart below summarizes the direction and scope of the system changes envisioned with the strategic plan.

Indicators	Our Past	Our Future
Concept of public safety	Incarcerating and committing offenders	Creating and restoring healthy families
Role of DYS	Responding to juvenile crime	Preventing juvenile delinquency
Response to system youth	Many in secure confinement	More in community-based services
Primary focus	Youth in trouble	Strength-based family systems
Budgets	Sprialing costs of incarceration	Money re-allocated to treatment
Method of operation	Independent bureaucracy	Responsive and agile network
Basis for decision making	Tradition and precedent	Practices proven effective and evidence-based
System employees	High stress and turnover	Highly trained and professional
Data system on youth	Fragmented and incomplete	Interactive, integrated and useful
Evaluation of providers	Compliance with contract	Positive outcomes for youth
Relationship with schools and courts	Independent efforts	Partners in prevention
Relationship with corrections	Feeder for adult prisons	Reverses path toward crime
National reputation	Behind national progress	Leader in reform

The strategic planning process began with the creation of a 50-member task force of stakeholders who identified issues and worked in small groups on action plans. Shortly after the creation of the task force, the department commissioned a comprehensive review of Arkansas's juvenile justice system by outside consultants Pat Arthur and Tim Roche. The consultant review was funded by the JEHT Foundation and was released in 2008. Director Ron Angel initiated a strategic planning process to respond to the conclusions and recommendations of the consultant report. The first step of the planning process was a three-day retreat of key stakeholders to develop a vision for the juvenile justice system in the state, and to develop long-term goals.

The retreat was facilitated by Dr. Angela Laird Brenton, Dean of the College of Professional Studies at the University of Arkansas at Little Rock. Results from the retreat were presented to the 50-member task force for review and comment in a series of four meetings. The first product of the strategic planning process was a transition plan to support requests during the legislative session starting in January 2009. The transition plan laid out steps needed during the next one to two years to lay the foundation for juvenile justice reform. A draft of the comprehensive plan was placed on a website for review and comment. It was also presented at meetings of a variety of stakeholder groups during the spring of 2009. The initial planning steering committee met in April to review feedback to the plan and to finalize a draft, review and reporting procedures, and a timeline. The plan was ratified at a meeting of the Juvenile Justice Task Force in May. The plan will be a "living document" with periodic review and revision. Goal 1 of the plan outlines a process to create a strategic plan subcommittee of the Juvenile Justice Task Force which will be responsible for overseeing plan implementation.

Throughout the process the hundreds of people who have given time, expertise, and funding have been motivated by one common goal expressed by Director Angel when he described why he accepted the job as Director of DYS after his federal retirement, "We're doing it for the kids." All of the participants have realized that the youth of Arkansas are our future. We cannot afford to fail them. A brighter future for all the children of Arkansas will contribute to a stronger state.

Even before the strategic planning process is completed, DYS is putting into motion a number of progressive initiatives including:

- Contracting with UAMS to provide a mobile assessment team to assess the mental, physical, and emotional status of youth who have entered the court system. The team has provided helpful information to judges, has reduced the time youth spend in detention facilities awaiting placement with a community service provider, and has promoted more effective treatment for assessed needs;
- Working with judges to modify the risk assessment instrument and procedures for judges to use in deliberating whether a youth should be committed to DYS;
- Planning a regional pilot in the Northwest Arkansas quadrant to encourage more community resources so youth can stay close to home in receiving services to meet their needs and assure that they become more functional and contributing members of their communities;
- Hiring a consultant to further develop Rite Track, a comprehensive data system which will ultimately help the department in tracking youth in all their interactions with state agencies, determine most effective methods of intervening with youth and families, and assure accountability to citizens and policy makers; and
- Reducing in dependence on juvenile detention centers (JDCs) based on efforts to speed up the intake process to move youth more quickly from commitment to placement.

This draft plan has three parts: 1) DYS mission and vision statements; 2) values which guide the planning process; and 3) prioritized goals, objectives and strategies.

Mission

The mission of the Division of Youth Services is to provide effective prevention, intervention and treatment programs to give opportunities for success to families and children in Arkansas and to ensure public safety.

Vision

Children and families in Arkansas are safe and have the resources they need in their communities to help them succeed.

Values

This plan is based on a number of shared values and beliefs among stakeholders for juvenile justice reform:

1. State resources and programs to support children and families in Arkansas should be coordinated in a system of care for maximum effectiveness. This imperative must infuse every goal and strategy in this plan.
2. Redirecting resources from incarceration and punishment to prevention and treatment will be more effective, less costly, and lead to greater public safety for citizens of the state.
3. Youth and families should receive services in community centers close to their homes whenever possible. This will allow more community buy-in, family involvement, and ease of transition after treatment.
4. Response to children in trouble should involve multi-system interventions with their families, and families should be involved in needs assessment and planning.
5. Programs and services should be strength-based and empower youth and families to succeed.
6. Programs and services should be evidence-based or have data showing effective outcomes. To achieve this accountability will require better baseline data and on-going data sharing as well as a commitment to data-based decision making.
7. All children and youth in the state should have equal opportunities for fairness, help and success without regard to gender, race or ethnicity, disability, geographic location, income level, or any other factor.
8. An effective juvenile justice system will require creative partnerships among state agencies, public and private schools, churches and faith-based organizations, local communities, the judicial system, and foundations.

Goals, Objectives, and Strategies

(Note: A separate timeline (indexed by goals) and a report card are included in appendices to provide tools for the Planning Implementation Advisory Committee to track progress toward plan goals rather than including dates on each strategy. Even though outcome measures are indicated within the plan for strategies, we anticipate that more holistic measures included in the report card will be the most significant measures of progress in juvenile justice reform).

Goal One: Create sustainable system changes in juvenile justice in Arkansas through broad consensus and shared responsibility among stakeholders.

> **Objective one:** Complete a comprehensive five-year plan with input and buy-in from broad stakeholder groups across the state.

Strategies:

1. Create a plan in consultation with the 50-member Juvenile Justice Reform Task force.
2. Discuss the plan with juvenile judges in regional meetings.
3. Gain buy-in on system reform from community service providers.
4. Host a youth summit to hear the voices of young people involved with the system or who have been involved in the past.
5. Hold public hearings in each region of the state to gain input.
6. Review successful juvenile justice programs and initiatives from other states.
7. Create an interactive Web page to disseminate drafts of the plan and solicit input from stakeholders.

Outcome:

1. Comprehensive five-year plan

Objective two: Increase training capacity within the Division of Youth Services (DYS) and throughout the juvenile justice system on effective treatment methods for children, youth, and families.

Strategies:

1. Designate staff within DYS to coordinate training efforts and resources around the state.
2. Seek technical assistance from federal agencies and private foundations to provide training on effective interventions and best treatment practices.
3. Determine effective training currently available in state agencies, community service providers, or other state sources and make it available to others within the juvenile justice system.
4. Continuously monitor the results of the training (including evaluation by trainees) to determine training modifications and re-training needs.
5. Develop minimum training standards for staff in all youth programs administered or contracted by DYS to take effect.

Outcomes:

1. Minimum training standards for all DYS staff and contract providers
2. Technical assistance obtained from the Office of Juvenile Justice and Delinquency Prevention (OJJDP) and other federal agencies and private foundations
3. At least six training sessions completed for community service providers
4. Inventory of state training resources identified

Objective three: Conduct a public information campaign on the need for juvenile justice reform.

Strategies:

1. Develop and refine messages about the human and financial costs of secure confinement for youth who pose no risk to themselves and others.
2. Develop information about the effectiveness of community-based treatment strategies for children, youth, and families.
3. Distribute messages to the public through all available means.
4. Focus information efforts on state legislators and the governor's office to gain support for reform.

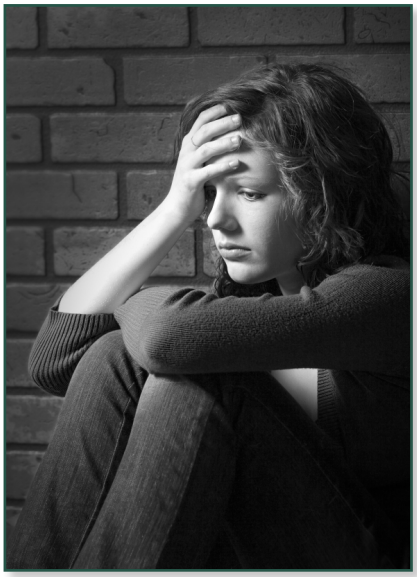
Outcomes:

1. Press conference to release the plan and promote the need for reform
2. Annual report card to promote progress in the juvenile justice reform effort
3. Enhanced support for reform efforts among state elected leaders

Objective four: Create and support cooperative partnerships to support juvenile justice reform.

Strategies:

1. Bring together community service providers, DYS administrators and juvenile judges in a series of regional meetings to enhance communication and relationships and to develop collaborative plans for achieving the goal of juvenile justice reform in the state.
2. Develop a strategic plan advisory committee as a subcommittee of the Juvenile Justice Reform Task Force. The advisory committee's role will be to oversee implementation of the strategic plan and to receive frequent reports on goal achievement. They will report results and make recommendations to the larger Juvenile Justice Task Force.



3. Improve communication and collaboration between DYS and the Department of Human Services – interagency services .
4. Form a network of community organizations including churches and faith-based organizations, schools, universities, non-profit organizations, businesses, community service providers and other groups, to provide and support culturally appropriate community-based services for families and youth.

Outcomes:

1. DYS strategic plan advisory committee created
2. Series of regional meetings with community-based providers, DYS leadership and juvenile justice conducted
3. Network of partnership resources created across the state to support reform efforts
4. Greater inter-agency collaboration to meet the needs of youth and families

Goal Two: Support children, youth, and families by providing appropriate services close to home with the result of less secure confinement of youth and greater safety of Arkansas communities.

Objective one: Develop a regional pilot program to provide comprehensive services for youth in the region.

Strategies:

1. Work with community service providers to promote a broader continuum of community-based services for youth in the region.
2. Implement principles from Systems of Care to provide comprehensive services for families, children, and youth.
3. Develop at least one school district partnership from the region to strengthen initiatives to reduce school-based referrals to juvenile court and youth commitments in the region.
4. Use a standardized intake risk assessment in all judicial districts in the region.
5. Ensure that as many youth as possible committed to DYS by judges in the region have treatment plans that can be executed in the region.

6. Commission an outside program evaluation, and report the results of the pilot to support funding for regionally tailored programs in other parts of the state.Outcomes:

Outcomes:
1. 25% more youth kept within their own region for treatment
2. Decrease secure confinement by 5% a year for two years within the region
3. Reduction in school-based referrals of youth to the juvenile justice system from the pilot school district in the region
4. Enhanced continuum of community-based service in the region

Objective two: Fund up to three competitively-selected pilot projects in high-need areas of the state to demonstrate the effectiveness of community treatment or prevention programs for children, family and youth.

Strategies:
1. Issue a Request for Proposals for community-based treatment or prevention programs.
    a. Applicants must document community needs and existing service gaps.
    b. Youth and families must be involved in project planning.
    c. Applicants must use treatment or prevention methods proven effective to serve children, youth, and families in their communities.
    d. Applicants must commit to outcome measures for the effectiveness of their programs.
2. Award up to three grants for two-year demonstration projects with a funding mechanism to encourage communities to keep youth in the community and to discourage DYS commitments.
3. Assess the pilots with an outside program evaluation and publicize results of the programs.

Outcomes:
1. Reduction in the use of secure confinement
2. Results from the pilot programs can provide the rationale and documentation for other successful community programs across the state
3. Cost savings from reduced use of secure confinement invested in successful community-based programming

Objective three: Roll out assessment procedures and tools statewide.

Strategies:
1. Develop a standardized risk assessment tool for statewide pre-adjudication use by juvenile judges.
2. In some cases when indicated, use the YLSI (a standardized professional risk assessment tool) in addition to inform judges prior to final judgment in the case.
3. Expand the UAMS mobile assessment team statewide to complete assessments of youth committed to DYS.
4. Validate all assessment tools.

Outcomes:
1. Better predictive data on risk and treatment needs, resulting in fewer commitments and more diversion to community programs
2. Enhanced public safety

Objective four: Develop or use community advisory councils as two-way communication vehicles to identify community youth needs and resources, and to disseminate information about effective programs and practices.

Strategies:

1. Identify current community or county advisory councils with a similar mission that might also serve in an advisory capacity for DYS.
2. Develop community advisory councils in communities/counties/regions without an existing council to represent the voices of youth, families, elected officials, community service providers, judicial officers, schools, churches and faith-based organizations, and other stakeholders.
3. Encourage the involvement of community advisory councils in proposals for DYS program funding.

Outcome:

1. Community advisory councils established in each part of the state to identify needs, resources, and opportunities for youth and families

Objective five: Map community and regional resources available to assist families, children, and youth in the state of Arkansas.

Strategies:

1. In cooperation with other state agencies, identify all state-funded programs offering services to juvenile justice involved youth.
2. Coordinate with System of Care, Prevention Resource Centers, Family and Youth Assistance Network (FYAN) and a variety of community organizations to map community resources and programs.
3. Work with the Department of Human Services (DHS) and the Family and Youth Assistance Network (FYAN) to develop a geographic resource mapping of all services for children and families by county to include: provider ID information, services provided, eligibility requirements such as services (length), and capacity (length of stay).
4. Coordinate with other divisions in DHS, FYAN and the Division of County Operations in creating a searchable on-line database of resources.

Outcome:

1. On-line map of community resources and identification of regional gaps

Objective six: Work with courts, schools, and community-based providers in developing a system of graduated sanctions for youth.

Strategies:

1. Develop a continuum of graduated interventions and services as alternatives to confinement.
2. Provide graduated sanctions training to judges, school officials, juvenile officers and others.
3. Provide data on results of successful graduated sanctions programs to judicial officers and to the general public.
4. Provide commitment reports to judges directly.

Outcomes:

1. Fewer youth in DYS secure confinement
2. Technical assistance on graduated sanctions obtained
3. Training on graduated sanctions provided to judges, school officials, juvenile officers, and others

Goal Three: Provide empowering and effective services for youth and families that focus on strengths and skill-building.

Objective one: Provide programs and services to families to prevent youth problems and to equip families to help youth.

Strategies:

1. Seek family input on their needs before developing intervention plans.
2. Employ a family needs assessment tool (conducted by community-based providers) which identifies family strengths to build on, such as the Youth Outcome Questionnaire developed by System of Care.
3. Provide families with a full range of non-traditional and traditional supports – such as family therapy, after school and summer programs, parenting education, support groups, respite services, self-advocacy training and other culturally appropriate programs which have been proven to be effective.
4. Provide "wraparound" services to youth and families through coordination among the Division of Youth Services, the Division of Developmental Disability Services, the Division of Child and Family Services, and the Division of Behavioral Health Services at local and state levels to identify services that meet the individual needs of youth.

Outcome:

1. An increase in community-based services available to youth and families, providing more options for judges and schools in intervention strategies

Objective two: Empower youth with life skills education and training.

Strategies:

1. Develop services that meet the needs of youth in the community such as mentoring programs, early interventions, day treatment, transitional living, life skills, parenting, career planning, job seeking and interviewing, and other training and services.
2. Increased intermediate levels of service.
3. Expand re-entry services, including mentoring.

Outcome:

1. An increase in community services available to youth with a corresponding decrease in recidivism rates, youth commitments and confinements, and school suspensions and expulsions

Objective three: Expand and strengthen alcohol and substance abuse programs.

Strategies:

1. Work with state and local judiciary and legislators to implement and evaluate juvenile drug courts.
2. Provide substance abuse services statewide that are evidence-based or have demonstrated promising outcomes for youth and families.

Outcomes:

1. An increase in court alternatives for youth with substance abuse problems
2. An increase in community substance abuse treatment programs statewide
3. Decrease in the confinement of youth with substance abuse problems

Goal Four: Strengthen programs for early identification and intervention to prevent juvenile delinquency, including school programs.

Objective one: Strengthen dialogue and relationships with school boards, superintendents, principals, and leaders in the Arkansas Department of Education (ADE) to develop strategies to keep more kids in school.

Strategies:

1. Bring together ADE, school superintendents, law enforcement, prosecutors, juvenile defenders, DYS officials, parents, youth, community service providers and judges to improve partnerships and explore changes in practices that will keep youth in school and out of the juvenile justice system.
2. Increase school representation on existing community boards and task forces.
3. Increase communication with school officials and administrators and with the Arkansas Department of Education to update them on juvenile justice reform efforts and why they are a necessary part of it.

Outcome:

1. Increased partnerships with schools and educators to address youth needs and problems

Objective two: Work with schools to identify and support pilot programs.

Strategies:

1. Develop partnerships to offer technical assistance to programs that are evidence-based or proven effective to reduce court referrals.
2. Work with school districts on successful re-entry for youth committed to DYS when they return to their local communities.
3. Identify and promote effective early intervention programs to reduce and prevent truancy.

Outcomes:

1. Successful joint pilot programs in schools
2. Reduced school referrals of youth to juvenile courts

Goal Five: Collect and analyze more data to determine needs of children, youth, families and communities, and use the results to improve the system.

Objective one: Complete a data flow analysis report summarizing gaps in the collection and use of information about youth in the juvenile justice system, and make recommendations for improvements in these systems in order to provide better information to judges, community service providers, researchers, educators, and DYS staff.

Strategies:

1. Hire an outside specialist to complete the work.
2. Seek grant funding to support the project.

Outcome:

1. Consultant report completed with recommendations on improving the data and information-collecting systems for juvenile justice involved youth

Objective two: Develop agreements with the Division of Developmental Disability Services (DDS), the Division of Behavioral Health Services (DBHS), and the Administrative Office of the Courts (AOC) and implement memoranda of agreement with the Division of Child and Family Services (DCFS) to share data and work cooperatively in early identification of problems in children and families .

Strategies:

1. Share data between DCFS, DYS and System of Care to determine the number of children involved in DCFS in abuse and neglect cases or foster care who go on to juvenile delinquency and/or DYS commitments.
2. Collect better data on juveniles placed on probation or pre-adjudication diversion.
3. Find ways to provide data by individuals rather than in aggregate statistical formats to be able to track individual youth as they move through the system.
4. Develop ways to protect confidentiality while sharing data.
5. Develop ways to share data among the Rite Track (the DYS database), CHRIS (the DCFS data base) and DNET (the AOC database).

Outcomes:

1. More comprehensive and integrated data and information collection systems for youth in the juvenile justice system
2. Better policy and treatment decisions

Objective three: Publish an annual assessment of the juvenile justice system. This report should include an analysis of the following:

- Characteristics/Profile of the Juvenile Population
- Juvenile Arrests
- Juvenile Court Filings
- Juvenile Commitments to DYS
- Risk Factors Associated with Juvenile Delinquency (including but not limited to teen pregnancy, alcohol and drug use, smoking, educational achievement, risky behaviors etc.)

Outcome:

1. An annual report to track progress and inform policy and decision making on juvenile justice reform

Goal Six: Develop the capacity of the system for cultural sensitivity and services to meet needs of special populations.

Objective one: Create accommodation for special populations in each judicial district to allow services to be provided close to home.

Strategies:

1. Develop and expand gender-responsible programming statewide, such as substance abuse treatment for girls.
2. Expand transitional living programs for juvenile sex offenders statewide.
3. Develop programs to meet the needs of system-involved youth with disabilities.

4. Assess unique needs of other special populations.

Outcomes:
1. More programs suitable for special populations in each part of the state
2. More community programs as an alternative to DYS commitment of youth
3. More local/regional youth treatment options

Objective two: Increase the capacity within the juvenile justice system to interact with youth and families in their own language and in culturally sensitive ways.

Strategies:
1. Build capacity to provide services to children, youth, and families in an appropriate language for them.
2. All paper work and forms should be translated into Spanish or other languages with a high incidence within system-involved youth.
3. Provide and require cultural sensitivity training for all DYS and contract staff, following a standard professional curriculum.

Outcomes:
1. Translated forms and documents
2. Cultural sensitivity training selected and promoted
3. Interpreters identified in each area of the state

Goal Seven: Ensure that secure facilities used to confine and treat youth are safe and humane and provide genuine opportunity for youth to succeed and to make educational progress.

Objective one: Enhance training and oversight of contract and DYS staff.

Strategies:
1. Support the hiring and funding of professional staff with minimum requirements for all contract and DYS staff.
2. Hire and train staff with a rehabilitation and therapeutic philosophy in working with youth.
3. Provide minimum training standards and on-going standardized training to DYS staff and contract providers working directly with youth on humane intervention techniques, trauma-informed care and positive behavior modification, and require evidence of completion.
4. Develop a multidisciplinary team to track, examine, and address serious incidents across programs.

Outcomes:
1. Lower staff turnover
2. Fewer incidents involving staff mistakes or misconduct
3. Better youth outcomes for youth in secure confinement

Objective two: Move toward the use of smaller therapeutic residential programs.

Strategies:
1. Support the transition to small therapeutic facilities that encourage group interaction and identification.
2. National "best practices" should be used in the design of any new facilities.

Outcomes:
1. Smaller, safer therapeutic facilities
2. Better outcomes for youth in secure confinement

Objective three: Improve education facilities and programs.

Strategies:
1. Make sure all secure facilities meet state educational adequacy standards for education and are in compliance with federal regulations on special education.
2. Create state-wide educational process/program for confined youth to assure progress.
3. Placements should facilitate the educational needs of each individual child.
4. Education should include independent living skills.
5. Partner with the Department of Workforce Education to provide vocational education options for system-involved youth.

Outcome:
1. More youth in secure confinement make educational progress as determined by pre-and post-educational assessments

Objective four: Build public trust and encourage accountability by insisting on system transparency.

Strategies:
1. Publicize data of rates of serious incidents (battery, sexual assault, and awols) at DYS-funded facilities.
2. Include materials on positive accomplishments as well such as occupational training completed, GEDs, enlistment in the armed services, recidivism rates, acceptance into secondary education institutions, etc.

Outcome:
1. More public trust in and stronger governmental support for the juvenile justice system

Goal Eight: Eliminate racial disparities in the juvenile justice system.

Objective one: Collect and analyze data on racial disparities in the juvenile justice system in Arkansas.

Strategies:
1. Develop data collection systems to capture data from schools, police, prosecutors, the courts, DYS, DHS, etc. to look at population demographics at every decision-making point in the juvenile justice system to help determine why racial disparity exists and at what point/stages such disparities occur.

2. Provide data on racial disparities to schools, staff, judges, police, prosecutors, probation officers, etc.

Outcome:
1. More understanding of existence of and reasons for racial disparities in juvenile justice

Objective two: Facilitate technical assistance and training for DYS and contract staff, judges, police, prosecutors, probation officers, etc.

Strategies:
1. Facilitate technical assistance and training to reduce racial disparities in the juvenile justice system.
2. Encourage the use of standardized assessment tools to foster more structured decision making at all critical decision-making points in the system.
3. Identify and promote successful programs on decreasing minority disparities in juvenile justice.

Outcome:
1. Decrease racial disparities in arrests, prosecutions, and commitments

Objective three: Coordinate with local communities to form Disproportionate Minority Contact (DMC) councils in regions in which racial disparities are the highest.

Strategies:
1. Expand the focus of disproportionate minority contact initiative to DYS pilot areas such as Hispanic populations in Northwest Arkansas.
2. Work with local communities to develop and support DMC councils in most affected areas to assess risk/needs.
3. Provide technical assistance and training to assist DMC ouncils to develop tailored, successful, and sustainable local solutions.
4. Connect community-based providers with local DMC ouncils to coordinate efforts.

Outcomes:
1. More community involvement in reducing racial disparities
2. Decreased racial disparities in arrests, prosecutions, and commitments

Goal Nine: Develop a stronger system of quality assurance and accountability to ensure that resources are producing measurable performance outcomes for children, youth, and families.

Objective one: Revise reporting measures in provider contracts.

Strategies:
1. Develop quality assurance standards to create a reporting and accountability system.
2. Revise current reporting requirements to encompass increased performance outcome measurement (standardized when possible to permit comparisons among providers).
3. Ensure that outcomes identified through System of Care's Youth Outcome Questionnaire are among tracked outcomes.
4. Review other states for development of a standardized performance outcome assessment tool/instrument for DYS programs by area of service.

5. Train on continuous quality improvement systems for community based and residential programs, using the results of outcome evaluation.
6. Pre/post assessment results will be kept in Rite Track.

Outcomes:

1. Performance outcome measures integrated into all provider contracts
2. Data systematically provided, analyzed, and used to permit continuous quality improvement

Goal Ten: Seek new sources of federal, state, and private funding for programs and services as well as reinvesting funds within DYS as the focus shifts from secure confinement to community treatment.

Strategies:

1. Maximize the potential for federal, state, and private funding through policies and placements.
2. Optimize the use of Medicaid funding for juvenile justice involved youth.
3. Utilize Title IV-E funding for foster youth committed to DYS.
4. Offer incentives to communities and judicial districts to contribute funding for services and programs.
5. Seek funding and assistance from foundations for system reform.
6. Work with the Department of Human Services to suspend rather than terminate Medicaid eligibility of youth committed to DYS in order to ease transition to community after-care services upon leaving DYS.
7. Also work on greater utilization of Medicaid funding for juveniles remanded to detention to facilitate mental health services for juveniles awaiting placements or placed on probation in the community.
8. Develop more funding for community-based services, including state, federal, and foundation funding.

Outcome:

1. Increased funding for community programs and juvenile justice reform efforts

Beyond DYS – Other Essential Elements of Juvenile Justice Reform

This plan has focused on reform efforts that DYS can lead or contribute toward. But DYS alone cannot achieve juvenile justice reform in the state of Arkansas. Other institutions and leaders are instituting their own reform efforts, and will be key players in juvenile justice reform goals. Examples include:

- Schools are attempting to meet the needs of all children in our state with more effective discipline policies and programs to meet the needs of students with various learning abilities and styles. They also are trying to support student success with programs such as mentoring, tutoring, parental involvement and education programs, after-school programs, and summer programs.
- Law enforcement officers seek ways to prevent and respond to juvenile crime and delinquency.
- Juvenile courts are seeking better ways to assess the risk juveniles pose to themselves and to others and to seek appropriate support and treatment alternatives.
- Other state agencies and divisions such as the Department of Human Services, the Division of Behavioral Health Services, System of Care, the Division of Children and Family Services, and the Administrative Office of the Courts are working to support healthy families and to address overlapping issues such as the high proportion of children who are victims of child abuse and neglect who go on to be juvenile offenders, or the high proportion of youth with mental health issues or development disabilities who become involved with the court system.
- The 13 community-based providers are doing work in the community to keep local delinquent and at-risk youth from further movement into the juvenile justice system with programs such as casework, aftercare, electronic monitoring, emergency shelter, parenting classes, day treatment, community mental health services, and residential treatment.
- Grassroots community organizations are increasingly forming to address needs they see in their communities to support family and youth.

All of these efforts need to be coordinated and integrated to work toward a positive outcome for families and youth in our state.

Juvenile Justice Report Card

The true measure of success of this plan is its impact on the well-being of children and families in the state of Arkansas. This report card will be published on-line each year in conjunction with the annual assessment report on the juvenile justice system mentioned in Goal 5. Over time trends in the report card measures will indicate progress in reducing youth crime and serving system-involved youth. For maximum usefulness, it would be desirable, if possible, for all measures to be reported in a state summary, but also reported for each county. State leaders should also be able to have a context for interpreting their results by seeing overall population figures and demographic breakdowns for their counties. Report card measures include:

1. Number of youth and families served by DYS-contracted community service providers in community settings (excluding aftercare), broken down by type of service and by residential and non-residential.
2. Number of youth committed to DYS custody, broken down by youth served in secure confinement and those served in community programs.
3. Average length of stay for DYS-committed youth in juvenile detention centers and average length of stay in residential programs.

4. Recidivism rate (reported both as re-commitment or adjudication) broken down by youth served in secure confinement and community programs. The rate should be reported as to whether the new offense was a technical violation or probation violation. The report card will also report the numbers of re-arrests of system-involved youth.
5. Percentage of youth eligible for high school completion during their commitment to DYS receiving high school diplomas or GEDs, broken down by age.
6. Educational progress of youth served by DYS, as measured by pre- and post-educational assessments. Data will be reported separately for special education students.
7. Number of negative incident reports involving youth in DYS custody reported in categories of staff/ youth incidents , youth/youth incidents, and self-injuries.
8. The proportion of minority youth committed to DYS compared to population percentage reported by judicial district and county.
9. The amount of DYS budget devoted to secure confinement compared to budgeted funds used to support community service programs.
10. Positive accomplishments of system-involved youth.

Executive Summary of Timeline

2009

Complete plan and set up Plan Implementation Advisory Committee

Regional meetings with judges, community-based providers and DYS leadership to enhance communication and working relationships

Launch pilot programs

Update data systems

Identify staff to coordinate training and set minimum standards

2010

Educate legislators and identify champions for juvenile justice reform

Pre-adjudication risk assessment statewide as a tool for juvenile judges

Training needs assessment for all DYS and contract employees

Data sharing among state agencies and data flow analysis

On-line directory of community services for youth and families

Work with existing community councils

First annual report on state of juvenile justice

Expand juvenile drug and alcohol programs

2011

DYS mobile assessment teams statewide

Dialogue with education leaders on mutual interests of keeping kids in school and increasing graduation rates

Outcome assessment measures on all provider contracts

Seek new state and private funding for juvenile justice reform efforts

Meet all federal and state education requirements for youth in confinement
Collect and analyze data on racial disparities in all parts of the juvenile justice system

On-going standardized training for all DYS and contract employees

2012

Assessment of pilot programs

Technical assistance for schools, judges, law enforcement, probation officers and others on graduated sanctions, disproportionate minority contact, and other topics.

Programs for special populations

Network of training resources fully developed

2013

Validate risk assessment tool used by juvenile judges

Assess training effectiveness

Promote best practices in educational programs for system-involved youth

2014

Full array of community resources to serve family and youth

50% reduction in youth in secure confinement

Timeline for Juvenile Justice Reform

2009

June

Complete plan and release with a press conference on juvenile justice reform (Goal 1, Obj. 1).

July

Complete instrument development for risk assessment for judges (Goal 2, Obj. 3).

Release an RFP for pilot programs and continue to select new pilots each year thereafter (Goal 1, Obj. 2).

Implement regional pilot in Northwest Arkansas (Goal 2, Obj. 2).

Create a strategic plan advisory committee to oversee implementation (Goal 1, Obj. 4).

December

Obtain technical assistance from OJJDP and other sources to train the trainer (ongoing) (Goal 1, Obj. 2).

Establish minimum training standards for DYS & contracted employees (Goal 1, Obj. 2 and Goal 7, Obj. 1).

Identify DYS staff to coordinate training resources (Goal 1, Obj. 2).

Conduct a series of regional meetings with judges, community-based providers and DYS leaders (repeated annually to facilitate relationships, communication and cooperation) (Goal 1, Obj. 4).

Discuss plan with stakeholder groups and gain input (Goal 1, Obj. 1).

Update Rite Track with federal stimulus funding (Goal 5, Obj. 2).

Create a data work group (Goal 5, Obj. 2).

Award funding for pilot programs (Goal 2, Obj. 2).

2010

March

Focus on legislative education on juvenile justice reform and identify champions (Goal 1, Obj 3).

Strengthen and expand drug and alcohol programs and support drug courts (Goal 3, Obj 3).

June

Develop outcome assessment measures for current community-based provider contracts (Goal 9, Obj. 2).

Implement statewide risk assessment instrument for judges (Goal 2, Obj. 3).

Complete statewide inventory of community resources for family and youth and create an on-line directory with annual updates. (Goal 2, Obj. 5).

Complete a training needs assessment for DYS and contracted employee (annual thereafter) (Goal 2, Obj. 2).

Create a fiscal incentive pilot to encourage judges and local communities to provide resources for family and youth as alternatives to DYS commitment (Goal 2, Obj. 2).

Develop data sharing among CHRIS, AOC, ACIC, Rite Track data bases and develop data access safeguards to protect confidentiality for individuals. (on-going) (Goal 5, Obj. 2).

Identity community councils that could coordinate with DYS on community needs and resources.

December

Complete at least six train-the-trainer sessions for DYS and contracted staff on Matrix, YAP, YSLMI, Multi-Systemic Family Therapy or other therapeutic approaches (Goal 1, Obj. 2).

Publish first annual report on the state of juvenile justice in Arkansas and release in a press conference to promote public education. Include reports of serious incidents and positive accomplishments at youth facilities in the report (Goal 5, Obj. 3, Goal 1, Obj. 3, Goal 7, Obj. 4).

Translate forms into Spanish and provide interpreters for families and youth across state (Goal 6, Obj. 2).

Complete a data flow analysis to identify gaps in current data available (Goal 5, Obj. 1).

2011

Make UAMS Mobile Assessment teams available statewide (Goal 2, Obj. 2).

Start dialogues with school leaders and the AR Department of Education on joint goals of keeping more students in school and achieving higher graduation rates (Goal 4, Obj. 1).

Build outcome assessment measures into all community-based provider contracts as they are renewed (Goal 9, Obj. 1).

Seek state funding in the legislative session and apply for major foundation funding to support reform efforts. (ongoing) (Goal 10).

Meet all current state and federal requirements for educational facilities and services for youth in secure confinement. (Goal 7, Obj. 3).

Create community councils and DMCs in areas without existing councils (Goal 1, Obj. 4, Goal 8, Obj. 3).

Collect and analyze data on racial disparities at each step of the juvenile justice process (Goal 8, Obj. 1).

Promote life skills training for youth in all parts of the state (Goal 3, Obj. 2).

Provide on-going standardized training for all DYS and contract employees (Goal 1, Obj. 2).

2012

Complete assessment of first round of pilot programs (Goal 2, Obj. 1 and 2).

Assess fiscal incentives pilot (Goal 2, Obj. 2).

Complete a network of training resources and services to meet training needs of DYS and contracted employees, community volunteers and others (Goal 1, Obj. 2).

Provide technical assistance for schools, judges, law enforcement, probation officers, and others on graduated sanctions, disproportionate minority contact, positive behavior modification, and other needed topics. (Goal 8, Obj. 2; Goal 1, Obj. 2; and Goal 2, Obj. 6).

Create and support programs to accommodate the needs of special populations in each region of the state. (Goal 6, Obj. 1).

2013

Validate risk assessment tool used by juvenile judges (Goal 2, Obj. 3).

Assess training effectiveness (Goal 1, Obj. 2).

Promote best practices in education programs for system-involved youth (Goal 4, Obj. 2).

2014

Achieve a full array of community resources to serve family and youth (Goal 2 and 3).

Decrease the number of youth in secure confinement by 50% (Goals 2 and 8).

Glossary of Terms and Abbreviations

ADE	Arkansas Department of Education
AOC	Administrative Office of the Courts
CHRIS	The database administered by the Division of Child and Family Services
DBHS	Division of Behavioral Health Services
DCFS	Division of Child and Family Services
DDDS	Division of Developmental Disability Services
DHS	Department of Human Services, the state agency over all the divisions
DMC	Disproportionate Minority Contact, the term used when minorities are over-represented in the juvenile justice system
DNET	The database administered by the Administrative Office of the Courts
DYS	Division of Youth Services, the division charged with juvenile justice programs
FYAN	The Family Youth Assistance Network
OJJDP	The Office of Juvenile Justice and Delinquency Prevention, a division of the U.S. Department of Justice
RFP	Request for proposals, an invitation to submit ideas for grant funding
Rite Track	The database administered by the Division of Youth Services
SOC	System of Care – a philosophy of social services that encourages coordination of services, parental/family involvement, and strength-based programs
UALR	University of Arkansas at Little Rock
UAMS	University of Arkansas for Medical Sciences
YLSI	Youth Life Skills Inventory, an assessment tool to determine youth needs
YOQ	Youth Outcome Questionnaire, a holistic assessment tool used by System of Care

ARKANSAS DEPARTMENT OF
HUMAN SERVICES

Table 1: Patients Referred for Outpatient Restoration – General Count – 4/10/2012 - 7/2/13	
Completed Outpatient Restoration	38 (34%)
Reevaluated & Found Competent and Responsible	*22*
Revaluated & Found Competent and Not Responsible	*8*
Reevaluated & Remained Unfit (Referred for ASH Admission)	*7[a]*
Awaiting Completion of Reevaluation or Report	*1*
Need for Hospitalization, ASH Admission	54[b] (48%)
Already admitted	*50*
Awaiting Admission	*4*
Remained in Outpatient Restoration	12(11%)
Charges Dropped "Nol Prossed"	7 (6%)
Deceased	1 (1%)
Total Patient Referred to the FORP	112

Forensic Outpatient Restoration Progress Report

- Of the 54 patients who were referred to ASH before completing the FORP:
  - 23 clients were treated and found Competent/Responsible
  - 11 clients were treated and found Competent/Not Responsible
  - 16 clients are still receiving services at ASH
  - Four clients are to be admitted to ASH.

Refer to Table 1 for additional details.

Table 2: Forensic Waiting List: Comparison between April, 2012 and the Current Waiting List (7/1/13)			
April 1, 2012		**July 1, 2013**	
Total 314's [i]	**5**	**Total 314's**	**0**
Total 310's [ii] in Jail	**45**	**Total 310's in Jail**	**16**
In Jail <45 Days	16	*In Jail <45 Days*	8
In Jail >45 Days	29	*In Jail >45 Days*	8
Total 310's not in Jail	**47**	**Total 310's not in Jail**	**9**
On Bond <45 Days	12	*On Bond <45 Days*	1
On Bond >45 Days	28	*On Bond >45 Days*	8
Other 310's	**7**	**Other 310's**	**1**
Total on ASH Waiting List	**104**	**Total on ASH Waiting List**	**26***

*At the time of distributing the waiting list, 13 of the 26 had completed or were receiving outpatient restoration services, including 10 of the 16 individuals in jail

ASH Inpatient Waiting List Report

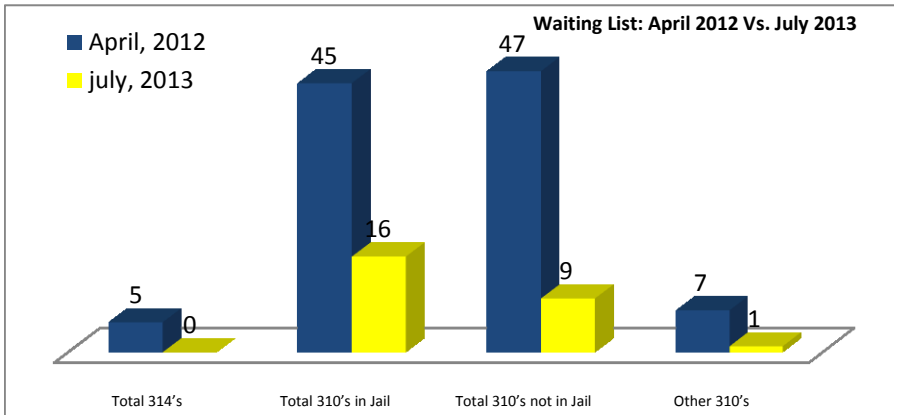


Table 3: Civil Bed Utilization (FORP Started 4/10/2012)			
12 Months Prior to FORP		**12 Months After FORP**	
Admission to Units A & B		Admission to Units A & B	
# of Civil Patients	207	# of Civil Patients	218
# of Forensic Patients	40	# of Forensic Patients	62
911[iii] Patients	27	*911 Patients*	31
310 Patients	7	*310 Patients*	23
314 Patients	6	*314 Patients*	8

Civil Bed Utilization Report

Admissions data from Civil Units A & B form January 2011 - May 2013 were obtained from the Admissions Department at ASH. A sample of patients admitted to those units was drawn to cover the admission events 12 months prior to the start of the FORP and 12 months after. Table 3 summarizes the data in the sample. Below are the percentages per admission type:

Admit Type	12 Months Prior (Total Admits = 247)	12 Months After(Total Admits = 280)
911	11%	11%
310	3%	8%
314	2%	3%
Civil	84%	78%

Table 4: Potential Forensic Outpatient Restoration Clients - Projection									
		CMHC Where Potential 310 Patients May be Referred for Restoration Treatment							
# of 305's [iv] evaluations	*# found Unfit to Proceed*	PCA	LRCMHC	OGC	HRA	SWACMHC	SARHC	MSHS	WAGCS

Forensic Outpatient Projection Data

This report is still under development. Dr. Kazi Ahmed and Serhan Al-Serhan are in the process of collecting the data needed for this report.

(a) All seven defendants under this category were either treated and found C/R or are still receiving services at ASH

(b) This number includes all defendants who reached maximum benefit of the outpatient restoration program and, therefore, were referred by the CMHC's for inpatient treatment at ASH. Both numbers marked by a & b are mutually exclusive.

i. 314: An acquittal order pursuant to A.C.A §5-2-314.
ii. 310: An order for treatment to restore competency pursuant to A.C.A §5-2-310.
iii. 911: Conditional Release Program pursuant to Act 911 of 1989.
iv. 305: A forensic evaluation order pursuant to A.C.A §5-2-305.

Arkansas Department of Human Services

Division of Behavioral Health Services

JUVENILE DRUG COURT PROGRAMS

1st JUDICIAL DISTRICT

Cross, Lee, Monroe, Phillips, St. Francis, Woodruff

HEALTH RESOURCES OF ARKANSAS, INC.

P.O. Box 2578 Batesville, AR 72503	Jim Clark Email: jclark@hra-health.org Site Telephone: 870-793-8900	Juvenile Drug Court

16th JUDICIAL DISTRICT

Cleburne, Fulton, Independence, Izard, Stone

HEALTH RESOURCES OF ARKANSAS, INC.

P.O. Box 2578 Batesville, AR 72503	Jim Clark Email: jclark@hra-health.org Site Telephone: 870-793-8900	Juvenile Drug Court

4TH JUDICIAL DISTRICT

Washington, Madison

YOUTH BRIDGE, INC.

3715 N. Business Drive, Suite 201 Fayetteville, AR 72703	Scott Linebaugh Phone: 479-521-1532 E-Mail: slinebaugh@youthbridge.com	Juvenile Drug Court

19TH JUDICIAL DISTRICT

Benton

YOUTH BRIDGE, INC.

1200 W. Walnut, Suite 1500 Rogers, AR 72756	Scott Linebaugh Phone: 479-636-0083 E-Mail: slinebaugh@youthbridge.com	Juvenile Drug Court

Revised 4/30/2013

10th JUDICIAL DISTRICT
Ashley, Bradley, Chicot, Desha, Drew

ALTERNATIVE OPPORTUNITIES – DAYSPRING BEHAVIORAL HEALTH

1371 Hwy 278 West Monticello, AR 71655	Carol Moore Phone: 870-367-2141 Email: cmoore@dayspringbhs.org	Juvenile Drug Court

18th JUDICIAL DISTRICT
Garland

QUAPAW HOUSE, INC.

500 Quapaw Avenue Hot Springs, AR 71901	Casey Bright Phone: 501-767-4456 E-Mail: caseybright@quapawhouseinc.org	Juvenile Drug Court

11th JUDICIAL DISTRICT
Jefferson, Lincoln

SOUTHEAST ARKANSAS BEHAVIORAL HEALTH SYSTEM, INC.

P.O. Box 1019 Pine Bluff, AR 71603	Kathy Harris Phone: 870-534-1834 E-Mail:Kathy@sabhs.org	Juvenile Drug Court

13TH JUDICIAL DISTRICT
Calhoun, Cleveland, Columbia, Dallas, Ouachita, Union

SOUTH ARKANSAS YOUTH SERVICES, INC.

P.O. Box 2058 Magnolia, AR 71754	Tracy Jackson Phone: 870-234-6550 E-Mail: tracy.jackson@saysyouth.org	Juvenile Drug Court

Revised 4/30/2013

22ND JUDICIAL DISTRICT
Saline

COUNSELING CLINIC, INC.

307 East Sevier Street Benton, AR 72015	Robert Bennett Phone: 501-315-4224 E-Mail: rbennett@cc-innc.org	Juvenile Drug Court

Revised 4/30/2013

I. Justice

The state of Arkansas elected to adopt Medicaid Expansion through what has been termed the Private Option. Utilizing a 1115 waiver, which is currently under public comment prior to seeking approval from the Center for Medicaid and Medicare Services (CMS), the Department of Human Services (DHS) Division of Medical Services (DMS) will purchase plans through the Healthcare Insurance Marketplace for individuals within the Medicaid Expansion population.

DHS, which includes the Division of Behavioral Health Services (DBHS), is currently analyzing the provisions within the Affordable Care Act that may alter access to coverage for individuals involved in the criminal justice system through the Private Option, specifically for individuals whom are pre-adjudicated.

In an effort to reduce the waiting list for the Arkansas State Hospital and reduce jail stays for individuals awaiting forensic evaluations, DBHS initiated the Forensic Outpatient Restoration Program in April 2012. Through this program, eight Community Mental Health Centers across the state have begun providing a range of mental health services specific to the forensics population outside the state hospital, including Restoration Curriculum, Outpatient Counseling, and Evaluations. Since the onset of the program, 112 patients have been referred to Outpatient Restoration. When the program was initiated there were 104 individuals on the waiting list for inpatient admission to the Arkansas State Hospital, as of July 2013 there are 26.

There are currently no behavioral health screenings provided to individuals prior to adjudication. However, the Department's goal is to develop a multi-system statewide action plan to more efficiently address the needs of individuals involved in the criminal justice and juvenile justice systems. An identified action step and Department of Human Services' priority is the statewide utilization of a behavioral health screen intended to aid law enforcement personnel in the identification of mental illness and/or substance use disorders.

DBHS coordinates with multiple agencies to promote diversion and provide treatment to individuals involved or likely to become involved in the juvenile and criminal justice system. There are currently 42 adult drug courts across the state. Arkansas drug courts, first established in 1994, are pre adjudication and post adjudication programs purposed to divert adults with identified substance abuse disorders into treatment services. DBHS has a representative on the Drug Court Advisory Council and funds more intensive substance abuse treatment services for drug court clients.

The Juvenile Drug Court (JDC) program of Arkansas operates under the guidance of a collaborative partnership between DBHS, the Administrative Offices of the Court (AOC), DHS Division of Youth Services (DYS), and direct substance abuse treatment provider organizations. JDC's were also authorized in Arkansas Act 1022 of 2007. By 2009, ten juvenile drug courts were established. In the 2011 legislative session, three more courts were authorized and funded bringing the total number to 13 juvenile drugs courts operational as of January 2012. Additional legislation was passed during the 2011 session authorizing district courts to authorizing district courts to preside over a drug court under certain circumstances and increasing the cost levied on misdemeanor possession of marijuana (i.e., the increased amount would go to a designated fund

that can be used by both adult and juvenile drug courts to pay for treatment costs). However, there is no funding available to establish new courts.

Act 1022 of 2077 also established the various roles and responsibilities two of the agencies involved in the Arkansas JDC program: DBHS (formerly referred to as Office of Alcohol and Drug Abuse Prevention) and AOC. The DBHS serves as the fiscal agent for funding treatment provided to juvenile drug court programs; certifies and licenses treatment providers and facilities to be considered for the provision of treatment services. DBHS supplies AOC with an ongoing list of licensed providers to assure eligibility for providing treatment services to program participants. One of the requirements for eligible providers is to the ability to an open bed for a participant within twenty-four hours of the request. DBHS also serves as a liaison between the licensed providers, the juvenile drug court programs, and DYS. Under the Act, AOC is the state authority responsible for providing state-level coordination and support to drug court judges and their programs. AOC serves as a liaison between drug court judges and other state level agencies—DBHS, DYS, and Department of Community Corrections. Training and education of drug court judges and other professionals are the responsibility of the Administrative Office of the Courts.

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.

Additionally, DBHS has applied for a federal re-entry grant to address specific care coordination needs of post adjudicated adults with mental illness in the criminal justice system, yet DBHS was not awarded this grant. A DBHS staff member is also leading a diverse workgroup to improve re-entry services in the state. The workgroup is working to develop a statewide action plan to assist in the transition of individuals out of prison.

While training and education of drug court judges and other court personnel are the responsibility of the Administrative Office of the Courts, DBHS serves as a collaborative resource for the agency.

IV: Narrative Plan

J. Parity Education

Narrative Question:

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

Please answer the following questions:

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

Footnotes:

J. Parity Education

The Division of Behavioral Health Services (DBHS) is still working to develop a plan to promote awareness surrounding the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its applicability to the Health Insurance Marketplace and other private plan. DBHS will reach out to interdepartmental resources in addition to working with the Regional Prevention Providers, Mental Health Providers, Substance Abuse Treatment Providers, and other stakeholders to develop a communication plan to educate and raise awareness about parity.

While not part of a formalized plan, Division staff have begun dialogues and presentations with providers 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.

In addition, the Division will consider conducting a media campaign to raise awareness about parity. DBHS hopes to target the general public and specific populations, in particular providers and consumers of behavioral health services. The development of informational tools such as PSAs, brochures, and fact sheets can be disseminated to increase the general public's knowledge. These developed materials can be distributed in the community mental health centers, substance abuse treatment facilities, Regional Prevention Providers and posted to the websites. In partnership with the Arkansas Foundations for Medical Care (AFMC), it may be possible to distribute materials and raise awareness to doctors throughout Arkansas by disseminating information in waiting rooms and doctor offices. The informational tools can be focused for specific target audiences to detail information about benefits. Coordination with Arkansas Foundation for Medical Care's Quality Improvement Councils, University of Arkansas for Medical Sciences' Department of Family and Preventative Medicine, and the Minority Health Commission will assist in reaching key populations.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

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

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?

2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?

3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?

4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.

5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.

6. Describe how your behavioral health providers are screening and referring for:

   a. heart disease,

   b. hypertension,

   c. high cholesterol, and/or

   d. diabetes.

Footnotes:

K. Primary and Behavioral Health Care Integration Activities

The Division of Behavioral Health Services (DBHS) is working closely with the Division of Medical Services (DMS), the State's Medicaid agency, to develop a Health Home State Plan Amendment proposal. The state is pursuing a Patient Centered Medical Home (PCMH) for all Medicaid enrolled individuals. In addition, the State is pursuing Health Homes for special populations, including long term care, developmentally disabled, and behavioral health.

In addition to the efforts mentioned above, the State of Arkansas is developing service packages that within the PCMH and using a 1915i State Plan Amendment that will allow for the expansion of care coordination. 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.

Efforts are underway to bridge the gaps between these provider groups. Arkansas has a long standing workgroup with the purpose of resolving this issue. Ever provider in our State is aware that these patients access our services and understand the importance of the coordinated care approach. Several applications for PBHCI grants have been made in an effort to move this forward.

In a partnership with the Arkansas Department of Health, DBHS has funded tobacco cessation services at multiple Community Mental Health Centers and Substance Abuse providers.

To expand upon this collaborative, all substance abuse providers contracted with DBHS to provide block grant funded services will be required to develop a "Tobacco Free" policy and procedure for their campus. DBHS and the Arkansas Department of Health will provide limited grant funds in order to assist providers with implementation and to provider nicotine replacement therapies, signage, supportive services and other tools to assist consumers and staff in efforts to decrease tobacco use.

In addition, the Arkansas Payment Improvement Initiative through Medicaid is expanding access to Medicaid funded tobacco cessation counseling and products.

Currently, the ability to track and monitor screening and referring for heart disease, hypertension, high cholesterol, and diabetes by behavioral health providers is lacking in Arkansas. Screenings and referral are occurring, but there is no formal tracking in place. With the requirement of an EHR and re-establishment of care coordination Arkansas will have the ability to track and ensure this is being provided for all clients involved in the behavioral health care system.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

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

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

In the space below please answer the following questions:

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

Footnotes:

L. Health Disparities

To develop plans to address and in the future reduce disparities, DBHS will:

- Conduct surveys or host community events/information fairs to get direct feedback from consumers;
- Staff should be equipped with the tools and resources needed to be effective in the communities they serve through diversity awareness and sensitivity training. Educational materials in appropriate languages and reading levels and cultural, language or sign language interpreters must be available. Lack of interpreter services or culturally/linguistically appropriate health materials is associated with patient dissatisfaction, poor comprehension and compliance, and ineffective or lower quality care; and
- Policies and programs are needed to help consumers to work within the healthcare system. Clinical decisions that are made in the organization should be reviewed, paying particular attention to decisions that might need to be more accommodating for cross-cultural groups and diverse groups.

DBHS will utilize block grant funding to:

- Educate the public about health disparities to increase awareness and capacity for behavioral health promotion and disease prevention in Arkansas.
- Support the development and dissemination of information, strategies, and policies which contribute to the improved behavioral health outcomes of underserved populations in Arkansas.
- Promotes awareness of health issues related to unequal treatment and social determinants of health in Arkansas with internal and external partners.
- Ensures representation of diverse populations in state health planning, program development and awareness initiatives, and leadership positions within the DBHS.
- The use of exit interviews to capture the experiences and outcomes of the consumer at all levels of care should be designed to capture the effectiveness of the various approaches to meeting or eliminating the disparities.
- Conduct follow-up interviews/surveys post treatment episodes to follow consumer success and provide the necessary supports to accomplish their goals in recovery.

IV: Narrative Plan

M. Recovery

Narrative Question:

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

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?

2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?

3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?

4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).

5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?

6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

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

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?

2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?

3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?

4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

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

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

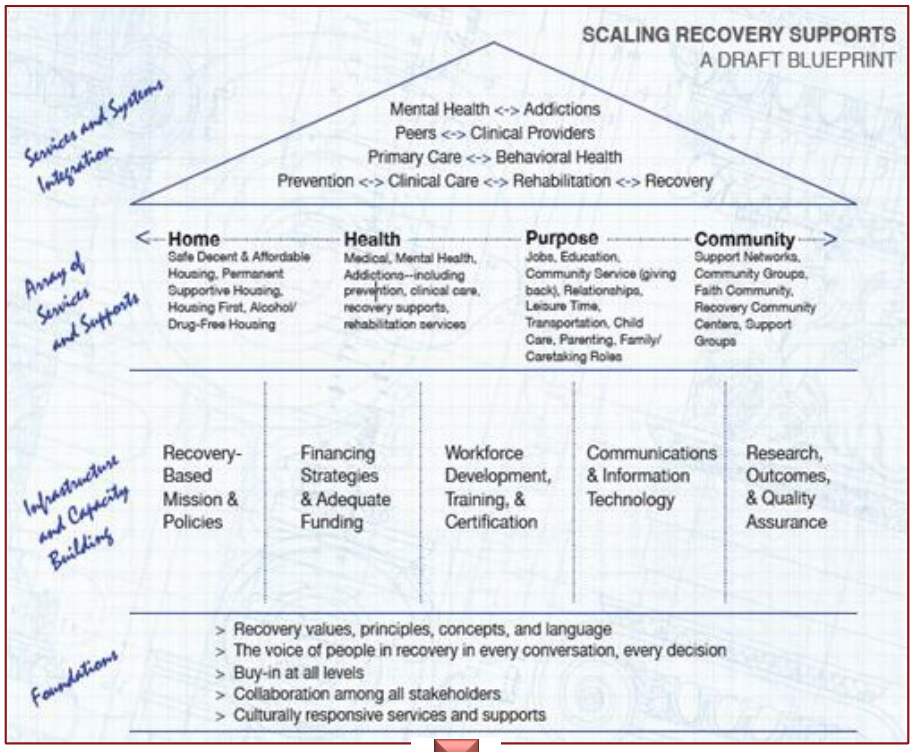
Footnotes:

BRSS TACS 2013 Policy Academy: Bringing Recovery Supports to Scale in the Context of the Affordable Care Act — LOGIC MODEL

State/Territory: *Arkansas*

BRSS TACS VISION:

Acknowledges person driven, family and community supported recovery for developing and (continued below) enhancing independence and quality of life as implemented by a credentialed workforce with lived experience.



BRSS TACS Team Strategies (Objectives)

1. *Develop data bases that demonstrate and support the benefits of adding Certified Peer Support Partners to the array of Behavioral Health Services/supports, using episodes of Care, State Epidemiological Data, research literature about Peer supports, data from the Criminal Justice System*
2. *Calculate Workforce Development needs for Certified Peer Support Partners*
3. *Measure outcomes that show progression of Peer/Consumer-driven Recovery supports coming to Scale in the context of the ACA in Arkansas*
4. *Establish five geographically strategic Community Conversations across Arkansas, comprised of key leaders in the Behavioral Health Communities (people with lived experiences of Addictions and Mental Health Problems, Program Administrators and informal community leaders) to begin dialogues about implementing the new Certified Peer Specialist position, the community's readiness to implement as well as what would help to facilitate and ease establishing the practice – with the purpose of building support for Peer Delivered Services/Supports under ACA, through Dialogues*
5. *Disseminate information about Arkansas' BRSS TACS 2013 Policy Academy at the Annual Behavioral Health Institute, the Annual Consumers Count Conference and the Annual Retreat for Strategic Planning with the Arkansas Behavioral Health Planning and Advising Council*
6. *Continue to add (and re-engage) strategic members to Ark. Team, with special emphasis on Addictions*

Strategy 1: *Standards of Recovery (impact on recovery by adding peer workers)*

Inputs (Resources)		Action Plan Steps				Outcomes
		Activities	**Participants** (responsible party)	**Timeline**		
Claims Data - episode of care - diagnosis switches - quality		Assemble relevant Claims Data	Medicaid staff	October 1, 2013		Develop paper that supports need to have people with lived

SWOT Summary

Strengths: -Reform is a catalyst for Recovery Based Practices -Timing is good – Medicaid reform, ACA, 1915i - Integration is going to happen - Awareness of value and need for peers	**Weaknesses:** -Lack of Standards of Recovery and Best Practices -Unintentional consequences from the system -Lack of peer services and supports -Lack of integration within Behavioral Health
Opportunities: - Diversity of Workforce -1915i and conceptualizations -Good timing -Incentives to develop new services	**Threats:** -Lack of data to measure outcomes and lack of recovery focus in policies for impact of adding peer workers -Lack of data to measure outcomes and Lack of recovery focus in policies that demonstrates recovery happens -Professional resistance, e.g., need to educate about what peer supports can do and their effectiveness Apathy in the workforce and family

Priority Areas:
Collect outcomes data that supports systemic changes
Begin Community Conversations with key stakeholders as a way to Bring Recovery Supports to Scale
Demonstrate integration of people with lived experiences throughout the Behavioral Health system of care

matrix - historical report State Epidemiological Data Peer Research Literature EBP Toolkit for COSP Crime Data Dept. of Ed Data		Pull relevant Epidemiological Data	Kazi Ahmed	October 1, 2013		experiences as peer support workers and working throughout the workforce to build the case for establishing peer positions in the array of services
		Pull relevant Peer Research Literature Pull relevant Crime Data Pull relevant Ed Data	Linda Donovan Virginia Jordan Deb Garrison	October 1, 2013		

Strategy 2: *Standards of Recovery (demonstrating that recovery is real)*

Inputs (Resources)		**Action Plan Steps**				**Outcomes**
		Activities	**Participants** (responsible party)	**Timeline**		
Data from existing literature that demonstrates recovery is possible and factors that contribute to recovery, such as protective factors in Prevention, Trauma Informed		Collect literature	Loretta Cochran Linda Donovan	August 1, 2013		Develop paper and dialogue-generating presentation that supports need to use Recovery as the overarching framework (covers each Activity for Strategy 2)
		Shared reading responsibilities to review and share with Team	All Team members	August 15, 2013		

Care and "Recovery, What Helps, What Harms?"						
Identify relevant webinars about recovery		Shared watching responsibilities to view and provide feedback to Team	All Team members	August 15, 2013		Final Product use for Community Conversa-tions
Data from Literature that identifies Quality of Life Measures		Collect Quality of Life Measures that are more peer/ consumer-driven that move the focus from traditional measures to whole person measures indicating improvement toward getting one's life back	Linda Donovan	September 1, 2013		Ability to conduct presentations throughout the state remotely

Strategy 3: *Array of Services for Peer Supports*

Inputs (Resources)		**Action Plan Steps**				**Outcomes**
		Activities	**Participants** (responsible party)	**Timeline**		
Use collected data to educate and inform		Power point that includes Addictions and Mental Health Problems and tells the history, development of recovery concept, reason for rationale and contexts, how to apply and important considerations	Linda Donovan with feedback from Team	Initial June 24, 2013 Final August 15, 2013		Use as tool for Community Conversa-tions at 5 targeted locations over Arkansas
Webinars and power point presentations that educate around topics, including for people with lived		Team view and provide feedback to use or not to use in Community Conversations	Team	August 15, 2013		Include in Community Conversa-tions presentation

experience that may be coming to 'the table' for the first time						
Develop formal presentation for professionals, people with lived experiences and community		Group review, feedback and consensus on final presentation for Community Conversations	Team	Sept. 1, 2013		
		Request TA from Ark. Dept. of Human Services IT to learn how to conduct on-line presentations including power point and camera	Linda Donovan and IT staff	Sept. 1, 2013		

Strategy 4: *Infrastructure to reduce unintended harm*

Inputs (Resources)		**Action Plan Steps**				**Outcomes**
		Activities	**Participants** (responsible party)	**Timeline**		
Education (including "What Helps/ What Harms", "Healing Neen"), and sharing stories		Awareness raising activities about iatrogenic harm and unintended harm from unawareness of power dynamics	Team	On-going		Initiate systemic culture change that addresses unintended harms and starts community-wide dialogues
		Request BRSS TACS TA regarding culture change around unintended harms	Linda Donovan	September 1, 2013		
Awards and						Raising

Recognitions		Explore venues and events and other possible mechanisms to offer recognition for individuals and organizations that address reduction of unintentional harms	Team	On-going		awareness of unintended systemic harms
Community Partners		Identify possible community partners that are already addressing unintended harm	Team	October 1, 2013 and on-going		Expanding network of allies throughout Arkansas and educating about recovery in behavioral health

Strategy 5: *Integration of Behavioral Health Services*

Inputs (Resources)		**Action Plan Steps**				**Outcomes**
		Activities	**Participants** (responsible party)	**Timeline**		
SAMHSA Literature		-Collect articles and information to develop concepts about many ways to envision recovery as well as how to implement Peer/ Consumer-driven recovery -Hold dialogues to gain shared understandings about consumer/ peer-driven recovery -Develop Consensus Statement about Peer/ Consumer-Driven Recovery - Initiate dialogues with key staff to identify points that need addressing to infuse recovery from	Loretta Cochran Linda Donovan Whole Team Whole Team Whole Team Whole Team	July16, 2013 and on-going		Beginning to address systemic culture change toward sustainable, overarching use of Recovery framework

		diverse peer/ consumer perspectives				
Recovery Oriented System of Care 'No Wrong Door' to Recovery and Individual-ized Recovery		Through Arkansas BRSS TACS Team, continuing dialoguing to develop shared understandings about the rational of 'no wrong door' to recovery	Whole Team	On-going		Beginning to address systemic culture change toward sustainable, overarching use of Recovery framework
Inclusivity and Cultural Competency Practices		Identify specific gaps in knowledge, abilities and skills Team has to implement an inclusive workforce that appreciates the unique values of peer workers in the services/ supports array. Begin to develop information and strategies for effectively engaging statewide stakeholders about inclusivity	Linda Donovan Loretta Cochran	July 9, 2013 and on-going		
Using national instruments, track outcomes showing Recovery-driven instruments that measure outcome indicators of recovery values throughout the behavioral health system of care		Identify instruments and discuss feasibility to apply	Kazi Ahmed Linda Donovan Loretta Cochran	July 16, 2013		Demonstrate impact of changes toward state-wide Consumer/ Peer-Driven Recovery
BRSS TACS 2013 Policy						Educate stakeholders

Academy Initiative to Transform Behavioral Health Care System		Disseminate information about Ark. BRSS TACS 2013 Policy Academy and Systems Transformation at various Conferences and Meetings	Tina Light Carl Jackson Loretta Cochran Linda Donovan	Beginning August 5, 2013 ABHPAC Strategic Retreat, August 7, 2013 Behavioral Health Institute and date TBA Consumer Counts Conference		about the BRSS TACS strategic initiative using Peer/ Consumer-driven Recovery

Budget

Award $50,000.00

Community Conversations Lunches for 150 lunches @$15.00 per lunch Per site (Monticello, Clarksville, Benton/ Bryant, Helena/ W. Helena and Texarkana) 4 Administrators (including Addiction and Mental Health Centers CEOs, Clinical Directors of Addictions and Mental Health Centers) 4 People with Lived Experiences from each area 1 Prevention Resource Center Regional Prevention Representatives (coordinating the events) (*Note: 10 individuals attending each of three meetings for a total of 30 individuals per site is the maximum estimated number of attendees; in the event there are fewer, these funds will be shifted toward Scholarships for CPS Training)	**$ 2,250***
Honorariums @$160/ day for 3 face to face meeting days for 2 People with Lived Experience	**960**
Lunches and Breaks for 3 days of Policy Academy On-Site Visits	**1,845**
Training	
Providing a four-day regional Certified Peer Specialist (CPS) Kick-off event for the state of Arkansas by the Mental Health Association of Southeastern Pennsylvania, Institute for Recovery and Community Integration	**10,450**
Conduct One (1) CPS Training Class (20 participants per class)	**25,780**
Scholarships for CPS Training	**8,715**
Total	**$50,000**

M. Recovery

Arkansas has not adopted a definition of recovery. The Division of Behavioral Health Services (DBHS) has identified this as a priority within the Block Grant. Steps have been outline with performance indicators and an overarching strategy that will ensure the inclusion of recovery oriented care in service plan developing across all behavioral health services.

In 2012, DBHS adopted a new mission statement inclusive of recovery:

> The Division of Behavioral Health Services provides leadership and devotes its resources to facilitate:
>
> - Effective prevention;
> - Quality treatment; and
> - Meaningful recovery

DBHS also adopted new goals:

> The Division of Behavioral Health Services facilitates services that are:
>
> - Trauma informed
> - Gender sensitive
> - Recovery based
> - Age Informed
> - Culturally and linguistically competent
> - Client centered
> - Family driven
> - Evidence based/informed
> - Cost effective
> - Performance and outcome driven

Currently, DBHS does not have a clearly defined Office of Consumer Affairs.

Arkansas does have some payment mechanisms that are already in place to be able to support some types of Self-Directed Care. At this point, there is no Self-Directed Care in Arkansas for people with primary mental health and substance use labels. At this point, there is no Participant-Directed Care in Arkansas for people with primary mental health and substance use labels. This has been recognized as an area that needs more focus

Efforts are underway to address the limited array of recovery supports and services in Arkansas. A 1915i State Plan Amendment has been developed and will include a more vigorous array of recovery supports and services, including peer support services, supported employment, and life skills development. NAMI Arkansas presently staff's the state's only statewide warm line, which is not available 24/7.

DBHS will continue to advocate for recovery based services to be funded through Medicaid. Additionally, DBHS is currently working to identify workforce development and training opportunities to ensure the workforce is prepared to delivery recovery oriented services. Once

the new Medicaid system is in place, DBHS will be identifying supplemental services to ensure a wide array of person centered and recovery oriented services are available.

Currently, the State does not have an accreditation program, certification program, or standards for peer-run recovery centers.

Through the State Epidemiology Outcomes Workgroup (SEOW), Arkansas is well positioned to build on state epidemiologic data to serve as a catalyst to receive and sustain future grant funding. One example of the data-driven approach is to actively try and identify the best approach to disseminate Prevention materials that are the most effective for Arkansas.

SAMHSA launched the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) initiative 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. Expanding recovery concepts through dialogues encourages multiple recovery perspectives from various Recovery Communities, such as People in Recovery from Addictions, from Mental Health Problems and/or Trauma, thus ensuring each unique individual's pursuit of recovery, based on her or his unique understanding. Additionally, the Policy Academy activities educates administrators, providers, and other stakeholders about the benefits of Peer, Youth and Family Support Partners; preparation to integrate the positions into the workforce and utilize the services in such a way as to maximize the benefits of the service/support positions. These activities will be addressed through holding Community Conversations at selected locations across Arkansas and with additional Technical Assistance from BRSS TACS that addresses systemic culture change toward sustainable, overarching use of the Recovery as the guiding framework.

Arkansas Behavioral Health Planning and Advisory Council (ABHPAC) has a Block Grant Committee that is composed of 12 to 15 ABHPAC members (families, consumers and other stakeholders). This committee has been in place for about 12 or 13 years. The committee begins to meet 6 – 7 months before the DBHS is scheduled to write. That allows ABHPAC to provide input to guide DBHS early in planning. ABHPAC completes a SWOT every year to gather information from its members regarding the current state of the behavioral health system.

Through the Children's System of Care, the DBHS distributes $2500.00 to each of the 14 areas for family support and advocacy training. In addition, DBHS provides funding to the Arkansas chapter of NAMI to provide advocacy and assistance to consumers of mental health services.

The State of Arkansas adheres to the principal of Housing First, also known as "rapid re-housing" which is evidence based program. Housing First is a relatively recent innovation in human service programs and social policy regarding treatment of the homeless and is an alternative to a system of emergency shelter/transitional housing progressions. Rather than

moving homeless individuals through different "levels" of housing, known as the Continuum of Care, whereby each level moves them closer to "independent housing" (for example: from the streets to a public shelter, and from a public shelter to a transitional housing program, and from there to their own apartment in the community) Housing First moves the homeless individual or household immediately from the streets or homeless shelters into their own apartments.

Housing First approaches are based on the concept that a homeless individual or household's first and primary need is to obtain stable housing, and that other issues that may affect the household can and should be addressed once housing is obtained. In contrast, many other programs operate from a model of "housing readiness" — that is, that an individual or household must address other issues that may have led to the episode of homelessness prior to entering housing.

Housing First model, used by nonprofit agencies throughout America, also provides wraparound case management services to the tenants. This case management provides stability for homeless individuals, which increases their success. 1) It allows for accountability and promotes self-sufficiency. The housing provided through government supported Housing First programs is permanent and "affordable," meaning that tenants pay 30% of their income towards rent. Housing First, as pioneered by Pathways to Housing, targets individuals with disabilities. 20 This housing is supported through two HUD programs. They are the Supportive Housing Program and the Shelter Plus Care Program. 3) Housing First model has been recognized by the Substance Abuse and Mental Health Services Administration as an Evidence-based practice.

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. Some of the available services under this grant include:

- outreach services
- screening and diagnostic treatment services
- habilitation and rehabilitation services
- community mental health services
- alcohol or drug treatment services
- staff training, including the training of individuals who work in shelters, mental health clinics, substance abuse programs, and other sites where homeless individuals require services
- case management services
- supportive and supervisory services in residential settings
- referrals for primary health services, job training, educational services, and relevant housing services
- minor renovation, expansion, and repair of housing;
- planning of housing
- technical assistance in applying for housing assistance
- improving the coordination of housing services
- security deposits

- the costs associated with matching eligible homeless individuals with appropriate housing situations
- 1-time rental payments to prevent eviction

IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?

4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?

5. How is the state's budget supportive of implementing the Strategic Prevention Framework?

6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)

7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

PREVENTION FOR A HEALTHY ARKANSAS

12/31/2012

Strategic Plan for Five Years

ARKANSAS DEPARTMENT OF HUMAN SERVICES

This Strategic Plan was prepared with a grant from the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention administered through Arkansas Department of Human Services, Division of Behavioral Health Services and approved by the Arkansas Alcohol and Drug Abuse Coordinating Council

Prevention for a Healthy Arkansas

STRATEGIC PLAN FOR FIVE YEARS

Arkansans will be drug-free and mentally healthy

The vision is very complex in its simplicity. It is rooted in a mission to:

- Educate citizens,
- Empower communities,
- Encourage collaboration, and
- Enhance prevention efforts through community mobilization to foster a healthy and positive environment.

In order to reach such a broad vision, it is imperative that a collaborative effort be undertaken by state agencies and communities alike in order to improve the lives of our fellow citizens in Arkansas. Certain core values are inherent in that effort. These include:

- Every person matters.
- Families matter.
- Empowered people help themselves.

The Division of Behavioral Health Services provides leadership and devotes resources to facilitate:

- Effective prevention;
- Quality treatment; and
- Meaningful Recovery

Introduction

In September 2011, the Arkansas Department of Human Services, Division of Behavioral Health Services received a Strategic Prevention Enhancement grant and set out to develop just such a collaborative effort. A meeting was held at the C.H. Vines 4-H Center in Ferndale Arkansas with representatives of professional associations, state agencies, community organizations, and special services agencies.

The Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP), FY2011 Strategic Prevention Framework State Prevention Enhancement grant (SPE grant) is designed to strengthen and extend SAMHSA's national implementation of the Strategic Prevention Framework (SPF), support states in strengthening and enhancing their current prevention infrastructure and to foster more responsive and interactive state prevention systems. The SPE grant is intended to support states and territories in building prevention capacities and enhancing prevention efforts by aligning the prevention infrastructure through the myriad State agencies offering prevention programs or providing direct prevention services and collaborating with other prevention stakeholders in the state to reduce the effect of substance abuse.

The Arkansas Department of Human Services (DHS), Division of Behavioral Health Services (DBHS) Prevention Section is the single state administrative authority responsible for the planning, development, implementation, regulation, and evaluation of substance abuse service in Arkansas. The Arkansas DBHS understands that substance abuse exists within the context of a larger environment and must be addressed by a collaborative effort across multiple agencies and sections; hence it is currently in the process of integrating the services of its main four sections - Prevention, Treatment, Recovery and Mental Health - for a more comprehensive behavioral health service.

The Arkansas Strategic Prevention Framework State Prevention Enhancement Grant (SPF SPE) project will enhance the state prevention infrastructure by bringing together State agency policy makers, health care providers, and public health personnel to be trained on the use of the Strategic Prevention Framework (SPF) planning process for planning future efforts. The plan will also strengthen and support the efforts of behavioral health providers, key stakeholders, and regional and community-level prevention coalitions.

Along with the goals and objectives of the strategic plan, this document includes some basic prevention theory and knowledge, a list of recommended evidence-based programs and strategies, and information about available data used for making effective decisions for community based work preventing substance abuse while promoting mental health. A description of the process used in development of the plan is also included.

The Strategic Prevention Framework process was followed to guide discussions and develop this plan. The process was also presented to various organizations and agencies throughout the state. A further discussion of the process can be found on page 21.

The plan is arranged to show the overarching goals of reducing alcohol use, prescription drug use, and suicide along with tobacco use. These goals also address enhancing collaboration among state agencies and community sectors while improving and increasing the prevention workforce.

A goal of this project is to align the State prevention infrastructure through State agencies, health care, and public health, which will be measured by future projects utilizing braided funding and joint efforts. A diverse workforce made up of health care professionals, public health professionals, and State agencies that are trained in the SPF and utilizes prevention practices within its scope of work will be a measure of this project. Another goal is to identify prevention data funded by the State and to data systems together so that communities will have easy access to prevention data for planning prevention activities.

In order to accomplish these goals, specific objectives and strategies which address underlying steps have been arranged according to the Strategic Prevention Framework process. For example, strategies for collecting data are listed under the first SPF step of assessment and the strategies tie to Goal of assessment. Strategies for the goals of collaboration and workforce development are listed under the SPF step for capacity building. Many of the objectives and strategies are cross-cutting and serve as conduits to establish skills and abilities to address the overarching goals in a broad sense.

The DBHS Prevention Section has developed this five- year strategic prevention enhancement plan to strengthen the behavioral health infrastructure and to enhance the health and safety of Arkansas citizens through the reduction of the overall impact of behavioral health problems.

The plan reflects year-long efforts by five workgroups formed from that initial meeting; four Capacity Building/Infrastructure Enhancement workgroups and an Evidence-based practices workgroup were developed to address the issues of:

- Training and Technical Service,
- Coordinated Services,
- Data Collection, and
- Evaluation

The Arkansas Alcohol and Drug Abuse Coordinating Council, because of its established membership of key leaders, were asked to serve as a policy consortium to provide oversight of this project and move the plan forward.

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WHAT IS PREVENTION?

Prevention is defined as interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder. (Preventing Mental, Emotional and Behavior Disorders Among Young People, National Research Council and Institute of Medicine, 2009)

The same report defines mental health promotion as interventions that aim to enhance the ability to achieve developmentally appropriate tasks and a positive sense of self-esteem, mastery, well-being, and social inclusion to strengthen the ability to cope with adversity. The report also strongly recommended that prevention and promotion work hand-in-hand to provide the best environment for youth and young people.

Prevention begins within communities by helping individuals learn that they can have an impact on 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.

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 creating population level changes, within the cultural context, in order to reduce risks and strengthen ability to cope with adversity.

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.

Much of Arkansas' prevention work is based on the risk and protective factor approach to prevention of problem behaviors developed from 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 the individual themselves and their peer interactions. Many of the problems 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.

Building coordinated prevention efforts through collaboration with state agencies, community organizations and special populations offer multiple strategies provide multiple points of access and coordinate and expand citizen participation in community activity as a most promising approach to preventing alcohol and other drug problems and youth related violence. A comprehensive approach to a particular problem or behavior is an effective way to achieve the desired permanent behavior or normative change.

Although there are a significant number of effective prevention programs and strategies across the Nation, they have not been coordinated to work together or fully integrated within our overall health care systems. All health-related prevention efforts should recognize and address the interrelated impact of mental health and substance use on overall well-being. (Description of a Modern Addictions and Mental Health Service System, SAMHSA, 2010)

Prevention Categories

Institute of Medicine's categorical definitions listed below.

Universal

These interventions are targeted and are beneficial to the general public or a general population. Two subcategories further define universal interventions:

- **Universal Indirect** provides information to a whole population who has not been identified as at risk of having or developing problems. Interventions include media activities, community policy development, posters, pamphlets, and internet activities. Interventions in this category are commonly referred to as environmental strategies.

- **Universal Direct** interventions target a group within the general public who has not been identified as having an increased risk for behavioral health issues and share a common connection to an identifiable group. Interventions include health education for all students, after school programming, staff training, parenting class, and community workshops.

Selective

This category of prevention interventions targets individuals or a population subgroup whose risk of developing mental or substance abuse disorders is significantly higher than average (prior to the diagnosis of the disorder). Examples of interventions include group counseling and social/emotional skills training for youth in low-income housing developments, and a clinician facilitated group discussion that provides education and support to families with parental depression.

Indicated

These interventions target individuals at high risk who have minimal but detectable signs or symptoms of mental illness or substance abuse problems (prior to a DSM IV diagnosis1). Examples include programs for high school students who are experiencing problem behaviors such as truancy, failing academic grades, juvenile depression, suicidal ideation, and early signs of substance abuse.

STRATEGIC PREVENTION FRAMEWORK

To meet the cross-system approach that health promotion and disease prevention demand, the U.S. Department of Health and Human Services has developed the Strategic Prevention Framework (SPF). The SPF implements a five-step process known to promote youth development, reduce risk-taking behaviors, and prevent problem behaviors across the life span. It is designed to build on science-based theory and evidence-based practices. To be effective, the SPF supports that prevention programs must engage individuals, families, and entire communities to achieve population level change. The SPF steps are used to:

1. Assessment – Determines needs, resources and causes of community issues
2. Capacity – Development of skills and knowledge for community members to address issues
3. Planning – Determines the best practices, strategies and action plans to be used to address issues
4. Implementation – The actual work done to address the issue
5. Evaluation – Reviews the process of implementation so adjustments can be made in the process, records success, and determines if goals were met.

SUMMARY OF ARKANSAS PREVENTION INFRASTRUCTURE

The Prevention Section of the Division of Behavioral Health Services (DBHS), Department of Human Services (DHS) is the single State agency responsible for substance abuse prevention in the State of Arkansas.

Funding for prevention services in Arkansas is solely through the Substance Abuse Prevention and Treatment (SAPT) Block Grant, Strategic Prevention Framework State Prevention Enhancement Grant (SPE) and a grant for State Epidemiology Workgroup (SEW). The State government does not allocate any general revenue to DBHS Prevention Section for prevention services.

The mainstay of DBHS Prevention Services is the 13 regional Prevention Resource Centers (PRCs) that function as intermediary structures to mobilize, facilitate, and support communities in planning, developing, implementing, and sustaining effective efforts to prevent and reduce alcohol and other drug abuse. The PRC provide technical assistance to local service providers, schools, agencies, and organizations within their respective regions. The PRCs promote evidence-based prevention programs to their communities by working with county coalitions, policy makers and other stakeholders in their regions.

The States' data infrastructure, includes the Arkansas Prevention Needs Assessment (APNA) Survey administered to Arkansas' youth in grades 6, 8, 10, and 12 to measure students' alcohol, tobacco and other drug (ATOD) use, antisocial behavior and delinquency, mental health, and violence. APNA Reports are accessible on line at the ADAP web site at http://preventionworksar.com/Home.aspx; The Risk Factors for Adolescent Drug & Alcohol Abuse in Arkansas (ARF) is a compilation of data reported by various state agencies (e.g. Department of Education, Highway Safety, Tobacco Control Board, AR Beverage Control, Department of Health, Division of Youth Services, etc.) which compilation provides DBHS providers, communities, schools, agencies, and organizations with readily accessible data needed for effective planning of prevention efforts. This report can be assessed online at http://preventionworksar.com/RiskFactorsData.aspx; The CORE Alcohol and Drug Survey was developed in the late 1980s by the U.S. Department of Education and advisors from several universities and colleges to measure alcohol and other drug usage, attitudes, and perceptions among college students at two and four-year institutions. More information on the CORE survey is available online at http://www.siu.edu/departments/coreinst/public_html/; The Arkansas State Police Highway Safety Office publishes annual reports that include information about vehicle and motorcycle accidents in a variety of situations (e.g. involving alcohol, inclement weather, varying road conditions, and different times of day) for both fatal and non-fatal crashes. These reports also include trending for year and age of driver as well as county and city statistics. Full reports can be found at http://www.asp.arkansas.gov/hso/hso_index.html; The State Epidemiological Workgroup (SEW) acquires and analyzes data from various sources, including but not limited to APNA survey, Alcohol Epidemiology Data System, Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavioral Surveillance System (YRBSS), CORE Alcohol and Drug Use Survey, National Survey on Drug Use and

Health (NSDUH), National Vital Statistics System (NVSS), and State Tax Data. More information on the State Epidemiological profile can be found online at http://preventionworksar.com/StateEpidemiologicalWorkgroupSEW.aspx; and the Prevention Reporting Management Minimum Data Set (MDS).

DBHS Prevention Section provides training opportunities for individuals interested in substance abuse prevention through the MidSouth Summer School and the MidSouth Prevention Institute (PI). More than 800 substance abuse professionals attend the annual MidSouth Summer School 5-day conference. The MidSouth PI conducts annual needs assessment of the workforce and provides substance abuse training statewide throughout the year.

DBHS Prevention Section collaborates with the Arkansas Colligate Drug Education Consortium (ACDEC) to provide opportunities for individual college and university campuses to initiate and maintain ongoing ATOD prevention and education programs.

The Arkansas Prevention Certification Board (APCB) is another agency devoted to the promotion of effective substance abuse prevention. APCB is an affiliate of the International Certification Reciprocity Consortium (ICRC) and provides the testing opportunities for Arkansans wishing to be certified in substance abuse prevention services.

DBHS Prevention Section contracts with RTI International to conduct monitoring and evaluation activities at the State and community levels to ensure that the prevention programs are achieving the milestones of assessment, capacity building, planning, and implementation. To track progress of prevention services, RTI evaluators conduct both process and outcome evaluations. RTI also provides technical assistance to DBHS Prevention Section staff and coalition members on needs assessment and evaluation.

In terms of personnel, the DBHS Prevention Section currently has three permanent staff, including the Program Coordinator, Project Officer, and an Administrative Assistant.

STATE INFRASTRUCTURE NEEDS IDENTIFIED

1. Need to source more funding from the state government and braiding of funds with other agencies.

2. Increase collaboration among behavioral health organizations

2. Restructuring of the technical assistance system at the regional/community level

3. Comprehensive data management system

4. Need for more behavioral health training and certification capacity

6. Need for more prevention services staff at the state and local levels.

COMMUNITY LEVEL BEHAVIORAL HEALTH NEEDS IDENTIFIED

Regional meetings were conducted around the state by the Prevention section of the Division of Behavioral Health as a listening tour. The aim of these meetings was to bring community members together to discuss behavioral health issues within their communities. Participants were asked to discuss major behavioral health issues seen in the counties how these issues have impacted their communities, why the communities believed the issues were occurring and what infrastructure and resources they have in place to tackle these issues. The participants were also asked what training and assistance they needed from DBHS. These meetings involved the first two stages of a five-step approach to data-driven practice: Assessment, Capacity-building, Planning, Implementation and Evaluation

Throughout the series of community focus group meetings held around the state, certain topics of concern consistently arose. Chief amongst those was parenting education and parent involvement in their children's live. Alcohol and prescription drug misuse was also consistently expressed as a problem in communities. Homelessness was discussed at every meeting as either a major problem or a consequence of another problem. Suicide, technology, and social media also regularly appeared as issues or consequences.

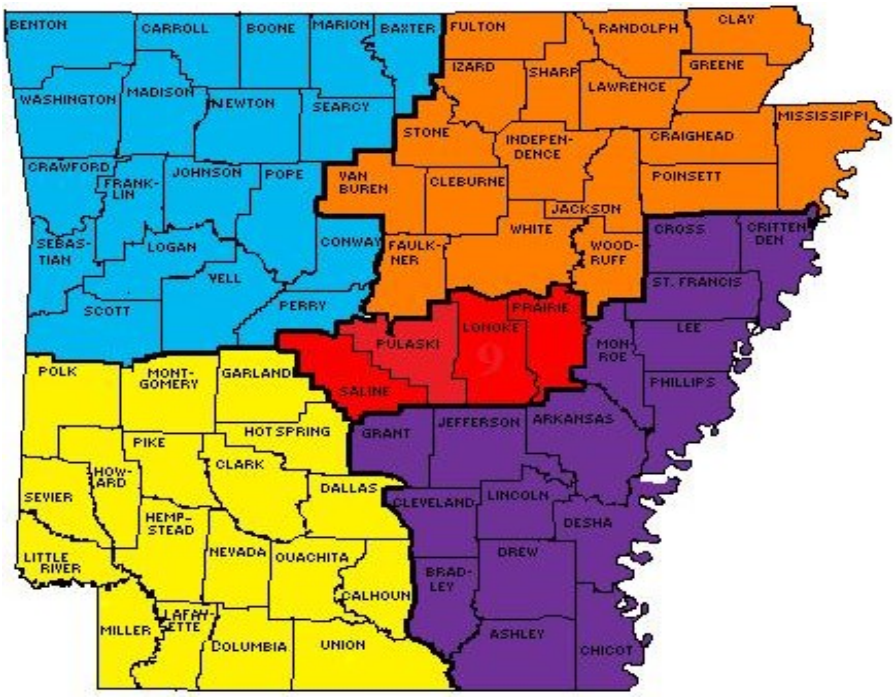
Lack of community resources and barriers to accessing community resources were reoccurring themes also. The rural nature of Arkansas, coupled with the poverty level, cause transportation to be a major barrier as many people in need of behavioral health services either do not have vehicles, cannot afford gas, or do not have access to public transportation to travel to prevention, treatment, and recovery resources. The number of people per square mile varies from 500 to 12, therefore, the number of service providers vary as well with some locations having many providers and some have very few.

Community meetings were held in the following five cities representing northwest, northeast, central, southeast and southwest communities in the state:

- Northwest Arkansas (Huntsville, Madison Co.) – Religiosity, inadequate mental health services, high alcohol use rate
- Northeast Arkansas (Walnut Ridge, Clark Co.) – lack of mental health treatment resources, breakdown of family unit and prescription drug abuse
- Central Arkansas (North Little Rock, Pulaski Co.) – Lack of community resources, breakdown of family structure and stigma for seeking services

- Southeast Arkansas (Dumas, Desha Co.) – education, economic hardships, and cultural issues
- Southwest Arkansas (Hope, Clark Co.) – lack of community networking, lack of parental involvement and lack of transportation.

See appendix VII for top three of the factors participants listed as major contributors to behavioral health issues in each of the regions.



Each meeting also brought forth unique issues as well. Religiosity as a risk factor rather than a protective factor was brought out in a discussion of how treatment is sometime not sought or dogma gets in the way of the faith-based community working together. Loss of identity by young men in a particular culture was a concern as they move from family to girlfriend's home without working, possessing property or having responsibilities that lead to life purpose. Hunger came forth in more than one meeting as an issue. Teen sexual health was linked to behavioral health through substance use, peer pressure, and stress of unplanned pregnancies.

At each community meeting, participants were asked the following questions:

a. What are the five biggest substance abuse and mental health problems in your county? Put these inside a large circle in the middle of each page.

b. What are the consequences for each of the problems? Place the consequences in smaller circles attached to each of the large circles.

c. What factors cause these five problems? Place these in small circles either attached to the large circle or attached to the consequences.

d. Are there common factors or consequences you see in each of the five problems?

TRAINING NEEDS IDENTIFIED

The Mid-South Prevention Institute (MSPI) administers an annual training needs assessment and provides a statewide report on training and technical assistance needs. The training needs assessment survey is given to substance abuse prevention providers, substance abuse treatment providers, mental health treatment providers, law enforcement personnel, Department of Education staff, Department of Community Correction staff, Department of Health Staff, social workers and counselors and other stakeholders.

The top ten (10) training needs as identified by survey respondents based on Prevention Workforce Needs Assessments in September 2011 are as follows:

	# of Respondents	Training Needs Identified
1.	320	Conducting a community assessment
2.	310	Creating and maintaining coalitions and partnerships
3.	308	Using Institute of Medicine categories to select the appropriate strategy
4.	147	Writing grant applications for funding
5.	120	Assessing community needs and resources
6.	116	Developing interventions
7.	108	Describing the process of addiction
8.	108	Knowledge of current trends in drug use patterns
9.	106	Creating a sustainability plan
10.	106	Maintaining proficiency in technology, facilitation and presentation skills

See appendix VIII for MidSOUTH Prevention Institute 2011 Training Survey and statewide reports.

PRIORITY SUBSTANCE ABUSE PREVENTION NEEDS (*RFA Section 2.3.1a*)

According to a report by PIRE as quoted in the Arkansas Epidemiological Profile, Arkansas has the fourth highest percentage of underage alcohol consumption when compared to other states. Fortunately, significantly fewer Arkansans age 12 to 20 reported binge drinking when compared to the national population. The Arkansas Prevention Needs Assessment still indicated alcohol is the most used drugs by students in 6th, 8th, 10th, and 12th grade despite efforts to lower the usage rate during the Strategic Prevention Framework State Incentive Grant. Arrest by adults for both public drunkenness and liquor law violations have increased. Alcohol remains the most common reason that adults seek treatment with 39% of residential treatment admissions being for alcohol.

For these reasons**, alcohol** is the first priority to be addressed in this strategic plan.

According to the Arkansas Epidemiological Profile, a significantly higher percentage of Arkansas youth consume tobacco products than the broader youth population in the United States. While cigarette use among youth has declined, it remains the most common type of tobacco product consumed. Use of chewing tobacco, snuff, and dip has remained unchanged among youth. Arkansas youth begin smoking at a very young age compared to national figures and this younger age of initiation may be a major contributing factor to the higher smoking rates of adults. As a percentage of their age group, more young adults (18 to25) use tobacco products than older adults do. Younger adults are less likely to believe that smoking poses a great risk to their health than other adults in Arkansas. Overall, as a percentage of the total population, fewer adult Arkansans accept that smoking poses a risk to their health than other U.S. residents. Smoking prevalence varies significantly with education and income. The least educated and lowest-income Arkansans are far more likely to smoke.

Tobacco will be the second priority to be addressed in this strategic plan.

Arkansas has a slightly higher percentage of nonmedical use of pain relievers in the past year for both teen and adult populations compared to national percentages. At one time, Arkansas had the fastest growing trend for this use in the nation. Sedative use appears to be higher among Arkansas school children than in the rest of the nation. The Arkansas rate of drug-induced deaths was higher than the national rate. Arkansas National Guard ranks high compared to the nation for positive drug screens. Treatment for opiates such as pain relievers is the third most common reason for admission to residential treatment.

Although much work has been done to lower usage of **prescription drugs**, much is still to be done and therefore, prescription drugs will remain a priority to be addressed in this strategic plan.

Substance abuse may be associated in half of suicide cases. Suicide is the 11th leading cause of death in Arkansas. People with alcohol problems constitute about 20% of suicides. Youth who report substance abuse are at higher risk for suicide. According to a recent report from the Office of Coordinated School Health, 14% of high school students seriously considered attempting suicide and 10% actually attempted suicide. There were 1692 attempted suicides across all ages in 2010 according to the Arkansas Department of Health's Injury Prevention section.

While the exact level of connection to the use of substances mentioned above has not been determined, it is known that a significant number of Arkansas National Guard units served multiple deployments during the conflicts in Iraq and Afghanistan. They return home with injuries (both physical and mental) which increase their risk of misusing substances, especially alcohol and prescription drugs. The Arkansas National Guard also ranks high in the nation for suicides. The stress on the family members at home was also tremendous and increases risk factors related to substance abuse.

Because of deeply held values and norms within the state, those residents with sexual orientations other than heterosexual are often isolated and intimidated. Therefore, more concrete data about this population has been hard to obtain. Antidotal data from youth within this population report an increased risk for both substance abuse and suicide. Therefore **suicide**, especially among these special populations, will be a priority within this strategic plan.

SHORT TERM AND LONG TERM CONSEQUENCES *(RFA Section 2.3.1b)*

Because Arkansas has a relatively high uninsured population, this means an increasing number of adults may have difficulty accessing services that could help them or that the burden for treating those with substance abuse will be increasingly shifted to the state. This cost shift may come in the form of higher demand for public mental health and substance abuse services or increased demand placed on the criminal justice system.

Substance abuse is also associated with many adverse health consequences. There is a high prevalence for chronic disease such as high blood pressure, diabetes, and heart disease. Poor mental health is one of the many risk factors to substance abuse and Arkansas youth experience major depressive episodes at a rate higher than national level for those ages 12-25. Both physical and mental health can be linked to specific cause of mortality in Arkansas. Of the top five causes of death in Arkansas, four may be caused or exacerbated by alcohol, tobacco, and other substance abuse. Thus, there is the potential for a portion of these health costs to also be shifted to the public responsibility via the Medicaid programs. The recession had already brought an increased number of new enrollees to Medicaid related programs and there is reason to anticipate a further increase in enrollees under the Affordable Health Care Act.

While these increased costs are primarily felt at the state level, there is a trickle-down effect for the communities through taxation. The following discussions of consequences are felt at both the state and community levels. At the community level, some are short-term and immediate effects with a pattern of behavior having the long-term consequences. It is the pattern of behaviors that cause the state level consequences.

Alcohol

According to the CDC, motor vehicle accidents are the leading cause of death among youth. In 2011, 26% of high school students reporting riding in a car or other vehicle driven by someone who had been

drinking alcohol and 8% of students who reporting drinking said that they had driven a car or other vehicle when they had been drinking.

The rate of alcohol- or drug-related traffic crashes was 1.4 per 1,000 population and the rate of crash injuries was 0.9 and the rate for crash fatalities was 0.1 per 1,000 in 2010. While there has been an 18% increase in alcohol-or drug-related traffic crashes, there has been a 45% decrease in alcohol-or drug-related injuries. This paradox may be partially explained by seat belt violations becoming a primary offense during the time.

In addition to legal problems and driving related injuries or death, alcohol abuse poses health risks. It can alter the still developing bran and lead to dependency even at an early age. The data suggests an association between alcohol use and lower academic performance. Heavy drinking can lead to health problems such as liver disease, pancreatitis and high blood pressure. Liver Disease was the 13th cause of death in Arkansas and hypertension was the 12th.

Alcohol abuse is also linked to high-risk sexual practices that can lead to pregnancies and sexually transmitted disease. Arkansas had a teen pregnancy rate over 1,700 in 2010 and there were 20,584 cases of sexually transmitted disease. Drinking during pregnancy is especially hazardous to the unborn child. While the number of women using alcohol while pregnant has been decreasing in Arkansas, the number of women pregnant while in treatment has increased.

Tobacco

Because the effects of tobacco consumption can take many years to manifest, the primary consequence for youth is the social effect of tobacco infractions at school which takes away time that the students would have devoted to study. In 2010, over 600 tobacco infractions occurred at the elementary and middle school level and over 2,000 at the high school level. This early age of initiation establishes life-long unhealthy habits which result in the health consequences seen in adults.

According to the American Cancer Society, an estimated 2,660 Arkansas developed lung or bronchial cancer in 2011. Additionally, approximately 2,030 Arkansans died of lung or bronchial cancer in 2011 that they had developed previously. Smokeless tobacco has been associated with increased risk of cancer of the oral cavity, gum disease and tooth decay. Insurance costs cause employers and non-smoking employees to be subsidizing the health care cost for smoking decisions.

Drug-related consequences

Arkansas had a narcotic arrest rate of 5.4 per 1,000 population age 18 and older and 3 per 1,000 for population under 18 in 2009. Over 30% of students reported laws and norms that favor drug use. Approximately 21% of arrests for drug possession involved barbiturates, narcotics, or stimulants.

The Arkansas rate of drug-induced deaths at 14.1 per 100,000 was higher than the national rate of 12.6 in 2008 and reflected a significant increase from the 2007 rate of 11.8.

DATA-DRIVEN GOALS AND OBJECTIVES (*RFA Section 2.3.2*)

Goals and objectives serve to ensure that strategies and activities selected for implementation will meet the needs identified during the assessment and capacity building phase of a planning effort. The Prevention Section of the Division of Behavioral Health Services, Arkansas Department of Human Services through the SPE efforts will strive to accomplish the following goals and objectives for the SFY 2013 through 2017.

Goal 1. Lower the reported 30 day alcohol usage rate according to the Arkansas Prevention Needs Assessment from 16.3% in 2011 to 13.3% by 2016.

Training and Technical Assistance Objective:

- 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.
- 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.
- Increase collaboration with Alcohol Beverage Control including coordinated merchant trainings and increase board responsiveness to communities desires surrounding private club permits.
- 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 Love and Logic, Guiding Good Choices, and Strengthening Families to Regional Prevention Representatives who will provide training in communities.

Coordination of Services Objective:

- 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.
- Initiate connection with the Arkansas Retail Beverage Association to solicit involvement by their merchant members in a social host law awareness campaign.
- Re-establish of the Arkansas Underage Drinking Prevention Taskforce to serve as an advocacy group.
- Develop a network of support providers focused on the LGBTQ population to enhance support network through consistent and strategic statewide services for LGBTQ concerns such as suicide and increased risk of substance abuse.
- Coordinate services for veterans, families, and other impacted by war to determine and fill gaps based on issues, geography, age, and gender.
- 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.

- Through MOUs, common terminology, and shared goals, design and implement leveraged funding with a common application process.

Data Objective:

- Develop survey about ATOD use among LGBTQ to be analyzed by DBHS Outcome and Performance section which can be administered through the LGBTQ consortium.
- Enhance or expand data being collected by veteran serving organization for ATOD usage.
- Analyze information collected during DASEP screenings to create aggregate data about adult usage risk factors.

Evaluation Objective:

- Implement standardized collection processes and expected measures for process and outcome data.

Goal 2. Lower the reported 30 day smokeless tobacco usage rate according to the Arkansas Prevention Needs Assessment from 5.6% in 2011 to 3.6% by 2016 and the cigarette usage rate from 8.8% in 2011 to 6.8% in 2016.

Coordination of Services Objective:

- Enhance coordination with Arkansas Dept. of Health Tobacco Prevention and Cessation and Arkansas Tobacco Control Board to coordinate trainings to create more community responsiveness.
- Initiate coordination with Arkansas Chapter of American Lung Association and the American Cancer Society to solidify coordinated efforts to reduce tobacco use.
- 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.
- 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.
- Through MOUs, common terminology, and shared goals, design and implement leveraged funding with a common application process

Training and Technical Assistance Objective:

- Coordinate efforts between Arkansas Tobacco Control Board, Arkansas Beverage Control, and DBHS for joint merchant education.
- Coordinate efforts around awareness campaign about law against smoking in cars with young children.
- 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 Love and Logic, Guiding Good Choices, and Strengthening Families to Regional Prevention Representatives who will provide training in communities.

Data Objective:

- Develop survey about ATOD use among LGBTQ to be analyzed by DBHS Outcome and Performance section which can be administered through the LGBTQ consortium.
- Enhance or expand data being collected by veteran serving organization for ATOD usage.
- Combine the Arkansas Prevention Needs Assessment and Youth Tobacco Survey.

Evaluation Objective:

- Implement standardized collection processes and expected measures for process and outcome data.

Goal 3. Lower the reported 30 day usage rate for prescription drugs according to the Arkansas Prevention Needs Assessment from 4.4% in 2011 to 2.1% by 2016.

Coordination of Services Objective:

- 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.
- Develop a network of support providers focused on the LGBTQ population to enhance support network through consistent and strategic statewide services for LGBTQ concerns such as suicide and increased risk of substance abuse.
- Coordinate services for veterans, families, and other impacted by war to determine and fill gaps based on issues, geography, age, and gender.
- 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.
- Through MOUs, common terminology, and shared goals, design and implement leveraged funding with a common application process

Training and Technical Assistance Objective:

- 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.
- Provide training about prevention to law enforcement, especially school resource officers, for better understanding of youth drug trends, behaviors, and appropriate environmental prevention strategies.
- 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.
- Work with addiction studies graduate students and Arkansas Dept. of Education to publish and make trainings about prevention available to all teachers so that they have a

better understanding of the science of addiction and how to work with individuals from substance addicted home.

- 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.
- 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 Love and Logic, Guiding Good Choices, and Strengthening Families to Regional Prevention Representatives who will provide training in communities.

Data Objective:

- Develop survey about ATOD use among LGBTQ to be analyzed by DBHS Outcome and Performance section which can be administered through the LGBTQ consortium.
- Enhance or expand data being collected by veteran serving organization for ATOD usage.
- Coordinate with the Arkansas Health Department to review data collected about prescribing trends through the Prescription Drug Monitoring Program.

Evaluation Objective:

- Implement standardized collection processes and expected measures for process and outcome data.

Goal 4. Lower the number of attempted suicide reported by the Arkansas Department of Health Injury Prevention from the 2010 rate of 1692 to 1400 by 2016.

Training and Technical Assistance Objective:

- Collaborate with Army One Source to provide training to social services providers, faith-based organizations and veterans support organizations about effects on veterans, families, and other impacted by war for better understanding of the behavioral health care needs of this special population.
- Provide training on suicide screenings to community providers and promote awareness of suicide as a preventable health issue by developing a better understanding the relationship between self-harm and mental health and substance abuse issues.
- 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 Love and Logic, Guiding Good Choices, and Strengthening Families to Regional Prevention Representatives who will provide training in communities.
- Train and provide technical assistance to the Arkansas Behavioral Health Policy Advisory Council to help this consumer advisory committee understand prevention and promotion of wellness.

Coordination of Services Objective:

- Develop a network of support providers focused on the LGBTQ population to enhance support network through consistent and strategic statewide services for LGBTQ concerns such as suicide and increased risk of substance abuse.
- Coordinate services for veterans, families, and other impacted by war to determine and fill gaps based on issues, geography, age, and gender.
- 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.
- Through MOUs, common terminology, and shared goals, design and implement leveraged funding with a common application process

Data Objective:

- Coordinate data about suicide attempts collected by the Arkansas Department of Health, crisis call placed to the Arkansas Crisis Center and cause of death data collected by the Arkansas State Crime Lab.

Evaluation Objective:

- Implement standardized collection processes and expected measures for process and outcome data.

PROCESSES AND PROCEDURES USED FOR PLAN DEVELOPMENT (*RFA Section 2.3.4*)

The Arkansas DBHS Prevention Section developed this Strategic Prevention Plan to contribute to meeting the overall mission of DBHS as well as specific outcomes in the behavioral health system. The prevention planning process is inclusive of community and state level stakeholders and takes into consideration the many needs and issues relating to behavioral health infrastructure, capacity and gaps in service throughout the state.

Following the award of the Strategic Prevention Framework State Prevention Enhancement (SPE) grant, the Prevention Section of Arkansas Division for Behavioral Services, Department Human Services obtained agreement from the Arkansas Alcohol and Drug Abuse Coordinating Council to serve as the State Policy Consortium (see State Policy Consortium members in appendix VI) and also convened a Stakeholders meeting as part of the requirements for the grant.

The Stakeholders kick-off meeting was held on September 22, 2011 and the theme of the meeting was 'Developing an Arkansas Prevention and Wellness Strategy'. More than 60 participants representing many agencies involved in substance abuse prevention attended the meeting. Stakeholders were briefed about the goals of the grant which include strengthening and extending SAMHSA's national implementation of the Strategic Prevention Framework; enhancing and aligning the prevention infrastructure through the myriad State agencies offering prevention programs or providing direct prevention services; and fostering more responsive and interactive state prevention systems.

From the stakeholders meeting, four (4) Capacity Building/Infrastructure Enhancement workgroups and an Evidence-based practices workgroup were formed. The different workgroups developed four (4) mini-plans that were submitted to SAMHSA/CSAP in December 2011 and revised in August 2012. The capacity building workgroups include;

- Coordination of Services Workgroup
- Technical Assistance and Training Workgroup
- Data Collection, Analysis and Reporting Workgroup
- Performance/Evaluation of Efforts Workgroup

An Evidence-based practices workgroup was developed to identify and select evidence-based programs and strategies that would address identified behavioral health needs and conceptual fits with the dynamics of Arkansas communities. Evidence-based strategies were selected to meet goals and objectives and will be implemented by the State and by community coalitions.

Community needs assessment meetings were held in five regions across the state to assess community readiness by identifying gaps in community behavioral health resources and needs in services, training and data collection and analysis. These meetings also assured community buy-ins because it allowed stakeholders to have an active part in the needs assessment, capacity building and planning process.

Numerous individual meetings with state agencies and organizations were held by DBHS staff. Plans created by those organizations were reviewed for commonalities to DBHS and CSAP initiatives.

A presentation of the Strategic Prevention Framework (SPF) was made to each of the groups involved in the planning process. All the groups were instructed to adhere to the components of SPF process during deliberations.

The Coordinating Council members participated in review and approval of the mini plans, and served on work groups that developed the recommendations and objectives for the plan. Recommendations in the “mini plans” were incorporated into the final goals and objectives in the State Prevention Enhancement Plan.

ARKANSAS'S STATE PREVENTION ENHANCEMENT (SPE) MINI-PLAN

PURPOSE

The Substance Abuse and Mental Health Services Administration (SAMHSA) grant requires the submission of four mini-plans for the Strategic Prevention Enhancement (SPE) grant from the Centers for Substance Abuse Prevention (CSAP). The four mini-plans include: Data Collection, Analysis and Reporting Plan; Coordination of Services Plan; Technical Assistance (TA) and Training; and Performance Management and Evaluation. The SPE grant will be used to act on the short-term and intermediate goals of these mini-plans and subsequently, on the longer term goals of a 5-year comprehensive state strategic prevention plan.

This document describes the potential framework for enhancing the Arkansas Behavioral Health System infrastructure by highlighting goals, implementing strategies and potential action plans for assessing internal processes, collaborating with other community and state organizations to identify types of prevention services and evidence-based programs(EBP), enhancing and developing new data collection processes, assessing training needs, and improving planning and evaluation methods needed to address the capacity for substance abuse prevention. The document also identifies responsible entities and time frames for addressing areas identified for enhancement within the state behavioral health system.

Information gathered during the process of mini-plan completion will serve as a roadmap for developing the 5-year strategic plan. The process is designed to be somewhat flexible to allow for adjustments in response to new information, resources, opportunities, and to best align the 5 year Plan with the Arkansas Behavioral Healthcare and Payment Improvement Initiative and the upcoming combined Block Grant application and plan.

See table below for list of acronyms used for responsible entities.

ADH	Arkansas Department of Health
AFMC	Arkansas Foundations for Medical Care
AG	Attorney General's Office
AOS	Army One Source
APCB	Arkansas Prevention Certification Board
APNA	Arkansas Prevention Needs Assessment
CAR	Center for Artistic Revolution
CHC	Community Health Center
CSOC	Children's System of Care
DASEP	Drug and Alcohol Safety Education Program
DBHS	Division of Behavioral Health Services
DCFS	Division of Children and Family Services
DHS	Department of Human Services
DHS IT	Department of Human Services Information Technology
DOE	Department of Education
DYS	Division of Youth Services
EBP	Evidence-based Programs and Practices
ISA	International Survey Associates
LGBTQ	Lesbian, Gay, Bi-sexual, Transgender, and Questioning
MISGRO	Minority Initiative Sub Grant Recipient Office
MSPI	MidSouth Prevention Institute
MSSS	MidSouth Summer School
NG	National Guard
PRC	Prevention Resource Centers
RTI	Research Triangle Institute
SDDO	State Drug Director's Office
SEOW	State Epidemiological Outcome Workgroup
TPCP	Tobacco Prevention and Cessation Program
UALR	University of Arkansas at Little Rock
UAMS	University of Arkansas Medical Sciences
UAPB	University of Arkansas at Pine Bluff
UDTF	Underage Drinking Task Force
YTS	Youth Tobacco Survey

Data Collection, Analysis and Reporting Mini-Plan

The Data Collection, Analysis and Reporting Mini-Plan reviews current state data system, identifies gaps in infrastructure, and explores opportunities for developing new or enhancing current State data systems to collect, analyze and report aggregated outcome and consequence data within the state system and across multiple agencies. Areas identified for enhancement in this category include:

1. Improve knowledge of all data sets used within the behavioral health service system;
2. Improve knowledge of all available state specific behavioral health system data available publicly and shared across state agencies and other sectors;
3. Improve comprehensive DBHS data collection and reporting infrastructure for consistent, reliable and usage of prevention data collection tools, procedures and reporting over time;
4. Creation of an on-line resource for aggregated behavioral health data for accessibility and utility of substance abuse-related health outcome information;
5. Updating the State Prevention System profile to be user friendly; and
6. Creation of a Behavioral Health System Performance tracking method.

Goal 1: Identify and assess the utilization of current data sets by state behavioral health system programs and services.		
Strategy: Undertake a systemic assessment of current data sets used by state prevention and mental health services to determine what data is used and what gaps in data or accessibility to data exist.		
Action Steps	**Responsible Entity**	**Timeline**
Review existing data sets to determine specifics of data sets currently being collected.	DBHS, AFMC	Dec. 2012
Identify gaps in data.	DBHS,AFMC, ISA	Jan. 2013
Explore data available through state data warehouse.	DBHS, DHS IT	Jan. 2013
Development of data collection instruments for special populations.	DBHS, RTI	May 2013
Review feasibility of merging APNA and YTS.	DBHS, ADH	May 2013
Goal 2: Review current behavioral health data available publicly and shared across state agencies.		
Strategy: Create surveys and meet with other agencies that collect behavioral health related data.		

Action Steps	Responsible Entity	Timeline
Survey State Policy Consortium for data collected by represented agencies.	DBHS, RTI	Jan. 2013
Conduct meetings with identified state agencies to assess available data.	DBHS	Apr. 2013
Goal 3: Explore the feasibility of creating a publicly-available site for the currently disparate data.		
Strategy: Create a web portal through which each data system can be identified and explained to make locating and using data easier and more effective.		
Action Steps	**Responsible Entity**	**Timeline**
Determine materials for the website.	DBHS, AFMC	Oct. 2012
Purchase domain and create website.	DBHS, AFMC	Oct. 2012
Promote website.	DBHS	Oct. 2012
Goal 4: Review and enhance current DBHS data infrastructure.		
Strategy: Review data collection capacity and reporting methods with a focus on (a) enhancing the ability to collect and report data in real time, (b) keeping data sets within DBHS rather than outsourcing.		
Action Steps	**Responsible Entity**	**Timeline**
Meet with DBHS data section and DHS IT section to discuss possibility of developing a new or enhancing current State data systems to collect, analyze and report data at all levels.	DBHS, DHS	Jun. 2013
Review and recommend contract oversight and language to insure data “ownership” and rights remain with DBHS.	DBHS, DHS	Dec. 2012
Goal 5: Review state prevention profile to meet the needs of the SPE project.		
Strategy: The State Epidemiological Outcome Workgroup (SEOW) will develop and use a mapping tool to evaluate current prevention network system and identify areas for enhancement to meet the goals of the SPE.		

Action Steps	Responsible Entity	Timeline
Identify members and invite to participate in the SEOW.	DBHS, SEOW	Mar. 2013
Guide SEOW in creating a user friendly profile with root causes, consumption & consequences.	DBHS, SEOW	Mar. 2013
Determine other data sets necessary for mapping project.	DBHS, SEOW	Mar. 2013
Goal 6: Create a Behavioral Health System Performance Framework and dashboard.		
Strategy: Develop a dashboard to track strategic priorities and capture behavioral health Outcomes, Access to Services, Service Delivery, and Collaboration efforts.		
Action Steps	**Responsible Entity**	**Timeline**
Collaborate with DBHS data section, state hospital, mental health section, treatment and recovery to provide input on development of dashboard.	All DBHS sections	TBD
Develop a Crosswalk between SAMHSA's National Outcome Measure Domains (NOMS) and existing DBHS Prevention Databases	DBHS	TBD
Identify gaps in NOMS that are not in the existing Prevention Databases	DBHS	TBD
Determine procedures to capture the remaining NOMS Data sets	DBHS	TBD
Dedicate a staff member to maintain the Dashboard and update NOMS on a regular basis	DBHS	TBD

Coordination of Services Mini-Plan

Effective coordination of services includes concepts of behavioral system integration, multi-sectorial collaboration, leveraging prevention services and resources (including braiding funds), minimizing duplication of services and promoting evidence-based and cost-effective services. Areas identified for enhancement in this category include:

1. Creation of inter-relationships across agencies and sectors involved in substance abuse and mental health's prevention, treatment, and recovery;
2. Improve knowledge of community capabilities for applying prevention and/or early intervention programs through coordination of efforts across sectors and disciplines;
3. Integrate existing behavioral health system networks, taskforces, and workforce; and
4. Promote State approved evidence-based prevention programs.

Goal 1: Identify current prevention services across Arkansas.		
Strategy: Meet with identified stakeholders to discuss ways of working collaboratively to capitalize on opportunities for cost savings from leveraging or braiding resources and services.		
Action Steps	**Responsible Entity**	**Timeline**
Identify existing partnerships.	DBHS, UALR, UAMS, UAPB, AHD (TPCP and Injury Prevention), C.A.R, SDDO	Jan. 2013
Identify and enhance relationships with additional partners.	DBHS, DYS, DCFS, HIV, DOE, AG, Drug Courts, CSOC, CHC	Jan. 2013
Review and identify opportunities for leveraging resources and funding.	DBHS, Partner agencies	Jan. 2013
Goal 2: Determine methods for assessing community readiness in the state.		
Strategy: Meet with regional coalition members to assess community readiness to implement prevention programs.		
Action Steps	**Responsible Entity**	**Timeline**
Facilitate community meetings to discuss collaborative efforts and leveraging of resources.	DBHS, PRCs	Apr. 2013
Review results of coalition leadership and consortium		

survey.	DBHS, RTI, PRCs	Apr. 2013
Goal 3: Identify ways to enhance provider networks to share information, lessons learned and ways to make changes to benefit the whole system.		
Strategy: Identify current provider networks and explore ways to develop collaborative efforts between the networks.		
Action Steps	**Responsible Entity**	**Timeline**
Conduct meetings with established networks of DBHS funded providers.	DBHS, PRCs, DASEP, Treatment providers	Mar. 2013
Solicit partnerships through engaging other coalitions and stakeholders	DBHS, Statewide Providers, Primary Care Networks and TBD	Feb. 2013
Re-establish the Underage Drinking Task Force.	DBHS, UDTF	Mar. 2013
Revitalize Suicide Prevention Task Force.	DBHS, Suicide Prevention Task Force	Jul. 2013
Goal 4: Identify members and invite to participate in the evidence-based program workgroup.		
Strategy: Develop criteria for establishing state-approved evidence-based programs and strategies.		
Action Steps	**Responsible Entity**	**Timeline**
Determine criteria to select best fit evidence-based programs and strategies for Arkansas communities.	DBHS, EBP Workgroup	Jul. 2012
Research evidence-based program registries for best fit evidence-based programs and strategies for Arkansas communities.	DBHS, EBP Workgroup	Jul. 2012
Outline resource structure for approved and recommended evidence-based programs.	DBHS, EBP Workgroup	Jul. 2012

TA and Training Mini-Plan

The TA and Training Mini-plan identifies areas where the current state prevention TA and Training infrastructure for prevention services need improvements to provide greater responsiveness to the needs of the behavioral health system. Areas identified for enhancement in this category include:

1. Need for improved knowledge and skilled prevention workforce in the state;
2. Need for improved prevention trainings for common knowledge, awareness and capabilities by enhancing multidisciplinary and multi-sectorial training activities; and
3. Need for the creation of a comprehensive technical assistance and training systems responsive to the needs of communities, providers, and other stakeholders.

Goal 1: Improve and increase skills and knowledge of the prevention workforce.		
Strategy: Assess current prevention workforce training and identify ways to improve the prevention workforce capacity in the state.		
Action Steps	**Responsible Entity**	**Timeline**
Assess prevention training needs among DBHS staff and develop training module.	DBHS	Jan. 2013
Develop standardized prevention training to establish a common prevention knowledge base and shared interests across sectors and disciplines.	DBHS, MSPI	Jul. 2013
Develop a basic Prevention Model System guide and toolkit with additional modules for specific community sectors to meet their unique training needs.	DBHS, MSPI	Jul. 2013
Develop a marketing plan to increase training opportunities both online and onsite for prevention providers and other stakeholders.	DBHS, MSPI, APCB, MSSS	May 2013
Increase greater variety and access to onsite and online training offerings to community coalitions, providers and stakeholders.	DBHS, SWCAPT, MSPI, APCB	Jan. 2013
Explore ways to expand the use of technology to support training through the existing prevention contractor.	DBHS, MSPI	Jan. 2013
Provide more opportunities for Training of Trainers	DBHS, MSPI	Jul. 2013

(TOT) for current prevention providers. Revise orientation and training manuals for DBHS prevention staff.	DBHS	Jul. 2013
Goal 2: Restructure current TA and Training programs for behavioral health, prevention, and special populations.		
Strategy: Review the TA and Training system infrastructure to assess current training opportunities for commonalities in goals and identify any gaps.		
Action Steps	**Responsible Entity**	**Timeline**
Review current training programs to identify gaps. Review annual workforce survey for most requested training topics.	DBHS, APCB, MSPI DBHS, MSPI	Apr. 2013 Apr. 2013
Goal 3: Create training systems that include TA that are responsive to the needs of the communities, special populations, and paid workforce.		
Strategy: Identify additional trainings needed at the community level, for licensure, and for special populations such as LGBTQ and military families that are evidenced-based.		
Action Steps	**Responsible Entity**	**Timeline**
Conduct community level focus groups to assess training needs specific to special populations. Conduct focus group with special populations such as LGBTQ groups and military families support groups to assess training needs and to identify potential implementation plan. Meet with certification and workforce training system to establish a sequential core curriculum for licensure. Review current TA system and explore feasibility of developing an on-line/electronic technical assistance system.	DBHS, PRCs, Coalitions DBHS, C.A.R, MISGRO, NG, AOS DBHS, APCB, MSPI DBHS	Jul. 2013 Jul. 2013 Jul. 2013 Jul. 2013

Performance/Evaluation Mini-Plan

Performance management and evaluation system monitors program progress, measures performance and goals, identifies areas for service improvement, and evaluates systems to collect both process and outcome data. Areas identified for enhancement in this category include:

1. Need for comprehensive utility of the SPF for process and outcome measures;
2. Need for formative and summative methods to collect process and outcome data; and
3. Need of structure for integrating process and outcome measures into program development.

Goal 1: Review process and outcome measures as utilized in the Strategic Prevention Framework (SPF), to foster more responsive and interactive state prevention systems.		
Strategy: Assess data collection and reporting methods for inclusion of process evaluation and comparison of process to outcome.		
Action Steps	**Responsible Entity**	**Timeline**
Evaluate minimum Data Set process for additional data to be collected.	DBHS, AFMC	May 2013
Compare number of services provided per county to consumption and consequence data from Arkansas Prevention Needs Assessment.	DBHS, AFMC, ISA	May 2013
Goal 2: Review current evaluation efforts and identify strategies to enhance evaluation systems to ensure process and outcome data is being used as well as formative and summative methods.		
Strategy: Meet with evaluation of efforts contractor to review current performance management and evaluation methods with a focus on enhancing the system.		
Action Steps	**Responsible Entity**	**Timeline**
Provide technical assistance on use of data for formative assessment for effectiveness of program and use of data for summative outcomes of behavioral changes.	DBHS, MSPI, RTI	May 2013
Determine specific evaluation methods which can be replicated consistently.	DBHS	May 2013
Goal 3: Create a structure whereby process and outcome measures can be integrated into		

program development.		
Strategy: Develop a structure to ensure consistency in the implementation of programs.		
Action Steps	**Responsible Entity**	**Timeline**
Review fidelity checklists associated with evidence-based programs.	DBHS	Jul. 2013
Develop standardized evaluation forms.	DBHS, PRCs, RTI	Jul. 2013
Provide technical assistance on use of outcome measures.	DBHS, MSPI, RTI	Jul. 2013

RECOMMENDED EVIDENCE-BASED PROGRAMS AND STRATEGIES (*RFA Section 2.3.5*)

"Evidence-Based" means those practices that are based on accepted practices in the profession and are supported by research, field recognition, or published practice guidelines. These programs are prevention methodologies that have been developed and evaluated by experts using scientific processes. Evidence-based is also referred to as science-based and research-based models.

Environmental strategies are focused on changing aspects of the environment that contribute to the use of alcohol and other drugs. Specifically, environmental strategies aim to decrease the social and health consequences of substance abuse by limiting access to substances and changing social norms that are accepting and permissive of substance abuse. They can change public laws, policies and practices to create environments that decrease the probability of substance abuse.

Members of the Arkansas Strategic Prevention Framework State Enhancement Grant (SPE) Evidence-Based Practices (EBP) Workgroup recommended Evidence-based Programs and Strategies for Arkansas prevention providers through the result of collaborative efforts.

The purpose for recommending EBPs is to identify and select evidence-based programs and strategies to assist Arkansas substance abuse prevention providers:

- Move towards evidence-based programs, practices or strategies
- Increase the use of evidence-based programs, practices or strategies
- Have access to evidence-based prevention programs, practices or strategies
- Invest in "what works" in an effort to demonstrate more positive outcomes and more effective and efficient utilization of limited prevention resources.
- Improve prevention program outcomes
- Future funding preference may be given to EBP providers

The following criteria were used to select the best fit evidence-based programs and practices for Arkansas prevention providers:

1. Evidence of effectiveness: have at least some documented evidence of effectiveness, and preferably have been rigorously tested and shown to have positive outcomes in multiple peer-reviewed evaluation studies.
2. Conceptual fit with the community's prevention priorities: specifically address one or more of the risk factors for substance abuse identified within the community or target population, have evidence of effectiveness within a similar community or target population and have been shown to drive positive outcomes.
3. Practical fit with the community's readiness and capacity:
4. Ability to implement with fidelity
5. Cultural fit within the community: programs likely to conform with the norms in Arkansas communities
6. High likelihood of sustainability within the community

Based on this, the following programs were selected (see appendix VI for Evidence-based Programs and Practices Matrix):

Evidence-based programs

1. Al's Pals
2. Big Brothers Big Sisters Community Mentoring
3. Brief Alcohol Screening and Intervention for College Students (BASICS)
4. Caring School Community
5. Community Trials
6. Families and Schools Together
7. Guiding Good Choices
8. Lead and Seed
9. Life Skills Training
10. Lion's Quest
11. Olweus Bullying Prevention Program
12. Parenting Wisely
13. Project Alert
14. Project Northland
15. Second Step
16. Strengthening Families
17. Team Awareness

The following strategies were selected (see appendix -- for table of evidence-based strategies)

Policy Change Strategies

1. Policies to Require Merchant Training
2. Community Event Alcohol Use Regulations
3. Public Availability Policies
4. Social Host Ordinance
5. Advertising Restrictions

Enforcement Strategies

1. Alcohol Outlet Compliance Checks
2. Sobriety Checkpoints to Enforce Impaired Driving Laws
3. Shoulder Tap Surveillance
4. Party Patrols
5. Enforcement of open container laws

Media/Communication Strategies

1. Alcohol Warning Signs
2. Retail Outlet Recognitions
3. Social Norms Misperceptions Campaigns
4. Counter-Advertising
5. Social Marketing

IMPLEMENTATION TIMELINE AND PLAN *(RFA Section 2.3.7)*

2013	2014	2015	2016
Re-establish Underage Drinking Task Force	Establish MOU's with partner agencies	Develop leveraged funding opportunities	Develop common funding applications
Develop LGBTQ consortium	Expand ACDEC program	Develop LGBTQ and Veteran's surveys	Combine APNA and YTS
Restructure TA system	Develop community training curriculums and conduct TOTs	Train partner sectors about addiction	Standardize process and outcome measure collection process
Conduct TOTs for parenting curriculums	Restructure workforce training	Train community providers about suicide	Outreach to Beverage Retailer on social host campaign
Outreach to additional partner agencies	Coordinate Veteran's services		Coordinate suicide data sources
Coordinated merchant education		Coordinate merchant training	

The first year of this strategic plan will be used to solidify relationships with partner agencies and begin the development of leveraged funding opportunities including the procedure and legal processes necessary for implementation of combined data collection, data sharing, and funding applications. Timing of current contracts also make it possible to set in place a restructured technical assistance system during the first year, but, this timing also causes changes in survey methods and restructure of workforce development systems to be delayed the latter years of this plan.

Curriculum development, marketing campaign development, and data collection methods will also occur during the latter years as the items are developed within the DBHS system or jointly with partners from other agencies and education organizations.

Study is underway for combining the Youth Tobacco Survey, given randomly to select schools, and the Arkansas Prevention Needs Assessment, given annual as a census survey of students in grades 6th, 8th, 10th, and 12th statewide. Implementation of a combined survey could begin in 2016.

Grants for direct community services are released on an annual basis from DBHS but are released on a multi-year basis from partner agencies. Those agencies recently awarded community grants and leveraged funding using a combined application cannot occur until 2016. Preparation for work with the military is set to be ready for implementation by the time of the massive troop return in 2014. Training of providers and coordination of services will be completed prior to that December timeline.

The LGBTQ consortium will be in place by December 2013. Input on data to be collected and best ways to administer a survey about usage rates within this population will come from the consortium. Actually survey administration will begin in 2015.

With the re-establishment of the Underage Drinking Task Force in 2013, a media campaign and relationship can be developed with the Beverage Retailer's Association for promotion of the social host law using the theme of "We don't sell to minors. You don't provide to minors."

The concept of a combined merchant education process for both tobacco and beverage control laws were piloted in 2012 with success. Expansion of this project will be completed by 2013.

Re-establishment of the Suicide Prevention Task Force will provide the assessment of service gaps, training needs, and data gaps necessary to train providers by 2015 and coordinate data by 2016.

EVALUATION PLAN *(RFA Section 2.3.8)*

Outcome measures noted at each of the strategic goals will be the ultimate indicator of success. These outcomes will be determined by a review of the Arkansas Prevention Needs Assessment and by Department of Health statistics. Social indicators published in the Archival risk Factors annually will be used to expand the causes and consequences associated with the targeted goals of alcohol use, prescription drug use, tobacco use, and suicide. The SEW group will be analyzing cause, consumption, and consequence data for trends and patterns of behaviors related to the target areas.

Process data will be collected in the Prevention Reporting Management Minimum Data Set to determine participation in meetings, trainings, and partner outreach. Minutes and relevant documentation such as results of brainstorming activities and specific project management plans will be maintained and reviewed by the partner agencies on a regular basis.

Another primary measure of the success of this plan will be the outputs generated. Memorandums of Understanding will be developed between partner agencies to assure that all parties understand their respective roles. Combined funding processes and applications will evaluate the efforts to leverage resources. The community comments will be used to modify and improve the application process. New surveys and combined surveys will be reviewed for ease of administration and the ability to continue collecting trend data while gaining new insight into behavior trends. The surveys are reviewed annual for appropriateness to collection of information needed for planning processes ad well as information needed by the diverse funding streams.

All trainings opportunities that are part of this plan include pre-post tests and surveys to determine changes in knowledge and attitude about the information received. This will include the training of direct service providers, community technical assistance providers and vendors selling tobacco and alcohol.

Another anticipated outcome of this plan is better identification of prevention resources at both the state agency and provider levels. The collection of MOU's will determine the increase in knowledge of resources as well as the improved collaboration among the resources. It will also identify gaps in services, therefore, generating need to explore enhancing existing resources or development of new

resources. This, in turn, may create the need for redistribution of funding or restructure to service provision.

ACTION/SUSTAINABILITY PLAN *(RFA Section 2.3.9)*

DBHS as an agency is going through a restructure process during the move to integrate substance abuse and mental health grants to develop a comprehensive behavioral health plan. Substance abuse funds have been provided oversight and coordination of services by the legislated body of the Arkansas Drug Abuse Coordinating Council. This Council served as the Policy Consortium for the State Prevention Enhancement grant because its makeup mirrored the grant requirements. Mental health funding was reviewed by the Arkansas Behavioral Health Planning Advisory Council. These two bodies will continue to provide oversight and coordination as the block grants merge. Inroads have been made during the SPE process to build coordination bridges between prevention service providers and funders at the state level and will continue as efforts are evaluated and enhanced.

Following the integration to behavioral health, the next logical step is the integration of physical health for a holistic approach. Therefore, workforce development through existing structures such as UAMS, UALR, UCA, and UAPB will continue to be expanded.

Data collection and analysis will be maintained and enhanced from consumption and consequence data to more cause and effect efforts through the SAPT funded contract for the SEOW workgroup. The data collected and the resulting analysis will be maintained on the prevention web portal www.preventionworksar.com which was created during the SPE process. Technical assistance and prevention resources will also be provided via this web portal.

Action steps include:

- Regional meetings with community key stakeholders first as a listening tour to hear their concerns and suggested solutions and then as a way to develop community buy-in for the strategic plan while scheduling necessary technical assistance and training visits.
- Expand the Arkansas Suicide Prevention Task Force, including additional members representing emerging groups in support of veterans and LGBTQ, to determine training, data and coordination of service needs.
- Re-establishment and expansion the Underage Drinking Task Force, which had dissipated, to provide the opportunity to clarify and update the strategic plan for addressing underage drinking, provide technical assistance and necessary data so that they can be effective advocates for underage drinking prevention policies.
- Coordinate Army One Source, SATI, and other military related behavioral health efforts with different veterans' organizations and the military family support programs to determine training, data, and coordination of service needs.
- Restructure of the prevention technical assistance system and workforce development agencies to provide working applications of integrated services in order to streamline the process. Bring data collection processes into DBHS infrastructure.

- Continue well-functioning prescription drug addiction efforts being spearheaded by the State Drug Director's and expand efforts to include emphasis on finding preventive solutions including training of healthcare professionals and health educators.
- Planning and training with the Arkansas Behavioral Health Planning Advisory Council, a group of local community providers, consumers, families, and concerned citizens focused on behavioral health issues with the objective of the meeting being to explain the SPF, current prevention efforts, proposed future prevention efforts and hear input on gaps that concern the group.
- Develop a consortium linking geographically separated LGBTQ support organizations to discuss training about prevention planning process, risk factors, data collection methods and a statewide network of services.
- Develop MOUs based on common language and shared goals for leveraged funding opportunities using either a combined application or common processes.

DATA SYSTEM *(RFA Section 2.4)*

Arkansas is a data rich state but more work needs to be done toward integrating the data to gain an overall view of the issues that impact both substance abuse and mental health.

A primary source of data for youth usage rates and risk factors is the Arkansas Prevention Needs Assessment, an annual survey conducted in the majority of public schools, which is based on the Communities That Care theory of change. The survey has been conducted on a census basis with 6th, 8th, 10th, and 12th graders since 2002. This allows for trend data that encompasses youth throughout their entire secondary career.

Currently, a random sample survey is done each year at different locations in the state as the Youth Risk Behavior survey through the CDC and Arkansas Dept. of Education. The Arkansas Department of Health conducts the Youth Tobacco Survey.

AFMC, the SAPT funded contractor for the State Epidemiological Workgroup, continues a comprehensive assessment of data that is currently available through State, national, and local agencies, and advocacy groups in collaboration with other workgroup members as it pertains to the topics in SAMHSA Initiative #1 Goals and SPE special topics.

- Relevant topics are
  - Substance abuse
  - Mental health risk factors
  - Underage drinking and adult problem drinking
  - Suicides, attempted suicides, and suicide risk factors especially for military family members and LGBTQ youth
  - Prescription drug misuse/abuse

AFMC has received data related to resources for substance abuse prevention and recovery within each drug abuse prevention region. This information has been synthesized into a database which includes region, county and other demographic information. The data will be subsequently placed on the web portal preventionworksar.com and will be searchable by county so that these resources are readily

available to providers, parents or other stakeholders. Approximately 800 resources are listed in the resource guide now under development and additional resources will be included as identified.

Data gaps, especially among adults, military and their families, and LGBTQ, have been identified and further work to develop data collection methods and locations is needed. By developing a consortium of LGBTQ support providers, a place and group which can administer a survey or other methodology will become available. Data is being collected for military but utilization of the data needed to be reviewed.

Data analysis for a better understanding of causes rather than just consumption and consequences will continue to be emphasized and developed as the SEW matures and expands and the DBHS data management section completes the creation of the Behavioral Health System Performance Framework and Dashboard.

Appendix I

Guiding Principles

1. Prevention is prevention is prevention. That is, the common components of effective prevention for the individual, family, or community within a public health model are the same – whether the focus is on preventing or reducing the effects of cancer, cardiovascular disease, diabetes substance abuse or mental illness.
2. Prevention is an ordered set of steps along a continuum to promote individual, family, and community health, prevent mental and behavioral disorders, support resilience and recovery, and prevent relapse. Prevention activities range from deterring diseases and behaviors that contribute to them, to delaying the onset of disease and mitigating the severity of symptoms, to reducing the related problems in communities. This concept is based on the Institute of Medicine (IOM) model that recognizes the importance of a whole spectrum of interventions.
3. Cultural competence and inclusiveness in working with populations of diverse cultures and identities is necessary to provide effective substance abuse prevention programming.
4. Resilience is built by developing assets in individuals, families, and communities through evidence-based health promotion and prevention strategies. For example, youth who have relationships with caring adults, good schools, and safe communities develop optimism, good-problem-solving skills, and other assets that enable them to rebound from adversity and go on with life with a sense of mastery, competence, and hope.
5. Prevention begins within communities by helping individuals learn that they can have an impact on 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. All sectors of the community, especially parents and youth, are needed in successful prevention work. Members of the education, law enforcement, public health and health care communities are critical partners in substance abuse prevention efforts.
6. The Spectrum of Prevention is a broad framework that includes seven strategies designed to address complex and significant public health problems. These include a) influencing policy and legislation, b) mobilizing neighborhoods and communities, c) fostering coalitions and networks, d) changing organizational practices, e) educating providers, f) promoting community education, and g) strengthening individual knowledge and skills.
7. Common risk and protective factors exist for many substance abuse and mental health problems. Good prevention focuses on those common risk factors that can be altered. For example, family conflict, low levels of basic school readiness, and poor social skills increase the risk for conduct disorders and depression, which in turn increase the risk for adolescent substance abuse, delinquency, and violence. Protective factors such as strong family bonds, social skills, opportunities for school success, and involvement in community activities can foster resilience and mitigate the influence of risk factors. Risk and protective factors exist in individuals, the family, the community and the broader environment.
8. Systems of prevention services works better than prevention silos. Working together, researchers and communities have produced a number of highly effective prevention strategies and programs. Implementing these strategies within a broader system of services increases the likelihood of successful, sustained prevention activities. Collaborative partnership enables communities to leverage scarce resources and make prevention everybody's business.

Prevention efforts are more likely to succeed if partnerships with communities and practitioners focus on building capacity to plan, implement, monitor, evaluate, and sustain effective prevention.

9. Substance abuse prevention shares many elements of commonality with other related fields of prevention (i.e. juvenile delinquency prevention, adolescent suicide prevention). Collaboration and cross training across the prevention field is needed to maximize resources (both human and material).
10. Prevention specialists need a set of core competencies and a commitment to lifelong learning to stay current with the rapidly evolving knowledge and skill base in our field.
11. Baseline data, common assessment tools, and outcomes shared across service systems can promote accountability and effectiveness of prevention efforts. A strategic prevention framework can facilitate community identification of needs and risk factors, adopt assessment tools to measure and track results, and target outcomes to be achieved. A data-driven strategic approach maximizes the changes for future success and achieving positive outcomes.
12. Evaluation is crucial in order for communities to identify their successful efforts and to modify or abandon their unproductive efforts.

Appendix II

Center of Substance Abuse Prevention's

Six Prevention Strategies

Listed below are the six strategies, an explanation of each, and examples of the types of activities appropriate to each strategy:

1. **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.
2. **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.
3. **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.
4. **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.
5. **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.
6. **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.

Strive to include at least three of the six prevention strategies in each activity or event!

Appendix III
Public Health Approach

The focus of public health is on the safety and well-being of entire populations by preventing disease rather than treating it. The Institute of Medicine defines public health as "what we, as a society, do collectively to assure the conditions for people to be health."

Key Characteristics

- Promotion and prevention
- Population based
- Risk and Protective factors
- Multiple contexts
- Development perspective
- Planning Process

Promotion and Prevention

Promotion is providing opportunity to optimize well-being and allow people to take responsibility for their own wellness.

Prevention aims to reduce behavioral problems by addressing the risk factors.

Population based

A public health approach concentrates on the health of the entire population, rather than at the individual level.

Risk and Protective Factors

The public health approach addresses those factors that contribute to the positive or negative health of a population.

Multiple contexts

The public health approach utilizes the multiple reams of individual, community and society which impact the population's health.

Development perspective

A public health approach takes into consideration and uses interventions appropriate to the development stage of the target population.

Planning Process

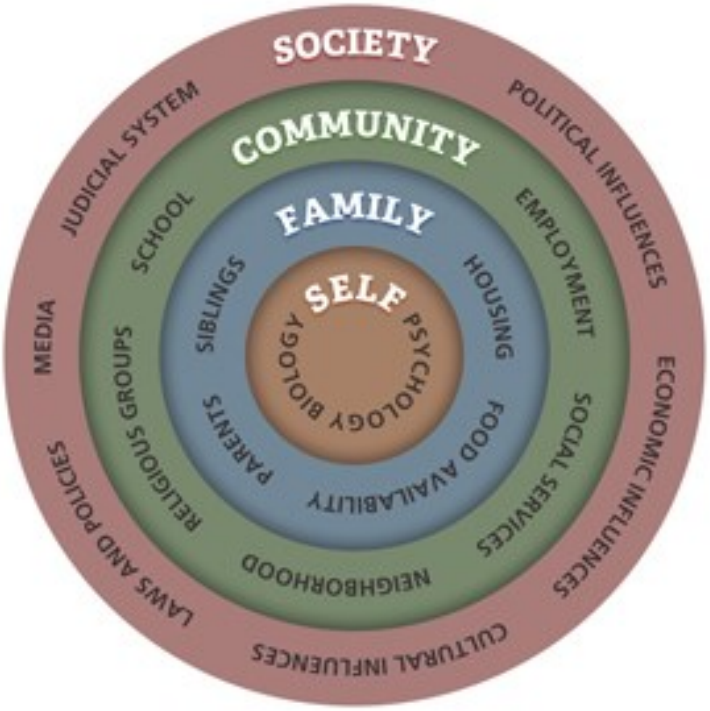
The public health approach uses a strategic planning process to determine the actions to be taken and the benefits.

Appendix IV

Risk and Protective Factors Exist in Multiple Contexts

Individuals come to the table with **biological and psychological** characteristics that make them vulnerable to, or resilient in the face of, potential behavioral health problems. Individual-level risk factors include genetic predisposition to addiction or exposure to alcohol prenatally; protective factors might include positive self-image, self-control, or social competence.

But individuals don't exist in isolation. They are part of families, part of communities, and part of society. A variety of risk and protective factors exist within each of these contexts. For example:



- In **families**, risk factors include parents who use drugs and alcohol or who suffer from mental illness, child abuse and maltreatment, and inadequate supervision; a protective factor would be parental involvement
- In **communities**, risk factors include neighborhood poverty and violence; protective factors might include the availability of faith-based resources and after-school activities
- In **society**, risk factors can include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity; protective factors include policies limiting availability of substances or anti-hate laws defending marginalized populations, such as lesbian, gay, bisexual, or transgender youth

Practitioners must look across these contexts to address the constellation of factors that influence both individuals and populations: targeting just one context is unlikely to do the trick. For example, a strong school policy forbidding alcohol use on school grounds will likely have little impact on underage drinking in a community where parents accept underage drinking as a rite of passage or where alcohol vendors are willing to sell to young adults. A more effective—and comprehensive—approach might include school policy plus education for parents on the dangers of underage drinking, or a city ordinance that requires alcohol sellers to participate in responsible server training.

Appendix V

Policy Consortium Members

Category	Appointee	Agency
Arkansas Drug Director	Fran Flener	Governor's Office
Alcohol and Drug Abuse Prevention	Ann Brown	Office of Alcohol and Drug Abuse Prevention
Statewide Law Enforcement	Colonel Winford Phillips Alternate: Lt. Jerry Digman	Arkansas State Police
Education	Dr. Tom Kimbrell Alternate: Tammy Harrell	Department of Education
Highway Safety	Dan Flowers Alternate: Ronald Burks, Chief	AR Highway and Transportation Department
Prison System	Ray Hobbs Alternate: Robert A. Parker	Department of Corrections
Finance	Richard Weiss Alternate: Ann Purvis	Department of Finance & Administration
Military	Major General William D. Wofford Alternate: LTC Marcus Hatley	National Guard
Attorney General	Dustin McDaniel Alternate: Laura Shue	Attorney General
State Crime Laboratory	Kermit Channell Alternate: Richard Gallagher	State Crime Laboratory
Blood Alcohol Levels	Laura Bailey Alternate: Kent Williams	Blood Alcohol Testing Program, Department of Health
Probation	David Eberhard	Department of Community Correction
Court System	J. D. Gingerich	Administrative Office of the Courts
Police Chief	Chief Everett Cox	Tillar Police Department
County Sheriff	Sheriff Marty Moss Cleburne County	Cleburne County Sheriff Department
Drug Court Judge	Judge Joe Griffin Miller County	Drug Court
Prosecuting Attorney	Larry Jegley Alternative: Jonathan Ross	Pulaski County Prosecuting Attorney
Private citizen not employed by the State or Federal government	Dennis Emerson	Poyen School District
Director of a publicly funded alcohol and drug abuse treatment program	Dr. Rob Covington	Horizon Adolescent Treatment
School drug counselor	Katrina Cavaness	Monticello Public Schools
Director of a drug abuse prevention program	Reverend Edna Morgan	Healing Place Ministries
DWI program	Jim Allen	Family Service Agency, Inc.
Health Professional	Charlotte Denton	University of Arkansas at Monticello
At Large Members	Teresa Belew	Private Citizen
	John Wiles	Person in Recovery
	Vivian Ozura	Private Citizen
	North Elliott	Narcotics Anonymous

Appendix VI

Recommended Evidence-based Programs and Strategies

↓= Decrease
↑ = Increase

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
Al's Pals: Kids Making Healthy Choices. The curriculum helps young children regulate their own feelings and behavior; creates and maintains a classroom environment of caring, cooperation, respect, and responsibility; teaches conflict resolution and peaceful problem-solving; promotes appreciation of differences and positive social relationships; prevents and addresses bullying behavior; conveys clear messages about the harms of alcohol, tobacco, and other drugs; and builds children's abilities to make healthy choices and cope with life's difficulties. Web Site(s): http://www.wingspanworks.com/educational_programs	Ages 0 to 12. Black or African American; Hispanic or Latino; White. School; other community settings.	↓ Alcohol use ↓ Tobacco use ↓ Other drug use	↑ social-emotional skills ↑ Problem-solving ↑ Healthy decision making ↑ Social competence ↑ Prosocial behaviors ↓ Antisocial behavior ↓ Aggressive behaviors	↓ Bullying Behavior ↓ Violence	Curriculum kit - $685 each; 2-day core training at centralized location - $300 per person; 2-day core training on site $6,500 for a group of 24, or $8,000 for a group of 30, plus trainer travel costs; Seven 2-hour online core training sessions - $325 per person or $4,300 for a group of 15; Free ongoing technical assistance/consultation; Evaluation services package $300 per classroom for online data entry, or $400 per classroom for paper data entry.
Big Brothers Big Sisters Mentoring Program. Designed to help participating youth ages 6-18 ("Littles") reach their potential through supported matches with adult volunteer mentors ages 18 and older ("Bigs"). The program focuses on positive youth development, not specific problems, and the Big acts as a role model and provides guidance to the Little through a relationship that is based on trust and caring. Web Site(s): http://www.bigbrothersbigsisters.org	Ages 6 to 17. Black or African American; Hispanic or Latino; White; American Indian or Alaska Native. Other community settings	↓ Initiation of drug use	↓ Aggressive behaviors ↑ Social competence ↑ Social achievement ↑ Family relationships ↓ Skipping school ↑ Complete homework	↓ Violence	Membership fee Varies depending on site resources (minimum of $150,000 per year for 3 years). Agency Information Management (AIM) System $2,000-$12,000 depending on the number of youth served

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
Brief Alcohol Screening & Intervention in College Students (BASICS). Prevention program for college students who drink alcohol heavily and have experienced or are at risk for alcohol-related problems. BASICS is delivered in an empathetic, nonconfrontational, and nonjudgmental manner and is aimed at revealing the discrepancy between the student's risky drinking behavior and his or her goals and values. Web Site(s): http://depts.washington.edu/abrc/basics.htm	Ages 18 to 25. Asian; Hispanic or Latino; White; American Indian or Alaska Native. Schools	↓ Frequency of alcohol use ↓ Quantity of alcohol use ↓ College Binge Drinking			$30 for Program manual; Training video - $250. 2- to 3-day, off-site training $4,000 per site per day; 1-day workshops $4,000 per site; Technical assistance $4,000 per site per day. Training (or supervision by trained personnel is recommended to implement BASICS and depending on staff experience, it can be completed in 1 to 2 days.
Caring School Community (NREPP). Universal elementary school program designed to create a caring school environment, supportive relationships, and collaboration among students, staff, and parents. Web Site(s): http://www.devstu.org/csc/videos/index.shtml	Ages 6 to 12. Asian; Black or African American; Hispanic or Latino; White School	↓ Alcohol use ↓ Marijuana use	↑ Social achievement ↑ Academic achievement ↑ Concern for others ↓ Disciplinary referrals		Teacher's package (including quality assurance materials) $225 per grade level, or $1,500 for K-6 combined; Principal's package $425 each; Read-aloud libraries (10 trade books) $61-$72 per grade level; 1-day workshops $2,600 per day; Follow-up visits $2,600 per day.
Community Trials Intervention To Reduce High-Risk Drinking. Multicomponent, community-based program developed to alter the alcohol use patterns and related problems of people of all ages. The program incorporates a set of environmental interventions to help communities reduce alcohol-related accidents and incidents of violence and the injuries that result from them. Web Site(s): http://www.pire.org/communitytrials/index.htm	Ages 13 and older Black or African American Hispanic or Latino Other community settings	↓ Alcohol use patterns and related problems ↓ Alcohol-related traffic crashes ↓ Alcohol-related assaults		↓ Violence	$0–10,000 Costs will vary by community. Implementation materials, training, technical assistance/consultation, and quality assurance materials Contact the developer

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
Families and Schools Together (FAST). Multifamily group intervention designed to build relationships between families, schools, and communities to increase well-being among elementary school children. Participants in the multifamily group work together to enhance protective factors for children, including parent-child bonding, parent involvement in schools, parent networks, family communication, parental authority, and social capital, with the aim of reducing the children's anxiety and aggression and increasing their social skills and attention spans. Web Site(s): http://familiesandschools.org http://cfsproject.wceruw.org/fastprogram.html	Ages 0 to 12. Black or African American; Hispanic or Latino; White. School; other community settings.	↓ Substance abuse	↓ Child problem behaviors ↑ Child social skills ↑ Academic competencies ↑ Family relationships ↑ Social functioning	↓ Violence	Training package $6,045 plus travel expenses. The training package includes all required implementation materials, training, the licensing fee, ongoing technical assistance, and an evaluation package.
Guiding Good Choices (GGC). Drug use prevention program that provides parents of children in grades 4 through 8 with the knowledge and skills needed to guide their children through early adolescence. Web Site(s): http://www.channing-bete.com/ggc	Ages 6 and older White. School	↓ Lifetime marijuana use ↓ Lifetime alcohol use ↓ Tobacco ↓ Other drugs use	↓ Rate of depression ↓ Delinquent activities ↑ Family relationships ↑ Social functioning		Core program kit $839 each; Family guide $13.99 each; 3-day, on-site training $4,200 for up to 12 people, plus travel expenses; On-site T/A $1,200 per day or $600 per half-day, plus travel expenses Pre- and posttests is free.
Lead and Seed. A youth empowered, environmental approach to preventing and reducing alcohol, tobacco and drugs in a community https://www.alutiiq.com/capabilities/lead-seed/	Elementary and High school School		↑human, technical and financial capacities ↑advocacy skills ↑ leadership, efficacy and environmental skills		Contact developer for pricing information. https://www.alutiiq.com/capabilities/lead-seed/

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
Life Skills Training. School-based program that aims to prevent alcohol, tobacco, and marijuana use and violence by targeting the major social and psychological factors. Web Site(s): http://www.lifeskillstraining.com	Ages 13 to 17. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White. School	↓ Alcohol use ↓ Cigarettes ↓ Marijuana use ↓ Inhalants	↓ Delinquency ↓ Fighting ↓ Aggression	↓ Violence	Grade level curriculum set $175-$275 depending on grade level; Elementary Program CD-ROM (available for some grade levels) $45.95 each; Smoking and biofeedback DVD $20 each; 1-day, on-site workshop $200 per participant for up to 20 participants, 2-day, on-site workshop $250 per participant for up to 20 participants; Pre- and posttest instruments is free.
Lion's Quest (NREPP). Multi-component, comprehensive life skills education program designed for school-wide and classroom implementation in grades 6 to 8. The goal of the program is to help young people develop positive commitments to their families, schools, peers, and communities and to encourage healthy, drug-free lives. Web Site(s): http://www.lions-quest.org	Ages 6 to 17. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White. School	↓ Past month alcohol use ↓ Past month chewing tobacco ↓ Lifetime marijuana use	↑ Academic performance ↑ Handling peer conflicts ↓ Misconduct ↑ Social functioning	↓ Violence	Student book $5.95 per student; Parent book $3.95 per parent; 2-day, on-site training $180-$330 per person plus travel expenses; 2-day, off-site training (includes starter set of implementation materials) $425-$500 per person; Electronic consultation $50 per hour; Unit tests and evaluation tools is free.
Olweus Bullying Prevention Program. The *Olweus Bullying Prevention Program* is designed to improve peer relations and make schools safer, more positive places for students to learn and develop.	Ages 5 to 15. School			↓ Existing bullying problems ↓ New bullying problems ↑ Peer relations at school	

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
Parenting Wisely. A set of interactive, computer-based training programs for parents of children ages 3-18 years. The programs aim to increase parental communication and disciplinary skills. Web Site(s): http://www.familyworksinc.com	Ages 0 to 17. Black or African American; White; Non-U.S. population Other community settings	↓ Substance abuse	↓ Child problem behaviors ↑ Parental sense of competence ↑ Family relationships ↑ Social functioning		American Teens program kit $659 each; Online version of American Teens program $39.95 with quantity discounts for bulk purchases of passwords; 1-day, on-site training $3,000 per site; free technical assistance by phone or email.
Project ALERT. Prevention program for middle or junior high school students that focuses on alcohol, tobacco, and marijuana use. It seeks to prevent adolescent nonusers from experimenting with these drugs, and to prevent youths who are already experimenting from becoming more regular users or abusers. Web Site(s): http://www.projectalert.com	Ages 13 to 17. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White. School	↓ Alcohol use ↓ Tobacco use ↓ Marijuana use	↑ Family relationships ↑ Mental health promotion		Curriculum in e-reader format with online videos and files for posters that can be projected is free; Free on-line training; Toll-free phone support, online resources, and ALERT Educator newsletter; Free fidelity instrument and alignment and assessment tools.
Project Northland. Multilevel intervention involving students, peers, parents, and community in programs designed to delay the age at which adolescents begin drinking, reduce alcohol use among those already drinking, and limit the number of alcohol-related problems among young drinkers. Web Site(s): http://www.hazelden.org/web/go/projectnorthland	Ages 6 to 17. American Indian or Alaska Native; White. School	↓ Tendency to use alcohol ↓ Past-week alcohol use ↓ Past-month alcohol use ↓ Peer influence to use alcohol ↑ Reasons not to use alcohol ↑ Parent-child communication about alcohol	↑ Family relationships		Grade 6-8 curricula $195 each; $429 for grade 6-8 curriculum set; $549 for grade 6-8 curriculum set plus program guide; 3-day, on-site basic or refresher training $6,200 per site plus travel expenses; 3-day, off-site basic or refresher training $600 per participant; Technical assistance $100 per hour.

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
Second Step. A classroom-based social-skills program for children 4 to 14 years of age that teaches socioemotional skills aimed at reducing impulsive and aggressive behavior while increasing social competence. Web Site(s): http://www.cfchildren.org	Ages 6 to 12. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White. School.	↓ Substance abuse	↑ Social competence ↑ Prosocial behavior ↓ Incidence of negative behaviors ↓ Aggressive behaviors ↓ Antisocial behaviors		Curricula kits, sets and videos $39 - $619; 2-day training at a regional location $525 per person; 2-day, on-site training $7,500 for up to 25 participants; 1-day, on-site training $4,000 for up to 40 participants; Free limited telephone/email technical assistance.
Strengthening Families. A family skills training program designed to increase resilience and reduce risk factors for behavioral, emotional, academic, and social problems in children 3-16 years old. Web Site(s): http://www.strengtheningfamiliesprogram.org	Ages 6 to 17; 26 to 55. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White; Non-U.S. population Home; school	↓ Substance abuse	↑ Family relationships ↑ Mental health Promotion ↑ Social functioning		CD containing materials for one age group: 3-5, 6-11, or 12-16 years $450 each; 2-day, on-site group leader training and one SFP CD master set $3,650 plus travel expenses for 2 trainers for groups of 35 or fewer; 2-day, on-site group leader training and one SFP CD master set $3,050 plus travel expenses for 1 trainer for groups of 15 or fewer; Evaluation services $1,950-$12,000 annually depending on number of participants and number of evaluation reports; Fidelity site visits $1,500.
Strengthening Families Program: For Parents and Youth 10-14. For parents and youth, a family skills training intervention designed to enhance school success and reduce youth substance use and aggression among 10- to 14-year-olds. Web Site(s): http://www.extension.iastate.edu/sfp	Ages 6 to 12; 26 to 55. White. School.	↓ Lifetime alcohol use ↓ Lifetime smoking ↓ Lifetime marijuana use ↓ Lifetime drunkenness ↓ Using alcohol without parent permission	↓ Aggressive behavior		Program materials $1,109 per set for 6-10 facilitators; 3-day, on-site or off-site staff training and technical assistance $6,000 for up to 30 people, including travel expenses; Fidelity observation checklists is free

Evidence-Based Program Summary	Target Population and Setting	Substance Use	Mental Health Promotion and Externalizing Disorders	Bullying, Violence and Suicide Prevention	Cost of Curriculum and Training
Team Awareness. Customizable worksite prevention training program that addresses behavioral risks associated with substance abuse among employees, their coworkers, and, indirectly, their families.		↓ Drinking ↓ Job-related hangovers	↑ Spiritual health ↑ Willingness to seek help		

↓= decrease
↑ = increase

Sources:

1. SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP): http://nrepp.samhsa.gov/
2. Institute of Medicine (IOM). Preventing Mental, Emotional, and Behavioral Disorders among Young People: Progress and Possibilities, March 2009. http://www.iom.edu/Reports/2009/Preventing-Mental-Emotional-and-Behavioral-Disorders-Among-Young-People-Progress-and-Possibilities.aspx
3. APPI. (2010). Clinical manual of prevention in mental health. Washington, D.C. American Psychiatric Publishing.

Appendix VII

Strategic Prevention Enhancement Community Meeting

Huntsville Behavioral Health Meeting

November 9, 2012

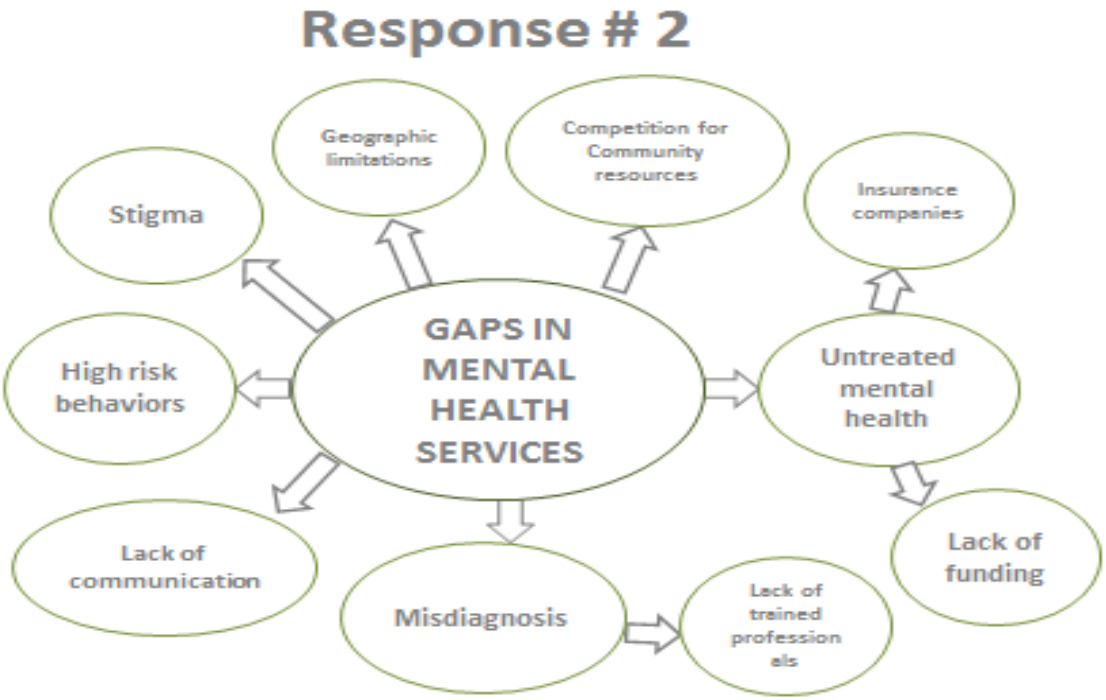
Participants at the behavioral health community meeting in Huntsville drew a picture of a region struggling with poverty and its related homelessness and hunger, untreated behavioral health issues, and substance use issues.

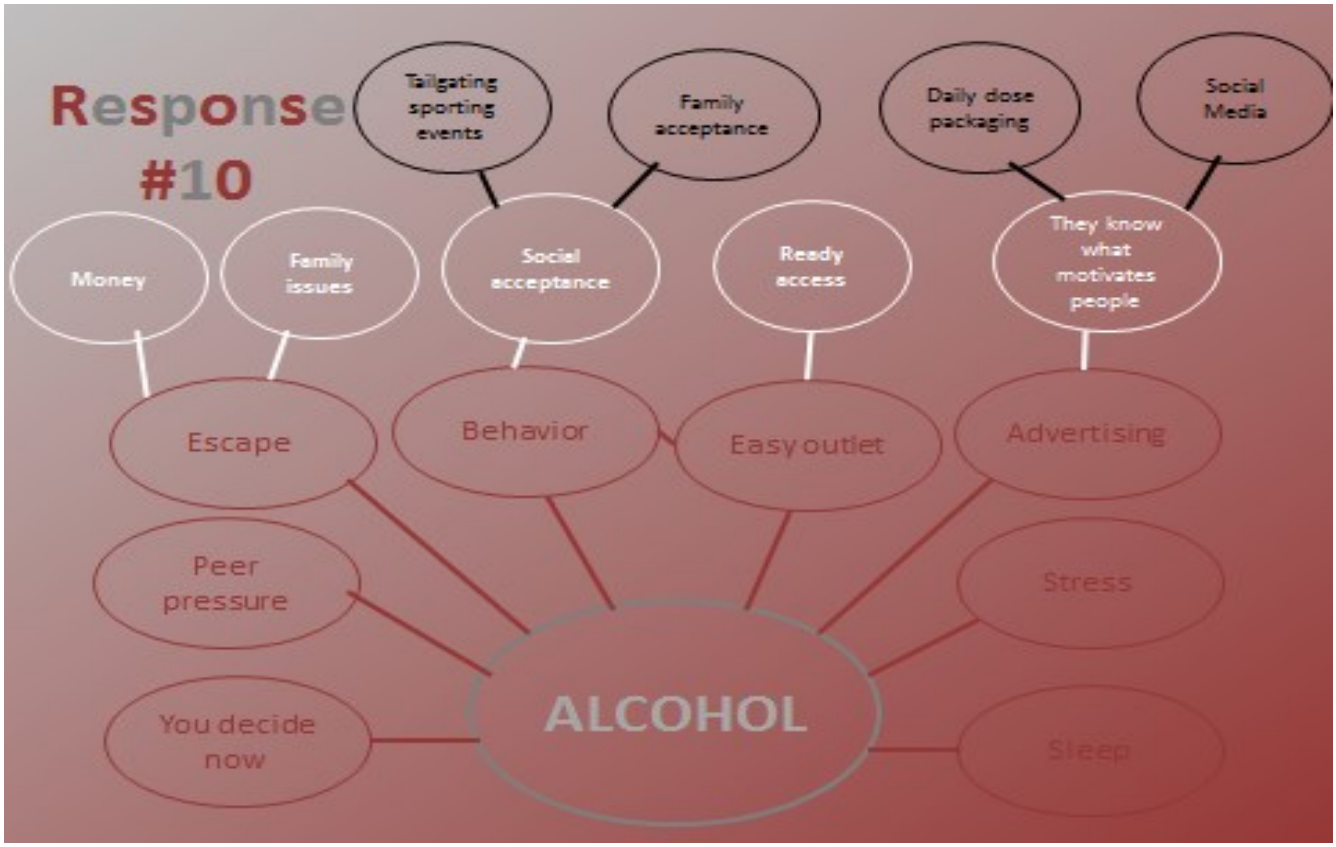
Gaps in mental health services stemmed from a lack of trained professionals which leads to misdiagnosis, lack of funding to pay for treatment, geographic limitations make it difficult for clients to reach services, fear of losing their employment and stigma. One particular mental health issue, depression, brought many topics together including violence, stigma, family dysfunction, social isolation, and job loss which lead to the poverty related issues and eventually substance use. Other consequences of depression could be suicide, job loss, divorce, violence, and jail. Participants also reiterated the fact that substance abuse may lead to the problems mentioned above.

Alcohol abuse was identified as the main substance of abuse in this region. Reasons for high use rate were attributed to peer pressure, social acceptability, advertising, easy access and as an escape for other problems like poverty, unemployment, family problems and other behavioral health problems.

The issue of religiosity was brought forth as a contributing factor to substance abuse and mental health issues. This is due to the lack of training of faith-based leaders on substance abuse and mental health issues as they are sometimes responsible for members of their congregation or other community members not receiving help, because they believe they can just pray about the issues and be healed.

Response #1
RELIGIOUSITY
Lack of training
Not getting help (effective)
Dogma
Fear
Addiction to God
Causes division in community
Need to have something to believe in


Response # 2
GAPS IN MENTAL HEALTH SERVICES
Geographic limitations
Competition for Community resources
Insurance companies
Untreated mental health
Lack of funding
Lack of trained professionals
Misdiagnosis
Lack of communication
High risk behaviors
Stigma



Walnut Ridge Behavioral Health Meeting

November 30, 2012

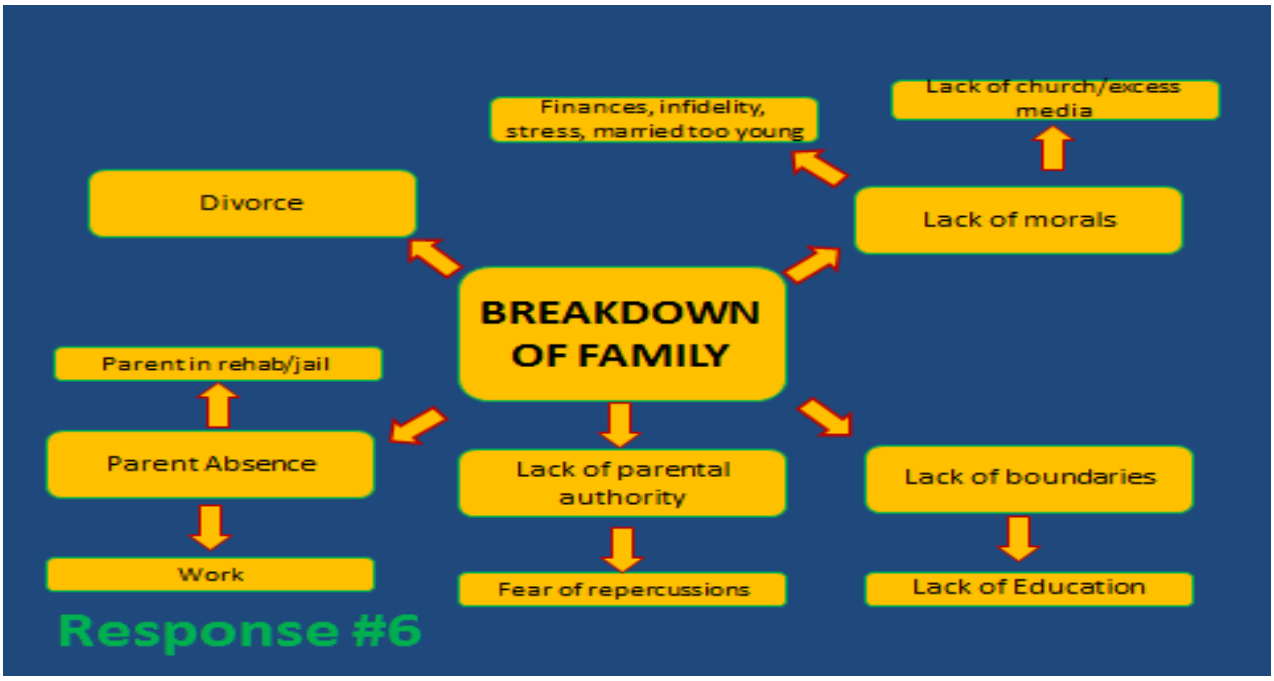
Lack of healthcare treatment included substance abuse treatment and mental health treatment. Participants mentioned the stigma attached with mental illness and a lack of cultural acceptance for seeking treatment. This lack of understanding and education caused people not to seek counseling and to self-medicate. Another resources that were identified as inadequate in this regions are drug courts.

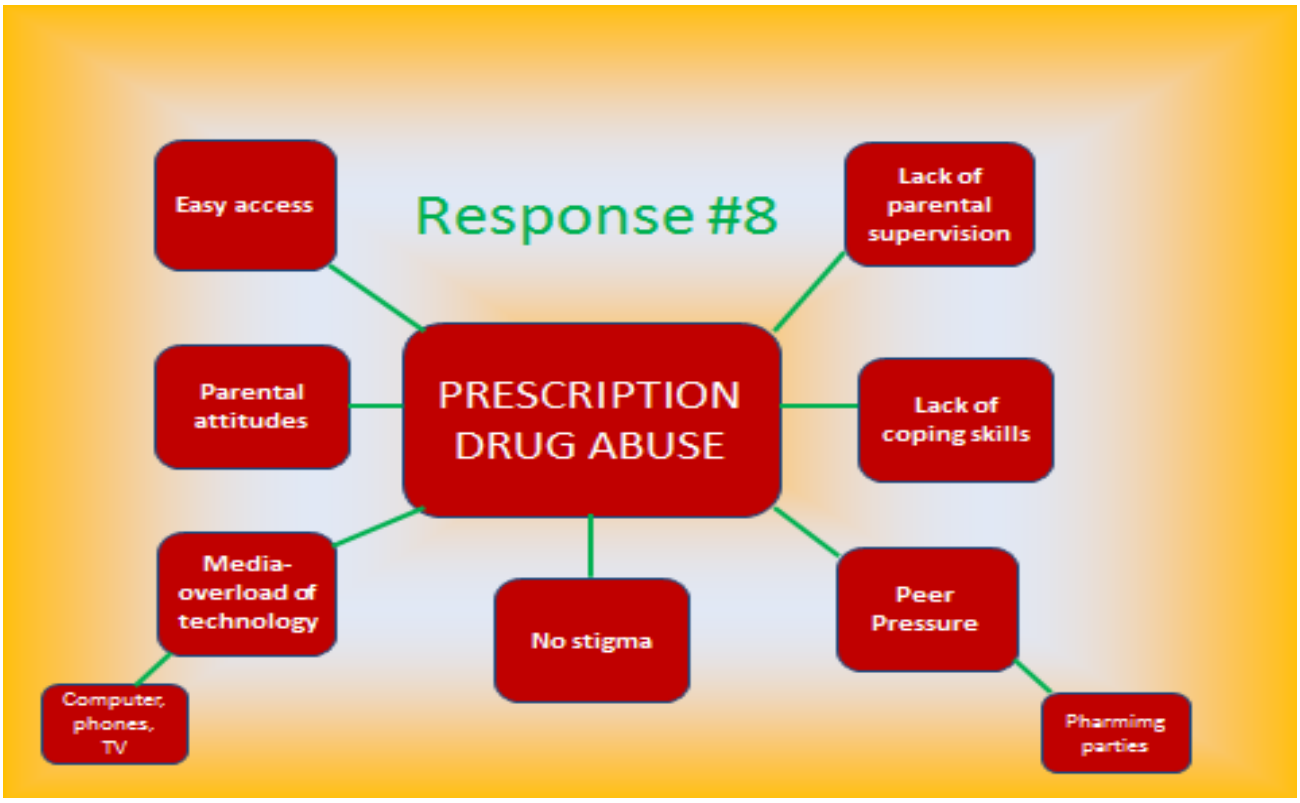
The participants stated that homelessness and hunger, mental health issues, poor physical health and low self-esteem could be consequences of contributing factors of a breakdown of the family unit. The contributing factors identified include parental absence, lack of parental authority, lack of parental skills and high divorce rates leading to single parent homes. This leads to home environment lacking stability and high risk for substance abuse.

Prescription drug abuse was sighted as a big problem in this region by participants. Reason for this problem were easy access, peer pressure, lack of stigma associated with, lack of parental awareness of harm from prescription drug abuse, technology and social media and lack of physician accountability. Breakdowns in both the medical community and in social systems were noted as biggest contributing factors to drug misuse. Other contributing factors for drug misuse were desire to please other and fit in

to a particular set, filling a void related to low self-esteem and lack of social skills, lack of resistance skills especially for students on their own for first time in unfamiliar environments, and negative neighborhood environments.

Lack of treatment resources and the environment in the home and community were the most often expressed concerns by the participants in this meeting. Economic issues were also noted but these impacted the community environment. While specific substance issues were listed as a major topic, the factors surrounding the substance use returned to the environment and resource issues.




Response #8
PRESCRIPTION DRUG ABUSE
Easy access
Parental attitudes
Media-overload of technology
Computer, phones, TV
No stigma
Lack of parental supervision
Lack of coping skills
Peer Pressure
Pharming parties

LACK OF MENTAL HEALTH TREATMENT
Stigma of mental illness
Lack of understanding
Lack of education
Lack of cultural acceptance
Resources
Lack of funding
Lack of counseling
Response #9

Dumas Behavioral Health Meeting

December 11, 2012

The participants attending the meeting described a region with economic hardships, an education system that needs assistance and a breakdown in culture values that impacts both health and family function.

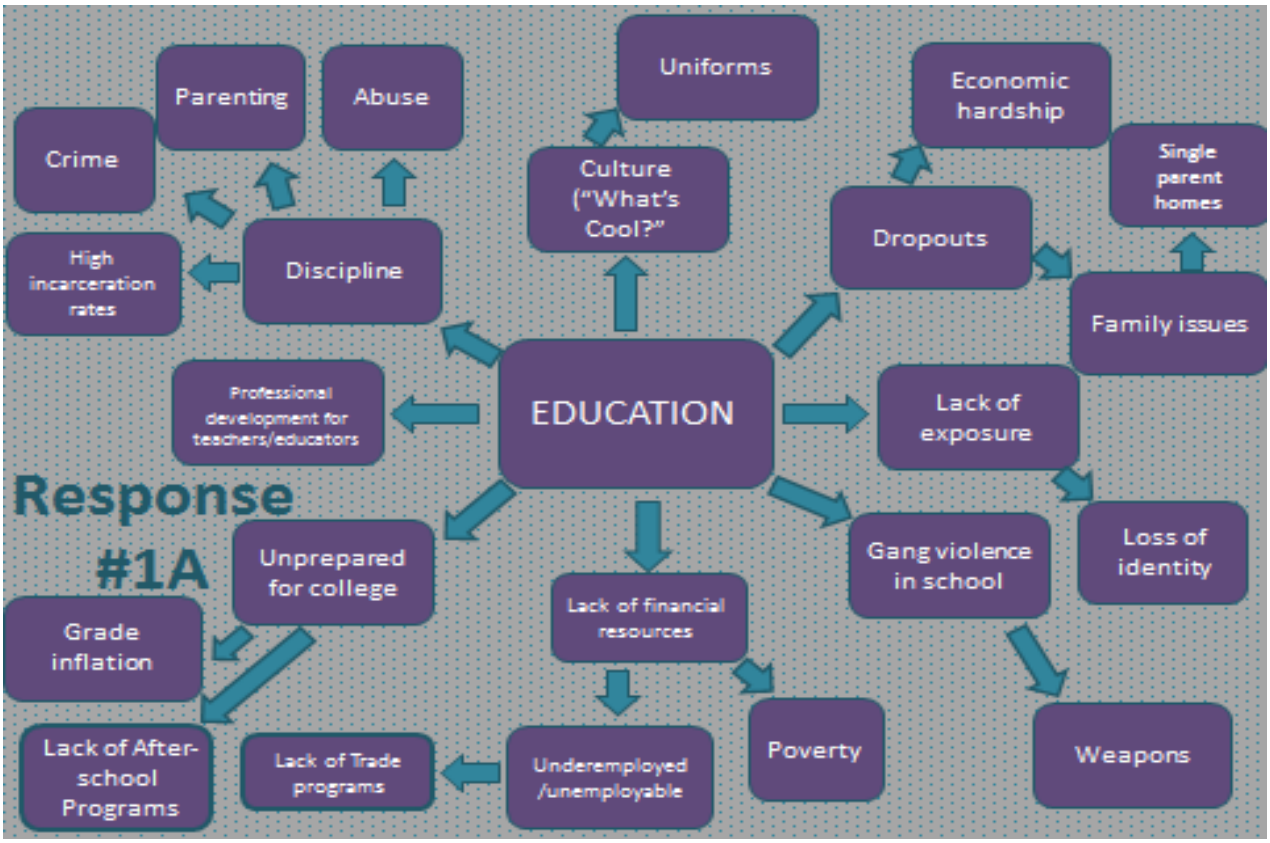
Economic hardship and education were closely tied together and seen as the major issues impacting the area, especially when it came to behavioral health and general wellness. Education issues included consequences such as dropouts, youth who were unprepared for college due to grade inflation and social promotion, professional development for educators, mainstreaming of special needs students, and lack of colleges and training programs for the trade. The educational consequences impacted both cultural issues such as parenting and the economic issues because of an unskilled workforce.

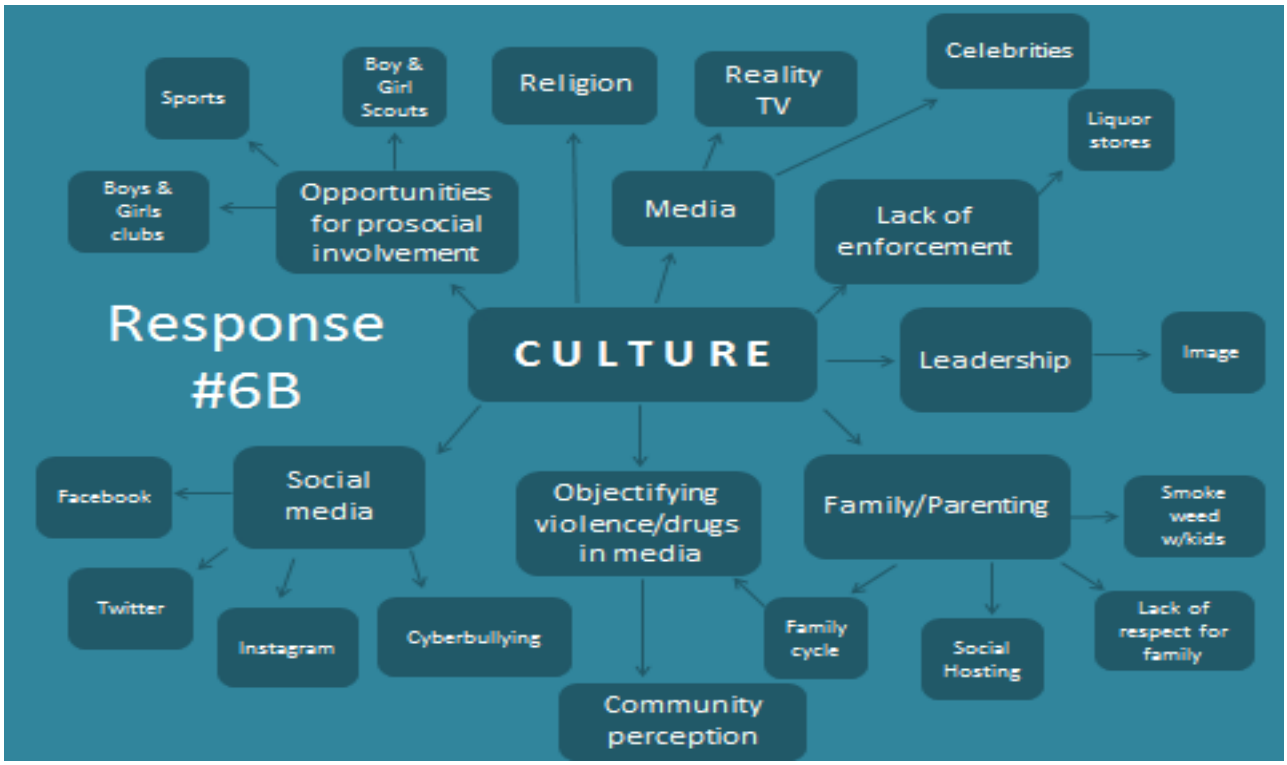
The economic hardships cause a lack of financial resources from unemployment or underemployment which leads to poverty which has a demonstrated effect on housing, education and health. Transportation was also discussed as both a drawback and a consequence. Without it, people cannot get to jobs and without jobs; they cannot afford vehicles and gas to get to jobs. Lack of industry and political leadership were seen as influences to the economic hardship issue. The stress factors related to economic problems exacerbated the mental health and substance abuse problems while reinforcing family dysfunction and crime rates.

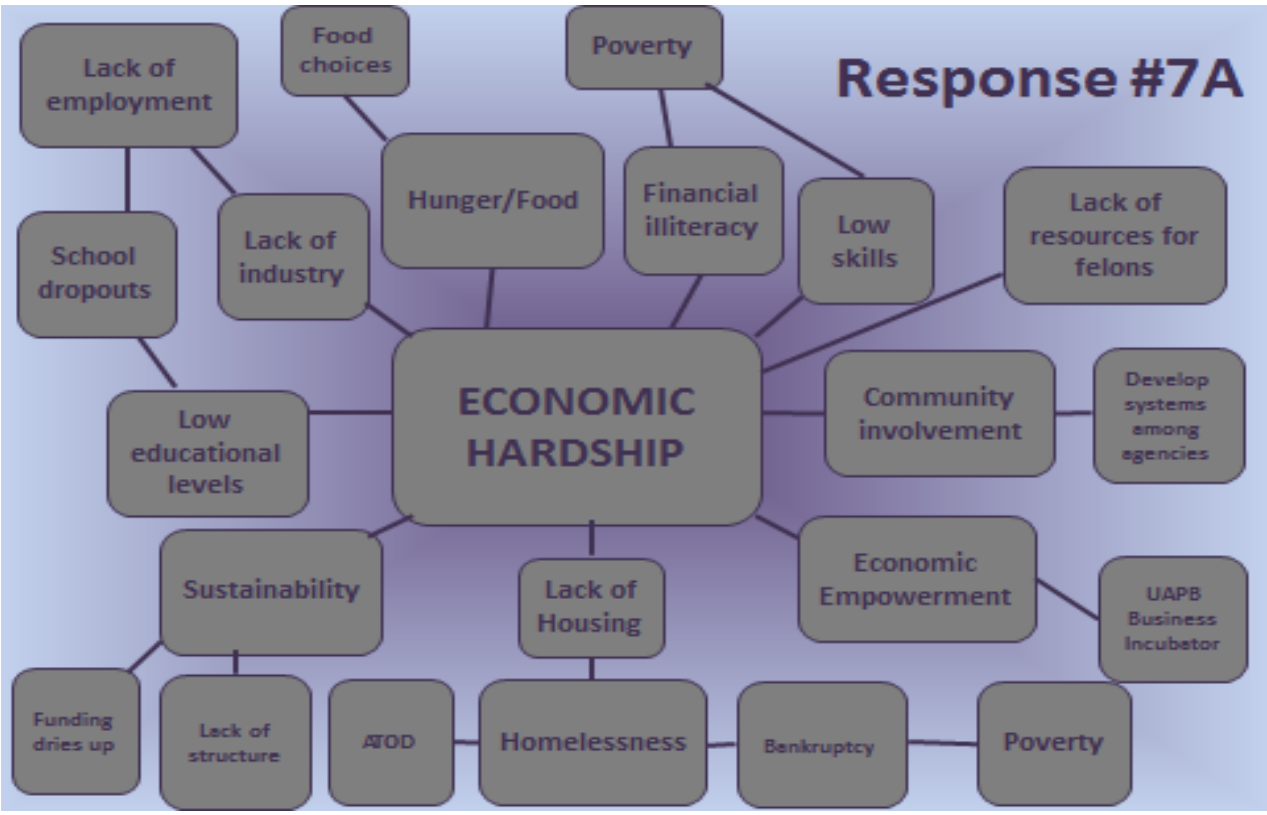
A breakdown in culture and family values was perceived to be one of the major contributors to substance abuse in this region. This leads to family dysfunction which ultimately leads to substance abuse and mental and physical health issues. Issues noted included things like parents smoking weed with their kids, broken homes with single parents, abuse and neglect, and lack of respect and discipline. Teen pregnancy was also attributed to family dysfunction. Young men falling off society's grid was also brought up with the example given of young men who went from living with their family who provided a vehicle and insurance in the parents' name to living with a young woman where all bills are in her name and then the young man does not work.

Apart from substance abuse, the breakdown in family values was also seen as a major contributor to the high rates of incarceration and gang violence seen in this region. A lack of resources for reentry of ex-offenders was also noted as a contributing factor to substance abuse as it leads to unemployment and poverty.

Another major issue that arose during discussions of education, health, and substance abuse was a lack of structured recreational activities. Youth organizations such as Boys and Girls Clubs, Boy and Girl Scouts, and parks with walking trails or sports programs were all mentioned. Sustainability for these programs along with educational and economic programs were seen as a challenge because of funding that dries up and lack of structure.


Response #1A
EDUCATION
Crime
Parenting
Abuse
Uniforms
Economic hardship
Single parent homes
High incarceration rates
Discipline
Culture ("What's Cool?"
Dropouts
Family issues
Professional development for teachers/educators
Lack of exposure
Unprepared for college
Grade inflation
Lack of financial resources
Gang violence in school
Loss of identity
Lack of After-school Programs
Lack of Trade programs
Underemployed /unemployable
Poverty
Weapons


Response #6B
CULTURE
Sports
Boy & Girl Scouts
Religion
Reality TV
Celebrities
Liquor stores
Boys & Girls clubs
Opportunities for prosocial involvement
Media
Lack of enforcement
Leadership
Image
Facebook
Social media
Objectifying violence/drugs in media
Family/Parenting
Smoke weed w/kids
Twitter
Instagram
Cyberbullying
Family cycle
Social Hosting
Lack of respect for family
Community perception



North Little Rock Behavioral Health Meeting

November 11, 2012

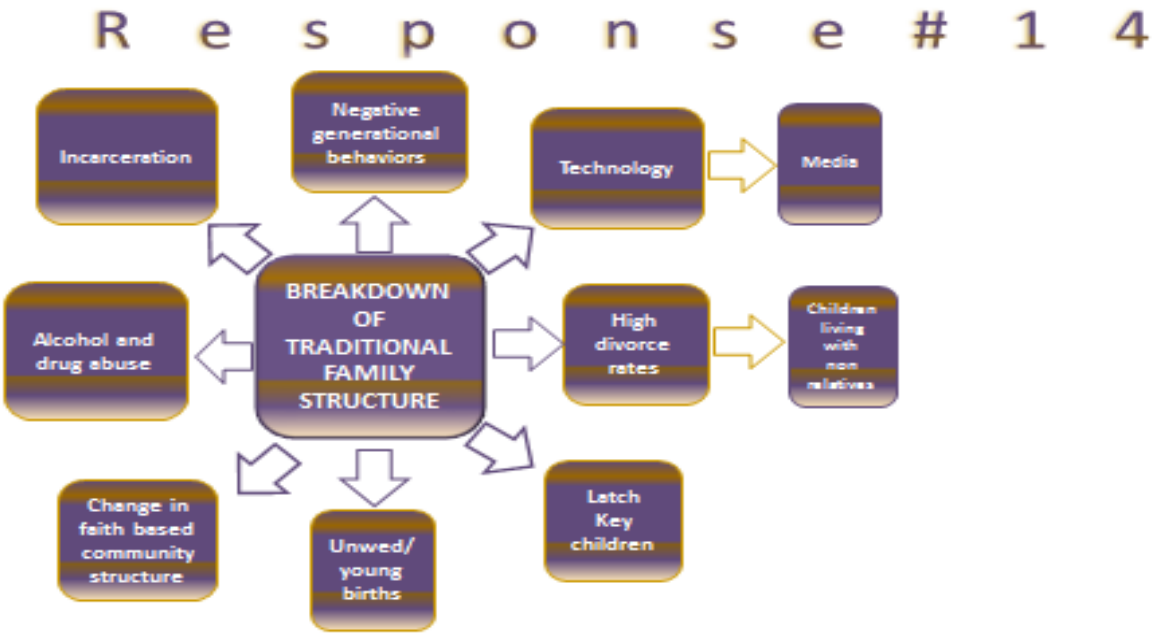
This community meeting covered a diversity of topics on risk factors for behavioral health issues. Lack of community resources, breakdown of family structure and stigma for seeking services were identified as the leading factors for substance abuse.

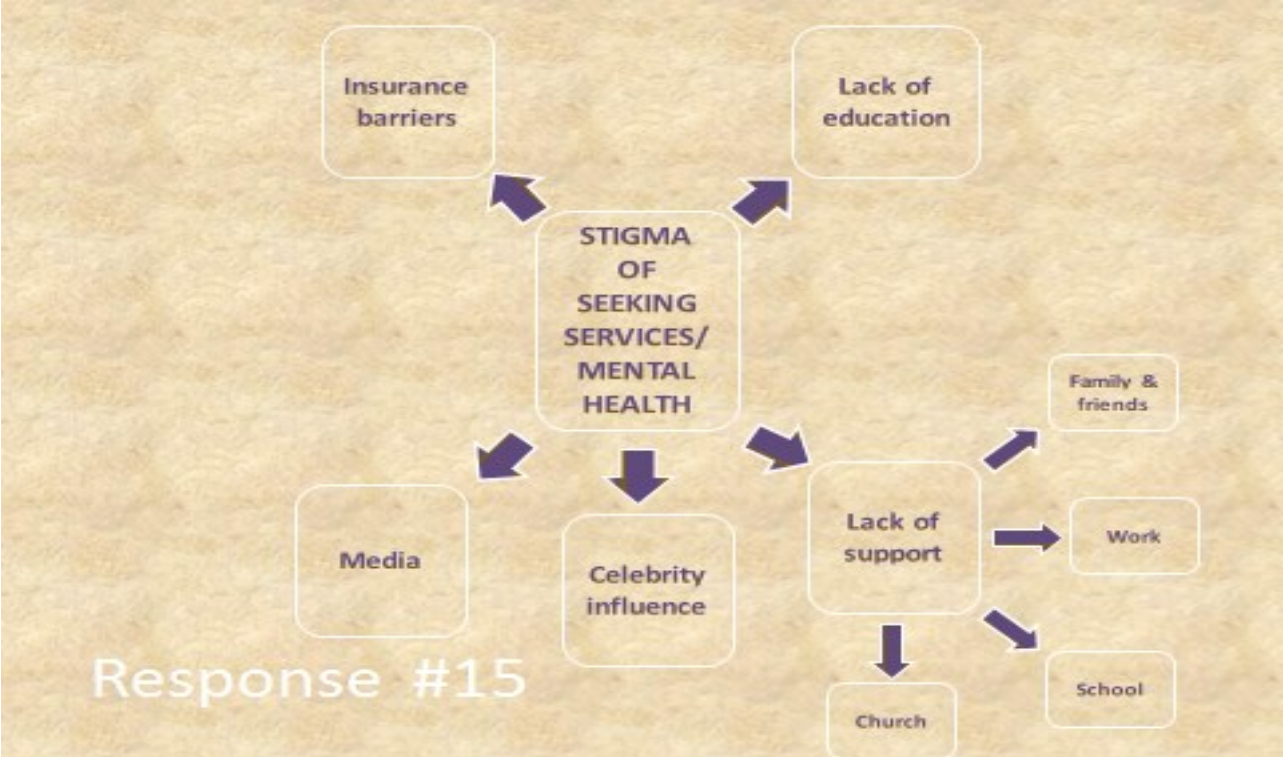
In some areas of this region there is a dearth of health behavioral health service. However in areas where services are available behavioral health providers do not communicate with each other and hence often operate in silos thereby giving a perception of lack of resources. This hinders referrals to appropriate facilities for such services.

A breakdown in the traditional family structure such as poor parenting skills, increase in single parent homes due to incarceration and high divorce rate, and a collapse of faith-based family units was identified as a huge factor in high substance use, misuse and abuse in this region.

Participants also identified stigma for seeking mental health and substance abuse prevention and treatment services as another factor contributing to substance abuse in this region. They pointed out that a lot of people do not seek such services as it may affect they current employment or ability to seek employment. Also the shame of being labeled as drug abuser or a psychiatric patient leads to self-medication or medicating with alcohol and other drugs.

Other factors identified as a consequence and risk factor for alcohol and drug abuse were homelessness especially among veterans, low graduation rates, poverty, lack of transportation, the legal system, race issues relating to unfair sentencing, and doctor shopping for prescription drugs.





Hope Behavioral Health Meeting

November 15, 2012

Primary concerns for high substance abuse expressed by the participants at this meeting centered on parenting and family involvement, lack of transportation, and lack of coordination or access to resources.

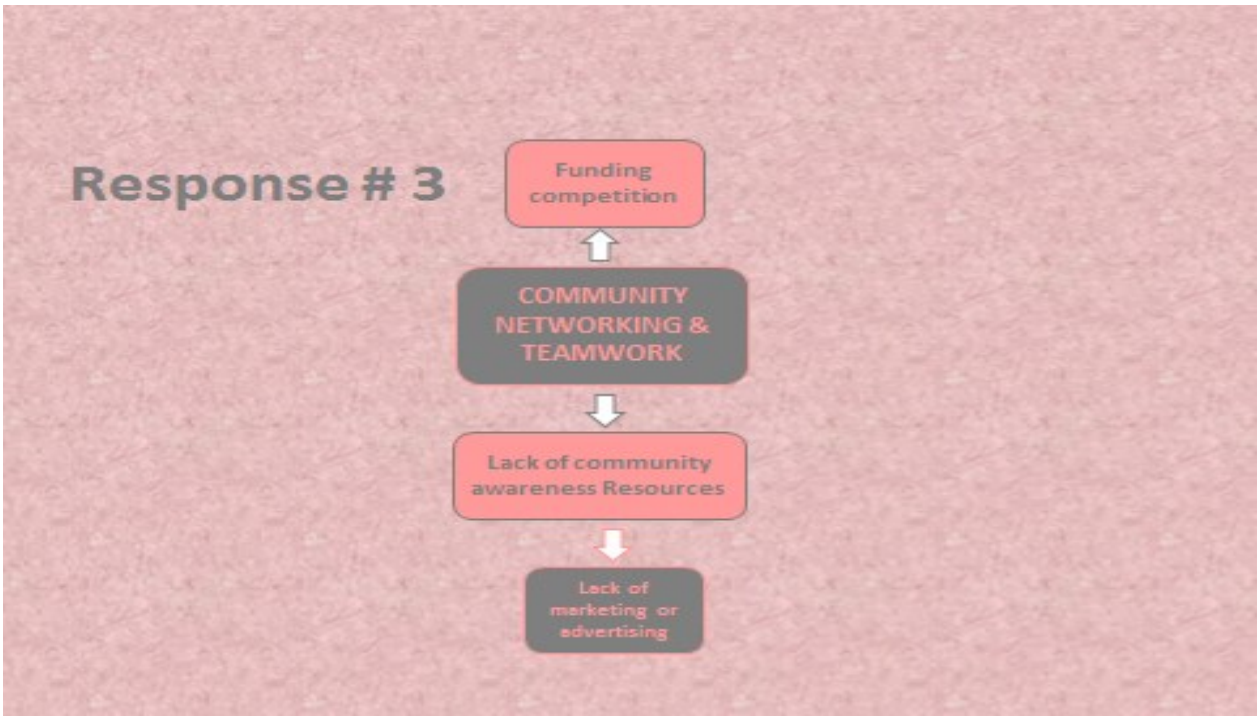
Parenting issues included a variety of factors such as parents feeling overwhelmed, fearing the system, or being self-absorbed. Participants talked about parent who act like teens or are teens themselves. Absentee parents were also mentioned due to incarceration, lack of father involvement, single parents having to serve in dual roles, and grandparents raising grandchildren. Parent education and lack of structure and skills were mentioned but it was also noted that parents who attend classes are sometimes labeled dysfunctional. Besides being a topic in itself, parenting was also seen as a risk factor for increased substance abuse in other topics.

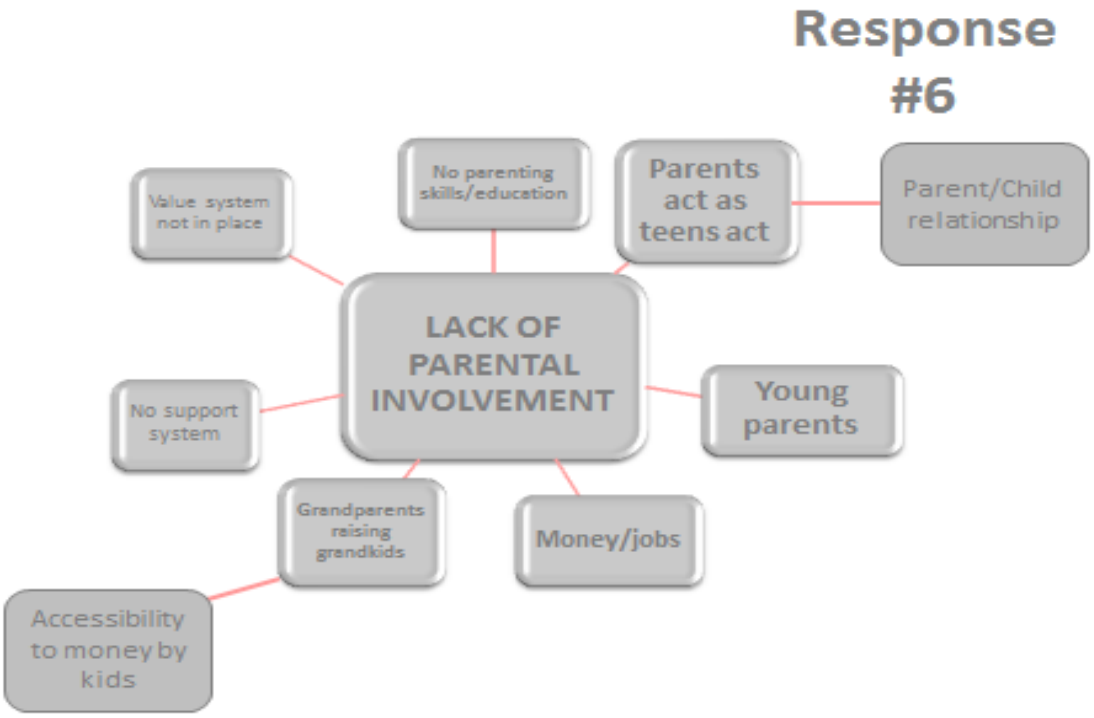
Due to the rural nature of these communities, lack of transportation was perceived to be a contributing factor to ATOD abuse. This limits access to prevention and treatment facilities, transportation to afterschool programs or facilities for alternative youth activities, to seek for employment, and even the purchase groceries. These limitations hence increase the risk of ATOD use as it leads to an increase in unemployment, inability to seek for healthcare and idleness especially among youths.

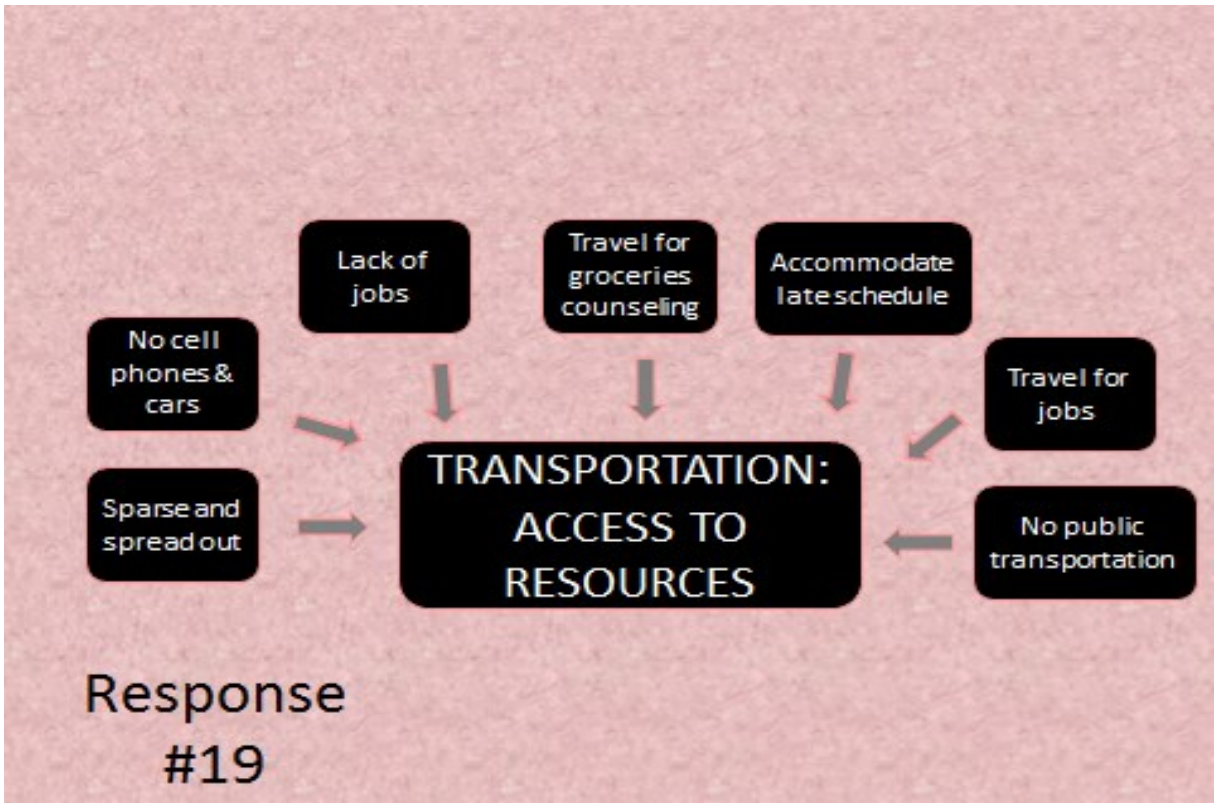
Lack of coordination and silos of services was seen as another major contributor of ATOD abuse. Participants explained that lack of collaboration among prevention providers themselves as well as with

prevention, treatment and mental health providers often lead to lack of services available within the communities.

Other factors identified were peer pressure, family and cultural norms, easy access, social media influences, limited behavioral health facilities, low self-esteem and lack of parental awareness of the dangers ATOD.






Lack of jobs
Travel for groceries counseling
Accommodate late schedule
No cell phones & cars
Travel for jobs
TRANSPORTATION: ACCESS TO RESOURCES
Sparse and spread out
No public transportation
Response #19

Appendix VIII

MidSOUTH Prevention Institute 2011 Training Survey

If you would like to complete the survey online go to https://www.midsouth.ualr.edu/survey/PIsurvey2011.html. Your time in completing this survey will provide the Prevention Institute with important information regarding the topics and locations for training which will assist us in planning upcoming workshops. It is very important that you complete **ALL** items. **Please submit your completed assessment to MSPI before Thursday, June 30, 2011.**

My work is **primarily (check only one)**:

- ☐ Education (teacher, counselor, administrator, school nurse)
- ☐ Prevention (prevention specialist, consultant, program administrator, ADAP)
- ☐ Correction/Law Enforcement (SRO, parole personnel)
- ☐ Volunteer
- ☐ Other not listed

What Arkansas County are you from: _____

Years of work experience: _____

I hold the following CPS or CPC certifications **(check only one)**:

- ☐ Certified Prevention Specialist (CPS)
- ☐ Certified Prevention Consultant (CPC)
- ☐ Enrolled in the process to become a CPS or CPC

Other certifications/licensures: _____

Please select the area you would most likely attend workshops, if offered **(check only one):**

- ☐ Arkadelphia
- ☐ Fayetteville
- ☐ Jonesboro
- ☐ Little Rock
- ☐ Monticello

Please submit your completed assessment before Thursday, June 30, 2011
Via mail or by clicking the link below

UALR – MidSOUTH Prevention Institute
2801 S. University Avenue, PP-103
Little Rock, AR 72204-1099
https://www.midsouth.ualr.edu/survey/PIsurvey2011.html

Prevention Resource Center Coordinators ONLY: Please provide an additional sheet to recommend advanced topics in which you need training.

Thank you again for taking the time to complete this assessment.
Your responses will be used to plan upcoming workshops.

Core Competencies	Check ✓ if you need training
Assessment:	
Creating and maintaining coalitions and partnerships	
Assessing community needs and resources	
Analyzing problems and goals	
Developing a framework or model of change	
Capacity:	
Building coalition leadership	
Increasing coalition participation	
Enhancing cultural competence	
Improving organizational management and development	
Planning:	
Developing strategic and action plans	
Implementation:	
Developing interventions	
Advocating for change	
Influencing policy development	
Writing grant applications for funding	
Evaluation:	
Evaluating initiatives	
Sustaining projects and initiatives	
ESSENTIAL PROCESSES	
Conducting a community assessment	
Developing a logic model (A picture of how an effort or initiative is supposed to work.)	
Creating an action plan	
Developing an intervention	
Creating an evaluation plan	
Creating a sustainability plan	
Prevention Knowledge & Responsibilities	
Using Institute of Medicine (IOM) categories to select the appropriate strategy	
Understanding models, theories, concepts and strategies of prevention	
Identifying human development/ life stages	
Listing and Describing risk and resiliency (protective) factors	
Developing measurable goals and outcome objectives	
Describing the process of addiction	
Knowledge of Center for Substance Abuse Prevention's (CSAP) 6 Prevention Strategies	
Knowledge of current trends in drug use patterns	
Practicing ethical behavior	
Adhering to legal and professional standards to protect the public and promote integrity of the profession	
Maintaining proficiency in technology, facilitation and presentation skills	
Knowledge of the National Outcome Measures (NOMs) (i.e. Abstinence from Drug/Alcohol Use, Return To/Stay in School)	

MidSOUTH School of Social Work

MidSOUTH Prevention Institute

Prevention Workforce Needs Assessment Report - Statewide
September 11

Statewide Results
(n=339)

Top training needs as identified by participants based on Prevention Workforce Needs Assessments:

1.	**320**	Conducting a community assessment
2.	**310**	Creating and maintaining coalitions and partnerships
3.	**308**	Using Institute of Medicine categories to select the appropriate strategy
4.	**147**	Writing grant applications for funding
5.	**120**	Assessing community needs and resources
6.	**116**	Developing interventions
7.	**108**	Describing the process of addiction
8.	**108**	Knowledge of current trends in drug use patterns
9.	**106**	Creating a sustainability plan
10.	**106**	Maintaining proficiency in technology, facilitation and presentation skills

University of Arkansas at Little Rock

Appendix IX

Recommended Data Sources

State Epidemiological Workgroup (SEW) Statewide Profile

The Arkansas Epidemiological Statewide Profile report provides an overview of substance use consumption and consequence at both statewide and county levels. The purpose of the profile is to provide state policy-makers with a comprehensive picture of substance abuse challenges faced in Arkansas. Substance abuse data is compiled from various national and state agencies (e.g. Department of Education, Highway Safety, Tobacco Control Board, AR Beverage Control, Department of Health, Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, etc.) to integrate information regarding the causes and consequences of the use of alcohol, tobacco, and other drugs in both adult and child populaces. The profile includes a general population profile, information about factors that may contribute to substance abuse, and in an effort to determine the effect of substance abuse in Arkansas, health and economic consequences. Specific county level data is included for each of the 75 counties as a resource for community leaders throughout Arkansas. This report is posted online at http://www.preventionworksar.org/.

Arkansas Prevention Needs Assessment

The Arkansas Prevention Needs Assessment (APNA) student Survey is conducted annually. APNA uses the Communities That Care Student Survey instrument which is based on risk and protective factors and collects information on drug use and social indicators. Arkansas public school students in 6th, 8th, 10th, and 12th grades are surveyed. Each participating district is provided its own data results in district and building level reports (providing the number of participants is large enough for student anonymity). Data results are also published at the county, region, and state levels and posted on line for public access. The APNA data has become a major planning resource for communities, schools, and state agencies. APNA data is used by a variety of organizations for both state and community level planning. APNA Reports are accessible online at the DBHS website at http://humanservices.arkansas.gov/dbhs/Pages/oadap.aspx. Scroll down and the link is in the left-hand column.

Arkansas Traffic Crash Statistics

The Arkansas State Police Highway Safety Officer publishes annual reports that include information about vehicle and motorcycle accidents in a variety of situations (e.g. involving alcohol, inclement weather, varying road conditions, and different times of day) for both fatal and non-fatal crashes. These reports also include trending for year and age of drivers as well as county and city statistics. Full reports can be found at http://www.asp.arkansas.gov/hso/hso_index.html.

Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas (ARF)

The Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas is a compilation of data reported by various state agencies (e.g. Department of Education, Highway Safety, Tobacco Control Board, AR Beverage Control, Department of Health, Division of Youth Services, etc.) Approximately 90 archival data indicators are collected annually and organized according to the following categories: Demographic data, Community Domain, Family Domain, School Domain, Peer/Individual Domain, and Consequences. The publication reports the data at the state region, and county levels. To depict data trends, the annual publication includes data for each of the most recent five ears and for the 10th year back (six years of data). This compilation provides DBHS and communities, schools, agencies, and organizations with readily accessible data needed for effective planning of prevention efforts. It has also proven to be a valuable

resource for other fields, including treatment, youth services, etc. This report is posted online at http://www.preventionworksar.org/.

Behavioral Risk Factor Surveillance System (BRFSS)

The Centers for Disease Control (CDC) designed the BRFSS to collect information on health conditions and risk behaviors in the United States. It is currently the primary source of data for states and the nation on health-related behaviors of adults. The BRFSS is administered by the Arkansas Department of Health with assistance from the CDC. All states ask a set of core questions and have the option of adding modules designed by the CDC or asking their own (state-designed) questions. Households are selected randomly by the CDC. Data is collected monthly through telephone interviews with adults (aged 18 and older), and data is analyzed and reported by both the CDC and designated state agencies. Annual Arkansas BRFFS information can be found online at http://brfss.arkansas.gov/.

CORE

The CORE Alcohol and Drug Survey was developed in the late 1980s by the U.S. Department of Education and advisors from several universities and colleges to measure alcohol and other drug usage, attitudes, and perceptions among college students at two and four year institutions. The survey is administered by the CORE Institute at Southern Illinois University –Carbondale (SIUC). The survey includes several types of items about alcohol and drugs. One type deals with the students' attitudes, perceptions, and opinions about alcohol and other drugs and the other deals with the students' own use and consequences of use. There are also several items on students' demographic and background characteristics as well as perception of campus climate issues and policy. More information on the CORE survey is available online at http://www,siu.edu/departments/coreinst/public_html/.

Monitoring the Future (MTF)

Monitoring the Future is an ongoing study of behaviors, attitudes, and values of American secondary school students, college students, and young adults. Each year, a total of approximately 50,000 8th, 10th, and 12th grade students are surveyed (12th graders since 1975, and 8thand 10th graders since 1991). In addition, annual follow-up questionnaires are mailed to a sample of each graduating class for a number of years after their initial participation. MTF reports are available online at http://www.monitoringthefture.org/.

National Survey on Drug Use and Health

The National Survey on drug Use and Health (NSDUH) is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals age 12 and older. The Substance Abuse and Mental Health Services Administration (SAMHSA), which funds NSDUH, is an agency within the U.S. Public Health, a part of the U.S. Department of Health and Human Services. Supervision of the project comes from SAMHSA's Office of Applied Studies (OAS). Data from the NSDUH provides national and state-level estimates of the past month, past year, and lifetime use of tobacco products, alcohol, illicit drugs, and non-medical use of prescription drugs. More information on the NSDUH is available online at http://www.oas.samhsa.gov/states.htm.

Appendix X

Acronyms and Terminologies

Acronyms

ADAP - Arkansas Office of Alcohol and Drug Abuse Prevention

AOD - Alcohol and Other Drugs

APNA- Arkansas Prevention Needs Assessment Survey

ARF - Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas

ATOD - Alcohol Tobacco and Other Drugs

BRFSS - Behavioral Risk Factor Surveillance System

CADCA - Community Anti-Drug Coalitions of America

CAPT - Center for the Application of Prevention Technologies

CDC - Centers for Disease Control and Prevention

CSAP - Center for Substance Abuse Prevention

DBHS - Arkansas Division of Behavioral Health Services

DEA - Drug Enforcement Administration

DFSCA - Drug-Free Schools and Communities Act

DHHS - U.S. Department of Health and Human Services

DOE - Department of Education

GPRA - Government Performance and Results Act

GIS - Geographic Information System

ICRC - International Certification Reciprocity Consortium

IOM - Institute of Medicine

MDS - Minimum Data Set System

MADD - Mothers Against Drunk Drivers

MTF - Monitoring the Future

NASADAD - National Association of State Alcohol and Drug Abuse Directors

NCADI - CSAP's National Clearinghouse for Alcohol and Drug Information

NIDA - National Institute on Drug Abuse (institute within NIH)

NIH - National Institute of Health

NPN - National Prevention Network

NREPP - National Registry of Evidence-based Programs and Practices

NSDUH - National Survey on Drug Use and Health

OJJDP - Office of Juvenile Justice and Delinquency Prevention

ONDCP - Office of National Drug Control Policy

PRC - Prevention Resource Center

SAPT - Substance Abuse Prevention and Treatment

SAMHSA - Substance Abuse & Mental Health Services Admin

SEOW - State Epidemiological Outcomes Workgroups

SPE - Strategic Prevention Framework State Prevention Enhancement Grant

SPF - Strategic Prevention Framework

SPF SIG - Strategic Prevention Framework State Incentive Grant

YRBS - Youth Risk Behavior Survey

Terminology

Alcohol and Drug Abuse Coordinating Council

A body created by legislation with the responsibility for overseeing all planning, budgeting, and implementation of expenditure of state and federal funds allocated for alcohol and drug education, prevention, treatment, and law enforcement.

Alternative Approaches

This CSAP strategy provides for the participation of target populations in activities that exclude substance use.

Binge Alcohol Use

Drinking five or more drinks on the same occasion (i.e. drinks are consumed at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

Capacity Building

Increasing the ability and skills of individuals, groups, and organizations to plan, undertake, and manage initiatives. The approach also enhances the capacity of the individuals, groups, and organizations to deal with future issues or problems.

Coalition

Coalition is the full partnerships or collaborations among organizations or sectors that require sharing resources and leadership within a community in which each group retains its identity but all agree to work together toward a common goal of building a safe, healthy, and drug-free community on an ongoing basis.

Community Development

Community Development is indicated by collaborative, collective action taken by local people to enhance the long-term social, economic, and environmental conditions of their community. The primary goal of community development is to create a better overall quality of life for everyone in the community.

Community Readiness

Community readiness is the degree of support for or resistance to identifying substance use and abuse as significant social problems in a community.

Community-Based Approach

A prevention approach that focuses on the problems or needs of an entire community, be it a large city, a small town, a school, a worksite, or a public place. Other popular approaches include school-based, family-based, environmental prevention.

Community-Based Process

This CSAP strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration building, and networking.

Contributing Factors

A set of community specific issues that compromise the intervening variables. They are the key link to identifying prevention strategies.

Consequence Data

Consequence Data identifies the prevalence and incidence of substance use. It is the data we use to determine who, what, when, where, and how often.

Consumption Data

Consumption Data identifies the impact of substance use on the individual and society. Substance use consequence data includes impacts on health (e.g. hospital admissions), criminal justice (e.g. arrests, traffic crashes), and children and adolescents (e.g. school performance).

Culturally Appropriate

Activities and programs that take into account the practices and beliefs of a particular social or cultural group so that the programs and activities are acceptable, accessible, persuasive, and meaningful.

Cultural Competence

Cultural competence describes the ability of an individual or organization to interact effectively with people of different cultures.

Data Driven

A process whereby decisions are informed by and tested against systematically gathered and analyzed information.

Effectiveness

Refers to whether the intervention typically is successful in actual clinical practice. SAMHSA Effective Programs are well-implemented, well-evaluated programs that produce a consistent positive pattern of results (across domains and/or replications).

Efficacy

Refers to whether the intervention can be successful when it is properly implemented under controlled conditions

Environmental Approaches

This is a CSAP strategy that establishes or changes community standards, codes, and attitudes and thus influences the incidence and prevalence of substance abuse.

Environmental Factors

Environmental factors are external or perceived to be external to an individual but that may nonetheless affect his or her behavior.

Epidemiology

Epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems.

Evaluation

Evaluation is a process that helps prevention practitioners to determine the strengths and weaknesses of their activities so that they can make improvements over time. Time spent on evaluations is well spent because it allows groups to use money and other resources more efficiently in the future.

Evidence-based Programs

These are successful, well-implemented, and well-evaluated programs that have been reviewed by the National Registry of Effective Programs and Practices (NREPP) according to rigorous standards of research.

Evidence Based Strategies

These are successful, well-implemented and well-evaluated programs, practices or policies that address contributing factors and their related risk behaviors.

Environmental Strategies

Establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two sub categories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.

Fidelity

Fidelity means maintaining the core components, framework, program elements, delivery schedule, and dosage/exposure as intended by the program developer. Ensuring programs maintain those core elements will enhance the likelihood that those original positive outcomes are achieved in a replication.

Heavy Alcohol Use

This is drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days. All heavy alcohol users are also binge alcohol users.

Indicated Prevention Measure

This is a prevention measure directed to specific individuals with known, identified risk factors.

Impact Evaluation

Impact evaluation is a type of outcome evaluation that focuses on the broad, long-term impacts or results of program activities. For example, an impact evaluation could show that a decrease in a community's crime rate is the direct result of a program designed to provide community policing.

Incidence

The number of new cases of a disease or occurrences of an event in a particular time period usually expressed as a rate, with the number of cases as the numerator and the population at risk as the denominator.

Intervention

An intervention is an activity or set of activities to which a group is exposed in order to change the group's behavior. In substance abuse prevention, interventions may be used to prevent or lower the rate of substance abuse or substance abuse-related problems.

IOM - Institute of Medicine

A nonprofit national component organization of the National Academies of Science specifically created to advice national policy makers, and federal agencies on matters of biomedical science, medicine and health. Its mission is to improve health by providing unbiased, evidence-based and authoritative information and advice concerning science and health policy.

Logic Model

Logic Model is a pictorial representation of connections between the activities, strategies and methods and goals of an initiative or enterprise; a flow chart. It explains why the strategy is a good solution to the problem at hand and makes an explicit, often visual, statement of activities and results. It keeps participants moving in the same direction through common language and points of reference. As an element of work itself, the logic model can energize and rally support by declaring what will be accomplished, and how.

Measures

The tools used to obtain the information or evidence needed to answer a research question.

Needs Assessment

Activities that include surveys of various targeted populations, assessment of prevention resources within the state, studies of current outcome indicators, demographic analyses of social marketing data, and household and school surveys

Outcome

The extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement. Depending on the nature of the intervention and the theory of change guiding it, changes can be short-term, intermediate, and longer-term outcomes.

Outcome Evaluation

A type of evaluation used to identify the results of a program's effort. It seeks to answer the question, what difference did the program make? It yields evidence about the effects of a program after a specified period of operation.

Outcome Measures

Assessments that gauge the effect or results of services provided to a defined population. Outcomes measures include the consumers' perception of restoration of function, quality of life, and functional status, as well as objective measures of mortality, morbidity, and health status.

Partnership

A partnership is a relationship where two or more parties, having common and compatible goals, agree to work together for a particular purpose and/or for some period of time.

Prevalence

The number of all new and old cases of a disease or occurrences of an event during a particular time period usually expressed as a rate, with the number of cases or events as the numerator and the population at risk as the denominator.

Prevention

Prevention is a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles

Preventionist

One who routinely practices prevention in his/her existing societal role, whether paid or volunteer, acting in a personal or professional capacity. Preventionists include parents, clergy, teachers, law enforcement, business owners, etc.

Process Evaluation

Evaluation design to document what policies and/or programs actually happened, detailing activities, participants involved, resources, methods of management, and other output indicators. It describes how the program operates, the services it delivers, and the functions it carries out. It addresses whether the program was implemented and is providing services as intended.

Program Evaluation

Program evaluation is the systematic collection of information to answer important questions about activities, characteristics, and outcomes of a program. Evaluation stages include design, data collection, data analysis and interpretation, and reporting.

Protective Factors

Protective factors are those characteristics that may strengthen resilience and thus guard against the occurrence of a particular problem.

Public Health Model

Public Health Model is a model that represents the interactions among the agent, host and environment. In substance abuse prevention, the agent is alcohol or drugs or the sources, supplies, and availability of alcohol and drugs. Hosts can be seen as the potential and/or active substance users. The environment is the social climate that encourages and supports the potential and/or actual use of substances. The public health model posits that all of these factors must be addressed together for prevention to be effective.

Quantitative Data

Quantitative data is numeric information that includes things like personal income, amount of time, or a rating of an opinion on a scale from 1 to 5. Quantitative data is used with closed-ended questions, where users are given a limited set of possible answers to a question. They are for responses that fall into a relatively narrow range of possible answers.

Qualitative Data

Qualitative data is a record of thoughts, observations, opinions, or words. Qualitative data typically comes from asking open-ended questions to which the answers are not limited by a set of choices or a scale. Qualitative data is best used to gain answers to questions that produce too many possible answers to list them all or for answers that you would like in the participant's own words.

Resilience

Resilience is either the capacity to recover from traumatically adverse life events and other types of adversity and achieve eventual restoration or improvement of competent functioning or the capability to withstand chronic stress and to sustain competent functioning despite ongoing stressful and adverse life conditions.

Risk Factors

Risk factors are characteristics associated with potential substance abuse problems. However, they are not necessarily the cause of the problem.

Stakeholder

A stakeholder is a person, group, organization, member or system that affects or can be affected by a community or an organization's actions.

Strategic Planning

A deliberate set of steps that assess needs and resources; define a target audience and a set of goals and objectives; plan and design coordinated strategies with evidence of success; logically connect these strategies to needs, assets, and desired outcomes; and measure and evaluate the process and outcomes.

Strategic Prevention Framework

The Strategic Prevention Framework (SPF) is a major SAMHSA initiative and includes five components: needs assessment, capacity, planning, implementation, and evaluation in an effort to encompass the state and all sectors of the community. This is the planning approach adopted by SAMHSA that is a required logic model process for grants supported by their funds.

Strategy

Strategies are types of activities (e.g., policy) that can be implemented to achieve specific objectives and for which a strong evidence base may or may not exist.

Universal Prevention Measure

A preventive measure directed to a general population or general subsection of the population not yet identified on the basis of risk factors, but for whom prevention activity could reduce the likelihood of problems developing.

Sources: Southwest Prevention Center, CADCA, SAMHSA/CSAP, DBHS

ANNUAL SYNAR REPORT

42 U.S.C. 300x-26

OMB № 0930-0222

FFY 2013

State: Arkansas

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INTRODUCTION

The Annual Synar Report (ASR) format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 U.S.C. 300x-26) and the Tobacco Regulation for the SAPT Block Grant (45 C.F.R. 96.130 (e)).

Public reporting burden for the collection of information is estimated to average 15 hours for Section I and 3 hours for Section II, including the time for reviewing instructions, completing and reviewing the collection of information, searching existing data sources, and gathering and maintaining the data needed. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to SAMHSA Reports Clearance Officer; Paperwork Reduction Project; 1 Choke Cherry Road, 7th Floor Rockville, Maryland 20857.

An agency may not conduct or sponsor and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0222 with an expiration date of 05-31-2013.

How the Synar report helps the Center for Substance Abuse Prevention

In accordance with the tobacco regulations, States are required to provide detailed information on progress made in enforcing youth tobacco access laws (FFY 2012 Compliance Progress) and future plans to ensure compliance with the Synar requirements to reduce youth tobacco access rates (FFY 2013 Intended Use Plan). These data are required by 42 U.S.C. 300x-26 and will be used by the Secretary to evaluate State compliance with the statute. Part of the mission of the Center for Substance Abuse Prevention (CSAP) is to assist States[1] by supporting Synar activities and providing technical assistance helpful in determining the type of enforcement measures and control strategies that are most effective. This information is helpful to CSAP in improving technical assistance resources and expertise on enforcement efforts and tobacco control program support activities, including State Synar Program support services, through an enhanced technical assistance program involving conferences and workshops, development of training materials and guidance documents, and onsite technical assistance consultation.

How the Synar report can help States

The information gathered for the Synar report can help States describe and analyze substate needs for program enhancements. These data can also be used to report to the State legislature and other State and local organizations on progress made to date in enforcing youth tobacco access laws when aggregated statistical data from State Synar reports can demonstrate to the Secretary the national progress in reducing youth tobacco access problems. This information will also provide Congress with a better understanding of State progress in implementing Synar, including State difficulties and successes in enforcing retailer compliance with youth tobacco access laws.

[1]The term "State" is used to refer to all the States and territories required to comply with Synar as part of the Substance Abuse Prevention and Treatment Block Grant Program requirements (42 U.S.C. 300x-64 and 45 C.F.R. 96.121).

Getting assistance in completing the Synar report

If you have questions about programmatic issues, you may call CSAP's Division of State Programs at (240) 276-2413 and ask for your respective State Project Officer, or contact your State Project Officer directly by telephone or email. If you have questions about fiscal or grants management issues, you may call the Grants Management Officer, Office of Program Services, Division of Grants Management, at (240) 276-1422.

Where and when to submit the Synar report

The Annual Synar Report (ASR) must be received by SAMHSA no later than December 31, 2012. The ASR must be submitted in the **approved OMB report format.** Use of the approved format will avoid delays in the review and approval process. The chief executive officer (or an authorized designee) of the applicant organization must sign page 1 of the ASR certifying that the State has complied with all reporting requirements.

The State must upload one copy of the ASR using the online WebBGAS (Block Grant Application System). In addition, the following items must be uploaded to WebBGAS:

- FFY 2013 Synar Survey Results: States that use the Synar Survey Estimation System (SSES) must upload one copy of SSES Tables 1–5 (in Excel) to WebBGAS. States that do not use SSES must upload one copy of ASR Forms 1, 4, and 5, and Forms 2 and 3, if applicable, (in Excel) to WebBGAS.
- Synar Inspection Form: States must upload one blank copy of the inspection form used to record the result of each Synar inspection.
- Synar Inspection Protocol: States must upload a copy of the protocol used to train inspection teams on conducting and reporting the results of the Synar inspections.

Each State SSA Director has been emailed a login ID and password to log onto the Synar section of the WebBGAS site.

Additionally, the State must submit one signed original of the report (including the signed Funding Agreements/Certifications), as well as one additional copy of the signed Funding Agreements/Certifications, to the Grants Management Officer at the address below:

Grants Management Officer
Office of Program Services
Division of Grants Management
Substance Abuse and Mental Health Services Administration

Regular Mail:	**Overnight Mail:**
1 Choke Cherry Road, Rm.7-1091 Rockville, Maryland 20857	1 Choke Cherry Road, Rm.7-1091 Rockville, Maryland 20850

FFY 2013: FUNDING AGREEMENTS/CERTIFICATIONS

The following form must be signed by the Chief Executive Officer or an authorized designee and submitted with this application. Documentation authorizing a designee must be attached to the application.

PUBLIC HEALTH SERVICES ACT AND SYNAR AMENDMENT
42 U.S.C. 300x-26 requires each State to submit an annual report of its progress in meeting the requirements of the Synar Amendment and its implementing regulation (45 C.F.R. 96.130) to the Secretary of the Department of Health and Human Services. By signing below, the chief executive officer (or an authorized designee) of the applicant organization certifies that the State has complied with these reporting requirements and the certifications as set forth below.
SYNAR SURVEY SAMPLING METHODOLOGY
The State certifies that the Synar survey sampling methodology on file with the Center for Substance Abuse Prevention and submitted with the Annual Synar Report for FFY 2013 is up-to-date and approved by the Center for Substance Abuse Prevention.
SYNAR SURVEY INSPECTION PROTOCOL
The State certifies that the Synar Survey Inspection Protocol on file with the Center for Substance Abuse Prevention and submitted with the Annual Synar Report for FFY 2013 is up-to-date and approved by the Center for Substance Abuse Prevention.
State:
Name of Chief Executive Officer or Designee:
Signature of CEO or Designee:
Title: _____ **Date Signed:** _____
If signed by a designee, a copy of the designation must be attached.

SECTION I: FFY 2012 (Compliance Progress)

YOUTH ACCESS LAWS, ACTIVITIES, AND ENFORCEMENT

42 U.S.C. 300x-26 requires the States to report information regarding the sale/distribution of tobacco products to individuals under age 18.

1. **Please indicate any changes or additions to the State tobacco statute(s) relating to youth access since the last reporting year. If any changes were made to the State law(s) since the last reporting year, please attach a photocopy of the law to the hard copy of the ASR and also upload a copy of the State law to WebBGAS.** *(see 42 U.S.C. 300x-26).*

   a. **Has there been a change in the *minimum sale age* for tobacco products?**

   ☐ **Yes** ☒ **No**

   *If **Yes,** current minimum age:* ☐ 19 ☐ 20 ☐ 21

   b. **Have there been any changes in State law that impact the State's *protocol for conducting Synar inspections?*** ☐ **Yes** ☒ **No**

   *If **Yes,** indicate change. (Check all that apply.)*

   ☐ Changed to require that law enforcement conduct inspections of tobacco outlets
   ☐ Changed to make it illegal for youth to possess, purchase or receive tobacco
   ☐ Changed to require ID to purchase tobacco
   ☐ Other change(s) *(Please describe.)* _____

   c. **Have there been any changes in the law concerning *vending machines?***

   ☐ **Yes** ☒ **No**

   *If **Yes,** indicate change. (Check all that apply.)*

   ☐ Total ban enacted
   ☐ Banned from location(s) accessible to youth
   ☐ Locking device or supervision required
   ☐ Other change(s) *(Please describe.)* _____

   d. **Have there been any changes in State law that impact the following?**

   Licensing of tobacco vendors ☐ **Yes** ☒ **No**
   Penalties for sales to minors ☐ **Yes** ☒ **No**

2. **Describe how the Annual Synar Report** *(see 45 C.F.R. 96.130(e))* **and the State Plan** *(see 42 U.S.C. 300x-51)* **were made public within the State prior to submission of the ASR.** *(Check all that apply.)*

   ☐ Placed on file for public review

   ☐ Posted on a State agency Web site *(Please provide exact Web address and the date when the FFY 2013 ASR was posted to this Web address.)*

http://humanservices.arkansas.gov/dbhs/Pages/dbhs_docs.aspx

☐ Notice published in a newspaper or newsletter
☐ Public hearing
☐ Announced in a news release, a press conference, or discussed in a media interview
☒ Distributed for review as part of the SAPT Block Grant application process
☐ Distributed through the public library system
☐ Published in an annual register
☐ Other *(Please describe.)* _____

3. **Identify the following agency or agencies** *(see 42 U.S.C. 300x-26 and 45 C.F.R. 96.130).*

   a. **The State agency(ies)** ***designated by the Governor for oversight of the Synar requirements:***

   Division of Behavioral Health Services (DBHS), Arkansas Department of Human Services (DHS)

   Has this changed since last year's Annual Synar Report? ☐ **Yes** ☒ **No**

   b. **The State agency(ies)** ***responsible for conducting random, unannounced Synar inspections:***

   Division of Behavioral Health Services (DBHS)

   Has this changed since last year's Annual Synar Report? ☐ **Yes** ☒ **No**

   c. **The State agency(ies)** ***responsible for enforcing youth tobacco access law(s):***

   Arkansas Tobacco Control(ATC) Board

   Has this changed since last year's Annual Synar Report? ☐ **Yes** ☒ **No**

4. **Identify the State agency responsible for tobacco prevention activities (the agency that receives the Centers for Disease Control and Prevention's National Tobacco Control Program funding).**

   Division of Behavioral Health Services (DBHS), ATC, and Center for Health Advancement (Arkansas Department of Health)

   Has the responsible agency changed since last year's Annual Synar Report?

   ☐ **Yes** ☒ **No**

   a. **Describe the coordination and collaboration that occur between the agency responsible for tobacco prevention and the agency responsible for oversight of the Synar requirements.** *(Check all that apply.)* **The two agencies**

   ☐ Are the same
   ☐ Have a formal written memorandum of agreement
   ☒ Have an informal partnership
   ☐ Conduct joint planning activities

☐ Combine resources

☐ Have other collaborative arrangement(s) *(Please describe.)* _____

5. **Please answer the following questions regarding the State's activities to enforce the youth access to tobacco law(s) in FFY 2012** *(see 42 U.S.C. 300x-26 and 45 C.F.R. 96.130(e)).*

   a. **Which one of the following describes the enforcement of youth access to tobacco laws carried out in your State?** *(Check one category only.)*

   ☐ Enforcement is conducted exclusively by local law enforcement agencies.

   ☒ Enforcement is conducted exclusively by State agency(ies).

   ☐ Enforcement is conducted by both local *and* State agencies.

   b. **The following items concern penalties imposed for violations of youth access to tobacco laws by LOCAL AND/OR STATE LAW ENFORCEMENT AGENCIES. Please fill in the number requested. If State law does not allow for an item, please mark "NA" (not applicable). If a response for an item is unknown, please mark "UNK." The chart must be filled in completely.**

PENALTY	OWNERS	CLERKS	TOTAL
Number of citations issued	317	304	621
Number of fines assessed	103	NA	103
Number of permits/licenses suspended	29		29
Number of permits/licenses revoked	0		0
Other *(Please describe.)* *214 – 1st offense warnings* *103- Fines totaling $34,300.00*			

   c. **Which one of the following best describes the level of enforcement of youth access to tobacco laws carried out in your State?** *(Check one category only.)*

   ☐ Enforcement is conducted only at those outlets randomly selected for the Synar survey.

   ☐ Enforcement is conducted only at a subset of outlets not randomly selected for the Synar survey.

   ☒ Enforcement is conducted at a combination of outlets randomly selected for the Synar survey and outlets not randomly selected for the Synar survey.

   d. **Did every tobacco outlet in the State receive at least one enforcement compliance check in the last year?**

   ☐ Yes

   ☒ No

   e. **What additional activities are conducted in your State to support enforcement and compliance with State tobacco access law(s)?** *(Check all that apply.)*

   ☒ Merchant education and/or training

☐ Incentives for merchants who are in compliance (e.g., nonenforcement compliance checks in which compliant retailers are given positive reinforcement and noncompliant retailers are warned about youth access laws)

☒ Community education regarding youth access laws

☐ Media use to publicize compliance inspection results

☒ Community mobilization to increase support for retailer compliance with youth access laws

☒ Other activities *(Please list.) Arkansas Tobacco Control Board(ATC) is predominantly funded through a Memorandum of Agreement with the Arkansas Department of Health's (ADH) Tobacco Prevention and Cessation Program (TPCP) and works with the Division of Behavioral Health Services (DBHS) Prevention Resource Centers (PRCs) to provide tobacco merchant education throughout the state of Arkansas. The training consists of reviewing the sales to minors law and explaining the penalties for violating the law. The training also covers what specific items are age restricted according to the law. Each student receives a driver's license brochure showing how to recognize an underage ID by the color coding and vertical format. The class gives each student an opportunity to ask any questions that they might have.*

The Arkansas Tobacco Control Board has been awarded a one year contract for services which includes data collection to be utilized by the Food and Drug Administration for regulatory activity.

ATCB recognizes a job well done by sending out what is called a "good news" letter within 24 hours of a passed compliance check. The letter is generated and mailed to the store's home office stating the date and the time the check occurred and that the store passed. The letter encourages management and their employees to keep up the good work.

DBHS's PRCs provide merchant education in their regions to assist with reducing sales of tobacco to underage youth. Also, each region may choose to have the list of merchants who did not sell to youth during the Synar checks reported in their local paper to recognize and congratulate those who were in compliance with the law. PRCs also participate as members in their local tobacco coalitions.

In local communities throughout the state, ADH's Hometown Health Initiative, as well as ADH/TPCP's funded coalitions help to promote tobacco prevention. ADH/TPCP's community-based coalitions' media activities include print and radio advertising, billboards, letters to the editor, and press releases on topics involving the dangers of tobacco use and secondhand smoke as well as promotion of the Arkansas Tobacco Quitline and local tobacco cessation resources. All of the coalitions work with their local news media and a small percentage of the coalitions also do local advertising.

Through the Master Settlement Agreement (MSA), the Arkansas Department of Health, Tobacco Prevention and Cessation Program (TPCP) supports local prevention and cessation efforts. The statewide tobacco counter-marketing activities, branded as SOS ("Stamp Out Smoking" and "Smokeless isn't Harmless"), include paid print, radio, and television advertising on topics involving the dangers of tobacco use and secondhand smoke and promote use of the Arkansas Tobacco Quitline. The paid advertising targets both young and adult audiences, particularly urging them to call the Quitline. Other health communication intervention activities include press releases, radio/television news stories, editorials, and event sponsorships (state and county fairs and other county festivals). These messages are strategically designed to target specific demographics through grassroots efforts as well as various types of media, such as print, television, radio, and internet. SOS has been instrumental in building favorable outcomes through its tobacco counter-marketing campaign. Since the inception of SOS, media recall for the Stamp Out Smoking brand is 80% in a 2010 survey. Additional indicators of success are the numbers of Public Services Announcements, community events, and media advertisement funds leveraged.

Since fiscal year 2003, local coalitions and community-based tobacco control programs have been funded. These programs are responsible for engaging youth in developing and implementing tobacco control interventions; developing partnerships with local organizations; conducting educational programs for young people, parents, enforcement officials, community and business leaders, health care providers, school personnel, and others; promoting governmental and voluntary policies to strengthen the Clean Indoor Air Act, restricting access to tobacco products, promoting cessation treatment and achieving other policy objectives; and educating on successful health initiatives regarding tobacco prevention.

Since fiscal year 2003, school-based and youth programs have been funded. These programs have been responsible for providing evidence-based tobacco prevention programs including curricula for all grade levels K-12 and while implementing comprehensive tobacco control policies in all the funded schools. While these programs have been successful, in fiscal year 2008, a coordinated school health initiative was implemented. The Coordinated School Health Initiative is a collaborative effort designed to provide children with the education, environment, and services necessary for optimal health and academic outcomes.

The Youth Leadership Initiative (YLI) is a program of Family Service Agency funded in part by Arkansas Department of Health as a statewide tobacco control youth movement committed to preventing the initiation of tobacco use among youth and reducing the use of tobacco products. The YLI program provides youth with opportunities to increase their knowledge on the harmful effects of tobacco use. The YLI develop and implement a counter-marketing campaign against the use of tobacco products. The YLI carried out through three interconnection programs: The Tobacco Control Youth Board, the YES Team,

and Team YES Speaks. Currently there are 25 Y.E.S! Team leaders with more than 2,500 Y.E.S! Team members across the state.

Briefly describe all checked activities:

f. Are citations or warnings issued to retailers or clerks who sell tobacco to minors for inspections that are part of the Synar survey? ☐ **Yes** ☒ **No**

If "Yes" to 5f, please describe the State's procedure for minimizing risk of bias to the survey results from retailers alerting each other to the presence of the survey teams:

g. Please describe the relationship between the State's Synar program and the Food and Drug Administration-funded enforcement program:

There is no relationship between the Food and Drug Administration-funded enforcement program and the State's Synar program.

SYNAR SURVEY METHODS AND RESULTS

The following questions pertain to the survey methodology and results of the Synar survey used by the State to meet the requirements of the Synar Regulation in FFY 2012 (see 42 U.S.C. 300x-26 and 45 C.F.R. 96.130).

6. Has the sampling methodology changed from the previous year? ☐ **Yes** ☒ **No**

The State is required to have an approved up-to-date description of the Synar sampling methodology on file with CSAP. Please submit a copy of your Synar Survey Sampling Methodology (Appendix B). If the sampling methodology changed from the previous reporting year, these changes must be reflected in the methodology submitted.

7. Please answer the following questions regarding the State's annual random, unannounced inspections of tobacco outlets *(see 45 C.F.R. 96.130(d)(2)).*

a. Did the State use the optional Synar Survey Estimation System (SSES) to analyze the Synar survey data? ☒ **Yes** ☐ **No**

*If **Yes,** attach SSES summary tables 1, 2, 3, and 4 to the hard copy of the ASR and upload a copy of SSES tables 1–5 (in Excel) to WebBGAS. Then go to Question 8. If **No,** continue to Question 7b.*

b. Report the weighted and unweighted Retailer Violation Rate (RVR) estimates, the standard error, accuracy rate (number of eligible outlets divided by the total number of sampled outlets), and completion rate (number of eligible outlets inspected divided by the total number of eligible outlets).

Unweighted RVR _____

Weighted RVR _____

Standard error (s.e.) of the (weighted) RVR _____

Fill in the blanks to calculate the <u>right limit</u> of the right-sided 95% confidence interval.

_____	+	(1.645	×	_____	=	_____
RVR Estimate	**plus**	(1.645	**times**	**Standard Error)**	**equals**	**Right Limit**

Accuracy rate _____

Completion rate _____

c. **Fill out Form 1 in Appendix A (Forms1–5).** *(Required regardless of the sample design.)*

d. **How were the (weighted) RVR estimate and its standard error obtained?** *(Check the one that applies.)*

☐ Form 2 (Optional) in Appendix A (Forms 1–5) *(Attach completed Form 2.)*

☐ Other *(Please specify. Provide formulas and calculations or attach and explain the program code and output with description of all variable names.)*

e. **If stratification was used, did any strata in the sample contain only one outlet or cluster this year?** ☐ **Yes** ☐ **No** ☐ **No stratification**

*If **Yes,** explain how this situation was dealt with in variance estimation.*

f. **Was a cluster sample design used?** ☐ **Yes** ☐ **No**

*If **Yes,** fill out and attach Form 3 in Appendix A (Forms 1–5), and answer the following question.*

*If **No,** go to Question 7g.*

Were any certainty primary sampling units selected this year? ☐ **Yes** ☐ **No**

*If **Yes,** explain how the certainty clusters were dealt with in variance estimation.*

g. **Report the following outlet sample sizes for the Synar survey.**

	Sample Size
Effective sample size (sample size needed to meet the SAMHSA precision requirement assuming simple random sampling)	
Target sample size (the product of the effective sample size and the design effect)	
Original sample size (inflated sample size of the target sample to counter the sample attrition due to ineligibility and noncompletion)	
Eligible sample size (number of outlets found to be eligible in the sample)	
Final sample size (number of eligible outlets in the sample for which an inspection was completed)	

h. **Fill out Form 4 in Appendix A (Forms 1–5).**

8. **Did the State's Synar survey use a list frame?** ☒ **Yes** ☐ **No**

*If **Yes,** answer the following questions about its coverage.*

a. **The calendar year of the latest frame coverage study:** 2012

b. **Percent coverage from the latest frame coverage study:** 100%

c. **Was a new study conducted in this reporting period?** ☒ **Yes** ☐ **No**

*If **Yes,** please complete Appendix D (List Sampling Frame Coverage Study) and submit it with the Annual Synar Report.*

d. **The calendar year of the next coverage study planned:** 2015

9. **Has the Synar survey inspection protocol changed from the previous year?**

☐ **Yes** ☒ **No**

The State is required to have an approved up-to-date description of the Synar inspection protocol on file with CSAP. Please submit a copy of your Synar Survey Inspection Protocol (Appendix C). If the inspection protocol changed from the previous year, these changes must be reflected in the protocol submitted.

a. **Provide the inspection period: From** 03/10/12 **to** 05/03/12
MM/DD/YY MM/DD/YY

b. **Provide the number of youth inspectors used in the current inspection year:**

93

NOTE: If the State uses SSES, please ensure that the number reported in 9b matches that reported in SSES Table 4, or explain any difference.

c. **Fill out and attach Form 5 in Appendix A (Forms 1–5).** *(Not required if the State used SSES to analyze the Synar survey data.)*

SECTION II: FFY 2013 (Intended Use):

Public law 42 U.S.C. 300x-26 of the Public Health Service Act and 45 C.F.R. 96.130 (e) (4, 5) require that the States provide information on future plans to ensure compliance with the Synar requirements to reduce youth tobacco access.

1. **In the upcoming year, does the State anticipate any changes in:**

   Synar sampling methodology ☐ **Yes** ☒ **No**
   Synar inspection protocol ☐ **Yes** ☒ **No**

   If changes are made in either the Synar sampling methodology or the Synar inspection protocol, the State is required to obtain approval from CSAP prior to implementation of the change and file an updated Synar Survey Sampling Methodology (Appendix B) or an updated Synar Survey Inspection Protocol (Appendix C), as appropriate.

2. **Please describe the State's plans to maintain and/or reduce the target rate for Synar inspections to be completed in FFY 2013. Include a brief description of plans for law enforcement efforts to enforce youth tobacco access laws, activities that support law enforcement efforts to enforce youth tobacco access laws, and any anticipated changes in youth tobacco access legislation or regulation in the State.**

Arkansas continues to work hard in its effort to reduce youth access to tobacco. Arkansas has strong enforcement of underage tobacco laws through the large number of compliance checks that are conducted annually by the Arkansas Tobacco Control (ATC) Board. During the period of October 1, 2011 through September 30, 2012, ATC conducted 3413 compliance checks at 2585 different locations.

ATC has continued conducting sales-to-minor saturations where several agents perform compliance checks simultaneously in one area. These saturations result in more accurate compliance check results because it does not give stores the opportunity to alert neighboring stores that ATC is in the area.

Sales-to-minor violations stay on a store's record for 48 months. For each offense in that 48 month period, penalties escalate. As a result, retailers with multiple sales-to-minor violations face more severe penalties. A total of $32,300 in fines was issued this year, including 29 suspensions totaling 92 days.

As penalties have increased over time, retailers have begun to work harder to equip their employees with the tools and knowledge necessary to make responsible tobacco sales. ATC continues to offer a certified training program for retailers who go above-and-beyond in their training efforts. A total of 22 companies, covering 239 stores have applied and met the criteria for this since it was first offered in 2006. Many other retailers have their employees attend regional merchant education seminars conducted by ATC. During the period of October 1, 2011, through September 30, 2012, 25 regional trainings and 20 individual store trainings were held, with a total of 1,219 employees in attendance. When a store reaches a

third offense the Board requires all employees of that location to attend training in the next six months. There have been 70 stores required to attend training, since July 2007.

ATC plans to continue its enforcement and training efforts around the state that has led to the success that we have experienced. In the coming year, we plan to conduct approximately 5,000 compliance checks and at least 40 regional training sessions at locations around the state.

3. **Describe any challenges the State faces in complying with the Synar regulation.** *(Check all that apply.)*

- ☐ Limited resources for law enforcement of youth access laws
- ☐ Limited resources for activities to support enforcement and compliance with youth tobacco access laws
- ☐ Limitations in the State youth tobacco access laws
- ☐ Limited public support for enforcement of youth tobacco access laws
- ☐ Limitations on completeness/accuracy of list of tobacco outlets
- ☐ Limited expertise in survey methodology
- ☐ Laws/regulations limiting the use of minors in tobacco inspections
- ☒ Difficulties recruiting youth inspectors
- ☒ Geographic, demographic, and logistical considerations in conducting inspections
- ☒ Cultural factors (e.g., language barriers, young people purchasing for their elders)
- ☐ Issues regarding sources of tobacco under tribal jurisdiction
- ☐ Other challenges *(Please list.)*_____

Briefly describe all checked challenges and propose a plan for each, or indicate the State's need for technical assistance related to each relevant challenge.

A.) It is frequently difficult to identify and recruit willing youth who appropriately reflect the demographics of the youth in a particular community to assist with the compliance inspections. Furthermore, parents often do not want their children involved in the inspection process. Often, when parents do agree, they require that their child conduct inspections in communities other than their own. Parents are concerned that their child might be stigmatized by neighbors or friends who witness an attempt to purchase tobacco products. DBHS will continue to encourage Prevention Resource Coordinators responsible for conducting the survey to strengthen their working relationship with youth serving agencies, organizations, and schools as this will facilitate youth recruitment.

B.) Arkansas is basically a rural state comprised of small towns and diverse terrain, both of which directly have an impact on Synar efforts. As there are often large distances between outlets, conducting an inspection of a single outlet demands extensive effort, in terms of time and cost. For example, to access a bait and tackle store located on a peninsula on the Arkansas lake, PRC Coordinators and youth inspectors must either access the outlet by boat or drive across the state line into Missouri and then turn down the tip of the peninsula. It is impossible to access this

remote site without being conspicuous. DBHS recommends that PRC Coordinators responsible for conducting the Synar survey allow more travel time to remote locations, and also to begin inspections the moment the Synar inspection time opens. PRC Coordinators should strive to recruit youth who are familiar with the remote locations so that they do not appear to be so "out of place" when entering an outlet.

C.) In rural areas and small towns, strangers or people of a different race stand out. Also, local residents are familiar to tobacco merchants. In such areas, merchants are much less likely to sell to customers who may be considered "outsiders". PRC Coordinators are to do all that they can to ensure that the youth used for the checks "fit in" with the demographic of the area.

D.) As the Hispanic population of Arkansas continues to increase, so do the number of Spanish-speaking establishments. In many of these establishments, the sales clerk can only speak Spanish. Thus, there may be instances in which an inspection cannot be completed as a youth inspector is unable to communicate with the store clerk. DBHS encourages the PRC Coordinators to work with other agencies and/or organizations that serve the Hispanic population to recruit Hispanic youth for compliance checks.

APPENDIX A: FORMS 1–5

SSES Table 1 (Synar Survey Estimates and Sample Sizes)

CSAP-SYNAR REPORT

State	AR
Federal Fiscal Year (FFY)	2013
Date	12/21/2012 10:28
Data	SSESv4_DataEntryTemplate_Cluster.xlsx
Analysis Option	Stratified Clustered with FPC

Estimates

Unweighted Retailer Violation Rate	3.7%
Weighted Retailer Violation Rate	3.3%
Standard Error	0.7%
Is SAMHSA Precision Requirement met?	YES
Right-sided 95% Confidence Interval	[0.0%, 4.5%]
Two-sided 95% Confidence Interval	[1.9%, 4.8%]
Design Effect	0.9
Accuracy Rate (unweighted)	85.1%
Accuracy Rate (weighted)	85.2%
Completion Rate (unweighted)	98.2%

Sample Size for Current Year

Effective Sample Size	147
Target (Minimum) Sample Size	229
Original Sample Size	582
Eligible Sample Size	495
Final Sample Size	486
Overall Sampling Rate	14.9%

SSES Table 2 (Synar Survey Results by Stratum and by OTC/VM)

STATE: AR
FFY: 2013

Samp. Stratum	Var. Stratum	Outlet Frame Size	Estimated Outlet Population Size	Number of PSU Clusters Created	Number of PSU Clusters in Sample	Outlet Sample Size	Number of Eligible Outlets in Sample	Number of Sample Outlets Inspected	Number of Sample Outlets in Violation	Retailer Violation Rate(%)	Standard Error(%)
All Outlets											
1	1	385	174	29	6	47	35	34	2	5.0%	
10	10	179	218	14	6	42	41	41	6	14.7%	
11	11	202	211	16	6	42	34	33	1	1.9%	
12	12	213	233	16	6	50	44	42	2	4.2%	
13	13	148	223	12	6	46	42	40	0	0.0%	
2	2	336	177	14	6	42	28	27	0	0.0%	
3	3	298	187	23	6	46	38	36	1	3.4%	
4	4	284	350	23	6	42	42	42	1	2.1%	
5	5	321	218	26	6	46	36	36	0	0.0%	
6	6	267	234	22	6	42	40	40	0	0.0%	
7	7	252	196	20	6	45	35	35	0	0.0%	
8	8	283	210	22	6	45	36	36	5	13.0%	
9	9	690	238	52	6	47	44	44	0	0.0%	
Total		3,858	2,869	289	78	582	495	486	18	3.3%	0.7%
Over the Counter Outlets											
1	1	383	174	29	6	47	35	34	2	5.0%	
10	10	176	218	14	6	41	41	41	6	14.7%	
11	11	202	211	16	6	42	34	33	1	1.9%	
12	12	213	233	16	6	50	44	42	2	4.2%	
13	13	148	223	12	6	46	42	40	0	0.0%	
2	2	336	177	14	6	42	28	27	0	0.0%	
3	3	298	187	23	6	46	38	36	1	3.4%	
4	4	283	350	23	6	42	42	42	1	2.1%	
5	5	309	218	26	6	45	36	36	0	0.0%	
6	6	267	234	22	6	42	40	40	0	0.0%	
7	7	252	196	20	6	45	35	35	0	0.0%	
8	8	266	210	22	6	43	36	36	5	13.0%	
9	9	667	238	52	6	46	44	44	0	0.0%	
Total		3,800	2,869	289	78	577	495	486	18	3.3%	0.7%

SSES Table 2 (Synar Survey Results by Stratum and by OTC/VM)

STATE: AR
FFY: 2013

Samp. Stratum	Var. Stratum	Outlet Frame Size	Estimated Outlet Population Size	Number of PSU Clusters Created	Number of PSU Clusters in Sample	Outlet Sample Size	Number of Eligible Outlets in Sample	Number of Sample Outlets Inspected	Number of Sample Outlets in Violation	Retailer Violation Rate(%)	Standard Error(%)
Vending Machines											
1	1	2	0	29	6	0	0	0	0	0.0%	
10	10	3	0	14	6	1	0	0	0	0.0%	
11	11	0	0	16	6	0	0	0	0	0.0%	
12	12	0	0	16	6	0	0	0	0	0.0%	
13	13	0	0	12	6	0	0	0	0	0.0%	
2	2	0	0	14	6	0	0	0	0	0.0%	
3	3	0	0	23	6	0	0	0	0	0.0%	
4	4	1	0	23	6	0	0	0	0	0.0%	
5	5	12	0	26	6	1	0	0	0	0.0%	
6	6	0	0	22	6	0	0	0	0	0.0%	
7	7	0	0	20	6	0	0	0	0	0.0%	
8	8	17	0	22	6	2	0	0	0	0.0%	
9	9	23	0	52	6	1	0	0	0	0.0%	
Total		58	0	289	78	5	0	0	0	0.0%	0.0%

SSES Table 3 (Synar Survey Sample Tally Summary)

STATE: AR
FFY: 2013

Disposition Code	Description	Count	Subtotal
EC	Eligible and inspection complete outlet	486	
Total (Eligible Completes)			486
N1	In operation but closed at time of visit	4	
N2	Unsafe to access	2	
N3	Presence of police	0	
N4	Youth inspector knows salesperson	0	
N5	Moved to new location but not inspected	0	
N6	Drive thru only/youth inspector has no drivers license	2	
N7	Tobacco out of stock	1	
N8	Run out of time	0	
N9	Other noncompletion	0	
Total (Eligible Noncompletes)			9
I1	Out of Business	11	
I2	Does not sell tobacco products	11	
I3	Inaccessible by youth	35	
I4	Private club or private residence	7	
I5	Temporary closure	8	
I6	Can't be located	14	
I7	Wholesale only/Carton sale only	1	
I8	Vending machine broken	0	
I9	Duplicate	0	
I10	Other ineligibility	0	
Total (Ineligibles)			87
Grand Total			582

SSES Table 4 (Synar Survey Inspection Results by Youth Inspector Characteristics)

STATE: AR
FFY: 2013

Frequency Distribution

Gender	Age	Number of Inspectors	Attempted Buys	Successful Buys
Male	14	0	0	0
	15	21	123	6
	16	27	141	4
	17	0	0	0
	18	0	0	0
	Subtotal	48	264	10
Female	14	0	0	0
	15	25	149	5
	16	20	73	3
	17	0	0	0
	18	0	0	0
	Subtotal	45	222	8
Other		0	0	0
Grand Total		93	486	18

Buy Rate in Percent by Age and Gender

Age	Male	Female	Total
14	0.0%	0.0%	0.0%
15	4.9%	3.4%	4.0%
16	2.8%	4.1%	3.3%
17	0.0%	0.0%	0.0%
18	0.0%	0.0%	0.0%
Other			0.0%
Total	3.8%	3.6%	3.7%

APPENDIXES B & C: FORMS

Instructions

Appendix B (Sampling Design) and Appendix C (Inspection Protocol) are to reflect the State's CSAP-approved sampling design and inspection protocol. These appendixes, therefore, should generally describe the design and protocol and, with the exception of Question #10 of Appendix B, are not to be modified with year-specific information. Please note that any changes to either appendix must receive CSAP's advance, written approval. To facilitate the State's completion of this section, simply cut and paste the previously approved sampling design (Appendix B) and inspection protocol (Appendix C).

APPENDIX B: SYNAR SURVEY SAMPLING METHODOLOGY

State: Arkansas
FFY: 2013

1. **What type of sampling frame is used?**

   ☒ List frame *(Go to Question 2.)*
   ☐ Area frame *(Go to Question 3.)*
   ☐ List-assisted area frame *(Go to Question 2.)*

2. **List all sources of the list frame. Indicate the type of source from the list below. Provide a brief description of the frame source. Explain how the lists are updated (method), including how new outlets are identified and added to the frame. In addition, explain how often the lists are updated (cycle*).*** *(After completing this question, go to Question 4.)*

   Use the corresponding number to indicate **Type of Source** ***in the table below***.

   1 – Statewide commercial business list
   2 – Local commercial business list
   3 – Statewide tobacco license/permit list
   4 – Statewide retail license/permit list
   5 – Statewide liquor license/permit list
   6 – Other

Name of Frame Source	Type of Source	Description	Updating Method and Cycle
AR Tobacco Control Board	3	List of State tobacco retail permit holders	Continuous update. Sample drawn from the most up-to-date tobaccco license list.

3. **If an area frame is used, describe how area sampling units are defined and formed.**

   a. **Is any area left out in the formation of the area frame?** ☐ **Yes** ☐ **No**

      *If **Yes,** what percentage of the State's population is not covered by the area frame?*
      _____%

4. **Federal regulation requires that vending machines be inspected as part of the Synar survey. Are vending machines included in the Synar survey?** ☒ **Yes** ☐ **No**

   *If **No,** please indicate the reason they are not included in the Synar survey.*

   ☐ State law bans vending machines.
   ☐ State law bans vending machines from locations accessible to youth.
   ☐ State has SAMHSA approval to exempt vending machines from the survey.
   ☐ Other *(Please describe.)* _____

5. **Which category below best describes the sample design?** *(Check only one.)*

☐ **Census** *(STOP HERE: Appendix B is complete.)*

Unstratified statewide sample:

☐ Simple random sample *(Go to Question 9.)*
☐ Systematic random sample *(Go to Question 6.)*
☐ Single-stage cluster sample *(Go to Question 8.)*
☐ Multistage cluster sample *(Go to Question 8.)*

Stratified sample:

☐ Simple random sample *(Go to Question 7.)*
☐ Systematic random sample *(Go to Question 6.)*
☐ Single-stage cluster sample *(Go to Question 7.)*
☒ Multistage cluster sample *(Go to Question 7.)*
☐ **Other** *(Please describe and go to Question 9.)* _____

6. **Describe the systematic sampling methods.** *(After completing Question 6, go to Question 7 if stratification is used. Otherwise go to Question 9.)*

7. **Provide the following information about stratification.**

   a. **Provide a full description of the strata that are created.**

   The state is geographically stratified into 13 strata; Alcohol and Drug Abuse Prevention Resource Regions. The 13 PRC regions are contiguous clusters of counties. This is the first sampling stratum.

   b. **Is clustering used within the stratified sample?**

   ☒ **Yes** *(Go to Question 8.)*
   ☐ **No** *(Go to Question 9.)*

8. **Provide the following information about clustering.**

   a. **Provide a full description of how clusters are formed.** *(If multistage clusters are used, give definitions of clusters at each stage.)*

   Some clusters (PSUs) are a single county, and some are a fraction of a county based on longitude, so that each cluster has between 13 and 26 outlets.

   b. **Specify the sampling method (simple random, systematic, or probability proportional to size sampling) for each stage of sampling and describe how the method(s) is (are) implemented.**

   The first stage of sampling is the selections of 6 PSUs from each stratum using SRS (Simple Random Sampling). The second stage is selection of outlets from sample PSUs at a constant rate via SRS.

9. Provide the formulas for determining the effective, target, and original outlet sample sizes.

Effective Sample Size = $n' = \dfrac{n}{(1+\dfrac{n}{N})}$; where

N = population size (total outlets),

$n = \dfrac{p(1-p)}{(0.0182)^2}$,

p = violation rate from the previous year's survey.
The denominator 0.0182 is based on a 3% tolerance of one-sided 95% CI.

Target Sample size = $n_t = Deff \times n'$; where

Design Effect (Deff) = $\{1+(m-1)\rho\}(1+CV_w^2)$,

m = average cluster size,

ρ = intra-class correlation,

CV_w = coefficient of variation of the sample weights.

Original sample size = $n_o = \dfrac{n_t}{r_a r_c}$; where

r_a = accuracy rate from previous year.

r_c = completion rate from previous year.

NOTE: The actual original sample size drawn in the field is often much larger than the calculated original sample size to allow for geographic/PRC region comparisons.

Design effect used in the calculations:

Deff = (1 + (n – 1) * ρ)*(1 + V) = 1.50, where n is the average cluster size, ρ is the intraclass correlation, and V is the coefficient of variation of the weights.

Average cluster size, n, is the target sample size/number of clusters, ρ is estimated *a priori* as 0.05, and V is computed from the previous year sample.

10. Provide the following information about sample size calculations for the current FFY Synar survey.

a. **If the State uses the sample size formulas embedded in the Synar Survey Estimation System (SSES) Sample Size Calculator, please provide the following information:**

Inputs for Effective Sample Size:
RVR:
Frame Size:

Input for Target Sample Size:
Design Effect:

Inputs for Original Sample Size:
Safety Margin:
Accuracy (Eligibility) Rate:
Completion Rate:

b. **If the State does not use the sample size formulas embedded in the SSES Sample Size Calculator, please provide all inputs required to calculate the effective, target, and original sample sizes as indicated in Question 9.**

a. 3858 (Total number of retail outlets in Arkansas Tobacco Control Board database, including vending machines);

b. 0.054 (Weighted non-compliance rate from previous year);

c. 0.830 (Weighted accuracy rate from previous year);

d. 0.990 (Unweighted completion rate from previous year);

e. 1.645 (.05 confidence level, one sided);

f. 0.03 (Tolerable error: (1/2 confidence interval));

g. 1.56 (Design effect ([1+ (Average cluster size - 1)*Intraclass correlation]*(1+Coef of Var of Baseweights from previous year's sample)).

APPENDIX C: SYNAR SURVEY INSPECTION PROTOCOL

State: Arkansas
FFY: 2013

Note: Upload to WebBGAS a copy of the Synar inspection form under the heading "Synar Inspection Form" and a copy of the protocol used to train inspection teams on conducting and reporting the results of the Synar inspections under the heading "Synar Inspection Protocol."

1. How does the State Synar survey protocol address the following?

a. Consummated buy attempts?

☒ Required ☐ Not permitted
☐ Permitted under specified circumstances ☐ Not specified in protocol

b. Youth inspectors to carry ID?

☐ Required ☒ Not permitted
☐ Permitted under specified circumstances ☐ Not specified in protocol

c. Adult inspectors to enter the outlet?

☐ Required ☐ Not permitted
☒ Permitted under specified circumstances ☐ Not specified in protocol

d. Youth inspectors to be compensated?

☐ Required ☐ Not permitted
☒ Permitted under specified circumstances ☐ Not specified in protocol

2. Identify the agency(ies) or entity(ies) that actually conduct the random, unannounced Synar inspections of tobacco outlets. *(Check all that apply.)*

☐ Law enforcement agency(ies)
☐ State or local government agency(ies) other than law enforcement
☒ Private contractor(s)
☐ Other

List the agency name(s): **13 Regional Prevention Resource Centers (PRC)**

3. Are Synar inspections combined with law enforcement efforts (i.e., do law enforcement representatives issue warnings or citations to retailers found in violation of the law at the time of the inspection?)?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☒ Never

4. **Describe the methods used to recruit, select, and train youth inspectors and adult supervisors.**

The PRCs recruit youth inspectors and adults from each of their Regions at the county and local level. They may also recruit and obtain youth from DBHS funded grant programs located in their region, since some of the DBHS grantees have staff and/or youth ages 15 and 16 that would be available to assist with conducting the compliance checks. Once the appropriate number of youth and adult supervisors are selected, the PRCs train all the youth inspectors and adult supervisors on the inspection methodology and protocol for conducting the compliance checks.

PRCs attend the annual Synar training and are then responsible for training their youth volunteers and any adult volunteers they may chose to use. PRCs sometimes bring adult volunteers to the Synar training.

5. **Are there specific legal or procedural requirements instituted by the State to address the issue of youth inspectors' immunity when conducting inspections?**

   a. **Legal** ☒ **Yes** ☐ **No** *(If **Yes,** please describe.)*

   Arkansas legislation states that it shall not be an offense if the minor was acting at the direction of an employee or authorized agent of a governmental agency authorized to enforce or ensure compliance with laws relating to the prohibition of the sale of tobacco in any form or cigarette papers to such minors. The Synar Youth Inspectors are under the auspices of an authorized agency.

   b. **Procedural** ☐ **Yes** ☒ **No** *(If **Yes,** please describe.)*

6. **Are there specific legal or procedural requirements instituted by the State to address the issue of the safety of youth inspectors during all aspects of the Synar inspection process?**

   a. **Legal** ☐ **Yes** ☒ **No** *(If **Yes,** please describe.)*

   b. **Procedural** ☒ **Yes** ☐ **No** *(If **Yes,** please describe.)*

   If the selected location is deemed unsafe by the adult driver and/or youth under the age of eighteen (18) or twenty-one (21) years, then the check should not be conducted. DBHS provides authorized adults to accompany youth inspectors on inspections during the specified period as a safety protocol and for quality control.

7. **Are there any other legal or procedural requirements the State has regarding how inspections are to be conducted (e.g., age of youth inspector, time of inspections, training that must occur)?**

   a. **Legal** ☒ **Yes** ☐ **No** *(If **Yes,** please describe.)*

The State law limits the circumstances under which a minor may be used to conduct compliance checks. The minor may act as an agent of the Arkansas Tobacco Control Board, Division of Behavioral Health Services (DBHS), and an Arkansas Retail Cigarette and Tobacco permit holder (who may use minor check on permit holder's own retail business).

b. Procedural ☒ **Yes** ☐ **No** *(If **Yes,** please describe.)*

Youth inspectors must be 15 or 16 years of age, have written parental approval to participate, and be trained by the Prevention Resource Center staff prior to conducting inspections. Established protocol outlines the procedures for conducting the inspections. DBHS provides authorized adults to accompany youth inspectors on inspections during the specified period as a safety protocol and for quality control.

☐ SALE **2012 OTC SYNAR SURVEY** NO SALE ☐

Note: To be completed immediately after each check. Answer all questions completely

PSU «psu»

«Name»
«PhysicalAddress1»
«PhysicalCity», «PhysicalState» «MAILZIP»
OWNER: «Owner» «PHONE1»

PERMIT#: «PermitNumber»

DATE OF CHECK (MONTH, DAY, YEAR) ____/____/_____

Time of check _____ (AM or PM)

NAME OF ADULT SUPERVISOR:_____ TELEPHONE: ( )

IS THE OUTLET INELIGIBLE?

I1 Out of business
I2 Does not sell tobacco products
I3 Inaccessible to youth
I4 Private club or residence
I5 Temporary closure
I6 Unlocatable
I7 Wholesale only
I10 Other ineligible reason *(Explain)*

STOP *STOP if any of these reasons apply.*

OUTLET NOT INSPECTED *(Eligible non-completes)*

N2 Unsafe to access
N5 Moved to a new location
N6 Drive-through only/ youth inspector has no license
N7 Tobacco out of stock
N8 Run out of time
N9 Other non-completion reasons *(Explain)*

STOP filling out form for any of the above reasons.

N1 In operation but closed at time of visit
N3 Presence of police
N4 Youth inspector knows sales person

Return with another youth ☐ First attempt Date: _____ ☐ Second attempt Date: _____ ☐ Third attempt Date: _____

TYPE OF OUTLET

1. Gas station only
2. Convenience (with gas)
3. Convenience (no gas)
4. Small food store (deli)
5. Supermarket/Grocery store
6. Drug store/pharmacy
7. Liquor store
8. Discount store
9. Hotel/motel
10. Restaurant
11. Tobacco outlet
12. Bar/club
13. Other (describe):

Complete this section ONLY IF OUTLET WAS INSPECTED

YOUTH'S INITIALS: _____ YOUTH'S GENDER: ☐ FEMALE ☐ MALE YOUTH'S AGE: _____

(Max of one youth per form) YOUTH'S RACE : White Black Hispanic Asian Other

STATUS OF THE INSPECTION

(Check one - Also mark box on top of page!)

☐ Sale Occurred ☐ Purchase attempted Sale Refused

HOW WAS THE TOBACCO PLACED FOR SALE

☐ Picked up tobacco without asking (self-serve) ☐ Had to ask clerk for tobacco (behind the counter)

Were you asked your age? ☐Yes ☐No Were you asked for identification? ☐Yes ☐No

Was there a NO SALES TO MINORS sign posted at the point of purchase? ☐Yes ☐No

Was a Tobacco Vending Machine PRESENT? ☐Yes ☐No

Type of tobacco attempted to buy: ☐Cigarettes ☐ Cigars ☐ Bidis ☐ Smokeless/Spit Tobacco

INFORMATION ON CLERK

If necessary, the adult escort may wish to go back into store to collect this information. CIRCLE ONE:

Was the clerk (1) Female (2) Male
Height of the clerk (1) Short (2) Average (3) Tall
How old was the clerk? (1) Teenager (2) Young adult (3) Adult (4) Senior
Race the clerk? (1) Black (2) White (3) Hispanic (4) Asian (5) Other
Hair color:_____
Clerk's Name (only if available without asking):_____
Describe other distinguishing characteristics (e.g. birth mark):_____
Location of sales counter:_____
COMMENTS:

Checked for accuracy by Prevention Resource SYNAR Coordinator:_____ **Date signed:** _____

☐ **SALE** **VENDING MACHINE** **NO SALE** ☐

2012 SYNAR DATA COLLECTION FORM

Note: To be completed immediately after each check. Answer all questions completely

PSU «PSU»

«Name»
«PhysicalAddress1»
«PhysicalCity», «PhysicalState» «MAILZIP»

Inspect # «machine» of «NUMBER» machines
Permit#: «PermitNumber»

DATE OF CHECK (MONTH, DAY, YEAR) ____/____/____

Time of check _____ (AM or PM)

NAME OF ADULT ESCORT
TELEPHONE: ( )

NAME OF ADULT SUPERVISOR:_____ TELEPHONE: ( )

IS THE OUTLE INELIGIBLE?

I1 Out of business
I2 Does not sell tobacco products
I3 Inaccessible to youth
I4 Private club or residence
I5 Temporary closure
I6 Unlocatable
I7 Wholesale only
I8 Vending machine broken
I10 Other ineligible reason (*Explain*)

STOP *STOP! If any of these reasons apply.* ☐

OUTLET NOT INSPECTED *(Eligible non-completes)*

N2 Unsafe to access
N5 Moved to a new location
N6 Drive-through only/ youth inspector has no license
N7 Tobacco out of stock
N8 Run out of time
N9 Other non-completion reasons (*Explain*)

☐

STOP filling out form for any of the above reasons.

N1 In operation but closed at time of visit
N3 Presence of police
N4 Youth inspector knows sales person

Return with another youth ☐ First attempt Date: _____ ☐ Second attempt Date: _____ ☐ Third attempt Date: _____

TYPE OF OUTLET

1. Gas station only
2. Convenience (with gas)
3. Convenience (no gas)
4. Small food store (deli)
5. Supermarket/Grocery store
6. Drug store/pharmacy
7. Liquor store
8. Discount store
9. Hotel/motel
10. Restaurant
11. Tobacco outlet
12. Bar/club
13. Other (describe):

☐

Complete this section ONLY IF OUTLET WAS INSPECTED ☐

YOUTH'S INITIALS: _____ *(Max of one youth per form)*

YOUTH'S GENDER: ☐ FEMALE ☐ MALE

YOUTH'S AGE: _____

YOUTH'S RACE : White Black Hispanic Asian Other

STATUS OF THE INSPECTION
(Check one - Also mark box on top of page!)

☐ Sale Occurred ☐ Purchase attempted Sale Refused

Was the machine under supervision? ☐ Yes ☐ No

Did the minor ask employee for change to purchase from the vending machine? ☐ Yes ☐ No

Were you asked your age? ☐ Yes ☐ No

Were you asked for identification? ☐ Yes ☐ No

Was there a NO SALES TO MINORS sign posted at the vending machine? ☐ Yes ☐ No

Type of tobacco attempted to buy: ☐ Cigarettes ☐ Cigars ☐ Bidis ☐ Smokeless/Spit Tobacco

Complete this section ONLY IF SALE OCCURRED:
If necessary, the adult escort may wish to go back into store to collect this information.

Location of Vending Machine:_____

Stamp #: _____ 2011 (ORANGE) **OR** _____ 2012 (HOT PINK)

COMMENTS:

Checked for accuracy by Prevention Resources SYNAR Coordinator _____ Date signed: _____

APPENDIX C: SYNAR INSPECTION PROTOCOL

Youth Recruitment

1. Only adolescents ages 15-16 will be recruited to conduct the study.
2. The age, race, and gender distribution of youth participants should reflect the distribution of the county.
3. Attempt to recruit enough youth so that no youth should make more than 9 visits.
4. Youth should look and dress their age.

Youth Training ~ Documenting Participants

1. Record data on youth participants and adults on appropriate sheets.
2. Obtain parental consent for each youth participating in the survey.
3. Fax copies of parental consent forms to the DBHS office for review and approval prior to conducting checks.
4. Keep parental consent forms on file at the agency conducting the checks.
5. Provide adult volunteers assisting in the checks with authorization letters from DHS/DBHS.
6. Take picture of youth each day to document that youth looks and dresses the appropriate age; keep picture on file with parental consent forms and send copy with inspection forms to contractor.
7. Be sure that each participant, WHO MADE THE PURCHASE, has initialed the form.
8. Return every single outlet form to ADH Health Statistics, regardless of visit or non-visit.

Training of Minors

1. Remind of the purpose, and goal of the survey.
2. Make sure that all participants understand the procedures and protocol.
3. Review how to make a “buy”.
4. Instruct youth not to take their IDs into the outlet.
5. Instruct youth that if the clerk asks his/her age, the youth is to give his/her exact age.
6. Instruct youth not to attempt to purchase tobacco in stores if they know someone who works there or is present at the time of visit.
7. Prepare participants for what to expect.
8. Review the inspection forms and how they are to be completed.

APPENDIX C: SYNAR INSPECTION PROTOCOL

Reasons for Ineligibility or Non-Visit

- ❑ Does not sell
- ❑ Inaccessible to youth
- ❑ No longer in business
- ❑ Unable to locate
- ❑ Not open during day
- ❑ Seasonal business
- ❑ Restricted Access
- ❑ Unsafe
- ❑ Broken vending machine

Data Collection ~ Over the Counter

1. The adult volunteer will locate and drive the youth volunteer to the establishment designated for OTC inspection.
2. The adult volunteer will park out of sight.
3. The youth volunteer will enter the establishment. The youth will not take forms into the store.
4. If the tobacco products are located away from the counter, the youth will choose a particular product and carry it to the clerk for check out.
5. If the tobacco products are located behind the counter, the youth will ask the clerk for assistance in obtaining the product.
6. The youth can choose to purchase other items, such as gum or candy, along with the tobacco product.
7. If the clerk asks the youth volunteer his/her age, the youth volunteer will give his exact age.
8. If the clerk makes the sale, the youth volunteer will take the tobacco product from the establishment, return to the car, give the product to the adult volunteer and provide the necessary information to complete the inspection form.
9. The adult volunteer will document all tobacco products purchased with the outlet code on the pack and date of purchase.
10. If the clerk refuses the sale, the youth will leave the establishment and note that there was no sale on the inspection form.
11. Forward to DBHS all properly labeled tobacco products purchased as a result of Synar compliance checks.
12. Fax a copy of completed inspection form denoting a sale to the Arkansas Tobacco Control Board.

APPENDIX C: SYNAR INSPECTION PROTOCOL

Special Instructions for Vending Machines

1. The adult volunteer will locate and drive the youth volunteer to the retail outlet designated for vending machine inspections.
2. The youth volunteer is to enter establishment and seek out vending machine. If the youth volunteer cannot find the vending machine, he/she is to ask the attendant where the vending machine is located.
3. The sample frame will uniformly consist of individual vending machines. In cases where the machines are listed as a group, the listing will be expanded so that each machine will be assigned an individual number, i.e. 1 of 3, 2 of 3, etc. The inspectors will attempt to identify all vending machines in a premise and number them left to right, going clockwise from the entrance point. The inspection will be conducted only on the individual vending machine or machines that are listed in the sample. If, for example, the sample form indicates to inspect machine 1 of 2, the inspector will inspect the first machine encountered on the left of the entrance, sweeping around the establishment in the clockwise direction.
4. Upon identifying the vending machine, the youth volunteer is to purchase tobacco from the vending machine unless attendant questions the youth volunteer.
    - If asked about his/her age, the youth volunteer will respond with his/her actual age and unless told by the attendant that they cannot purchase, the youth volunteer is to purchase the tobacco from the vending machine.
    - If told he/she cannot purchase, the youth volunteer will leave the outlet.
5. Once the youth volunteer has completed the purchase, the youth will exit the outlet, return to the car, give the cigarettes to the adult volunteer and provide the necessary information to complete the inspection form.

APPENDIX D: LIST SAMPLING FRAME COVERAGE STUDY

(LIST FRAME ONLY)

State: Arkansas
FFY: 2013

1. **Calendar year of the coverage study:** 2012

2. a. **Unweighted percent coverage found:** 100**%**
   b. **Weighted percent coverage found:** 100**%**
   c. **Number of outlets found through canvassing:** 162
   d. **Number of outlets matched on the list frame:** 162

3. a. **Describe how areas were defined.** *(e.g., census tracts, counties, etc.)*

   Areas defined by census tracts.

   b. **Were any areas of the State excluded from sampling?** ☒ **Yes** ☐ **No**

   *If **Yes,** please explain.*

   Yes, one census tract was excluded as it has a population size of zero.

4. **Please answer the following questions about the selection of canvassing areas.**

   a. **Which category below best describes the sample design?** *(Check only one.)*

   ☐ **Census** *(Go to Question 6.)*

   Unstratified Statewide sample:
   ☐ Simple random sample *(Respond to Part b.)*
   ☐ Systematic random sample *(Respond to Part b.)*
   ☐ Single-stage cluster sample *(Respond to Parts b and d.)*
   ☐ Multistage cluster sample *(Respond to Parts b and d.)*

   Stratified sample:
   ☒ Simple random sample *(Respond to Parts b and c.)*
   ☐ Systematic random sample *(Respond to Parts b and c.)*
   ☐ Single-stage cluster sample *(Respond to Parts b, c, and d.)*
   ☐ Multistage cluster sample *(Respond to Parts b, c, and d.)*
   ☐ **Other** *(Please describe and respond to Part b.)* _____

   b. **Describe the sampling methods.**

Twenty-six census tracts were randomly selected by using SAS PROC SURVEYSELECT and specifying the selection of two tracts per PRC region.

c. Provide a full description of the strata that were created.

Synar Survey FFY 2013 provided an estimate of 3689 eligible tobacco outlets in Arkansas. Based on a total of 624 census tracts (1 tract not populated), there are 5.883 eligible outlets per census tract.

Selection of 22 census tracts will yield sample size of 130 and 34 census tracts, sample size of 200; minimum and maximum sample sizes recommended by SAMHSA.

With 13 PRC regions in Arkansas, random selection of 2 census tracts per region would yield a sample size of approximately 153 eligible outlets.

d. Provide a full description of how clusters were formed.

5. Were borders of the selected areas clearly identified at the time of canvassing?

☒ **Yes** ☐ **No**

6. Were all sampled areas visited by canvassing teams?

☒ **Yes** *(Go to Question 7.)* ☐ **No** *(Respond to Parts a and b.)*

a. Was the subset of areas randomly chosen?

☐ **Yes** ☐ **No**

b. Describe how the subsample of visited areas was drawn. Include the number of areas sampled and the number of areas canvassed.

7. Were field observers provided with a detailed map of the canvassing areas?

☒ **Yes** ☐ **No**

*If **No,** describe the canvassing instructions given to the field observers.*

8. Were field observers instructed to find all outlets in the assigned area?

☒ **Yes** ☐ **No**

*If **No,** respond to Question 9.*
*If **Yes,** describe any instructions given to the field observers to ensure the entire area was canvassed, then go to Question 10.*

See attached Canvassing Instruction Sheet.

9. If a full canvassing was not conducted:

a. **How many predetermined outlets were to be observed in each area? _____**

b. **What were the starting points for each area? _____**

c. **Were these starting points randomly chosen? ☐ Yes ☐ No**

d. **Describe the selection of the starting points.**

e. **Please describe the canvassing instructions given to the field observers, including predetermined routes.**

10. Describe the process field observers used to determine if an outlet sold tobacco.

Field observers enter all stores/shops and visibly check for tobacco products. If none seen, field observer verbally checks with clerk/store attendant if tobacco products are sold.

11. Please provide the State's definition of "matches" or "mismatches" to the Synar sampling frame? (i.e., address, business name, business license number, etc).

Business license number.

12. Provide the calculation of the weighted percent coverage (if applicable).

100 X (number of matched outlets/total number of outlets found by coverage survey)

100 X (162/162) = 100%

APPENDIX D: LIST SAMPLING FRAME COVERAGE STUDY

(Question 8: Canvassing Instructions)

SYNAR COVERAGE SURVEY, 2012
Canvassing Instructions

CONTENTS OF CONVASSING PACKET

1. Each Prevention Resource Center (PRC) region will receive 2 Coverage Study packets.
2. Each packet consists of the following:
   a. Maps of census tracts;
   b. Log sheets (You may make more copies of the log sheet if required);
   c. Return business envelope;
   d. Instruction sheet.

DESCRIPTION OF MAPS

Maps consist of the following:

- Statewide map that shows the location of the census tract in relation to neighboring parts of the state.
- Local map that shows the location of the census tract in relation to other local areas.
- Close up maps (there may be more than one close up map per census tract). These show the streets, roads, parks, malls or other locations that will be canvassed.

MAP LEGEND

	County
	Selected Census Tracts
	City limit
	Water

CANVASSING DIRECTIONS

1. Each PRC must provide needed staff to travel
2. Canvasser must travel all routes (streets, roads, parks, mall) in selected census tract
3. Canvasser must physically enter all stores/shops etc
4. Each canvasser must **record only tobacco outlets** found using log sheet provided

- Note: Canvasser must stay within yellow-orange lines (i.e. census tract).
- **Note: Where yellow-orange line falls on a street, canvasser must canvass the side of the street on the inside of the census tract only.**

COMPLETING LOG SHEETS

- Log sheet must be fully completed!!!
  *** PRC Region, Name of County, and Census Tract # are already provided.
  - Name of canvasser
  - Date of canvass
  - Outlet details
    - Name of outlet
    - Address of outlet
    - Type of business
    - Accessible to youth? Is the outlet accessible to youth? If not note why!
    - Area Code and Telephone Number (Provide this information if possible)
    - Tobacco License Number (Provide this information if possible)

********* Return completed log sheets in business envelopes included in packet.**

1

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Behavioral Health Services
Prevention Services

Prevention Principles, Guidelines and Models for Behavioral Health Systems

January 2013

Revised June 2013

Behavioral Health is Essential to Health

Prevention Works

Treatment is Effective

People Recover

THERE IS NO HEALTH WITHOUT BEHAVIORAL HEALTH!

"Heal the soul and the body will follow."

- Stevenson Kuartei, Minister of Health, Republic of Palau

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Purpose of this Guide

The purpose of this document is to provide staff, providers, potential providers, and key stakeholders information about the guiding principles, theory, and practices of effective prevention for behavioral health.

The following information serves as the guiding principles driving the work of prevention throughout the state of Arkansas. It sets forth guidelines for how providers will accomplish work in the communities by providing expectations, background information, and overarching visions and missions.

The guidelines in this document are broad-based guidelines, providers and potential providers are advised to carefully review current and any future Request for Funding Application (RFA) for specifics related to the grant or contract of interest. The specifics in that RFA or RFP will govern the expected outcomes and products to result from the grant or contract.

Arkansas Department of Human Services
Division of Behavioral Health Services
Prevention Services

Vision:

- Arkansans will be drug-free and mentally healthy

Mission:

- Educate citizens,
- Empower communities,
- Encourage collaboration, and
- Enhance prevention efforts through community mobilization to foster a healthy and positive environment.

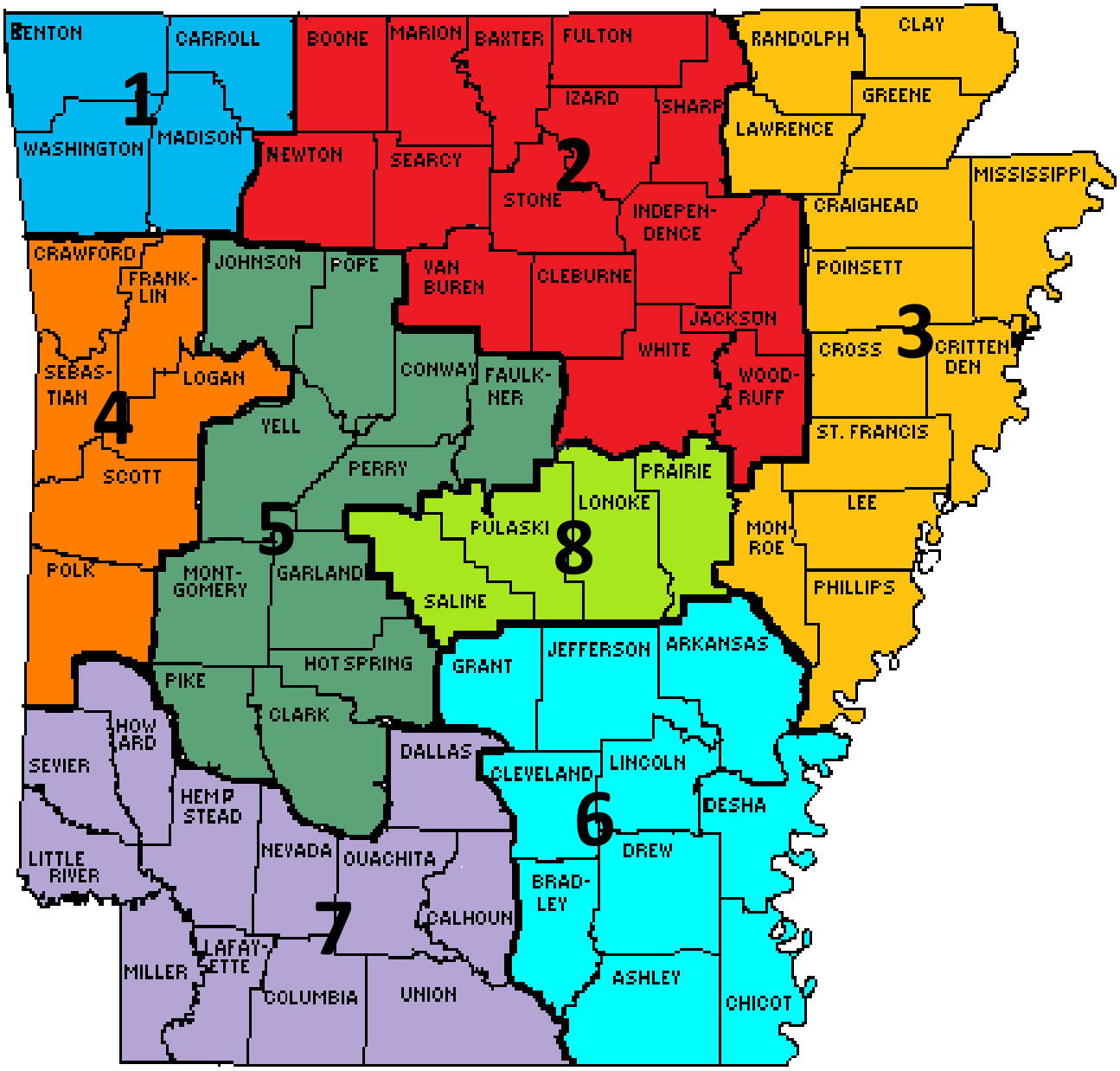
In order to reach such a broad vision, it is imperative that a collaborative effort be undertaken by state agencies and communities alike in order to improve the lives of our fellow citizens in Arkansas. Certain core values are inherent in that effort. These include:

- Every person matters.
- Families matter.
- Empowered people help themselves.

The Division of Behavioral Health Services mission statement provides leadership and devotes resources to facilitate:

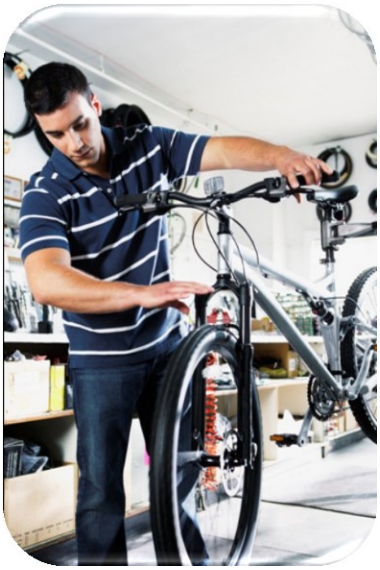
- Effective prevention;
- Quality treatment; and
- Meaningful Recovery

ARKANSAS REGIONAL MAP



Introduction

One in five people in the U.S. experience a mental illness each year (SAMHSA DSDUH report 2012: http://www.samsha.gov/data/NSDUH/2K10MH_Findings/). One in five of these individuals have a substance abuse disorder (O'Connell, M. E., Boat, T., & Warner, K. E. (2009). In the past, public health practitioners have focused on the prevention of a single disorder, such as substance abuse. In recent decades, researchers are finding that substance abuse and other behavioral health problems—such as psychological distress and suicide—are interrelated and can be addressed at the same time.



SAMHSA's CAPT developed a set of fact sheets designed to help practitioners think about their substance abuse prevention work in the overall context of behavioral health:

- A behavioral Lens on Prevention describes the scope and impact of behavioral health problems, the relationship between substance abuse and other behavioral health problems, and an introduction to the *Behavioral Health Continuum of Care Model*.
- Levels of Risk, Levels of Intervention provides an introduction to risk and protective factors, underscoring the importance of matching prevention interventions to a target population's level of risk and clarifying the difference between individual- and population-level risk.
- Key Features of Risk and Protective Factors describes how risk and protective factors influence each other and behavioral health outcomes, over time.
- Strategic Prevention Framework is a five-step process that addresses both risk and protective factors for substance abuse by promoting youth development, reducing risk-taking behaviors, and preventing problem behaviors across the life span.

What is Behavioral Health?

While many of us working in the substance abuse field have long-recognized the value of prevention, placing this work in the context of overall behavior health requires a critical shift in perspective. Applying a behavioral health lens to our current prevention efforts helps us to see the connections between substance abuse and related problems and to take the necessary steps to address these problems in a comprehensive and collaborative way.

Behavioral health is a state of mental/emotional being and/or choices and actions that affect wellness. Substance abuse and misuse are one set of behavioral health problems. Others include (but are not limited to) serious psychological distress, suicide, and mental illness (SAMHSA, 2011). Such problems are far-reaching and exact an enormous toll on individuals, their families and communities, and the broader society. Consider these statistics from Information sheet 1: A behavioral health lens for prevention (SAMHSA 2011)

- By 2020, mental and substance use disorders will surpass all physical diseases as a major cause of disability worldwide.
- The annual total estimated societal cost of substance abuse in the United States is $510.8 billion, with an estimated 23.5 million Americans aged 12 and older needing treatment for substance use.
- Each year, approximately 5,000 youth under the age of 21 die as a result of underage drinking.
- More than 34,000 Americans die every year as a result of suicide, approximately one every 15 minutes.
- Half of all lifetime cases of mental and substance use disorders begin by age 14 and three-fourths by age 24—in 2008, an estimated 9.8 million adults in the U.S. had a serious mental illness.

What Is Prevention?

Prevention is defined as interventions that occur prior to the onset of a disorder that are intended to prevent or reduce risk for the disorder. (Preventing Mental, Emotional and Behavior Disorders Among Young People, National Research Council and Institute of Medicine, 2009)

The same report defines mental health promotion as interventions that aim to enhance the ability to achieve developmentally appropriate tasks and a positive sense of self-esteem, mastery, well-being, and social inclusion to strengthen the ability to cope with adversity. The report also strongly recommended that prevention and promotion work hand-in-hand to provide the best environment for youth and young people.

Prevention begins within communities by helping individuals learn that they can have an impact on 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.

Prevention efforts aim to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the individual's life span. Risk-focused prevention is based on a simple premise: To prevent a problem from happening.

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 creating population level changes, within the cultural context, in order to reduce risks and strengthen ability to cope with adversity.

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.

Much of Arkansas' prevention work is based on the risk and protective factor approach to prevention of problem behaviors developed from 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 the individual themselves and their peer interactions. Many of the problems 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.

Building coordinated prevention efforts through collaboration with state agencies, community organizations and special populations offer multiple strategies provide multiple points of access and coordinate and expand citizen participation in community activity as a most promising approach to preventing alcohol and other drug problems

and youth related violence. A comprehensive approach to a particular problem or behavior is an effective way to achieve the desired permanent behavior or normative change.

Although there are a significant number of effective prevention programs and strategies across the Nation, they have not been coordinated to work together or fully integrated within our overall health care systems. All health-related prevention efforts should recognize and address the interrelated impact of mental health and substance use on overall well-being. (Description of a Modern Addictions and Mental Health Service System, SAMHSA, 2010)

Prevention efforts aim to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the individual's life span.

Risk-focused prevention is based on a simple premise: To prevent a problem from happening, we need to identify the factors that increase the risk of that problem developing and then find ways to reduce the risks. Just as medical researchers have found risk factors for heart attacks such as diets high in fats, lack of exercise, and smoking, research has defined a set of risk factors for drug abuse.

Co-Occurring Disorders: Overlapping Problems, Collaborative Solutions

Mental and substance use conditions often co-occur. In other words, individuals with substance use conditions often have a mental health condition at the same time and visa versus (SAMHSA: *Co-Occurring Disorder*).

In the past, practitioners and researchers saw substance abuse prevention as distinct from the prevention of other behavioral health problems. But mounting evidence indicates that the populations affected by these problems overlap significantly, as do the factors that contribute to these problems. Consequently, improvements in one area often have direct impacts on the other.

"One in five individuals with a diagnosable mental health disorder also suffers from a substance abuse disorder." (O'Connell, 2009)

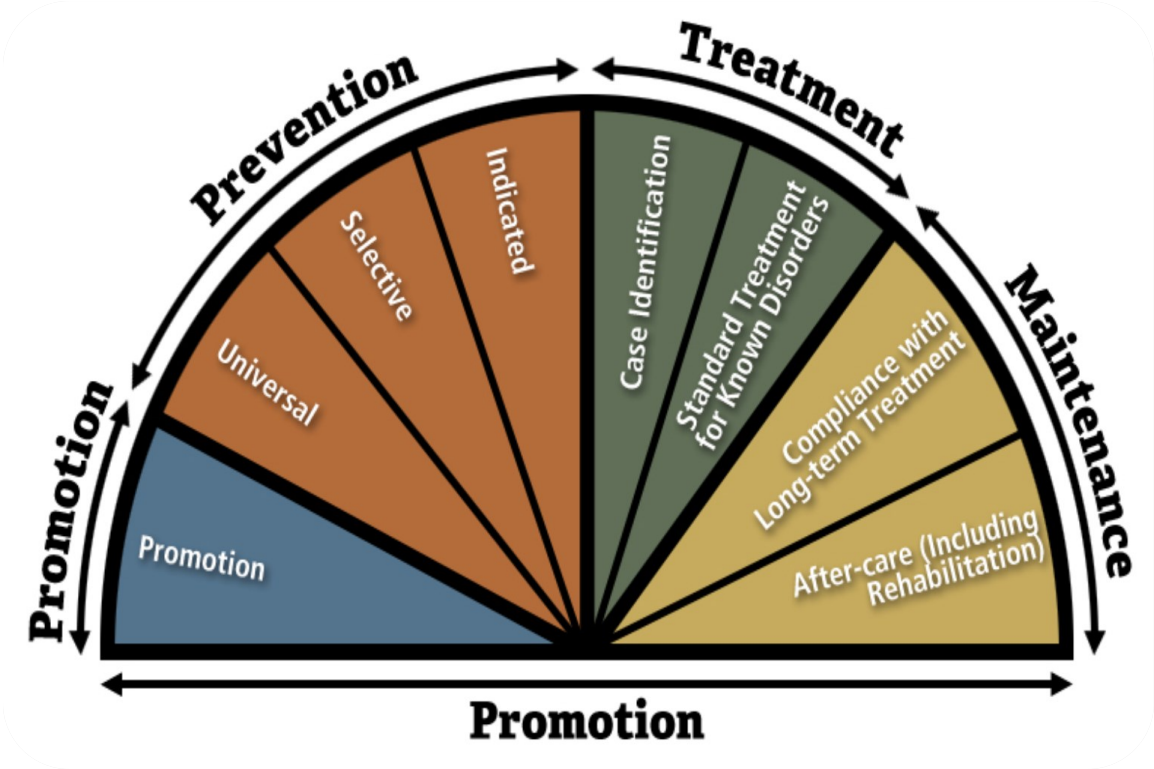
Many young people have more than one behavioral disorder. These disorders can interact and contribute to the presence of other disorders, leading to concurrent diagnosable disorders or "comorbidity". An estimated 37% of alcohol abusers and 53% of other drug abusers also have at least one serious mental illness.

Despite extensive research documenting strong associations between multiple problems, it's not always clear what leads to what. For example, can substance abuse lead to thoughts of suicide, or can thoughts of suicide lead to substance abuse? Or are they both the product of a third, unknown causal factor?

Mental and physical health is also connected. Good mental health often contributes to good physical health. Similarly, the presence of mental health disorders, including substance abuse and dependence, is often associated with physical health disorders (O'Connell, 2009). A large number of studies provide strong evidence that drinking alcohol is a risk factor for primary liver, breast, and colorectal (colon) cancer. Positive lifestyle adjustments, however—like sleep, diet, and activity and physical fitness—can also significantly strengthen mental health (O'Connell, 2009).

As prevention practitioners, our responsibility is to be mindful of these linkages and see our work as part of a broader effort to improve overall health. Recognizing these linkages can help us identify opportunities to address health in a more comprehensive way—by working across disciplines, pooling resources, and reaching people in those settings and during those times in their lives where and when services are most likely to have an impact.

Prevention as Part of a Continuum of Care



A comprehensive approach to behavioral health also means seeing prevention as part of an overall continuum of care. The *Behavioral Health Continuum of Care Model* helps us recognize that there are multiple opportunities for addressing behavioral health problems and disorders. Based on the *Mental Health Intervention Spectrum*, first introduced in a 1994 Institute of Medicine report, the model includes these components:

- **Promotion**: These strategies are designed to create environments and conditions that support behavioral health and the ability of individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services.
- **Prevention**: Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health

problem, such as underage alcohol use, prescription drug misuse and abuse, and illicit drug use.

- **Treatment**: These services are for people diagnosed with a substance use or other behavioral health disorder.
- **Maintenance**: These services support individuals' compliance with long-term treatment and aftercare.

Keep in mind, however, that interventions do not always fit neatly into one category or another. For example, consider co-morbidity. If some disorders (like substance use) are risk factors for other disorders (like depression)—does that mean that all treatment can be seen as prevention? Each prom season, communities across the nation implement safe driving campaigns—are they promoting healthy lifestyles or preventing potential substance use?

Working across the Continuum

The *Continuum of Care* model reminds us to think, more explicitly, about the relationships between promotion, prevention, and treatment. All too often these relationships are overlooked, opportunities for collaboration are missed, and outcomes are compromised.

IOM's Prevention Categories

In the **Institute of Medicine's** category prevention is classified as:-

Universal

Universal preventive interventions take the broadest approach, targeting "the general public or a whole population that has not been identified on the basis of individual risk" (O'Connell, 2009). Universal prevention interventions might target schools, whole communities, or workplaces.

Example: Community policies that promote access to early childhood education, implementation or enforcement of anti-bullying policies in schools, education for physicians on prescription drug misuse and preventive prescribing practices, social and decision-making skills training for all sixth graders in a particular school system.

Two subcategories further define universal interventions:

- **Universal Indirect** provides information to a whole population who has not been identified as at risk of having or developing problems. Interventions include media activities, community policy development, posters, pamphlets, and internet activities. Interventions in this category are commonly referred to as environmental strategies.

- **Universal Direct** interventions target a group within the general public who has not been identified as having an increased risk for behavioral health issues and share a common connection to an identifiable group. Interventions include health education for all students, after school programming, staff training, parenting class, and community workshops.

Selective

This category of prevention intervention targets individuals or a population subgroup whose risk of developing mental or substance abuse disorders is significantly higher than average prior to the diagnosis of the disorder (O'Connell, 2009). Selective interventions target biological, psychological, or social risk factors that are more prominent among high-risk groups than among the wider population.

Example 1: Group counseling and social/emotional skills training for youth in low-income housing developments, and a clinician facilitated group discussion that provides education and support to families with parental depression.

Example 2: Prevention education for new immigrant families living in poverty with young children, peer support groups for adults with a history of family mental illness and/or substance abuse.

Indicated

These prevention interventions target "high-risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental, emotional, or behavioral disorder" prior to the diagnosis of a disorder (IOM, 2009). Interventions focus on the immediate risk and protective factors present in the environments surrounding individuals.

Example 1: Information and referral for young adults who violate campus or community policies on alcohol and drugs; screening, consultation, and referral for families of older adults admitted to emergency rooms with potential alcohol-related injuries.

Example 2: Include programs for high school students who are experiencing problem behaviors such as truancy, failing academic grades, juvenile depression, suicidal ideation, and early signs of substance abuse.

Strategic Prevention Framework

According to Phil Rabinowitz in the community tool box, most communities all across the country deal with the use of alcohol, tobacco and other drugs (ATOD) problems. Some communities are comparatively successful in addressing these problems by having comprehensive plans in place to prevent initiation of ATOD use and abuse hence reducing the incidence and prevalence rates in their communities. Others communities however, are struggling in combatting substance abuse problems despite strong efforts to address the problems.

The difference is sometimes in the way they approach the problem. Those that are most successful often try to prevent the problem from starting. The most successful prevention programs use a structured, community-based approach to substance abuse prevention by employing proven model(s). They focus on the community as a whole, and try to devise ways to help the community members who are most at risk to avoid the behaviors or situations that would put them in harm's way. These successful communities try to reduce substance abuse permanently by taking a long-term perspective such as involving the communities in the decision and planning efforts, employing programs that have been proven to work in settings or communities similar to theirs and making sustainability and cultural competence the core of their prevention efforts.

There are many models for prevention efforts that address substance use, misuse and abuse problems. Most of the models look to address both the current issue and issues that may arise in the future.

To meet the cross-system approach that health promotion and disease prevention demand, the Center for Substance Abuse Prevention (CSAP), part of the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (DHHS) developed the Strategic Prevention Framework (SPF).

The SPF implements a five-step process known to promote youth development, reduce risk-taking behaviors, and prevent problem behaviors across the life span. These steps include assessment, capacity building, planning, implementation and evaluation. Throughout all five steps, implementers of the SPF must address issues of sustainability and cultural competence.

The SPF addresses both risk and protective factors for substance abuse by outlining a process that an organization, initiative, community, or state can follow in order to prevent and reduce the use and abuse of alcohol, tobacco, and drugs.

It is designed to build on science-based theory and evidence-based practices. To be effective, the SPF supports that prevention programs must engage individuals, families, and entire communities to achieve population level change. There are three, key prevention principles on the SPF process:-

- Local people solve local problems best;
- People support what they help create; and
- Use of proven programs is very important.

Assessment

The assessment phase helps define the problem or the issue that a project needs to tackle. Hence it determines needs, resources and causes of community issues. To begin, a working group is assembled that includes representatives of all stakeholders to survey the community and decide on the most pressing issue that can be successfully addressed with the resources available. This phase involves the collection of data to:

- Understand a population's needs
- Review the resources that are required and available
- Identify the readiness of the community to address prevention needs and service gaps.

To gather the necessary data, States and communities will create an epidemiological workgroup. The data gathered from this workgroup is vital because it will greatly influence a program's strategic plan and funding decisions.

Capacity

Capacity building involves mobilizing human, organizational, and financial resources to meet project goals. Training and education to promote readiness are also critical aspects of building capacity. SAMHSA provides extensive training and technical assistance (TA) to fill readiness gaps and facilitate the adoption of science-based prevention policies, programs, and practices.

Planning

Planning involves the creation of a comprehensive plan with goals, objectives, and strategies aimed at meeting the substance abuse prevention needs of the community. In the course of planning, the group adopts a logic model or framework for action; chooses from among a number of possible evidence-based “best practices;” and determines the costs and other resources that will be needed to implement the plan successfully. They also determine costs and resources needed for effective implementation.

Implementation

The implementation phase of the SPF process is focused on carrying out the various components of the prevention plan, as well as identifying and overcoming any potential barriers. During program implementation, organizations detail the evidence-based policies and practices that need to be undertaken, develop specific timelines, and decide on ongoing program evaluation needs.

Evaluation

Evaluation helps organizations recognize what they have done well and what areas need improvement. The process of evaluation involves measuring the impact of programs and practices to understand their effectiveness and any need for change. Evaluation efforts therefore greatly influence the future planning of a program. It can also impact sustainability, because evaluation can show sponsors that resources are being used wisely.

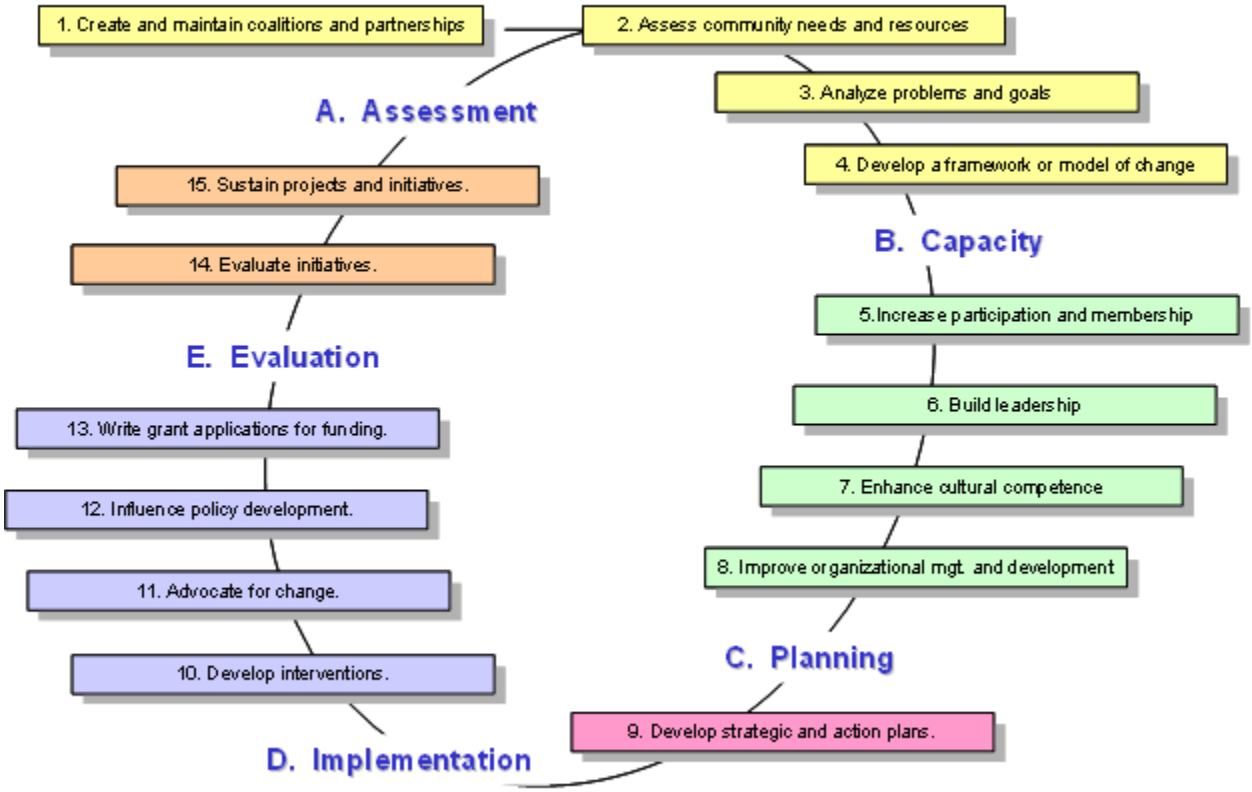
Sustainability

Sustainability refers to the process through which a prevention system becomes a norm and is integrated into ongoing operations. Sustainability is vital to ensuring that prevention values and processes are firmly established, that partnerships are strengthened, and that financial and other resources are secured over the long term.

Cultural Competence

Cultural competence is the process of communicating with audiences from diverse geographic, ethnic, racial, cultural, economic, social, and linguistic backgrounds. Becoming culturally competent is a dynamic process that requires cultural knowledge and skill development at all service levels, including policymaking, administration, and practice.

Strategic Prevention Framework Steps



Source: http://ctb.ku.edu/en/tablecontents/sub_section_main_210.aspx

For more information on the Strategic Prevention Framework, please visit http://captus.samhsa.gov/prevention-practice/strategic-prevention-framework.

SPF and Epidemiology

Epidemiology is the study of the distribution and determinants of the health and wellness of populations. In the substance abuse prevention field, epidemiologists study the patterns of use and abuse and the factors associated with an increased or decreased risk of developing substance abuse problems. Substance abuse epidemiology is the science behind SAMHSA's Strategic Prevention Framework (SPF), ensuring that decisions are data-driven and appropriate. In substance abuse prevention, epidemiologists are concerned with two big questions:

1. What is the nature, extent, and pattern of substance use behaviors and their associated consequences?
2. What risk and protective factors influence the substance abuse behaviors?

These two questions drive the SPF's planning process. Basing decisions on epidemiological data ensures that prevention programs are selected appropriately and implemented effectively to address identified priority problems and reach those populations in greatest need.

SAMHSA's Strategic Prevention Framework (SPF) follows an outcomes-based prevention model, which begins with assessment of negative consequences or outcomes that result from substance abuse:

Using epidemiology to understanding the nature and extent of substance abuse and related behavioral health problems and consequences (i.e. outcomes) is a critical first step to ensuring the success of prevention policies and programs. However, using epidemiological data is essential throughout the SPF process—for prioritization, implementation, and evaluation. Some epidemiological tasks include the following:

Beginning with SPF step one, States, Tribes, and Jurisdictions create epidemiological profiles to describe the nature, magnitude, and distribution of substance use and related consequences. This information helps to inform stakeholders from the multiple organizations, agencies, and individuals across the State whose activities affect substance abuse prevention decision-making.

Prevention practitioners are encouraged to:

- Use epidemiology at each step of the SPF to ensure that prevention efforts are data-driven and outcomes-focused
- Identify and use different types of epidemiological data to focus and refine prevention activities based on substance abuse patterns and consequences
- Develop an epidemiological profile that answers the "two big questions" above for a particular State, Tribe, or Jurisdiction
- Use a variety of sources and tools to find existing data or gather new data
- Analyze data in a systematic way to inform prevention planning, implementation, and evaluation efforts
- Enlist the support of epidemiological workgroups to provide strong analytical capacity and help interpret and communicate epidemiological data and results to key stakeholders

***Assessment*:** Epidemiologists collect and analyze epidemiological data related to substance-related consumption patterns and consequences and then interpret and present them in an epidemiological profile

***Capacity-Building*:** Planners use epidemiological data to mobilize key stakeholders and enhance State and community resources and capacity to address prevention priorities

***Planning*:** Epidemiological data detail key substance abuse and behavioral health problems, including their impact on specific target populations and geographic areas, and help to guide decisions about prevention priorities and allocation of prevention funds

***Implementation*:** Decision-makers at the State and community levels use epidemiological data to determine strategies that effectively address identified priority problems and target populations

***Evaluation*:** Ongoing data collection and analysis help to understand changes over time in behavioral health problems and patterns of consumption and support ongoing decision-making about prevention priorities and resource allocation

Prevention Approach

Some substance abuse prevention interventions are designed to help individuals develop the intentions and skills to act in a healthy manner. Others focus on creating an environment that supports healthy behavior.

Research tells us that the most effective prevention interventions are those that incorporate both these approaches. In other words, it's not enough to just convince a teenager that underage drinking is harmful or provide her with the skills to resist peer pressure; you also need to make it difficult for him to obtain the alcohol in the first place—by training liquor store clerks to check identification and enforcing laws that penalize merchants who sell to underage patrons.

This different prevention approaches include

1. Individual-level Strategies
    - Programs that focus on life and social skills are most effective.
    - Programs that involve interactions among participants and encourage them to learn drug refusal skills are more effective than non-interactive programs.
    - Interventions that focus on direct and indirect (e.g., media) influences on substance use appear to be more effective than interventions that do not focus on social influences.
    - Programs that emphasize norms for and a social commitment to not using drugs are superior to those without this emphasis.
    - Adding community components to school-based programs appears to add to their effectiveness.
    - Programs delivered primarily by peer leaders have increased effectiveness.
    - Adding training in life skills to trainings that focus on social resistance skills may increase program effectiveness.
2. Communication and Education
    - Public Education
    - Social Marketing
    - Media Advocacy
    - Media Literacy
    - Targeted Education and Training

3. Policy Adoption
    - Economic policies
    - Restrictions on access and availability
    - Restrictions on location and density
    - Deterrence
    - Restricting use
    - Limiting the marketing of alcohol products
4. Enforcement
    - Surveillance
    - Penalties, fines, and detention
    - Community policing
    - Incentives
5. Strong Collaboration

    •Coalitions of interest

    •Interagency collaboration

    •Intra-agency collaboration

Public Health Approach

Another prevention method is the Public Health Approach. The focus of public health is on the safety and well-being of entire populations by preventing disease rather than treating it. The Institute of Medicine defines public health as "what we, as a society, do collectively to assure the conditions for people to be health."

Key Characteristics

- Promotion and prevention
- Population based
- Risk and Protective factors
- Multiple contexts
- Development perspective
- Planning Process

Promotion and Prevention

Promotion is providing opportunity to optimize well-being and allow people to take responsibility for their own wellness.

Prevention aims to reduce behavioral problems by addressing the risk factors.

Population based

A public health approach concentrates on the health of the entire population, rather than at the individual level.

Risk and Protective Factors

The public health approach addresses those factors that contribute to the positive or negative health of a population.

Multiple contexts

The public health approach utilizes the multiple reams of individual, community and society which impact the population's health.

Development perspective

A public health approach takes into consideration and uses interventions appropriate to the development stage of the target population.

Planning Process

The public health approach uses a strategic planning process to determine the actions to be taken and the benefits.

Risk and Protective Factors

Risk factors are characteristics associated with potential substance abuse problems and other behavioral health problems. However, they are not necessarily the cause of the problem. Protective factors on the other hand, are those characteristics that may strengthen resilience and thus guard against the occurrence of a particular problem.

1. Risk and Protective Factors Exist in Multiple Contexts

Individuals come to the table with **biological and psychological** characteristics that make them vulnerable to, or resilient in the face of, potential behavioral health problems. Individual-level risk factors include genetic predisposition to addiction or exposure to alcohol prenatally; protective factors might include positive self-image, self-control, or social competence.

But individuals don't exist in isolation. They are part of families, part of communities, and part of society. A variety of risk and protective factors exist within each of these contexts. For example:

- In **families**, risk factors include parents who use drugs and alcohol or who suffer from mental illness, child abuse and maltreatment, and inadequate supervision; a protective factor would be parental involvement
- In **communities**, risk factors include neighborhood poverty and violence; protective factors might include the availability of faith-based resources and after-school activities
- In **society**, risk factors can include norms and laws favorable to substance use, as well as racism and a lack of economic opportunity; protective factors include

policies limiting availability of substances or anti-hate laws defending marginalized populations, such as lesbian, gay, bisexual, or transgender youth.

Practitioners must look across these contexts to address the constellation of factors that influence both individuals and populations: targeting just one context is unlikely to do the trick. For example, a strong school policy forbidding alcohol use on school grounds will likely have little impact on underage drinking in a community where parents accept underage drinking as a rite of passage or where alcohol vendors are willing to sell to young adults. A more effective—and comprehensive—approach might include school policy plus education for parents on the dangers of underage drinking, or a city ordinance that requires alcohol sellers to participate in responsible server training.

2. Risk and Protective Factors are Correlated and Cumulative

Risk factors tend to be positively correlated with one another, and negatively correlated with protective factors. That is to say, young people with some risk factors have a greater chance of exposure to still more risk factors—they are also less likely to have protective factors.

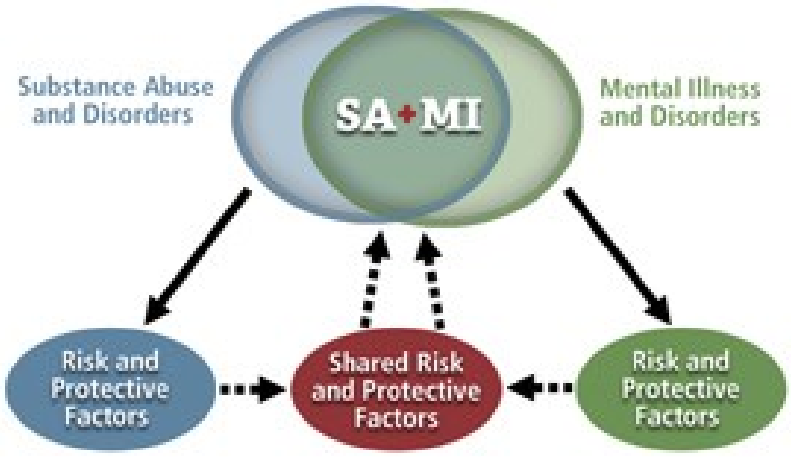
Risk and protective factors also tend to have a cumulative effect on the development—or reduced development—of behavioral health problems. Young people with multiple risk factors have a greater chance of developing a problem or disorder; young people with multiple protective factors are at reduced risk.

Understanding how risk and protective factors influence one another—that they *do*, in fact, influence one another—underscores the importance of (1) intervening early, and (2) developing interventions that target multiple factors, rather than addressing individual factors in isolation.

3. Individual Factors Can be Associated with Multiple Problems

Though preventive interventions are often designed to produce a single outcome, research shows that some risk and protective factors are associated with multiple outcomes. For example, negative life events, such as divorce or sustained neighborhood violence, are associated not only with substance abuse but also with anxiety, depression, and other behavioral health problems.

What this tells us is that preventive efforts targeting a particular set of risk and protective factors have the potential to produce positive effects in multiple areas. Interventions with multiple benefits can lead to broad improvements in health are a cost-effective investment for society.



4. Risk and Protective Factors are Influential Over Time

Risk and protective factors can strengthen or limit the presence of other factors and disorders over a lifetime. For example, risk factors such as poverty and family dysfunction, can contribute to later psychosocial problems and behavioral disorders, such as risky sexual behavior and depression. Moreover, risk and protective factors within one particular context—such as the family—may also influence or be influenced by factors in another context. For example, effective parenting has been shown to mediate the effects of multiple risk factors, including poverty, parental divorce, parental bereavement, and parental mental health problems.

The more we understand about how risk and protective factors interact, the better prepared we will be to develop appropriate interventions. In the past, prevention practitioners typically focused on a select group of factors that they thought contributed to a specific issue or produced a single outcome. Today, practitioners have begun broadening their lens—to look at connections *between* risk factors and implement effective programs strategically to address multiple outcomes.

Guiding Principles

1. **Prevention is prevention is prevention.** That is, the common components of effective prevention for the individual, family, or community within a public health model are the same – whether the focus is on preventing or reducing the effects of cancer, cardiovascular disease, diabetes substance abuse or mental illness.
2. Prevention is an ordered set of steps along a continuum to promote individual, family, and community health, prevent mental and behavioral disorders, support resilience and recovery, and prevent relapse. Prevention activities range from deterring diseases and behaviors that contribute to them, to delaying the onset of disease and mitigating the severity of symptoms, to reducing the related problems in communities. This concept is based on the Institute of Medicine (IOM) model that recognizes the importance of a whole spectrum of interventions.
3. Cultural competence and inclusiveness in working with populations of diverse cultures and identities is necessary to provide effective substance abuse prevention programming.
4. Resilience is built by developing assets in individuals, families, and communities through evidence-based health promotion and prevention strategies. For example, youth who have relationships with caring adults, good schools, and safe communities develop optimism, good-problem-solving skills, and other assets that enable them to rebound from adversity and go on with life with a sense of mastery, competence, and hope.
5. Prevention begins within communities by helping individuals learn that they can have an impact on 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. All sectors of the community, especially parents and youth, are needed in successful prevention work. Members of the education, law enforcement, public health and health care communities are critical partners in substance abuse prevention efforts.
6. The Spectrum of Prevention is a broad framework that includes seven strategies designed to address complex and significant public health problems. These include (a) influencing policy and legislation, (b) mobilizing neighborhoods and communities, (c) fostering coalitions and networks, (d) changing organizational practices, (e) educating providers, (f) promoting community education, and (g) strengthening individual knowledge and skills.
7. Common risk and protective factors exist for many substance abuse and mental health problems. Good prevention focuses on those common risk factors that can be altered. For example, family conflict, low levels of basic school readiness, and poor social skills increase the risk for conduct disorders and depression, which in turn increase the risk for adolescent substance abuse, delinquency, and violence. Protective factors such as strong family bonds, social skills, opportunities for school success, and involvement in community activities can

foster resilience and mitigate the influence of risk factors. Risk and protective factors exist in individuals, the family, the community and the broader environment.

8. Systems of prevention services works better than prevention silos. Working together, researchers and communities have produced a number of highly effective prevention strategies and programs. Implementing these strategies within a broader system of services increases the likelihood of successful, sustained prevention activities. Collaborative partnership enables communities to leverage scarce resources and make prevention everybody's business. Prevention efforts are more likely to succeed if partnerships with communities and practitioners focus on building capacity to plan, implement, monitor, evaluate, and sustain effective prevention.
9. Substance abuse prevention shares many elements of commonality with other related fields of prevention (i.e. juvenile delinquency prevention, adolescent suicide prevention). Collaboration and cross training across the prevention field is needed to maximize resources (both human and material).
10. Prevention specialists need a set of core competencies and a commitment to lifelong learning to stay current with the rapidly evolving knowledge and skill base in our field.
11. Baseline data, common assessment tools, and outcomes shared across service systems can promote accountability and effectiveness of prevention efforts. A strategic prevention framework can facilitate community identification of needs and risk factors, adopt assessment tools to measure and track results, and target outcomes to be achieved. A data-driven strategic approach maximizes the changes for future success and achieving positive outcomes.
12. Evaluation is crucial in order for communities to identify their successful efforts and to modify or abandon their unproductive efforts.

Center of Substance Abuse Prevention Strategies

CSAP's Six Prevention Strategies					
1. Information Dissemination/ Public Awareness ☐	**2. Education** ☐	**3. Alternative Activity** ☐	**4. Community Based Process** ☐	**5. Problem Identification and Referral** ☐	**6. Environmental Approach** ☐
Activity/Program ☐Info packet ☐Website/ Resource ☐Newspaper/ Newsletter Articles ☐Campaign/PSA's ☐Events/Speaker ☐Other	**Activity/Program** ☐Webinar ☐Classroom/ Group Session ☐Evidence Based Education Program ☐Conference ☐Trainings ☐Other	**Activity/Program** ☐Community Service Activity ☐Cultural Based Activity ☐Recreational Activity ☐Mentoring Program ☐Social Activity ☐Recognition Event ☐Other	**Activity/Program** ☐Coalition/ Collaboration ☐Assessment/ Readiness Surveys ☐Community Bonding Activities ☐Cross Systems Planning ☐Decreased Barrier Activity ☐Other	**Activity/Program** ☐DUI Education Programs ☐Stud./Employee Assistant Program ☐Screening programs ☐Crisis lines or hotlines ☐Tobacco Cessation ☐Other	**Activity/Program** ☐Establishing Policy/ Practice ☐Enforcement/ Judicial ☐Norms/Attitudes ☐Public Perceptions ☐School Norms ☐Media Strategies ☐Vendor Education ☐Other

The table above shows the six CSAP prevention strategies and types of activities and programs under each strategy. Strive to include at least three of the six prevention strategies in each activity or event! Listed below are the six strategies and activities appropriate to each strategy.

1. **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.
2. **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.
3. **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.

4. **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.
5. **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.
6. **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.

Evidence-based Programs and Practices

"Evidence-Based" means those practices that are based on accepted practices in the profession and are supported by research, field recognition, or published practice guidelines. These programs are prevention methodologies that have been developed and evaluated by experts using scientific processes. Some of these prevention activities help individuals develop the intentions and skills to act in a healthy manner. Others focus on creating an environment that supports healthy behavior. Evidence-based is also referred to as science-based or research-based models.

Environmental strategies are focused on changing aspects of the environment that contribute to the use of alcohol and other drugs. Specifically, environmental strategies aim to decrease the social and health consequences of substance abuse by limiting access to substances and changing social norms that are accepting and permissive of substance abuse. They can change public laws, policies and practices to create environments that decrease the probability of substance abuse.

SAMHSA has identified these criteria for defining an intervention as evidence-based:

- It is included in Federal registries of evidence-based interventions
- It is reported (with positive effects on the primary targeted outcome) in peer-reviewed journals
- It has documented evidence of effectiveness, based on guidelines developed by SAMHSA/CSAP and/or the State. These guidelines include the following:

Guideline 1: The intervention is based on a theory of change that is documented in a clear logic or conceptual mode; AND

Guideline 2: The intervention is similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature; AND

Guideline 3: The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; AND

Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, e.g., officials from law enforcement and education sectors or elders within indigenous cultures.

Members of the Arkansas Strategic Prevention Framework State Enhancement Grant (SPE) Evidence-Based Practices (EBP) Workgroup recommended Evidence-based Programs and Strategies for Arkansas prevention providers through the result of collaborative efforts.

The purpose for recommending EBPs is to identify and select evidence-based programs and strategies to assist Arkansas substance abuse prevention providers:

- Move towards evidence-based programs, practices or strategies
- Increase the use of evidence-based programs, practices or strategies
- Have access to evidence-based prevention programs, practices or strategies
- Invest in "what works" in an effort to demonstrate more positive outcomes and more effective and efficient utilization of limited prevention resources.
- Improve prevention program outcomes
- Future funding preference may be given to EBP providers

The following criteria were used to select the best fit evidence-based programs and practices for Arkansas prevention providers:

1. Evidence of effectiveness: have at least some documented evidence of effectiveness, and preferably have been rigorously tested and shown to have positive outcomes in multiple peer-reviewed evaluation studies.
2. Conceptual fit with the community's prevention priorities: specifically address one or more of the risk factors for substance abuse identified within the community or target population, have evidence of effectiveness within a similar community or target population and have been shown to drive positive outcomes.
3. Practical fit with the community's readiness and capacity:
4. Ability to implement with fidelity
5. Cultural fit within the community: programs likely to conform with the norms in Arkansas communities
6. High likelihood of sustainability within the community

Based on this, the following programs were selected:-

1. Al's Pals
2. Active Parenting of Teens: Families in Action
3. Big Brothers Big Sisters Community Mentoring
4. Brief Alcohol Screening and Intervention for College Students (BASICS)
5. Caring School Community
6. Community Trials
7. Families and Schools Together
8. Guiding Good Choices
9. Lead and Seed
10. Life Skills Training
11. Lion's Quest
12. Nurturing Parents Program
13. Olweus Bullying Prevention Program
14. Parenting Wisely

15. Project Alert
16. Project Northland
17. Screening, Brief Intervention, and Referral to Treatment (SBIRT)
18. Second Step
19. Strengthening Families
20. Team Awareness

Effective prevention strategies are those strategies that reinforce healthy norms, support the development of protective factors, help youth to develop social skills and critical thinking skills and teach decision making and refusal skills. The following strategies were selected.

Policy Change Strategies
1. Policies to Require Merchant Training
2. Community Event Alcohol Use Regulations
3. Public Availability Policies
4. Social Host Ordinance
5. Advertising Restrictions

Enforcement Strategies
1. Alcohol Outlet Compliance Checks
2. Sobriety Checkpoints to Enforce Impaired Driving Laws
3. Shoulder Tap Surveillance
4. Party Patrols
5. Enforcement of open container laws

Media/Communication Strategies
1. Alcohol Warning Signs
2. Retail Outlet Recognitions
3. Social Norms Misperceptions Campaigns
4. Counter-Advertising
5. Social Marketing

National Outcome Measures

The Substance Abuse and Mental Health Services Administration's (SAMHSA) National Outcome Measures (NOMS) are an effort to develop a reporting system that will create an accurate and current national picture of substance abuse and mental health services. The NOMS serve as performance targets for state- and Federally-funded programs for substance abuse prevention and mental health promotion, early intervention, and treatment services.

Within the NOMS are eleven priority areas, one of which addresses co-occurring disorders (COD). Each area is subdivided into three areas: Mental health services, Substance abuse treatment and Substance abuse prevention

Each area is further subdivided into ten domains:

- Reduced Morbidity
- Employment/Education
- Crime and Criminal Justice
- Stability in Housing
- Social Connectedness
- Access/Capacity
- Retention
- Perception of Care (or services)
- Cost Effectiveness
- Use of Evidence-Based Practices

SAMHSA developed the NOM domains in collaboration with the States and jurisdictions to measure whether the agency's vision is being achieved. The domains are designed to embody meaningful, real life outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in their communities.

SAMHSA is using data from the NOMs to manage and measure performance. Associated with the domains are relevant outcomes for people who are striving to attain and sustain recovery; build resilience; and work, learn, live, and participate fully in their communities. The SAMHSA website (www.nationaloutcomemeasures.samhsa.gov) presents a matrix which defines these domains, outcomes, and specific measures for mental health, substance abuse prevention, and substance abuse treatment.

SAMHSA's National Outcome Measure Domains

DOMAIN	OUTCOME	MEASURES		
		Treatment		Prevention
		Mental Health	Substance Abuse	Substance Abuse
ABSTINENCE	Abstinence from drug/alcohol use	N/A	Reduction in/no change in frequency of use at date of last service vs. date of first service	30-day substance use (non-use/reduction in use) Perceived risk of use Age at first use
	Decreased mental illness symptoms	Under development	N/A	Perception of disapproval N/A
EMPLOYMENT / EDUCATION	Increased / retained employment or return to school	Profile of adults by employment status & of children by increased school attendance	Increase in/no change in # of employed or in school at date of last service vs. first service	ATOD suspensions & expulsions; workplace AOD use & perception of workplace policy
CRIME AND CRIMINAL JUSTICE	Decreased criminal justice involvement	Profile of client involvement in criminal & juvenile justice systems	Reduction in/no change in # of arrests in past 30 days from date of first service to date of last service	Drug-related crime; alcohol-related car crashes & injuries
STABILITY IN HOUSING	Increased stability in housing	Profile of client's change in living situation (including homeless status)	Increase in/no change in # of clients in stable housing situation from date of first service to date of last service	N/A
ACCESS / CAPACITY	Increased access to services (service capacity)	# of persons served by age, gender, race and ethnicity	Unduplicated count of persons served; penetration rate – #s served compared to those in need	# of persons served by age, gender, race & ethnicity
RETENTION	Increased retention in treatment – sub abuse	N/A	Length of stay from date of first service to date of last service Unduplicated count of persons served	Total # of evidence-based programs & strategies
	Reduced utilization of psychiatric inpatient beds – mental health	Decreased rate of readmission to State psychiatric hospitals within 30 days and 180 days	N/A	N/A
SOCIAL CONNECTEDNESS	Increased social supports / social connectedness	Under development	Under development	Under development
PERCEPTION OF CARE	Client perception of care	Clients reporting positively about outcomes	Under development	N/A
COST EFFECTIVENESS	Cost effectiveness	# of persons receiving evidence-based services / # of evidence-based practices provided by the State	# of States providing substance abuse treatment services w/in approved cost per person bands by the treatment type	Increase services provided w/in cost bands w/in universal, selective, and indicated programs
USE OF E.B.P.	**Use of evidence-based practices**		**Under development**	**Total # of E.B.P. and strategies**

SAMHSA's Eight Behavioral Health Strategic Initiatives

http://www.samhsa.gov/about/strategy.aspx

SAMHSA has identified eight Strategic Initiatives to focus its resources on areas of urgency and opportunity. They will also enable SAMHSA to respond to National, State, Territorial, Tribal, and local trends and support implementation of the Affordable Care Act and the Mental Health Parity and Addictions Equity Act.

People are at the core of SAMHSA's mission, and the Initiatives will guide its work through 2014 to help people with mental and substance use disorders and their families, build and support strong and supportive communities, prevent costly and painful behavioral health problems, and promote better health and functioning for all Americans.

1. **Prevention of Substance Abuse and Mental Illness:** Creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families
   Initiative Page: http://www.samhsa.gov/prevention/

2. **Trauma and Justice:** Reducing the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health, behavioral health, and related systems and addressing the behavioral health needs of people involved in or at risk of involvement in the criminal and juvenile justice systems.
   Initiative Page: http://www.samhsa.gov/traumaJustice/

3. **Military Families:** Supporting America 's service men and women—Active Duty, National Guard, Reserve, and Veteran—together with their families and communities by leading efforts to ensure that needed behavioral health services are accessible and that outcomes are positive.
   Initiative Page: http://www.samhsa.gov/militaryFamilies

4. **Recovery Support:** Partnering with people in recovery from mental and substance use disorders to guide the behavioral health system and promote individual-, program, and system-level approaches that foster health and resilience; increase permanent housing, employment, education, and other necessary supports; and reduce barriers to social inclusion.
   Initiative Page: http://www.samhsa.gov/recovery

5. **Health Reform:** Broadening health coverage to increase access to appropriate high-quality care and to reduce disparities that currently exist between the availability of services for substance abuse, mental disorders, and other medical conditions such as HIV/AIDS.
   Initiative Page: http://www.samhsa.gov/healthReform

6. **Health Information Technology:** Ensuring that the behavioral health system, including States, community providers, and peer and prevention specialists, fully participates with the general health care delivery system in the adoption of Health Information Technology (HIT) and interoperable Electronic Health Records (EHR).
   Initiative Page: http://www.samhsa.gov/healthIT

7. **Data, Outcomes, and Quality:** Realizing an integrated data strategy and a national framework for quality improvement in behavioral health care that will inform policy, measure program impact, and lead to improved quality of services and outcomes for individuals, families, and communities.
   Initiatives Page: http://www.samhsa.gov/dataOutcomes

8. **Public Awareness and Support:** Public Awareness and Support —Increasing the understanding of mental and substance use disorders to achieve the full potential of prevention, help people recognize mental and substance use disorders and seek assistance with the same urgency as any other health condition, and make recovery the expectation.
   Initiative Page: http://www.samhsa.gov/publicAwareness

State Prevention Initiatives

Drug and Alcohol Safety Education Program (DASEP)

The mission of the Arkansas Drug and Alcohol Safety Education Program (DASEP) is to promote public safety by reducing the number of injuries and fatalities due to driving while under the influence of alcohol or other drugs. DASEP strives to prevent behavioral health problems caused by substance use. Individuals attend a DASEP course because their use of alcohol or other drugs has put them and others at risk. The course encourages effective decision-making and the reduction of recidivism by providing participants with accurate information about alcohol and other drugs and assisting them in making changes to any high-risk substance abuse behavior.

Gambling Prevention Initiative

This initiative centers on information dissemination to raise awareness of the signs of problem gambling and where help can be received.

Suicide Prevention and Early Intervention Initiative

Key stakeholders from all over the state, representing numerous agencies, organizations, foundations, and programs are participating in updating the State Suicide Prevention Plan to be congruent with the National Strategies for Suicide Prevention. Suicide prevention/intervention programs such as, Gatekeeper Training and ASIST are on-going throughout Arkansas through local schools, youth-serving agencies, military unit locations, colleges and universities, and community coalitions.

SBIRT Initiative

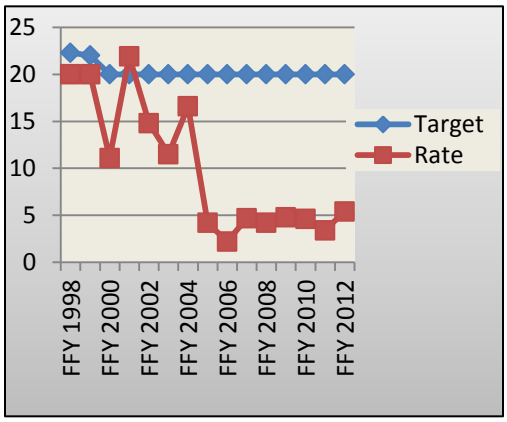
SBIRT, or Screening Brief Intervention, and early Referral to Treatment, is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for people with substance use disorders and people who are at risk of developing these disorders.

Synar Compliance Checks and Coverage Study

The major purpose of the Synar Legislation passed by Congress is to reduce youth access to tobacco by requiring States to have and enforce laws prohibiting the sale of tobacco products to anyone under the age of 18. The U.S. Department of Health and Human Services launched two complementary efforts in support of this legislation. First, the Substance Abuse and Mental Health Services Administration (SAMHSA) promulgated and is enforcing the Synar Regulation, which instructs States on implementation of the legislation. Second, the Food and Drug Administration (FDA) issued a rule in 1996 mandating that tobacco retailers not sell tobacco to anyone under age 18 and that they require a picture identification card from anyone under the age of 27 who attempts to purchase tobacco.

Tobacco compliance checks are conducted annually as a research project to determine the percentage of merchants willing to sell to underage youth. These random checks use youth 15-16 who attempt to purchase tobacco products. Periodically, a coverage study is done where all roads within a census tract are traveled and all businesses visited to determine the validity of the list of tobacco merchants.

The Requirements of the Synar Legislation and Regulation



In July 1992, Congress enacted the ADAHA Reorganization Act (P>L> 102-321), which included an amendment (Section 1926) aimed at decreasing access to tobacco products among individuals age 18. Named for its sponsor, Congressman Mike Synar of Oklahoma, the Synar Legislation requires states to enact and enforce laws prohibiting a manufacturer, retailer, or distributor from selling or distributing tobacco products to individuals under the age of 18. The legislation further requires States to conduct random, unannounced inspections of tobacco outlets and report the findings annually to the Secretary of the U.S. Department of Health and Human Services (DHHS). This report must also include that year's enforcement activities. While the immediate goal of the legislation is to reduce the number of successful illegal purchases by minors, DHHS' ultimate goal is to eliminate both illegal tobacco sales and tobacco use by minors.

Baseline rates were first rates reported by the States the FFY 1997 and these rates were used to negotiate future interim target rates. Arkansas was among seven states that did not establish their baseline rates until FFY 1998. Since the establishment of rates and the implementation of the Synar Legislation, successful buys by minors has markedly gone down.

Successful implementation of the Synar Legislation and Regulation is important for several reasons. First, it is expected to reduce youth access to tobacco products, thereby reducing youth tobacco use and facilitating reduction of both current and future health problems among adolescents. Second, the public supports measures to prevent the use of tobacco by young people and, specifically, efforts to discourage tobacco sales to minors (HHS, 1994). Finally, successfully reducing the failure rates on random, unannounced inspections is important to the States so that they can continue to receive their full SAPT Block Grant funding.

The graph above shows the State Target and Reported Retailer Violation Rates for Arkansas from Federal Fiscal Years 1998 to 2012.

State Prevention Support System

Arkansas Collegiate Drug Education Consortium

ACDEC focuses on intervention and prevention issues. It is comprised of student services personnel responsible with providing drug and alcohol abuse programming. ACDEC maintains contact with each campus through the school representatives.

Arkansas Prevention Certification Board

The Arkansas Prevention Certification Board (APCB) oversees and evaluates the certification process for the state of Arkansas. APCB is a member of the International Certification and Reciprocity Consortium (IC&RC). The IC&RC is a voluntary organization of certifying bodies which awards administrative reciprocity to prevention professionals who have fulfilled the certification requirements of its members.

Arkansas Prevention Network (APNet)

This is a statewide prevention association that represents preventionists who are working together to advocate for public policy and to seek funding that will benefit the prevention field at local, regional, and State levels. The major goals of APNet are to

- Promote public recognition of prevention as a viable, distinct, personal, and professional discipline.
- Promote the science of prevention, provide new information and resources, and to be the leaders in the State regarding prevention issues.
- Advocate for the prevention and practitioners by working to promote, establish, and maintain a support system for them.

MidSouth Prevention Institute

The MidSOUTH Prevention Institute is a workforce development initiative that 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. Prevention Institute resources include training, technical assistance, and a resource library housed on the UALR campus. The Prevention Institute provides training on a variety of prevention topics reflecting the most current, science-based approaches to prevention.

MidSouth Summer School

MidSOUTH Summer School provides a forum for cost-effective and relevant workshops dealing with the unique challenges faced by individuals delivering treatment services, prevention programs, and related alcohol and other drug education.

Regional Prevention Providers (RPP)

RPPs provide prevention capacity development within regions and communities they serve to support statewide prevention efforts and programming. Capacity development is accomplished through various initiatives that include information dissemination, education/training, problem identification and referral, alternative activities, community-based process and environmental strategies. RPPs use the Strategic Prevention Framework to plan, develop, implement and sustain effective prevention initiatives.

- **Regional Prevention Representatives (RPR)** are employed by the RPPs to serve as trainers, provide technical assistance, and identify and raise awareness of behavioral health issues within eight geographical regions defined in the state. The primary focus 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.

Research Triangle Institute

Provide consultation on the major substantive issues including the evaluation of the state prevention section efforts and effectiveness, program progress from baseline to follow-up, surveys of the prevention workforce and key stakeholders, conduct data analysis and provide guidance on federal performance reporting requirements.

Youth Organizations

- **Lead and Seed:** Lead and Seed is a nationally recognized program that empowers youth to accomplish substance abuse prevention work within their communities using the Strategic Prevention Framework. Youth are one of the most vulnerable populations for these risk factors and yet they are one of the most powerful at impacting their peers. Putting youth across the state in leadership roles is critical to accomplishing the prevention goal of influencing youth before they have a problem.

- **Youth MOVE:** 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

Guidelines for Materials

- Materials make clear that illegal and unwise drug use 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 especially recovering alcoholics and drug addicts, or persons taking prescription or non-prescription drugs.
- Material gives a clear message of no alcohol use for persons under 21 years of age.
- Material states clearly that pregnant women must not use any drugs (prescription or non-prescription) without first consulting their physicians. Materials give a clear message of no alcohol use by pregnant women.
- Material does not glamorize or glorify the use of alcohol and other drugs.
- 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.
- Materials do not “blame the victim” or pass judgment.
- Materials 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.
- Material is appropriate for target audience at cognitive and developmental levels.
- The institutional source of materials is credible for target audience.
- Individuals delivering the message are appropriate for the target audience.
- Language should be appropriate and grammatically correct whether English or another language.
- 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 professional in appearance, attractive and well written with the format appropriate to the audience.
- Messages must be appealing, believable, create awareness, persuasive, call for action and be pretested.
- Materials need to be combined with other messages and/or materials to be effective.
- Readability level should reflect the skills of the target audience.

Recommended Data Sources

The **Arkansas Epidemiological Statewide Profile** report provides an overview of substance use consumption and consequence at both statewide and county levels. The purpose of the profile is to provide state policy-makers with a comprehensive picture of substance abuse challenges faced in Arkansas. Substance abuse data is compiled from various national and state agencies (e.g. Department of Education, Highway Safety, Tobacco Control Board, AR Beverage Control, Department of Health, Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration, etc.) to integrate information regarding the causes and consequences of the use of alcohol, tobacco, and other drugs in both adult and child populaces. The profile includes a general population profile, information about factors that may contribute to substance abuse, and in an effort to determine the effect of substance abuse in Arkansas, health and economic consequences. Specific county level data is included for each of the 75 counties as a resource for community leaders throughout Arkansas. This report is posted online at http://www.preventionworksar.org/.

The **Arkansas Prevention Needs Assessment (APNA)** student Survey is conducted annually. APNA uses the Communities That Care Student Survey instrument which is based on risk and protective factors and collects information on drug use and social indicators. Arkansas public school students in 6th, 8th, 10th, and 12th grades are surveyed. Each participating district is provided its own data results in district and building level reports (providing the number of participants is large enough for student anonymity). Data results are also published at the county, region, and state levels and posted on line for public access. The APNA data has become a major planning resource for communities, schools, and state agencies. APNA data is used by a variety of organizations for both state and community level planning. APNA Reports are accessible online at http://www.arkansas.pridesurveys.com/

The **Arkansas State Police Highway Safety Office** publishes annual reports that include information about vehicle and motorcycle accidents in a variety of situations (e.g. involving alcohol, inclement weather, varying road conditions, and different times of day) for both fatal and non-fatal crashes. These reports also include trending for year and age of drivers as well as county and city statistics. Full reports can be found at http://www.asp.arkansas.gov/hso/hso_index.html.

The **Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas** is a compilation of data reported by various state agencies (e.g. Department of Education, Highway Safety, Tobacco Control Board, AR Beverage Control, Department of Health, Division of Youth Services, etc.) Approximately 90 archival data indicators are collected annually and organized according to the following categories: Demographic data, Community Domain, Family Domain, School Domain, Peer/Individual Domain, and Consequences. The publication reports the data at the state region, and county levels. To depict data trends, the annual publication includes data for each of the most recent five ears and for the 10th year back (six years of data). This compilation provides DBHS and communities, schools, agencies, and organizations with readily accessible data needed for effective planning of prevention efforts. It has also proven to be a valuable resource for other

fields, including treatment, youth services, etc. This report is posted online at http://www.preventionworksar.org/.

The Centers for Disease Control (CDC) designed the **Behavioral Risk Factor Surveillance System (BRFSS)** to collect information on health conditions and risk behaviors in the United States. It is currently the primary source of data for states and the nation on health-related behaviors of adults. The BRFSS is administered by the Arkansas Department of Health with assistance from the CDC. All states ask a set of core questions and have the option of adding modules designed by the CDC or asking their own (state-designed) questions. Households are selected randomly by the CDC. Data is collected monthly through telephone interviews with adults (aged 18 and older), and data is analyzed and reported by both the CDC and designated state agencies. Annual Arkansas BRFFS information can be found online at http://brfss.arkansas.gov/.

The **CORE Alcohol and Drug Survey** was developed in the late 1980s by the U.S. Department of Education and advisors from several universities and colleges to measure alcohol and other drug usage, attitudes, and perceptions among college students at two and four year institutions. The survey is administered by the CORE Institute at Southern Illinois University –Carbondale (SIUC). The survey includes several types of items about alcohol and drugs. One type deals with the students' attitudes, perceptions, and opinions about alcohol and other drugs and the other deals with the students' own use and consequences of use. There are also several items on students' demographic and background characteristics as well as perception of campus climate issues and policy. More information on the CORE survey is available online at http://www,siu.edu/departments/coreinst/public_html/.

Monitoring the Future is an ongoing study of behaviors, attitudes, and values of American secondary school students, college students, and young adults. Each year, a total of approximately 50,000 students in grades 8th, 10th, and 12th are surveyed (12th graders since 1975, and 8th and 10th graders since 1991). In addition, annual follow-up questionnaires are mailed to a sample of each graduating class for a number of years after their initial participation. MTF reports are available online at http://www.monitoringthefture.org/.

The **National Survey on Drug Use and Health (NSDUH)** is an annual nationwide survey involving interviews with approximately 70,000 randomly selected individuals age 12 and older. The Substance Abuse and Mental Health Services Administration (SAMHSA), which funds NSDUH, is an agency within the U.S. Public Health, a part of the U.S. Department of Health and Human Services. Supervision of the project comes from SAMHSA's Office of Applied Studies (OAS). Data from the NSDUH provides national and state-level estimates of the past month, past year, and lifetime use of tobacco products, alcohol, illicit drugs, and non-medical use of prescription drugs. More information on the NSDUH is available online at http://www.oas.samhsa.gov/states.htm.

Glossary

Acronyms

AOD - Alcohol and Other Drugs

APNA- Arkansas Prevention Needs Assessment Survey

ARF - Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas

ATOD - Alcohol Tobacco and Other Drugs

BRFSS - Behavioral Risk Factor Surveillance System

CADCA - Community Anti-Drug Coalitions of America

CAPT - Center for the Application of Prevention Technologies

CDC - Centers for Disease Control and Prevention

CSAP - Center for Substance Abuse Prevention

DBHS - Division of Behavioral Health Services

DHHS - U.S. Department of Health and Human Services

ICRC - International Certification Reciprocity Consortium

IOM - Institute of Medicine

MDS - Minimum Data Set System

MTF - Monitoring the Future

NIDA - National Institute on Drug Abuse (institute within NIH)

NPN - National Prevention Network

NREPP - National Registry of Evidence-based Programs and Practices

NSDUH - National Survey on Drug Use and Health

ONDCP - Office of National Drug Control Policy

RPP - Regional Prevention Provider

RPR - Regional Prevention Representative

SAPT - Substance Abuse Prevention and Treatment

SAMHSA - Substance Abuse & Mental Health Services Admin

SEW - State Epidemiological Outcomes Workgroups

SPE - Strategic Prevention Framework State Prevention Enhancement Grant

SPF - Strategic Prevention Framework

SPF SIG - Strategic Prevention Framework State Incentive Grant

YRBS - Youth Risk Behavior Survey

Terms and Definitions

Alcohol and Drug Abuse Coordinating Council

A body created by legislation with the responsibility for overseeing all planning, budgeting, and implementation of expenditure of state and federal funds allocated for alcohol and drug education, prevention, treatment, and law enforcement.

Alternative Approaches

This CSAP strategy provides for the participation of target populations in activities that exclude substance use.

Binge Alcohol Use

Drinking five or more drinks on the same occasion (i.e. drinks are consumed at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

Capacity Building

Increasing the ability and skills of individuals, groups, and organizations to plan, undertake, and manage initiatives. The approach also enhances the capacity of the individuals, groups, and organizations to deal with future issues or problems.

Coalition

Coalition is the full partnerships or collaborations among organizations or sectors that require sharing resources and leadership within a community in which each group retains its identity but all agree to work together toward a common goal of building a safe, healthy, and drug-free community on an ongoing basis.

Community Development

Community Development is indicated by collaborative, collective action taken by local people to enhance the long-term social, economic, and environmental conditions of their community. The primary goal of community development is to create a better overall quality of life for everyone in the community.

Community Readiness

Community readiness is the degree of support for or resistance to identifying substance use and abuse as significant social problems in a community.

Community-Based Approach

A prevention approach that focuses on the problems or needs of an entire community, be it a large city, a small town, a school, a worksite, or a public place. Other popular approaches include school-based, family-based, environmental prevention.

Community-Based Process

This CSAP strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance abuse disorders. Activities in this strategy include organizing, planning, enhancing efficiency and effectiveness of services implementation, interagency collaboration building, and networking.

Contributing Factors

A set of community specific issues that compromise the intervening variables. They are the key link to identifying prevention strategies.

Consequence Data

Consequence Data identifies the prevalence and incidence of substance use. It is the data we use to determine who, what, when, where, and how often.

Consumption Data

Consumption Data identifies the impact of substance use on the individual and society. Substance use consequence data includes impacts on health (e.g. hospital admissions), criminal justice (e.g. arrests, traffic crashes), and children and adolescents (e.g. school performance).

Culturally Appropriate

Activities and programs that take into account the practices and beliefs of a particular social or cultural group so that the programs and activities are acceptable, accessible, persuasive, and meaningful.

Cultural Competence

Cultural competence describes the ability of an individual or organization to interact effectively with people of different cultures.

Data Driven

A process whereby decisions are informed by and tested against systematically gathered and analyzed information.

Effectiveness

Refers to whether the intervention typically is successful in actual clinical practice. SAMHSA Effective Programs are well-implemented, well-evaluated programs that produce a consistent positive pattern of results (across domains and/or replications).

Efficacy

Refers to whether the intervention can be successful when it is properly implemented under controlled conditions

Environmental Approaches

This is a CSAP strategy that establishes or changes community standards, codes, and attitudes and thus influences the incidence and prevalence of substance abuse.

Environmental Factors

Environmental factors are external or perceived to be external to an individual but that may nonetheless affect his or her behavior.

Epidemiology

Epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems.

Evaluation

Evaluation is a process that helps prevention practitioners to determine the strengths and weaknesses of their activities so that they can make improvements over time. Time spent on evaluations is well spent because it allows groups to use money and other resources more efficiently in the future.

Evidence-based prevention

This refers to a set of prevention activities that evaluation research has shown to be effective. Some of these prevention activities help individuals develop the intentions and skills to act in a healthy manner. Others focus on creating an environment that supports healthy behavior.

Evidence-based Programs

These are successful, well-implemented, and well-evaluated programs that have been reviewed by the National Registry of Effective Programs and Practices (NREPP) according to rigorous standards of research.

Evidence Based Strategies

These are successful, well-implemented and well-evaluated programs, practices or policies that address contributing factors and their related risk behaviors.

Environmental Strategies

Establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of substance abuse in the general population. This strategy is divided into two sub categories to permit distinction between activities that center on legal and regulatory initiatives and those that relate to the service and action-oriented initiatives.

Fidelity

Fidelity means maintaining the core components, framework, program elements, delivery schedule, and dosage/exposure as intended by the program developer. Ensuring programs maintain those core elements will enhance the likelihood that those original positive outcomes are achieved in a replication.

Heavy Alcohol Use

This is drinking five or more drinks on the same occasion on each of 5 or more days in the past 30 days. All heavy alcohol users are also binge alcohol users.

Indicated Prevention Measure

This is a prevention measure directed to specific individuals with known, identified risk factors.

Impact Evaluation

Impact evaluation is a type of outcome evaluation that focuses on the broad, long-term impacts or results of program activities. For example, an impact evaluation could show that a decrease in a community's crime rate is the direct result of a program designed to provide community policing.

Incidence

The number of new cases of a disease or occurrences of an event in a particular time period usually expressed as a rate, with the number of cases as the numerator and the population at risk as the denominator.

Intervention

An intervention is an activity or set of activities to which a group is exposed in order to change the group's behavior. In substance abuse prevention, interventions may be used to prevent or lower the rate of substance abuse or substance abuse-related problems.

IOM - Institute of Medicine

A nonprofit national component organization of the National Academies of Science specifically created to advice national policy makers, and federal agencies on matters of biomedical science, medicine and health. Its mission is to improve health by providing unbiased, evidence-based and authoritative information and advice concerning science and health policy.

Logic Model

Logic Model is a pictorial representation of connections between the activities, strategies and methods and goals of an initiative or enterprise; a flow chart. It explains why the strategy is a good solution to the problem at hand and makes an explicit, often visual, statement of activities and results. It keeps participants moving in the same direction through common language and points of reference. As an element of work itself, the logic model can energize and rally support by declaring what will be accomplished, and how.

Measures

The tools used to obtain the information or evidence needed to answer a research question.

Mental Health

Mental Health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community.

Mental Health Promotion

Mental Health Promotion consists of interventions to enhance the ability to achieve developmentally appropriate tasks and a positive sense of self-esteem, mastery, well-being, and social inclusion and to strengthen the ability to cope with adversity. This ability to cope is referred to as resilience.

Mental Health Treatment

Mental Health Treatment is the provision of specific intervention techniques by a professional for conditions identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). These interventions should have proven effectiveness, the ability to produce measurable changes in behaviors and symptoms, and should be person- and family-centered and culturally and linguistically appropriate.

Mental Illness

Mental Illness is defined as “collectively all diagnosable mental disorders” or “health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.” Under these definitions, substance use might be classified as either a mental health problem or a mental illness, depending on its intensity, duration, and effects.

Needs Assessment

Activities that include surveys of various targeted populations, assessment of prevention resources within the state, studies of current outcome indicators, demographic analyses of social marketing data, and household and school surveys

Outcome

The extent of change in targeted attitudes, values, behaviors, or conditions between baseline measurement and subsequent points of measurement. Depending on the nature of the intervention and the theory of change guiding it, changes can be short-term, intermediate, and longer-term outcomes.

Outcome Evaluation

A type of evaluation used to identify the results of a program's effort. It seeks to answer the question, what difference did the program make? It yields evidence about the effects of a program after a specified period of operation.

Outcome Measures

Assessments that gauge the effect or results of services provided to a defined population. Outcomes measures include the consumers' perception of restoration of function, quality of life, and functional status, as well as objective measures of mortality, morbidity, and health status.

Partnership

A partnership is a relationship where two or more parties, having common and compatible goals, agree to work together for a particular purpose and/or for some period of time.

Prevalence

The number of all new and old cases of a disease or occurrences of an event during a particular time period usually expressed as a rate, with the number of cases or events as the numerator and the population at risk as the denominator.

Prevention

Prevention is a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles.

It is a step or set of steps along a continuum to promote individual, family, and community health; prevent mental and substance use disorders; support resilience and recovery; and prevent relapse.

Preventionist

One who routinely practices prevention in his/her existing societal role, whether paid or volunteer, acting in a personal or professional capacity. Preventionists include parents, clergy, teachers, law enforcement, business owners, etc.

Process Evaluation

Evaluation design to document what policies and/or programs actually happened, detailing activities, participants involved, resources, methods of management, and other output indicators. It describes how the program operates, the services it delivers, and the functions it carries out. It addresses whether the program was implemented and is providing services as intended.

Program Evaluation

Program evaluation is the systematic collection of information to answer important questions about activities, characteristics, and outcomes of a program. Evaluation stages include design, data collection, data analysis and interpretation, and reporting.

Protective Factors

Protective factors are those characteristics that may strengthen resilience and thus guard against the occurrence of a particular problem.

Public Health Model

Public Health Model is a model that represents the interactions among the agent, host and environment. In substance abuse prevention, the agent is alcohol or drugs or the sources, supplies, and availability of alcohol and drugs. Hosts can be seen as the potential and/or active substance users. The environment is the social climate that encourages and supports the potential and/or actual use of substances. The public

health model posits that all of these factors must be addressed together for prevention to be effective.

Quantitative Data

Quantitative data is numeric information that includes things like personal income, amount of time, or a rating of an opinion on a scale from 1 to 5. Quantitative data is used with closed-ended questions, where users are given a limited set of possible answers to a question. They are for responses that fall into a relatively narrow range of possible answers.

Qualitative Data

Qualitative data is a record of thoughts, observations, opinions, or words. Qualitative data typically comes from asking open-ended questions to which the answers are not limited by a set of choices or a scale. Qualitative data is best used to gain answers to questions that produce too many possible answers to list them all or for answers that you would like in the participant's own words.

Recovery

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. People with mental illnesses can and do recover from these conditions, and hope plays an essential part in overcoming the internal and external challenges, barriers, and obstacles. Controlling or managing symptoms is part of this process. Reducing or eliminating substance use is critical for recovery from addiction.

Recovery Support Services

Recovery Support Services include a focus on providing for the health, housing, vocational, and social support needs of people with mental health problems. These include peer- and family-operated services.

Resilience

Resilience is either the capacity to recover from traumatically adverse life events and other types of adversity and achieve eventual restoration or improvement of competent functioning or the capability to withstand chronic stress and to sustain competent functioning despite ongoing stressful and adverse life conditions.

Risk Factors

Risk factors are characteristics associated with potential substance abuse problems. However, they are not necessarily the cause of the problem.

Stakeholder

A stakeholder is a person, group, organization, member or system that affects or can be affected by a community or an organization's actions.

Strategic Planning

A deliberate set of steps that assess needs and resources; define a target audience and a set of goals and objectives; plan and design coordinated strategies with evidence of success; logically connect these strategies to needs, assets, and desired outcomes; and measure and evaluate the process and outcomes.

Strategic Prevention Framework

The Strategic Prevention Framework (SPF) is a major SAMHSA initiative and includes five components: needs assessment, capacity, planning, implementation, and evaluation in an effort to encompass the state and all sectors of the community. This is the planning approach adopted by SAMHSA that requires a logic model process for grants supported by their funds.

Strategy

Strategies are types of activities (e.g., policy) that can be implemented to achieve specific objectives and for which a strong evidence base may or may not exist.

Substance Abuse

Substance Abuse is defined as the use of alcohol or drugs despite negative consequences.

Substance Use

Substance Use is defined as the consumption of low or infrequent doses of alcohol and other drugs, sometimes called experimental, casual, or social use.

Trauma

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

Universal Prevention Measure

A preventive measure directed to a general population or general subsection of the population not yet identified on the basis of risk factors, but for whom prevention activity could reduce the likelihood of problems developing.

Young People/Youth

Young People/Youth are defined here as persons up to age 25.

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ARKANSAS DEPT OF HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
PREVENTION, TREATMENT & RECOVERY SERVICES

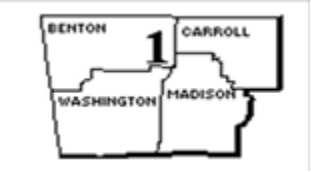
July 1, 2012 – June 30, 2013

PREVENTION SERVICE PROVIDERS BY REGION

KEY

CC - Collegiate Consortium
DTS - Data Technical Support
L & S- Lead & Seed Grantees
PRC- Prevention Resource Center
WFD -Workforce Development

REGION 1



REGION 1 PREVENTION RESOURCE CENTER
Operated by Alternative Opportunities, Inc.
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Springdale, AR 72764
PRC

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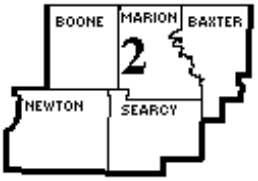
REGION 2



REGION 2 PREVENTION RESOURCE CENTER
Operated by North Arkansas Partnership for Health Education Area Health Education Center (AHEC-NW) at Harrison

(Mailing Address)
1515 Pioneer Drive
Harrison, AR 72601
PRC

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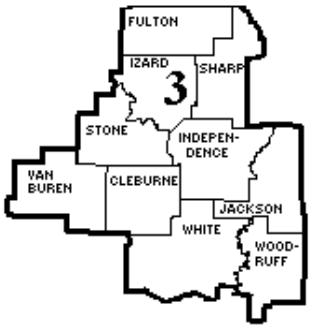
REGION 3



REGION 3 PREVENTION RESOURCE CENTER
Operated by Health Resources of AR, Inc.
(Mailing Address) (Physical Address)
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PRC

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REGION 3 PREVENTION RESOURCE CENTER
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REGION 4

REGION 4 PREVENTION RESOURCE CENTER
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PRC

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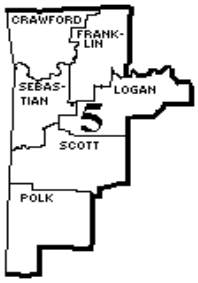
REGION 5



REGION 5 PREVENTION RESOURCE CENTER
Operated by Harbor House, Inc.

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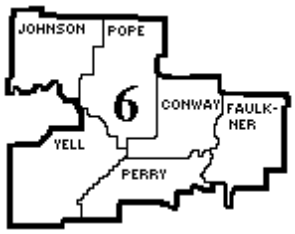
REGION 6



REGION 6 PREVENTION RESOURCE CENTER
Operated by Community Service, Inc.

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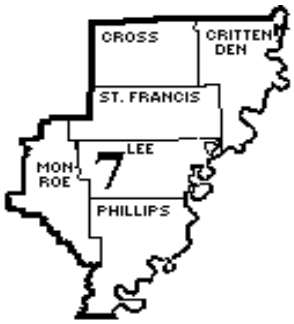
REGION 7



REGION 7 PREVENTION RESOURCE CENTER
Operated by Crowley's Ridge Development Council
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REGION 8

REGION 8 PREVENTION RESOURCE CENTER
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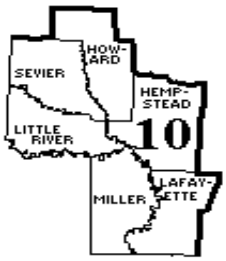
REGION 10



REGION 10 PREVENTION RESOURCE CENTER
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REGION 11

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REGION 12

REGION 12 PREVENTION RESOURCE CENTER
Operated by St. James United Methodist Church
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PRC

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Ms. Marie Jones, Associate
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REGION 12 LEAD AND SEED GRANTEE
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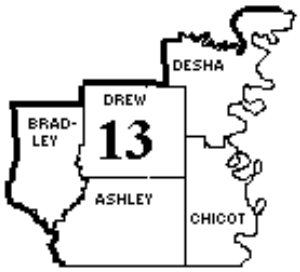
REGION 13



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Phoenix Youth & Family Services

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Rev. 06/26/12

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Rev. 06/26/12

N1. Evidence Based Prevention and Treatment Approaches

The Arkansas State Epidemiological Workgroup (AR-SEW) was developed in 2005 and was initially funded through the Strategic Prevention Framework State Incentive Grant (SPF SIG) from the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention (SAMHSA/CSAP). It continues to be funded through the Substance Abuse Prevention and Treatment Block Grant.

Previous Arkansas State Profiles focused 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. For instance, Arkansas has one of the highest rates of nonmedical prescription pain reliever abuse, which indicates that Arkansas should utilize more resources into educating the public about the dangers related to this type of abuse, as well as increasing the reach of efforts that are already in place, for instance, by increasing the number of permanent Arkansas Take Back collection sites. Further, knowing the rates and prevalence of consumption and consequences also allows policy-makers and community leaders to prioritize prevention efforts.

In an effort to further inform the strategic planning of prevention efforts, the current Arkansas State Epidemiological Profile also focuses on shared risk 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 mental health disorders. For instance, one indicator that is associated with the development of substance use and mental health disorders later in life is the percentage of youth that have tried smoking cigarettes, which is much higher in Arkansas than across the nation. This data indicates that perhaps current efforts used to reduce smoking are possibly not reaching Arkansas youth and that perhaps the strategies being used need to be reevaluated.

The workgroup is continuously seeking and collecting data in order to provide a data driven core. This data compilation supports a significant enhancement to community and provider access to critical data about substance abuse that was previously too diffuse to adequately serve data needs.

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.
- **Lead and Seed Youth Leadership Coalitions:** Lead and Seed is a nationally recognized program that empowers youth to accomplish substance abuse prevention work within their communities using the Strategic Prevention Framework.

- **Arkansas Collegiate Drug Education Consortium (ACDEC):** ACDEC is comprised of student services personnel responsible with providing drug and alcohol abuse programming at the college level.
- **The MidSOUTH Prevention Institute (MSPI):** MSPI 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.
- **MidSOUTH Summer School (MSSS):** MSSS provides a forum for cost-effective and relevant conferences and workshops dealing with the unique challenges faced by individuals delivering treatment services, prevention programs, and related alcohol and other drug education.
- **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 aadvocates 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.
- **Research Triangle Institute (RTI):** Provide consultation on the major substantive issues including the evaluation of the state prevention section efforts and effectiveness, program progress from baseline to follow-up, surveys of the prevention workforce and key stakeholders, conduct data analysis and provide guidance on federal performance reporting requirements.

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

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. DBHS is working with Southwest Center for the Application of Prevention Technologies (SWCAPT) to organize Training-of-Trainers (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 outcome data to be collected are the six CSAP Strategies. The table below shows the outcomes data collected for the last two State Fiscal Years (SFYs). Note that the total numbers served markedly went down by 146,995. This is because DBHS lost funding, notably the SPF SIG grant and the Prevention Service Programs, Youth Leadership Development Program, and Early Childhood Program. Also note that for the SFY 11/12, environmental strategy is 0% of clients served, this due to a problem with the MDS reporting system. This may also have contributed to the lower total number of clients served. DBHS hopes to serve more clients by securing new funding sources.

Total SFY11/12	43,696	100%	Total SFY10/11	190,661	100%
Info. Dissemination	18,144	41%	Info. Dissemination	86,173	45%
Comm. Base	17,379	40%	Comm. Base	62,049	33%
Education	230	1%	Education	18,158	9%
Alternative	6,245	14%	Alternative	13,176	7%
Environmental	0	0%	Environmental	7,940	4%
Prob. ID & Referral	1,698	4%	Prob. ID & Referral	3,165	2%

The prevention providers are trained in the Strategic Prevention Framework (SPF) and the SPF process is promoted and trained within the state agencies and communities that are served. The state's block grant is the funding source for the efforts of the SPF that are begin carried out throughout the state of Arkansas.

DBHS intends to increase the percentage of the SABG set-aside for evidence-based practices and environmental strategies by purchasing more EBP curriculums and organizing TOTs on evidence-based practices and environmental strategies for the Regional Prevention Representatives and other prevention providers.

IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

N2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

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 2014 (beginning July 1, 2013 and ending June 30, 2014) were distributed and are being fully utilized by the CMHCs for program support.

Within those contracts, each CMHC is responsible for providing the following:

CHILD AND ADOLESCENT SERVICES

A. Performance Indicator: In addition to the services listed as part of the basic services plan, the CMHC must deliver at least two of the following seven services as a part of the CMHC's Child and Adolescent Services. These services shall be delivered in a timeframe that is consistent with the prescription of the individualized treatment plan.

Allowable Services:

a. After School Programs - Can meet several needs for youth that are experiencing serious emotional problems and their families. Such programs may be able to offer youth additional academic tutoring. After school programs offer a safe, supervised environment for the development of social skills, and they offer the youth a variety of recreational opportunities.

b. Home-based Services - Crisis-oriented services, provided on an outreach basis to work intensively with children and families in their homes.

c. Independent Living Services - Services that provide both preparation to live more independently (particularly for child's who have no viable family to live with and cease to be eligible for the services they are receiving when they turn 18). Services include individual preparation for paid employment. The preparation for employment requires the close involvement of the vocational education component of school systems, vocational rehabilitation agencies and job training programs.

d. Respite Care - A planned break for parents/care givers who are caring for a difficult child. Respite providers supervise the child for a brief time to allow the parents a break from the constant strain of parenting a child who is experiencing serious emotional problems. Respite care can be provided in the home or in a variety of out-of-home settings or by simply having a worker take a child on an outing for several hours to allow the parent some time at home alone. Respite can be provided on a planned or emergent basis. This may be because of a crisis between parent and child, or because a crisis affecting the parent requires the parent to be gone for a period of time.

e. School-based Day Treatment Program - Serves children and adolescents who for various reasons are unable to maintain themselves in the regular school setting. It provides an integrated set of educational, counseling and family interventions that involve a child for at least five hours a day. These programs frequently involve collaboration between mental health and education agencies.

f. Summer Programs - Provide youth with therapeutic recreation, skill building and opportunities to develop peer relationships while also providing parents with respite.

g. Therapeutic Foster Care – Recruit and train therapeutic foster parents to provide homes for SED foster children that cannot be maintained in a regular foster home due to behavioral issues, as well as providing intensive, outpatient clinical services, according to the established treatment plan.

Funding for the above services are supported through MHBG funds and the Division of Behavioral Health Service (DBHS) will work with the CMHC to determine how to continue these needed services while carving out the required 5% for evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention.

Although the program is not funded by MHBG, a number of CMHCs have been trained in Trauma Focused Cognitive Behavioral Therapy and provide the service in conjunction with children identified by Arkansas' child welfare agency, Department of Human Services (DHS) Division of Children and Family Services (DCFS). Arkansas Building Effective Services for Trauma (AR BEST) is a grant funded through State General Revenue. According to DCFS, 10,927 children were victims of maltreatment during SFY 2012. More than 8,000 children were confirmed to be victims of physical or sexual abuse or a combination of both. The mission of AR BEST is to improve outcomes for traumatized children and their families in Arkansas through excellence in clinical care, training, advocacy, and research.

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?

4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

O. 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. Admission to inpatient programs of the State Mental Health System is utilized when determined necessary through an assessment process conducted by the Community Mental Health Centers.

The DBHS recognizes that in order to successfully treat children and youth, family and community involvement is essential. 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.

The State of Arkansas is currently in the third year of state general revenue supported Children's System of Care project. The system uses the wraparound approach and is funded in all 14 of the DBHS catchment areas across the state. The funding allows sites to employee a Community Care Director (CCD) who 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. DBHS also provides oversight for the Child Adolescent Service System Program (CASSP). 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 CCC.

Therapy services are supported through the Medicaid Rehabilitation Services for Persons with Mental Illness (RSPMI) for the under age 21 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 65,000 children served through this program per year. The therapy services can be provided in a clinic, home, or school setting. In addition, over 5,000 children per year are provided services in a psychiatric residential treatment setting. The Wraparound program focuses on providing services for those children/youth and their families who are at this highest level of need.

Juvenile Drug Court services are available in ten different judicial district. 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, case management, and random 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. This new program began enrolling providers in March 2011 and offering services in July 2011. The services available within the new SATS Program for Medicaid eligible participants include: Addiction Assessments; Treatment Planning; Care Coordination; Multi-Person (Family) Group Counseling; Individual Counseling; Group Counseling; Martial/Family Group; Medication Management. There are 15 DBHS SATS Medicaid Providers sites across the state.

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 certification of the services requested.

The DBHS Wraparound sites are monitored through monthly reports, chart reviews, assistance provided by DBHS Technical Assistance Specialists as well as annual site visits.

The DBHS leads a monthly meeting with the DHSs child serving divisions including: Division of Children and Family Services (DCFS), Department of Youth Services (DYS), Division of Medical Services (DMS), Division of Developmental Disability Services (DDS) and Division of Child Care and Early Childhood Education (DCCECE). In addition to this meeting, DBHS staff members work on various projects with each division. Some examples of the activities include DBHS staff participation on: DYS Re-entry Task Force, Arkansas Infant Mental Health Association, Social Emotional Work Group, DCFS 4E Waiver, DCFS Intensive Family Services, DCFS Differential Response, DCFS Antipsychotic Medication for Foster Children work group, Court Team Project, and School Based Mental Health work group co-led with the Department of Education.

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 of care for individual children and adolescents with serious emotional disturbance when the current system is not adequately meeting their needs.

The state uses funds from various grants and state general revenue funding to provide training. Some of the training projects include:

Youth Outcome Questionnaire (Y-OQ®)
In 2010, DBHS implemented the Y-OQ® to guide service decisions and outcomes for children and youth in Rehabilitative Services for Persons with Mental Illness (RSPMI) agencies. The Y-OQ® and the outcome database OQ Analyst® is registered as an Evidence Based Practice with the Substance Abuse and Mental Health Services Administration. The Y-OQ® uses the parent and youth voice to guide treatment, while feedback from the OQ Analyst® system allows clinicians to quickly assess behavioral health symptoms and change treatment when it is not producing adequate progress. Behavioral health therapists in the RSPMI system are trained to use the Y-OQ® to guide treatment.

Trauma Focused Cognitive Behavioral Therapy
According to Arkansas' Division of Children and Family Services, 10,927 children were victims of maltreatment during SFY 2012. More than 8,000 children were confirmed to be victims of physical or sexual abuse or a combination of both. The mission of AR BEST is to improve outcomes for traumatized children and their families in Arkansas through excellence in clinical care, training, advocacy and research.

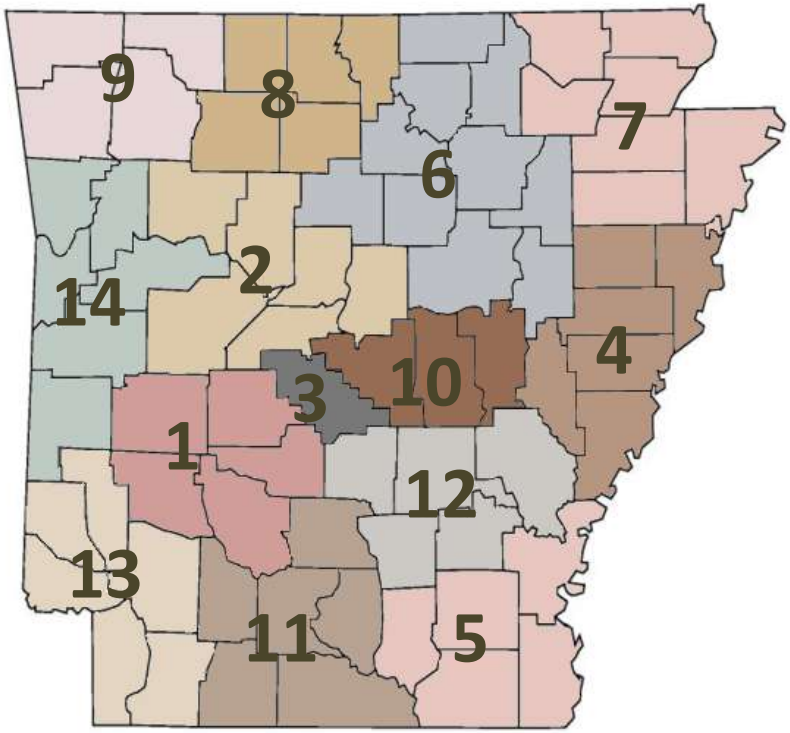
- Clinical Care - Implement evidence-based assessment and treatment practices throughout the state to create a comforting and safe environment for children and adolescents who are traumatized and optimize their physical and mental health outcomes.
- Training - Provide state-of-the-art training, supervision and learning environments that will maximize the adoption of quality interventions for traumatized children and adolescents.
- Advocacy - Enhance awareness, expand knowledge and promote collaboration among all individuals working with traumatized children and adolescents and their families.
- Evaluation / Research - Constantly monitor, assess the effectiveness of, and develop and test new models of interventions for traumatized children and adolescents to provide the safest and most effective care available.

Wraparound

During the 2012 year, quality assurance and fidelity to the Wraparound model has continued to be a focus for the DHS SOC team. A two and a half day Advanced Wraparound Practitioner Training was conducted in February 2013. DHS SOC contracted with Mid-South Health Systems (MSHS) to provide this training. Technical assistance site visits were also conducted by MHSH. Sixty-four people received certification. A satisfaction questionnaire was returned from participants in 12 sites.

DBHS, along with 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® is given to children and youth who receive RSPMI services 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 Y-OQ® data is matched with data from the RSPMI claims data to determine length of treatment, cost and utilization of treatment. The tracking system allows DBHS to determine costs and outcomes for children and youth who have had effective treatment (make significant clinical progress) as well, as costs and outcomes for children and youth who have had made no progress or deteriorated during the course of treatment.

ARKANSAS COMMUNITY CASSP PROVIDER SITES



AREA	PROVIDER	PHONE	DIRECTOR	COUNTIES SERVED	
1	**Community Counseling Services**	501-624-7111	Stacy Casbon	Clark Garland Hot Spring	Montgomery Pike
2	**Counseling Associates**	501-327-4889	Jeannie Tindall	Conway Faulkner Johnson	Perry Pope Yell
3	**Counseling Clinic**	501-315-4224	Deann Balisterri	Saline	
4	**Counseling Services of Eastern Arkansas**	870-630-3800	Karen Williams	Cross Crittenden Lee	Monroe Phillips St. Francis
5	**Delta Counseling Associates**	870-367-9732	Selena Collier	Ashley Bradley Chicot	Desha Drew
6	**Health Resources of Arkansas**	870-793-8900	Staci Ringwald	Cleburne Fulton Independence Izard Jackson	Sharp Stone Van Buren White Woodruff
7	**Mid South Health Systems**	870-972-4050	Derek Spiegel	Clay Craighead Greene Lawrence	Mississippi Poinsett Randolph
8	**Health Resources of Arkansas**	870-793-8900	Amy Cole	Baxter Boone Marion	Newton Searcy
9	**Ozark Guidance Center**	479-750-1903	Vicky Strange	Benton Carroll	Madison Washington
10	**Professional Counseling Associates**	501-221-1843	Shamika Trimble	Lonoke Prairie	Pulaski
11	**South Arkansas Regional Health Center**	870-862-7921	Roshonda Anderson	Calhoun Columbia Dallas	Nevada Ouachita Union
12	**Southeast Arkansas Behavior Health Care**	870-534-1834	Brenda Willis	Arkansas Cleveland Grant	Jefferson Lincoln
13	**Southwest Arkansas Counseling and Mental Health Center**	870-773-	Jennifer Lacefield	Hempstead Howard Miller	Lafayette Little River Sevier
14	**Western Arkansas Counseling & Guidance Center**	479-452-6650	JoLynn Gerdes	Crawford Franklin Polk	Logan Sebastian Scott

Child & Adolescent Service System Program

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ARKANSAS DEPARTMENT OF HUMAN SERVICES

ARKANSAS CHILDREN'S SOC/CASSP SERVICE PROVIDERS

Counties Served	Area & Provider	Main Program Contact Information	Community Care Director	Wraparound Specialists	Finance	Clinical Supervisor	Program Administration
Clark Garland Hot Spring Montgomery Pike	**Area 1** **Community Counseling Services, Inc.**	501-624-7111 125 Dons Way Hot Springs, AR 71913 http://www.communitycounselingservices.org/	Stacy Casbon 501- 620-5188 stacyc@hsccs.org	Natalie Caldwell 501-620-5255 ncaldwell@hsccs.org	Susan Singleton	James Vasilos Ph.D. 501-620-5279 jamesv@hsccs.org	Donald Martin Executive Director 501-624-7111 susan@hsccs.org
Pope Yell Johnson Faulkner Conway Perry	**Area 2** **Counseling Associates, Inc.**	501-327-4889 110 Skyline Dr. Russellville, AR 72801 http://www.caiinc.org/	Jeannie Tindall 501-336-8300 jtindall@caiinc.org	Brittany Titsworth btitsworth@caiinc.org Shalon Holloway shollaway@caiinc.org	Lori Eshnaur 479-967-5570	Lou Strain 501-336-8300 x2226 kstrain@caiinc.org	Lee Koone Director of Children's Services 501-354-7712 x5229 lkoone@caiinc.org Steve Newsome snewsome@caiinc.org
Saline	**Area 3** **Counseling Clinic, Inc.**	501-315-4224 307 E Sevier St. Benton, AR 72015 http://cc-inc.org/	Deann Balisterri 501-326-6701 dbalisterri@cc-inc.org	Brenda Henley 501-326-6708 bhenley@cc-inc.org	Jim Robertson 501-326-6718 jrobertson@cc-inc.org	Joyce Schimenti 501-626-6750 jschimenti@cc-inc.org	Mike King Director of Youth Services 501-326-6709 mking@cc-inc.org Jim Gregory jgregory@cc-inc.org
Cross Crittenden Lee Monroe Phillips St. Francis	**Area 4** **Mid South Health Systems, Inc.**	870-630-3800 2707 Browns Lane. Jonesboro, AR 72401 http://www.mshs.org/	Shane Ham 870-735-5118 kham@mshs.org	Marquetta Moore mmoore@mshs.org	Polly Jones 870-972-4010	Lynn Fernon 870-630-3805 Dfernon@mshs.org	Bonnie White, CEO bwhite@mshs.org
Ashley Bradley Chicot Desha Drew	**Area 5** **Delta Counseling Associates**	870-367-9732 790 Roberts Drive Monticello, AR 71655 http://www.deltacounseling.org/	Selena Collier 870-367-2461 s.collier@deltacounseling.org	Misty Jones 870-367-2461 x1112 m.jones@deltacounseling.org Shae Kulbeth s.kulbeth@deltacounseling.org.	Lilly Wells 870-367-2461 x1120	Stacey Davis 870-367-2461 x1121 sjdavis@ccc-cable.net	Patrick Haynie p.haynie@deltacounseling.org

ARKANSAS CHILDREN'S SOC/CASSP SERVICE PROVIDERS

Counties Served	Area & Provider	Main Program Contact Information	Community Care Director	Wraparound Specialists	Finance	Clinical Supervisor	Program Administration
Cleburne Fulton Independence Izard Jackson Sharp Stone Van Buren White Woodruff	**Area 6** **Health Resources of Arkansas**	870-793-8900 PO Box 2578 Batesville, AR 72503 http://www.healthresourcesofarkansas.com/	Staci Ringwald 870-834-9942 sringwald@hra-health.org		Bernis Medlock Ext 1122	Patricia Gann 501-230-0485 pgann@hra-health.org	David Coleman dcoleman@hra-health.org
Clay Craighead Greene Lawrence Mississippi Poinsett Randolph	**Area 7** **Mid-South Health Systems**	870-972-4000 2707 Browns Lane Jonesboro, AR 72401 http://www.mshs.org/	Derek Spiegel 870-972-4029 dspiegel@mshs.org	Toni Garihan 870-972-4000	Polly Jones 870-972-4010	Hayden Huckabee (870) 972-4000 hhuckabee@mshs.org	Bonnie White, CEO bwhite@mshs.org
Baxter Boone Marion Newton Searcy	**Area 8** **Health Resources of Arkansas**	870-793-8900 PO Box 2578 Batesville, AR 72503 http://www.healthresourcesofarkansas.com/	Amy Cole 870-405-9168 acole@hra-health.org	Shannon Williams 866-308-9928 X1874 swilliams@hra-health.org	Bernis Medlock Ext 1122	Patricia Gann (501) 230-0485 pgann@hra-health.org	David Coleman dcoleman@hra-health.org
Benton Carroll Madison Washington	**Area 9** **DaySpring**	479-872-5580 5537 Bleaux Ave. Springdale, AR 72762 http://www.aoinc.org/	Michele Meggars 479-750-1272 mmeggarsl@dayspringbhs.com		479-750-1272	Vashonda Eason veason@daysprinbhs.com	Rusty Cranford (903) 826-0692 rcranford@dayspringbhs.com
Benton Carroll Madison Washington **CASSP PROVIDER**	**Area 9** **Ozark Guidance Center**	479-750-2020 PO Box 6430 Springdale, AR 72766 http://ozarkguidance.org/	Vicky Strange 479-750-1903 vicky.strange@ozarkguidance.org		Christine Gattin 479-725-5293		

ARKANSAS CHILDREN'S SOC/CASSP SERVICE PROVIDERS

Counties Served	Area & Provider	Main Program Contact Information	Community Care Director	Wraparound Specialists	Finance	Clinical Supervisor	Program Administration
Pulaski Lonoke Prairie	**Area 10** **Professional Counseling Associates**	501-221-1843 P.O. Box 15968 Little Rock, AR 72231 http://www.pca-ar.org/	Shamika Trimble 501- 221-1843	Precious Williamson precious.williamson@pca-ar.org Terri Kelley Terry.kelley@pca-ar.org	Leslie Nalley De Burnett	Erica Moseby (501) 221-1843 Erica.moseby@pca-ar.org	Jannie Cotton jannie.cotton@pca-ar.org
Calhoun Columbia Dallas Nevada Ouachita Union	**Area 11** **South Arkansas Regional Health Center**	870-862-7921 715 N College Ave. El Dorado, AR 71730 http://sarhc.org/	Roshonda Anderson 870-862-7921 randerson@sarhc.org	Demetrick Andrews Jennifer Oliver	MH Chandler Kristi Rose 870-864-2457	Cindy Dupuis 870-862-7921 cdupuis@sarhc.org	William C. Peel wpeel@sarhc.org
Arkansas Cleveland Grant Jefferson Lincoln	**Area 12** **Southeast Arkansas Behavioral Healthcare System, Inc.**	870-534-1834 PO Box 1019 Pine Bluff, AR 71613 http://sabhs.org/	Brenda Willis brenda@sabhs.org (870) 534-1834	Patti Yates 870-534-1834	Kristine Barbaree P.O. Box 1019 Pine Bluff, AR 71613	Bessie Lancelin 870-534-1834 Bessiel@sabhs.org	Kathy Harris kathy@sabhs.org
Hempstead Howard Miller Lafayette Little River Sevier	**Area 13** **Southwest Arkansas Counseling and Mental Health Center**	870-773-4655 2904 Arkansas Blvd. Texarkana, AR 71854	Jennifer Lacefield (903) 490-3250 jlacefield@swacmhc.com	Lorisa Kegley 870-773-4655X2260 903-490-3522 lkegley@swacmhc.com	Michael Gregory	Danny Stanley 903-824-4471 dstanley@swacmhc.com	Dwight Sperry dsperry@swacmhc.com
Crawford Franklin Polk Logan Sebastian Scott	**Area 14** **DaySpring**	479-872-5580 5537 Bleaux Ave. Springdale, AR 72762 http://www.aoinc.org/	Cole Mitchell 501-617-2233 cmitchel@dayspringbhs.com	Kelli Price 479-522-0463 kprice@dayspringbhs.com	479-750-1272	T.C. Long tlong@dayspringbhs.com	Rusty Cranford 903-826-0692 rcranford@dayspringbhs.com

ARKANSAS CHILDREN'S SOC/CASSP SERVICE PROVIDERS

Counties Served	Area & Provider	Main Program Contact Information	Community Care Director	Wraparound Specialists	Finance	Clinical Supervisor	Program Administration
Crawford Franklin Polk Logan Sebastian Scott CASSP PROVIDER	**Area 14** **Western Arkansas Counseling and Guidance Center**	479-452-6650 PO Box 11818 Ft. Smith, AR 72917 http://wacgc.org/	JoLynn Gerdes 479-452-6650 x 1062 JoLynn_Gerdes@wacgc.org				

To make corrections, please contact Becky Webber with the correction at: rebecca.webber@arkansas.gov
12/29/10

Arkansas Children's Behavioral Health Care Commission

2012 Report to the Governor

Arkansas Children's Behavioral Health Care Commission
2012 Report to the Governor

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Expanding the Statewide System of Care

Recently, the State of Arkansas received a Substance Abuse and Mental Health Services Administration (SAMHSA) funded grant, *Expansion of the Comprehensive Community Mental Health Services for Children and their Families*, to plan the implementation, expansion, and sustainability of a statewide children's System of Care (SOC). The Department of Human Services (DHS) Division of Behavioral Health Services (DBHS) submitted an application in 2011 and was funded in 2012. The award of $724,676 will be used to support a project period ending in September 2013.

This one year project will take a multi-faceted approach to plan for the *Implementation of a Statewide System of Care (ISSOC)* initiative which will expand the statewide family-driven, youth-guided, and culturally competent SOC across the state of Arkansas by emphasizing:

- Training and certification for service providers
- Outcome measurement to ensure efficacy
- Infrastructure for financial sustainability

These three areas will be addressed by work groups that will include representation from the state SOC, child welfare, juvenile justice staff, but also youth, families, local and state child serving agencies, and others stakeholders to ensure an inclusive project with widespread input and support.

The planning process for the Arkansas SOC is focused on an improved system of behavioral health care, integrating all child serving agencies, and serving all children and youth who meet the identified target population. The defined target population will include children and youth identified with: Serious Emotional Disturbance (SED), receiving psychiatric services in a residential setting or at-risk of being placed in a residential setting, multisystem involved, and/or multiple acute hospitalizations.

Care Coordinating Councils

Family and Youth Engagement

The 14 Care Coordinating Councils (CCCs) across the state will be engaged in the planning process to ensure input and support from families and youth. Each council will have the opportunity to train local families and youth to facilitate local meetings, such as family nights and roundtable discussions, to both report work group progress and gather input from a family/youth perspective on proposed strategies and needs in their local communities. Family/youth representatives from each of the 14 areas will form the Family and Youth Expansion Advisory Council to ensure the family/youth voice is included in all aspects of the planning process.

Expanding the Statewide System of Care

Key Focus Areas

The Implementation of a Statewide System of Care (ISSOC) work groups will focus on three key areas and will address strategies to achieve the overall goals of the planning process.

All Work Groups:

- Identify additional intensive care coordination services and supports for target population
- Increase capacity for Family Support Partners.
- Develop capacity for Youth Support Partners.
- Develop a plan to implement policy, administrative and regulatory changes to support SOC service provision.
- Reinforce statewide Cultural Competence and Linguistics efforts.

Outcomes Work Group:

- Identify effective measures for state and local outcomes for Wraparound, Family Support Partner, and Youth Support Partner services.
- Create accurate local outcome reporting and tracking systems.
- Refine statewide outcome measures and data tracking system to meet the needs of multiple stakeholder groups.

Finance Work Group:

- Expand funding of Wraparound services and supports to include Medicaid, block grant, waivers, etc.
- Determine methodology for shifting funding of Wraparound, Family Support Partner, and Youth Support Partner services.
- Develop infrastructure for creating financial sustainability for Family Support Partners Youth Support Partners and Wraparound Specialists positions.

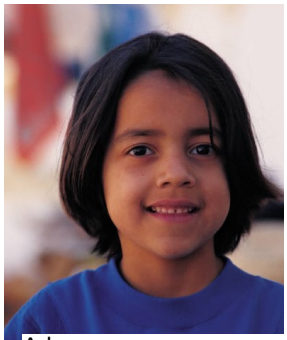
Training/ Certification Work Group:

- Identify SOC training needs for target population and needed services.
- Identify and develop certification curriculum and ongoing training for Wraparound Specialists, Family Support Partners and Youth Support Partners.
- Identify or develop a Wraparound fidelity tool.
- Refine technical assistance and monitoring process.

The planning project will bring together stakeholders that have been representatives in previous SOC efforts. This includes members of the Arkansas Children's Behavioral Health Care Commission, Arkansas Department of Human Services' child-serving agencies, the Family and Youth Expansion Advisory Council, and other entities whose work and planning have focused on promoting the SOC goals and philosophy. These stakeholder groups will guide the process and function as the system of care expansion team.

Wraparound Sites

Wraparound is a family-driven, youth-guided, team-based approach that wraps services and supports around a family whose child or youth is at risk of removal from their home, school, and community due to severe to moderate behavioral health issues. The purpose of the Arkansas System of Care (AR SOC) is to facilitate the development of local systems of care and provide funding for 14 Department of Human Services (DHS) behavioral health service areas through the Wraparound sites.



Arkansas System of Care (AR SOC) efforts in 2012 focused on enhanced quality assurance and improvements to the Wraparound training. In collaboration with Mid-South Health System (MSHS), the DHS Division of Behavioral Health Services (DBHS) hosted a two and a half day training that emphasized fidelity to the Wraparound model and quality assurance. This Advanced Wraparound Practitioner Training provided demonstrations and practice drills of scenarios that Wraparound providers have experienced. Sixty-eight participants earned certification as a Wraparound Practitioner and completed a follow-up technical assistance call with MSHS staff.

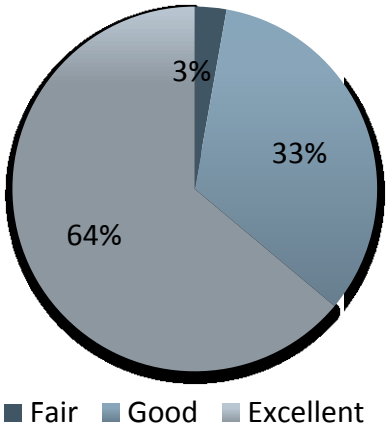
Further efforts to improve the SOC included development of supplementary best practice guidelines to assist Wraparound Specialists (WAS) in the following areas:

- Wraparound team member composition;
- Multi-agency Plans of Service (MAPS) eligibility guidelines; and,
- Use of flexible funding for subsistence needs for families.

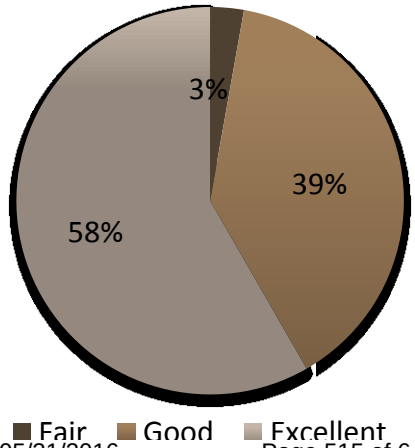
DHS SOC Technical Assistants continue to provide on-going support to all sites on maintaining fidelity to the Wraparound Model. Furthermore, Community Care Directors (CCD), Wraparound Specialists (WAS) and Family Support Partners (FSP) attended monthly meetings to discuss: establishing protocols for mentoring and respite services, creating and maintaining meaningful family nights, and promoting natural family supports in Wraparound teams.

Satisfaction Survey Results
Advanced Wraparound Practitioner Training:

Training focused on areas requested



Training was helpful to the site:



Wraparound Sites

The purpose of the Arkansas System of Care (AR SOC) Wraparound sites is to facilitate the development of local systems of care and to provide funding for 14 DHS behavioral health service areas. The focus in 2012 was to assist these areas in developing quality improvement measures to meet the goals of AR SOC.

Each year, sites are audited to determine program effectiveness, document expenditures, and monitor compliance with performance indicators. During the state fiscal year 2012, the DHS AR SOC staff developed the SOC Systematic Evaluation Plan with a goal of improving quality and outcomes for families in Wraparound. As part of the Evaluation Plan, sites are assessed on a standard set of objectives, processes, and outcomes.

SOC Focus Areas for Wraparound Site Audits:

- Develop the Care Coordinating Council (CCC) governance structure;
- Oversee Wraparound plans and services;
- Use flexible funds for a variety of non-traditional services and supports;
- Provide family support activities to strengthen, educate and build family involvement; and,
- Develop Family Support Partners (FSP) to assist families in the communities.

The DHS AR SOC staff also evaluated the ability of each site's CCC to provide oversight to local SOC efforts. A variety of areas are examined during the audit process including allowing families to actively participate and establishing a system for monitoring the quality of Wraparound meetings using a 5-point rating system.

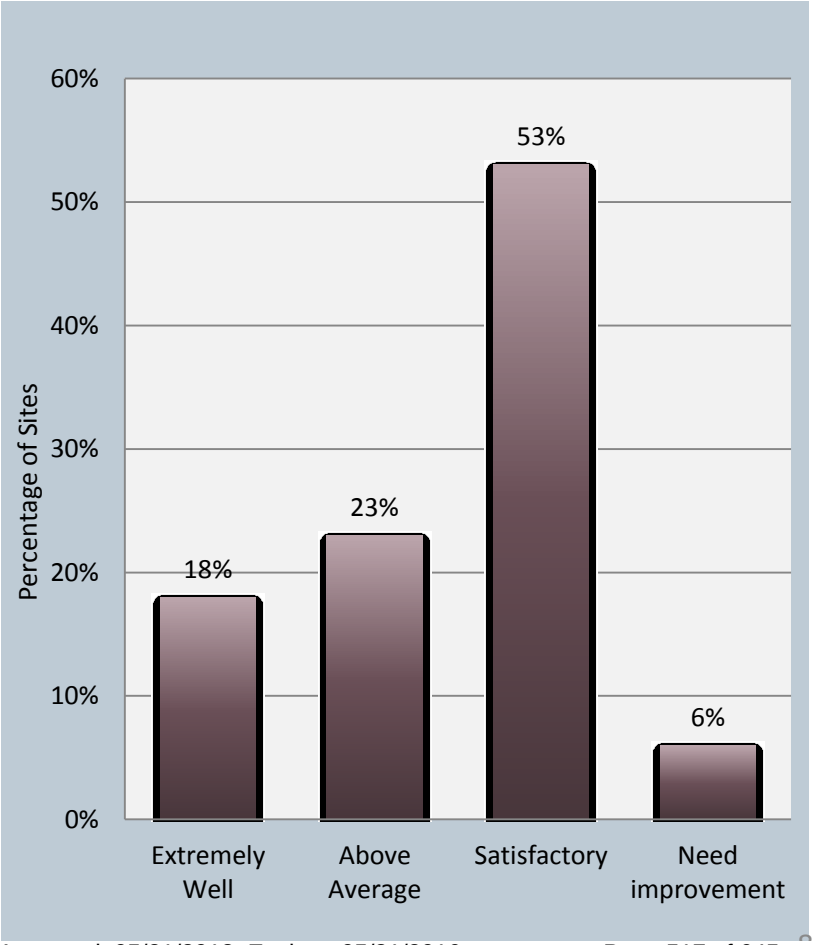
Wraparound Sites

Following the on-site audit, which included parent, youth, and local SOC provider interviews, the DHS AR SOC staff provided detailed reports to each site based on the findings. The reports summarized strengths and recommended action steps to improve the fidelity to the Wraparound model for each site.

DHS AR SOC Technical Assistants (TA) reviewed the actions steps with the sites to help develop quality improvement tasks. The sites were asked to address each recommended action step by identifying specific tasks and objectives to enhance the development of the CCC and to strengthen the Wraparound process. The TA visited each site at least quarterly to ensure the action steps were being implemented and to monitor progress.

Next year, the annual site audits will initially focus on those specific recommendations made to the site in the previous year and the progress towards achieving each goal. The audits will also review the program performance.

Wraparound Site Audits: Fidelity to Model



Family Support Activities

Wraparound providers are required to provide family support activities. They are generally held monthly or bi-monthly. The purpose is to provide a regular opportunity for caregivers to learn valuable skills to strengthen their families. These events serve as prevention level activities to offer youth and families support, education, and leadership skills.

Family support activities throughout the state vary by provider, as they are based on the communities' needs. The activities allow caregivers and youth opportunities to interact with one another and to provide peer support and encouragement. These events not only provide opportunities for family socialization, but also serve as an avenue to identify stumbling blocks to recovery.

In 2012, 180 family events were held with each focusing on one or more of the following categories, although each site may present unique content. The events are reported in order to track outcomes and successes especially in these areas:

- Family support
- Education
- Governance

For example, providers held workshops on effective communication skills and implementation of positive discipline. Caregivers and youth may use these newly developed skills to assist them in actively participating in their local Care Coordinating Councils (CCC).

Family Support Partners (FSP) and participating families take responsibility for hosting the family nights in their communities. The event management responsibility differs by site depending primarily upon the level of family engagement within the group. Each of the 14 service areas receive $2,500.00 each year to support these activities.

Families and youth continue to demonstrate growth, new abilities, and overall success from participating in the family support activities.

From January – December 2012, there were 180 family activities with 5066 individuals attending. A comparison of the number of events and participants in 2011 and 2012 are shown below:

Family Events	Children 12 Years Old and Under	Youth 13 – 18 Years Old	Adult Family Members
• 2012 - 180 • 2011 - 72	• 2012 - 1876 • 2011 - 317	• 2012 - 1196 • 2011 – 358	• 2012 – 1994 • 2011 - 370

Family Support Partners

The Family Support Partners (FSP) initiative has made tremendous progress in providing support to many Arkansas families in the last two years. In the spring of 2011, representatives from the local systems of care teams identified Legacy Families in their area that were interested in being trained to become FSPs. Nine family members completed the training and were hired as FSPs to serve in the eight areas of the state.

The Department of Human Services (DHS) has continued to work with the Family and Youth Support Partners (FYSP) work group to establish a network of Family Support Partners (FSP) throughout Arkansas.

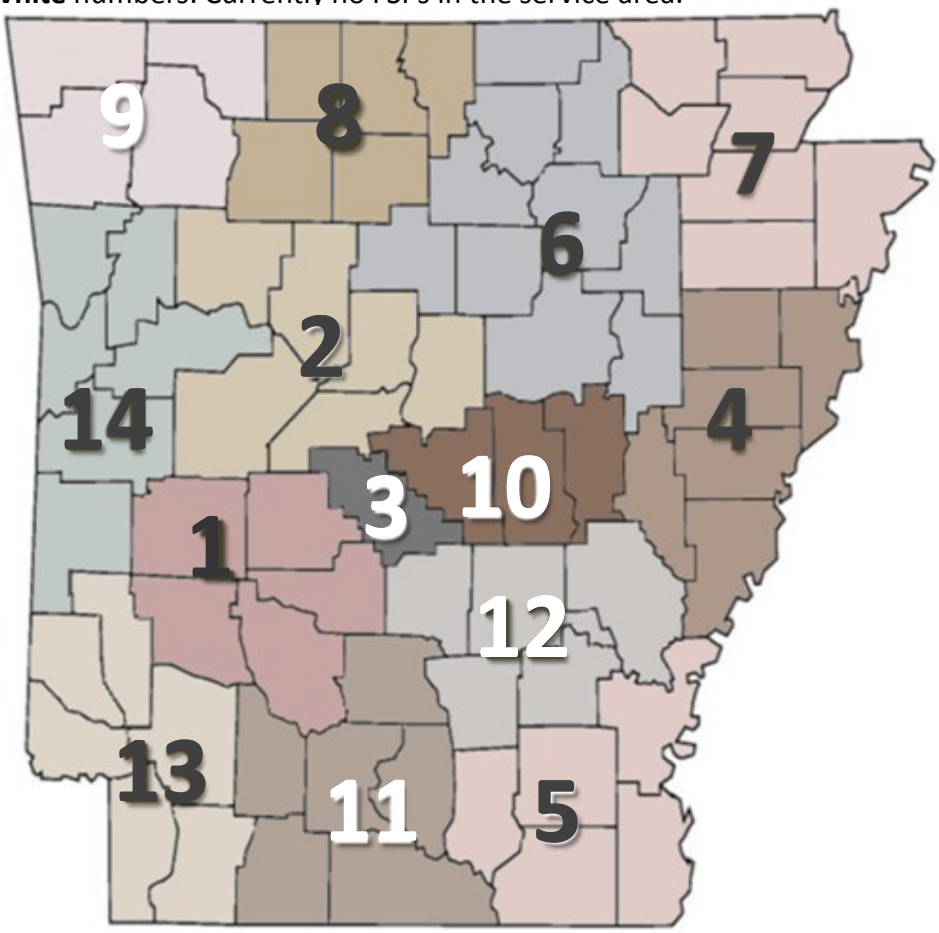
FSPs are peer counselors who model recovery and resiliency in overcoming obstacles common to those who live with children or youth with behavioral health care needs. **Legacy Families**, those that have had multiple experiences with the mental health and broader social service system, are recruited to 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.

Over the last year, the FYSP work group has continued to seek opportunities to grow and improve the services provided by developing a proposed set of core competencies for classification as a certified FSP and creating a Code of Ethics with identified ethical codes and statements for guidance.

Family Support Providers throughout Arkansas

Black numbers: Service areas with FSPs working at provider sites.
White numbers: Currently no FSPs in the service area.



During 2012, eight FSPs served and supported 142 families within nine service areas encompassing 50 counties in the state.

Family Support Partners

The core competencies developed by the Family Youth Support Partners (FYSP) work group have eight domain areas with 55 competencies listed under those domain headings.

Family Support Partners
Core Competency Domains

- Personal Attributes
- Confidentiality
- Advocacy
- Wellness
- Crisis Prevention Planning
- Empowerment
- Communication
- Knowledge of the child serving systems in Arkansas

These core competencies serve as the basis to structure a required six day training and certification workshop to become a FSP in Arkansas.

The domains were also used to develop a services satisfaction questionnaire for parents that measures perception of services, family disruptions, family functioning, improvements, and satisfaction with FSP services. Currently, the FSP Coordinator reviews this information and formulates a report, which is used for quality improvement purposes. Additionally, DBHS is working to develop an IT framework for reporting aggregate data and measuring trends over time.

Family and Youth Assistance Network

The Family Youth and Assistance Network's (FYAN) primary objective is facilitating a coordinated network of supports that are child centered, youth guided, and family driven. Family involvement is nationally recognized as a valuable component within behavioral health systems of care.

Advocacy networks ran by family members have made significant contributions to the development of policy and have been able to champion support for families of children with behavioral healthcare needs. Like other states, Arkansas recognizes the need to engage parents, caregivers, and family members in shaping the delivery of services and reforms.

In January 2012, as FYAN moved forward with implementing a strategic plan, the FYAN Steering Committee began the process of expanding the governing body and evaluating the network's activities for effectiveness. By hosting local family roundtable discussions, the FYAN sought to inform its current activities by speaking with families and eliciting their feedback about children's behavioral health supports and resources within their local communities.

Working collaboratively with the DHS Fellows for Public Service Program, discussion sessions were held in the North Central, Southeastern, and Central regions of the state (Yellville, Batesville, Helena-West Helena, Monticello, Russellville, and Hot Springs). Families shared their stories and experiences with representatives from the Arkansas System of Care. Many of the families represented were single parents or grandparents raising one or more children with serious emotional disturbances. Children participating in FYAN activities ranged in age from 4 to 17 years of age and some families also received services from the child welfare or juvenile justice system.

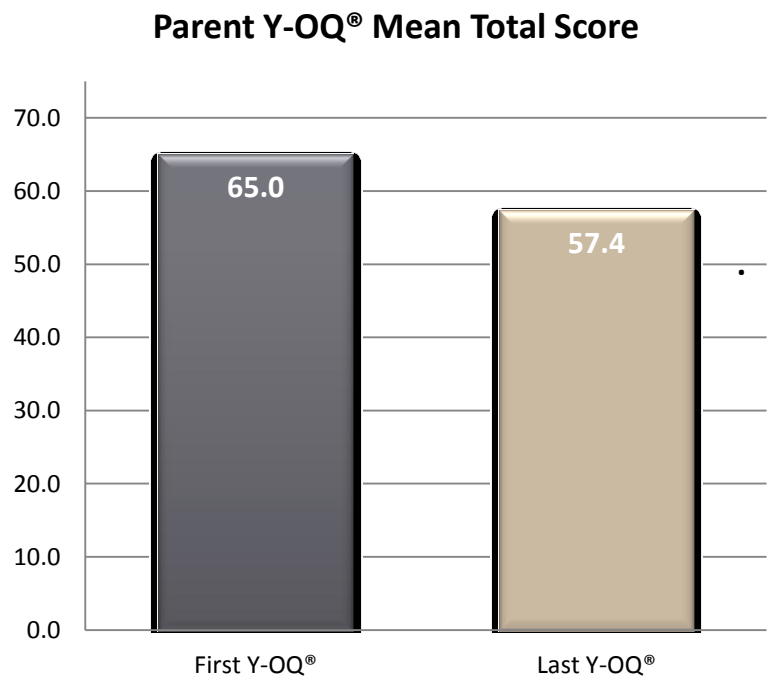
Most recently the FYAN Resource Center has served as a platform for sharing resources with families, youth, and Arkansas communities by operating a web-based resource directory. As a result of these roundtable discussions with families, FYAN determined that a web-based resource directory was not the most effective tool for engaging families or for providing resources at a local level. Also based on family feedback regarding their support needs, FYAN currently functions as a statewide coalition purposed to build collaborative partnerships among family/child serving agencies and to identify the local support needs of families within the Arkansas children's behavioral health system.

The Department of Human Services continues to support the FYAN by collaborating to better meet the needs of Arkansas children, youth, and families.

Youth Outcome Questionnaire®

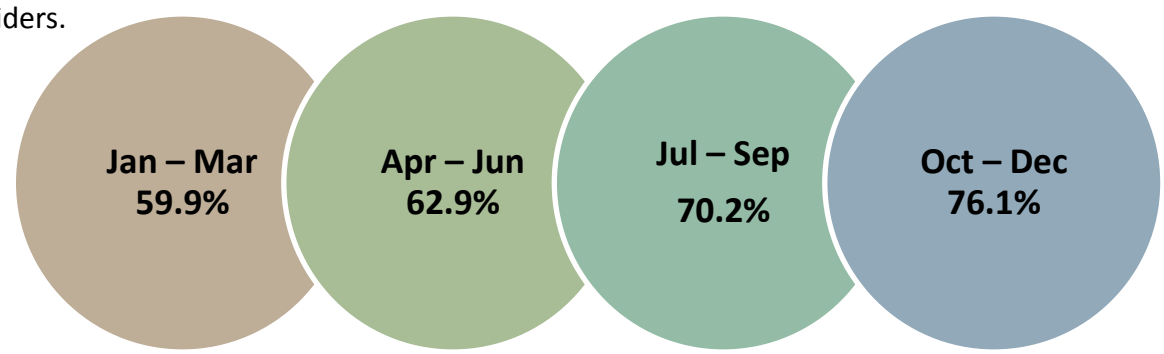
The Youth Outcome Questionnaire® (Y-OQ®) is the assessment tool used by behavioral health care organizations to measure the effectiveness of services provided to children and youth. Parents and youth are asked to complete the Y-OQ® at intake and at least every 90 days afterwards until the child or youth is discharged. Feedback from the Y-OQ® allows clinicians to monitor treatment progress and identify cases where clients are not showing improvement.

In 2012, AR SOC staff produced an initial outcomes report with data for all Y-OQs® completed between July 2010 and September 2012. The results from the parent Y-OQ®, or 7,547 clients having two or more valid Y-OQ® assessments, show a reduction of the total score between the first to last Y-OQ® administration (lower score indicates improvement).



Compliance Rates

To ensure timely Y-OQ® assessments, behavioral healthcare organizations are required to administer the Y-OQ® to parents and youth at least once every 90 days. Compliance rates are calculated by comparing the number of completed parent or youth Y-OQs® with the number of clients receiving behavioral health services. The compliance rates for the four quarters of 2012 show an increase from 60% compliance during the first quarter to 76% during the last quarter, which means the majority of children receiving services are consistently receiving assessments. Achieving adequate compliance rates was a necessary initial step in implementing the YOQ® across the state, before the DHS Division of Behavioral Health Services (DBHS) could move to the outcomes phase of data reporting. The improved compliance rates are due in part to DBHS efforts to increase technical assistance to providers.



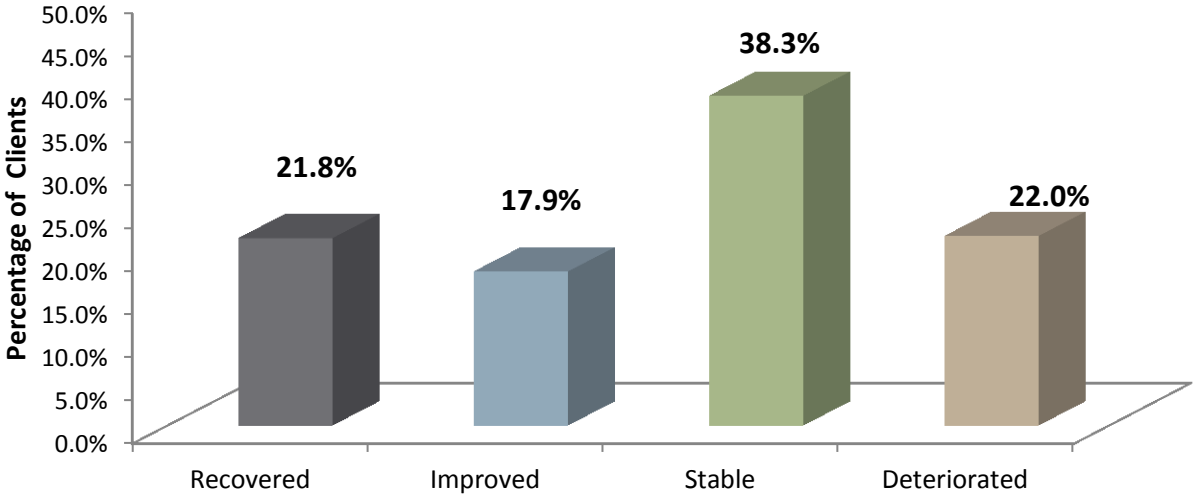
Youth Outcome Questionnaire®

Outcomes

The Y-OQ® measures change in children's symptoms and behaviors. Outcomes are measured after children/youth complete an episode of treatment. Children and youth who were not active in behavioral health services for 120 days or more were considered as Inactive or "discharged" from services. Outcomes are measured by an increase or decrease in the total Y-OQ® scores and are calculated by subtracting the last Y-OQ® total score from the initial Y-OQ® total score. The amount of change is classified into one of four categories: Recovered, Improved, Stable, or Deteriorated. Each category represents clinically significant change and is defined as follows:

- **Recovered:** Change in scores is considered similar to children who are not receiving behavioral health treatment.
- **Improved:** Change in scores is considered as a clinically significant improvement.
- **Stable:** Change in scores indicates there may be some improvement, but not clinically significant.
- **Deteriorated:** Change in scores indicates no clinical improvement or an increase in total score.

2012 Parent Y-OQ® Outcomes of Inactive Clients



Future efforts will focus on continuing to provide technical assistance to providers regarding proper administration and interpretation for the YOQ ® and conducting additional analysis of YOQ® data along with outcome information for the Arkansas Indicators (see page 15 for information on the Arkansas Indicators).

Arkansas Indicators

Combined with clinical data from the Youth Outcome Questionnaire® (Y-OQ®), the Arkansas Indicators provides a comprehensive outcomes measurement process for children and youth receiving behavioral health services.

The Arkansas Indicators tool was created to measure client functioning, satisfaction with services, and treatment barriers.

In 2012, the Arkansas Indicators work group was convened to review the Arkansas Indicators tool and propose changes in content and method of administration. Work group members from behavioral health care organizations and the Department of Human Services (DHS) proposed a shortened Arkansas Indicators for youth and parents. The work group developed both a parent and youth version and recommended that the Arkansas Indicators could be completed by the clinician through a parent or youth interview or completed directly by the parents or youth.

The revised Arkansas Indicators consists of four questions that include a variety of response options and will continue to be administered in conjunction with the Y-OQ®. The questions are detailed in the graphic below. The revised Arkansas Indicators were reviewed and approved by the Arkansas Children's Behavioral Health Care Commission in October 2012.

Thereafter, the tool was piloted with three behavioral health provider agencies; 59 persons completed the revised questionnaires and reported the updated tool was short, easy to complete, and understandable. The Arkansas Indicators will be implemented in the next release of the OQ® Measures software, the software system used to collect YO-Q® and Arkansas Indicators data, in 2013.

The AR System of Care (SOC) staff is currently exploring the best mechanism for collecting information on satisfaction with treatment and treatment barriers since these questions were removed from the Arkansas Indicators and should be administered in a manner that ensures the data is reliable. This new process will be implemented in concert with the launch of the new AR Indicators.

Living Situation	In the past 3 months, my child or the child I care for has resided at home with one or both of his or her parents.
School	In the past 3 months, my child or the child I care for has graduated or received a GED.
Legal Involvement	In the past 3 months, my child or the child I care for has not been involved in activities that are illegal.
Activities/Community	In the past 3 months, my child or the child I care for has been involved in the following activities or groups.

RSPMI Certification Policy

The Department of Human Services (DHS) Division of Behavioral Health Service's (DBHS) continues to monitor and certify behavioral health organizations that provide services through the that Rehabilitative Services for Persons with Mental Illness (RSPMI) program in Arkansas. The RSPMI Certification Policy, effective January 1, 2011, continues to drive DBHS monitoring efforts. Offering technical assistance to ensure compliance with the Certification Policy has been a major effort for DBHS. Behavioral health providers receive technical assistance by telephone or onsite visits that may focus on staff training or the review and development of agency policies and procedures.

Monitoring and compliance activities have included coordinated efforts among the DHS Division of Medical Services (DMS) Program Integrity and Provider Enrollment units and ValueOptions to facilitate accuracy of provider documentation, reporting, and training. This ongoing engagement with providers during the monitoring and certification processes has helped to strengthen provider and division relationships. As of December 31 2012, all provider sites had been surveyed and reviewed for policy compliance and are now on a certification renewal cycle that runs concurrently with their national accreditations.

This effort also underscores the DHS commitment to enhancing the standard of care for behavioral health services in Arkansas. Other major activities regarding licensure and certification were accomplished in 2012:

- The moratorium for new provider sites was extended to remain in effect until December, 31, 2014. Currently, all residents in Arkansas have access to at least one RSPMI service provider within 50 miles of their home location.
- The DBHS licensure and certification unit integrated the duties of licensure and certification of substance abuse providers to form the Policy, Certification and Licensure unit at DBHS.
- Responsibilities for certification of individual private practitioners applying for Medicaid provider enrollment is now administered by DBHS. Currently, there are 24 certified master's level providers that bill Medicaid as an individual private practice in Arkansas.

ACTION for Kids

Funded by a system of care grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), the ACTION for Kids (AFK) project provided comprehensive mental health services for children, youth, and families. The project site was administered through the DHS Division of Behavioral Health Services (DBHS), Counseling Services of Eastern Arkansas, and Mid-South Health Systems.

The population of focus was children and youth under 21 years of age at risk of entering or returning to an out-of-home placement in Craighead, Lee, Mississippi, and Phillips counties. Across the six year grant period, 268 youth received Wraparound services through AFK.

The AFK program completed the sixth and final grant year in September of 2012. During the last year, supported by extending remaining grant funds beyond the initial five year period, AFK focused on ensuring the sustainability of family-run organizations, Youth M.O.V.E. (Motivating Others through Voices of Experience), and Positive Behavior Interventions and Supports (PBIS) program.

Three family-run nonprofit organizations that provide support for families of children and youth with mental, emotional, and behavioral disorders were established in 2012. These organizations work to identify resources for families, to offer support for managing the challenges of child mental health, and to advocate for parental and child rights and services related to mental health. As part of the Action for Kids project, these family-run non-profit organizations were supported in starting their organizations and in building their infrastructure.

PBIS, a school-based social and academic success program, started as a partnership between AFK and 41 schools in a four county area of Arkansas. PBIS is a systems approach for establishing the culture and behavioral supports needed for schools to be positive and effective learning environments. PBIS focuses on prevention of behavioral issues in the student population, reducing issues in children who are experiencing behavioral problems, and providing Wraparound services for children and families with more complex needs. PBIS has been successful in ensuring a safe school climate and enabling stronger academic achievement within schools.

To ensure sustainability, AFK transitioned the PBIS efforts into a partnership with the Arkansas State University (ASU) Center for Community Engagement. ASU subsequently has developed training, evaluation, and technical assistance support to assist current PBIS sites and to expand PBIS services to schools outside the AFK four county area. ASU's Center for Community Engagement now hosts monthly trainings on PBIS and has participated in or provided training and assistance to

Youth M.O.V.E.

Youth M.O.V.E. (Motivating Others through Voices of Experience) Arkansas (YMA)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. Youth M.O.V.E Arkansas is a local affiliate of the national Youth M.O.V.E organization.

Photos are from the 2012 Youth Empowerment Conference

YMA has grown into six active chapters across the state and made strides through peer-to-peer counseling, speaking engagements, and several statewide initiatives. The focus is to improve services for children, youth, and families by establish partnerships and gaining the support of respected community leaders to strengthen the systems within programs and agencies addressing the behavioral health needs of area youth.

YMA partnered with the DHS Division of Children and Family Services (DCFS) Youth Advisory Board to host the Winter Leadership Ball at the Peabody Hotel in Little Rock, AR. The formal dinner and dance provided an evening filled with opportunities for youth to have a voice and to connect with other youth and adult leaders involved in the movement.

In April 2012, an Employment Readiness Seminar was held for youth to learn about practical work skills, social competence, job seeking, and interview techniques. YMA celebrated National Mental Health Month in 12 communities. The Mayors' Offices issued proclamations in each of these communities declaring May as National Mental Health month. At each celebration, local youth presented poems or essays addressing the importance of education of mental health needs.

In August 2012, the 2nd Annual YMA Youth Empowerment Conference was held at Arkansas State University with 170 youth and adults in attendance. The theme for the conference was "See Us Shine" and the conference featured a keynote speaker from Vital Communication in Little Rock, AR and offered a series of breakout sessions with topics including finding success in life, being healthy, managing money, implementing community projects, and starting college.

YMA plans to host a Winter Leadership Retreat in 2013 that will bring members of local YMA Boards together for a series of trainings on organizational development and leadership. YMA continues working on the development of new chapters or youth organizations across the state by offering technical assistance and site visits. For more information, please see: http://www.youthmovear.org/index.php.

Intensive Family Services

The Intensive Family Services (IFS) program is primarily intended to prevent out-of-home placements for children whose families are involved with the DHS Division of Children and Family Services (DCFS). Additionally, IFS works to reunite children with their families who have already experienced an out-of-home placement. The goal of IFS is to safely keep children with their families, when possible, by providing services aimed at restoring family units in crisis to acceptable levels of functioning.

IFS includes time limited counseling, skill building, support services, and referrals to resources that target the needs of families. Services are typically delivered over a four to six week period in the family's home or other natural environments.

During 2012, DHS Division of Children and Family Services (DCFS) contracted with eight providers for IFS, making these services available in approximately 75% of the counties throughout the state. In SFY 2012, 324 families, which included 775 children, received IFS.

In 2011, the North Carolina Family Assessment Scale for General Services and Reunification (NCFAS) was adopted as the assessment instrument to be used by all contracted IFS providers. The tool helps assess a families functioning levels, assists with identifying strengths and areas of need for families in up to ten domains, and provides a measure of the families progress after receiving IFS. The NCFAS was developed by the National Family Preservation Network (NFPN), a national organization that provides research-based tools, training resources, and technical assistance to public and private child, and family service agencies. NFPN conducts annual trainings with IFS providers on administering the NCFAS.

6 NCFAS Family Functioning Levels:

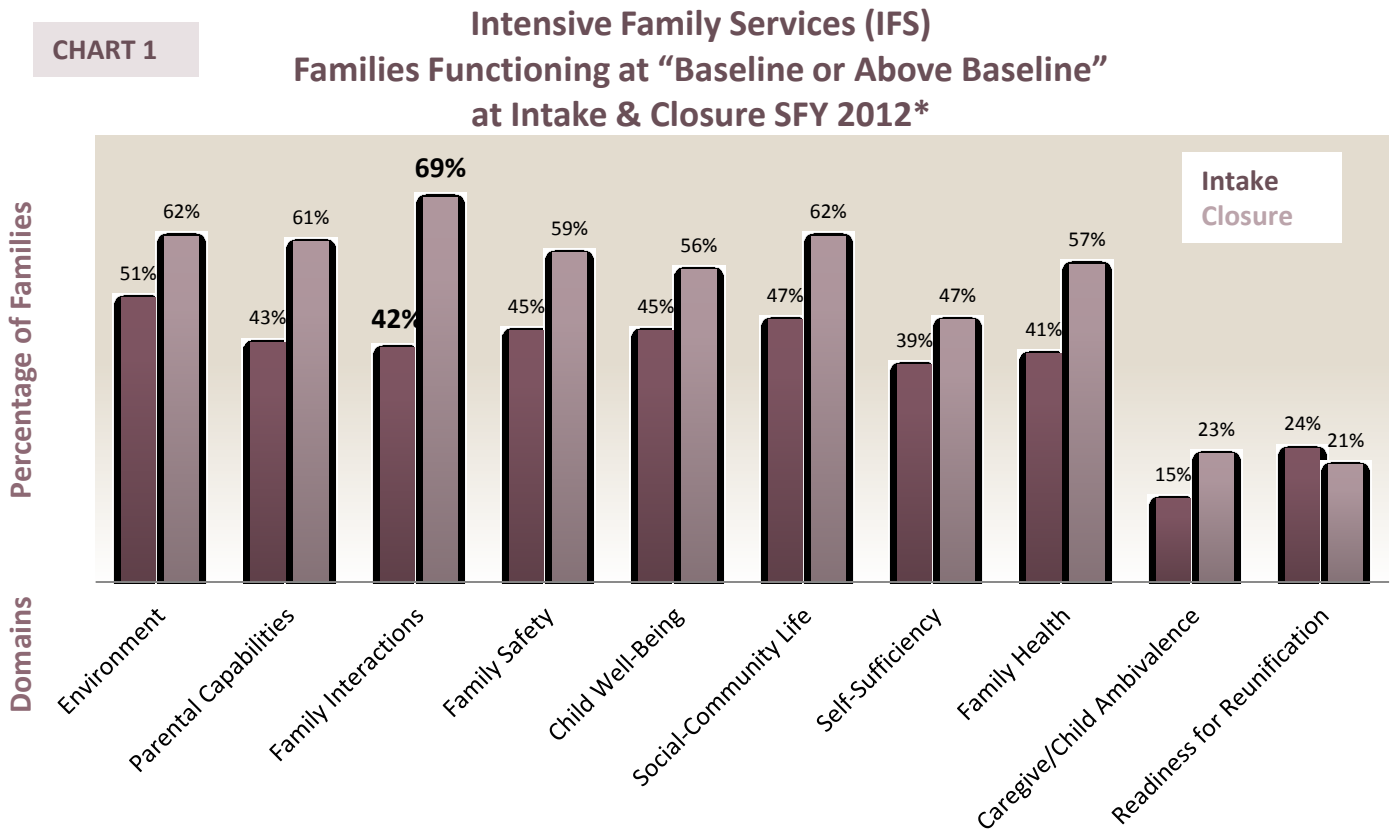
Clear Strength	Mild Problem
Mild Strength	Moderate Problem
Baseline/Adequate	Serious Problem

10 NCFAS Domains:

Environment	Social-Community Life
Parental Capabilities	Self-Sufficiency
Family Interactions	Family Health
Family Safety	Caregiver/Child Ambivalence
Child Well-Being	Readiness for Reunification

Intensive Family Services

CHART 1



*The "Baseline/Adequate" family functioning level is the threshold measure whereby there is no need for intervention in that domain. However, a family with ratings above or at Baseline/Adequate at intake in a particular domain does not prohibit the offer or acceptance of services.

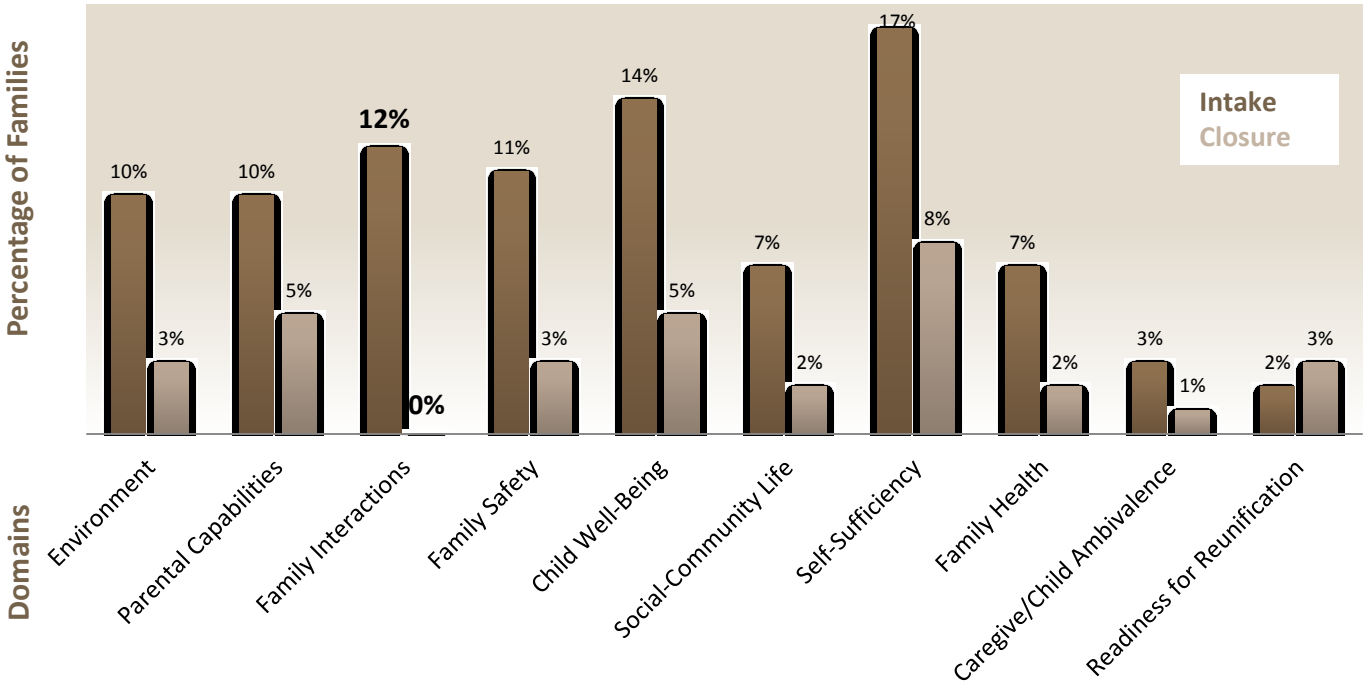
According to NCFAS data submitted to DCFS during the SFY 2012, a total of 150 families received the NCFAS at both intake and at closure. Results indicated increased family functioning in almost every domain (see Chart 1). The domain with the most improvement was "Family Interaction." The families who functioned at or above the baseline (an adequate and safe functioning level) increased 27% between the intake and closure of the services.

The only domain that showed a slight reduction was the "Readiness for Reunification" domain. Since the primary intent of IFS is to prevent an out-of-home placement, there is a disproportionately small number of families served that have reunification goals. Consequently, IFS providers often reported "blank" information in the domain since this is only applicable to a small number of families. Training on how to accurately report information for "Readiness for Reunification" will be addressed during the upcoming data collection period.

Intensive Family Services

CHART 2

Intensive Family Services (IFS)
Families Functioning with "Moderate or Serious Problems“ at Intake & Closure SFY 2012*



*Families with ratings of “Mild, Moderate or Serious Problems” at intake in any domain are closely monitored to determine whether there is a decrease (fewer families) with these ratings at closure, which would indicate an improvement in family functioning.

As reflected in Chart 2, there was a considerable decrease in families at the “Moderate or Serious Problems” level in almost every domain which indicates improvement in family functioning. The domain with the greatest improvement was in the “Family Interaction” domain with a decrease from 12% at intake to 0% at closure.

Similar to the previous section, the increase in the “Readiness for Reunification” domain results from the fact that the primary intent of IFS is to prevent an out-of-home placement. As such, there is a disproportionately small number of families with reunification goals and IFS providers often reported left this section “blank” in the NCFAS domain “Readiness for Reunification,”. This issue skewed the reporting in this area since this was not applicable to all families. Training on how to accurately report information in this domain will be addressed during the upcoming data collection period.

Access to Recovery

Access to Recovery (ATR) is a four year initiative funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) through September 2014. ATR shifts the focus of behavioral health care from acute substance abuse treatment to building on the strengths of clients in recovery and sustained recovery management. Recovery is supported by assisting clients meet identified needs through a self-directed recovery plan. This approach has been a success in other states and is being piloted in thirteen counties in Arkansas: Benton, Washington, Crawford, Sebastian, Craighead, Garland, Saline, Pulaski, Lonoke, White, Faulkner, Jefferson, and Independence counties.

ATR Eligible participants must meet the following criteria:

- Eighteen years of age or older
- Reside in one of the pilot counties
- Screen positive for substance use disorder
- Be at or below 200% of the federal poverty level
- Be in one of the targeted groups listed below:
    - A member of the active military, Reserves, Arkansas National Guard and/or combat veteran, or
    - A pregnant woman; or An adult family member of child(ren) with Division of Children and Family Services (DCFS) or Division of Youth Services (DYS) involvement, or at risk for child welfare involvement; or Person with a Drinking Under the Influence /Driving While Intoxicated conviction (targeting multi-offenders).

ATR Outcomes

The ATR initiative has demonstrated a significant impact on substance abuse recovery based on data collected and reported to SAMHSA. The ATR program measures recovery outcomes by comparing various factors relating to employment, housing, substance use, and legal involvement at the time of intake and six months after intake. In 2012, 2787 clients initiated participation, with 1778 clients completing a six-month follow-up assessment.

One of the most significant improvements is the reduced number of ATR parents with children in out-of-home placements. Results indicate that 40.1% of children transitioned from custody back into the home. Other encouraging outcomes for Arkansas ATR clients include the following:

Substance Use/Abuse Abstinence: (did not use alcohol or illegal drugs): 53.7% at intake to 80.9% at 6 months

Employment/Education: (currently employed or attending school): 24.1% at intake to 42.9% at 6 months

Stability in Housing: (had a permanent place to live in the community): 32.0% at intake to 50.4% at 6 month intake

Crime and Criminal Justice: (had no past 30 day arrests): 89.6% at intake to 96.9% at 6 months

For more information, please visit: http://humanservices.arkansas.gov/dhhs/Pages/AccessToRecovery.aspx

Juvenile Drug Courts

Recognizing the need for adolescent substance abuse treatment, Arkansas judicial districts started specialized drug courts to provide judicial supervision and coordinate substance abuse treatment for drug-involved juveniles. This innovative practice was modeled from adult drug courts already implemented in the state.

Juvenile Drug Court programs are an interdisciplinary, non-adversarial judicial process for diverting youth within the juvenile justice system. Youth that have demonstrated problems with substance abuse are diverted into a treatment program that includes drug screening, therapy, counseling, care coordination, and regular court appearances to monitor program compliance. A juvenile drug court judge maintains oversight of each case through frequent status hearings. Drug court teams are typically comprised of the judge, court staff, a behavioral health professional, a prosecutor, a public defender or private attorney representing the youth, a probation or parole officer, and drug counselor. Together, the team determines how best to address the substance abuse and related issues resulting in the youth's involvement with the justice system.

Treatment services are delivered through community providers and continue an average of eighteen months. Currently, there are 13 juvenile drug court programs functioning throughout the state of Arkansas. Some courts are pre-adjudication programs while others are post-adjudication programs; some courts provide a combination of both. This varies based on the particular needs of the community where the court program is established.

According to DHS Division of Behavioral Health Services (DBHS) data, in state fiscal year 2013 approximately 185 juveniles received substance abuse services through this program statewide. The average age at admission is 16 years of age and males made up 78% of program admissions. DBHS continues to work collaboratively with community providers and the Arkansas Administrative Offices of the Courts to ensure quality behavioral health services remain at the center of juvenile drug courts.

Admission Age	%
15 years or younger	30.3
16-18 years old	68.4
19 years or older	1.3
Average Admit Age	16

Race	%
White	61
Black	24
Hispanic	13
Amer Ind/Nat Hawaiian/PI/Asian	2

Primary Substance/ First Choice	%
Marijuana/Hashish	81
Alcohol	7
Amphetamines	3
Methamphetamine	2
Cocaine	1
Other Opiates & Synthetics	1
Other	5

Youth Advocacy Program

The DHS Division of Youth Services (DYS) piloted three Youth Advocacy Programs (YAP) beginning in January 2010. The purpose of this initiative was to enhance and expand community-based programs by implementing a model to target juvenile crime and provide positive and cost-effective alternatives to detention in several sites in Arkansas.

Description
YAP is an intervention strategy used to assist in stopping the trend of youth violence by offering an intense community-based program for youth at risk of being committed to DYS or youth who are in aftercare and at risk of commitment to DYS. The program is designed to provide opportunities for targeted youth and their families to develop, contribute, and be valued as assets so that communities have safe, proven effective and economical alternatives to institutional placement. An advocate with extensive YAP training will spend 10 – 15 hours per week with youth in structured educational, social, and recreational activities.

Community-based service providers were contracted to be hosts the YAP program in local communities. Since the initial launching of the YAP initiative in 2010, two additional provider sites were added for a total of five sites that hosts YAP programs statewide.

YAP Site Locations:

Judicial District	Counties Served
District 6	Pulaski, Perry
District 11	West Jefferson, Lincoln
District 20	Faulkner, Van Buren, Searcy
District 13	Dallas, Cleveland, Ouachita, Calhoun, Union, Columbia
District 10	Ashley, Bradley, Chicot, Desha, Drew

Each provider was charged with developing a program that suited the needs of the judicial districts with the goal of creating a program structure and deliverables that could be replicated. At the end of the 2012 program year, DYS worked with the Department of Criminal Justice at the University of Arkansas at Little Rock to complete an evaluation of the program.

Evaluation findings show that the majority of youth participating in this program were successful. This was based on data indicating that 56 of 67 youth were currently active or had graduated from the program; only two youth were removed due to commitment or recommitment to a juvenile correctional or treatment facility. Seventy percent (70%) of youth participating in the program indicated that the program provided a good or excellent experience. The youth also reported that they had a good relationship with their advocate and felt they were treated with respect.

Overall, the providers met all performance indicators and deliverables outlined in the YAP contracts. All sites have built a strong advocate group within each of their communities to provide guidance and support for youth. The next opportunity for the YAP is to strengthen the program by developing an aftercare youth support program that provides services for youth that have completed the YAP.

Youth Advocacy Program

The YAP model embraces the following core principles:

- **Individualized Service Planning**: Interventions and goals are tailored to each youth and family's unique needs, strengths, and interests.
- **Cultural Competence**: Staff demonstrate respect for and knowledge of different cultures and values in practice.
- **Partnership with Parents**: The unit of intervention is the entire family. Families are co-designers of their own services and are invested in having the plan succeed. Staff work with families in achieving their goals as opposed to doing things for them.
- **Focus on Strengths**: Intervention and Service Plans build on youth, family, and community strengths to address deficits and weaknesses.
- **Teamwork**: A team of professional and non-professional individuals who care about the youth and family work together in helping the family achieve their goals. YAP works with all team members to ensure that all team members contribute in a meaningful way to helping the family achieve their goals.
- **Community-Based Care**: Supportive persons and associations are organized on behalf of the family from within the community. These are both formal (professional/system) and informal (natural) supports.
- **Unconditional Caring**: Staff show consistent positive regard for families despite resistance or non-compliance. Staff maintain a "never give up" approach with all youth.
- **Giving Back**: Staff identify with youth and families a way for them to contribute to their community through building upon their strengths and interests.
- **Corporate and Clinical Integrity**: Staff maintain professional relationships with youth and families and other systems. Staff report accurate hours and maintain ethical practice.

Division of Youth Services Diversion Grant

In April 2012, eight states were competitively selected to participate in the project, *Improving Diversion Policies and Programs for Justice Involved Youth with Co-Occurring Mental Health and Substance Use Disorders: An Integrated Policy Academy/Action Network Initiative.* States selected for participation include: Arkansas, Kentucky, Michigan, Minnesota, Mississippi, New York, South Carolina, and Virginia. The Substance Abuse and Mental Health Services Administration (SAMHSA) and the John D. and Catherine T. MacArthur Foundation collaborated on this effort.

According to SAMHSA, 60% - 70% of youth in the juvenile justice system have a mental illness and more than 60% suffer from a substance abuse disorder. Many of these youth end up in the juvenile justice system rather than receiving treatment for their underlying disorders. The program will combine SAMHSA's Policy Academy initiative and the MacArthur Foundation's Models for Change Action Network. The states selected will have access to leading experts in the field and the latest research and information on front-end diversion policies and programs.

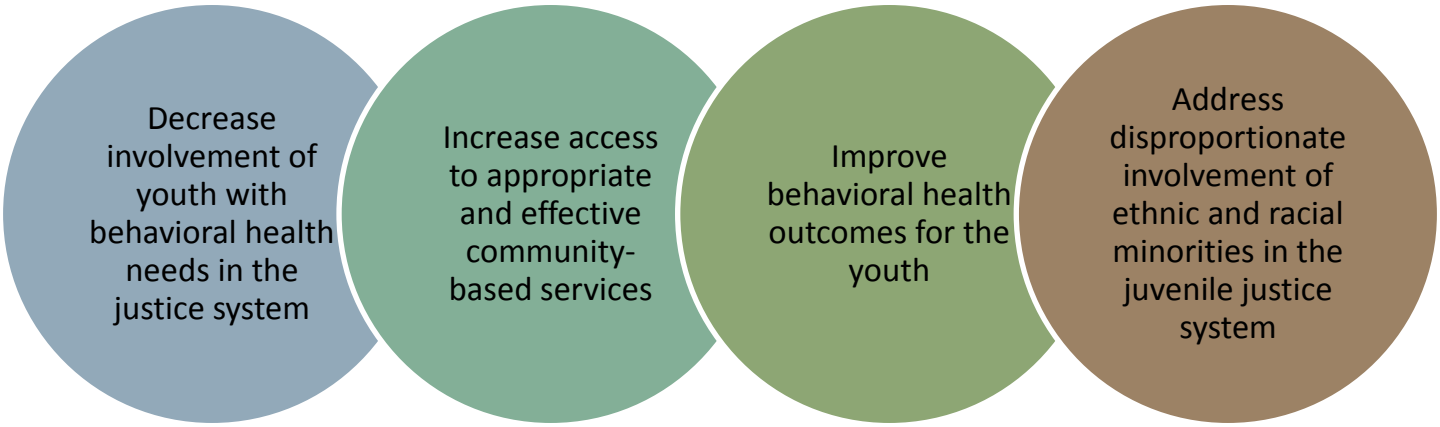
Arkansas will pilot a juvenile justice diversion program in Judicial District 8N, Hempstead and Nevada Counties. The program will incorporate mental health, substance use, and co-occurring screening and assessment practices in the juvenile justice system. The program will emphasize the use of evidence-based practice, treatment, and trauma-informed services.

On June 27-28, 2012, a kick-off meeting for the initiative was held in Bethesda, Maryland with more than 100 people in attendance, including a team representing Arkansas.

"This innovative effort will help ensure that fewer at-risk young people fall through the cracks and into an overburdened juvenile justice system that is very often unable to address their underlying behavioral health problems."

-SAMHSA Administrator Pam Hyde

Ultimate Goals of the Initiative are:



Fetal Alcohol Spectrum Disorders

The Fetal Alcohol Spectrum Disorders (FASD) project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and administered through the Department of Human Services (DHS) Division of Children and Family Services (DCFS) from February 2008 to May 2012. Recognizing the value of the FASD project, DCFS will continue this work beyond the grant period and expand the project statewide. The DHS Division of Behavioral Health Services (DBHS) plays a key role in the FASD project expansion by providing support through the 13 Prevention Resource Centers (PRCs) in the state. The PRCs disseminate information, provide education, and promote awareness of FASD across Arkansas.

The FASD project aims to:

- Identify children with FASD as early as possible to begin the necessary interventions
- Help stabilize the home environment as much as possible, and,
- Assist permanency planning with the biological family or adoptive family when reunification is not possible.

By identifying FASD early in life, secondary disabilities and related complications may be prevented. There are multiple secondary disabilities associated with FASD that can include: behavioral health disorders, disrupted school experience, criminal justice involvement, inappropriate sexual behavior, alcohol/drug problems, dependent living, and employment problems. The FASD project will continue to serve the children and families of Arkansas to prevent, identify, and treat FASD.

One FASD pilot project being conducted through the foster care unit of the DHS DCFS is located in Pulaski County. This pilot project serves children within the geographic region in foster care between two to seven years of age. Through the FASD project, these children receive early and timely screening, diagnosis, and interventions to address their specific healthcare needs. The project's efforts to implement early interventions ensures a comprehensive, coordinated, and timely approach to case planning, case management, and follow-up for appropriate care in order to decrease secondary disabilities.

To support this effort, the Governor's Office issued a proclamation designating September 9, starting in 2012, as Fetal Alcohol Spectrum Disorders Awareness Day in the state of Arkansas. The related events allowed DBHS to distribute 500 FASD awareness pins and engage 35 churches and city halls from around the state to participate in the international bell ringing ceremony at 9:00 am on the ninth day of the ninth month for FASD awareness.

Safe Babies Court Team

The Safe Babies Court Team is a national systems change initiative focused on improving how the courts, child welfare agencies, and related child serving organizations work together, share information, and expedite services for children. The goal of the project was to meet the developmental needs of maltreated infants and toddlers and hence prevent the developmental delays, health problems, and poor life outcomes associated with early maltreatment.

The Arkansas Pilot Safe Babies Court Team (AR SBCT) was initiated to reduce child maltreatment in the state. The AR SBCT monitors the cases of children, birth to 3 years of age, who have come into the custody of the Department of Human Services due to abuse or neglect. Thus far, the AR SBCT is made up of 118 members, has served 23 children, 11 of whom had open cases in the last reporting period. The AR SBCT is focused on: 1) hosting cross-site trainings, 2) partnership engagement efforts, and 3) family support through improving and expediting services.

Training

During the previous year, the AR SBCT worked to increase knowledge about the negative impact of abuse and neglect on very young children by hosting trainings on selected topics related to the needs of maltreated infants and toddlers and their families. The SBCT hosted nine trainings focused on the social and emotional development of children and on infant and child mental health. These trainings reached 223 multi-disciplinary professionals across Arkansas.

Engaging Partners

In 2012, the AR SBCT project engaged 116 multi-disciplinary partners. Members participated in monthly Court Team meeting discussions on the development of local resources for families, the progress of the team's subcommittees, and resources offered by local service providers such as the Arkansas Literacy Council.

Working with Families

The Arkansas Pilot Court SBCT's greatest accomplishment this reporting period was improving and expediting services for children and families. During the reporting period, the Court Team monitored ten children across six families. The analysis on the following page uses the data from the ten children served during this reporting period to demonstrate how project goals are being met.

Safe Babies Court Team

Update on Goals for Arkansas Safe Babies Court Team:

- 100% of the children received a developmental screening/assessment.
- 90% of the children had no more than two changes of placement.
- 100% of the children had case plans that included a concurrent plan for achieving permanency.
- 100% of the children spent time with their parents at least two times per week.
- 100% of children with siblings participated in visits with their siblings at least twice a week.
- 10% of children have received Child Parent Psychotherapy.

  * The Court Team has not achieved the goal of 50% due to access barriers in receiving therapy. The National Child Traumatic Stress Initiative grant, obtained by the UAMS Psychiatric Research Institute, will fund training for 25 Arkansas clinicians in Child-Parent Psychotherapy to help reach this the goal.

In addition to monitoring the successes, the Court Team reviews all cases that reach legal permanency after 12 months to assess barriers to permanency.

While the Arkansas Pilot Court Team has met most of the goals chosen related to improving outcomes for children and families, the Court Team continues to look for additional ways to improve outcomes for young children and their families. For example, one initiative is the facilitation of family team meetings for all families in the project. In order to make certain all parties have equal input into the progress of the case and the well-being of the children, the Court Team has partnered with the Bowen School of Law to provide a trained facilitator/mediator to facilitate all monthly family team meetings. The Court Team has also made tremendous progress with implementing successful family team meetings by having a protocol and facilitator in place.

Behavioral Health Payment Improvement Initiative

In 2012, the Arkansas Department of Human Services (DHS) and several key partners launched the Arkansas Payment Improvement Initiative (APII) in an effort to transform Arkansas's health care landscape. As a part of the APII, DHS seeks to develop an improved behavioral health delivery system by achieving the triple aim of the United States Department of Health and Human Services' National Quality Strategy:

> **Better Care:** Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
> **Healthy People/Healthy Communities:** Improve the health of the population by supporting proven interventions to address behavioral, social, and environmental determinants of health, in addition to delivering higher-quality care.
> **Affordable Care:** Reduce the cost of quality health care for individuals, families, employers, and government.

DHS intends to support this strategy through episode-based and population-based care delivery models, with a priority placed on integrated care coordination to better manage and improve health outcomes. The APII will implement episode-based health care models, patient-centered medical home (PCMH), and health home (HH) initiatives. These models will encourage a team-based approach to care by rewarding coordinated, high quality care for the management of designated conditions. As such, emphasis has been placed on: care coordination, evidence-based practices, practice accountability, and performance-based reporting for quality improvement.

Attention deficit/Hyperactivity Disorder and Oppositional Defiant Disorder are the initial behavioral health episodes currently being developed and implemented, in conjunction with emerging PCMH and HH initiatives. These conditions were identified as appropriate for a episode-based model because they meet the following necessary criteria:

- Clinical guidelines are clear and exhibit the ability to predict level of need
- Diagnosis guidelines are concrete and reliable
- Diagnosis guidelines are separable and distinguishable from other episodes
- Episode trajectory is consistent across patient profiles
- Episode condition is of meaningful size

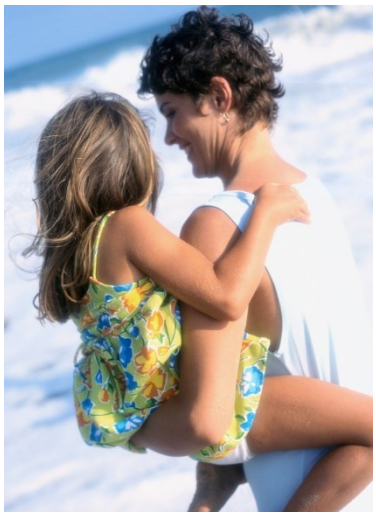
Attention Deficit/Hyperactivity Disorder (ADHD) Episode

In an effort to provide better care and outcomes to children with Attention Deficit/Hyperactivity Disorder (ADHD), an episode-based approach was developed to address care delivery fragmentation and encourage evidenced-based best practices.

The ADHD episode is defined as:

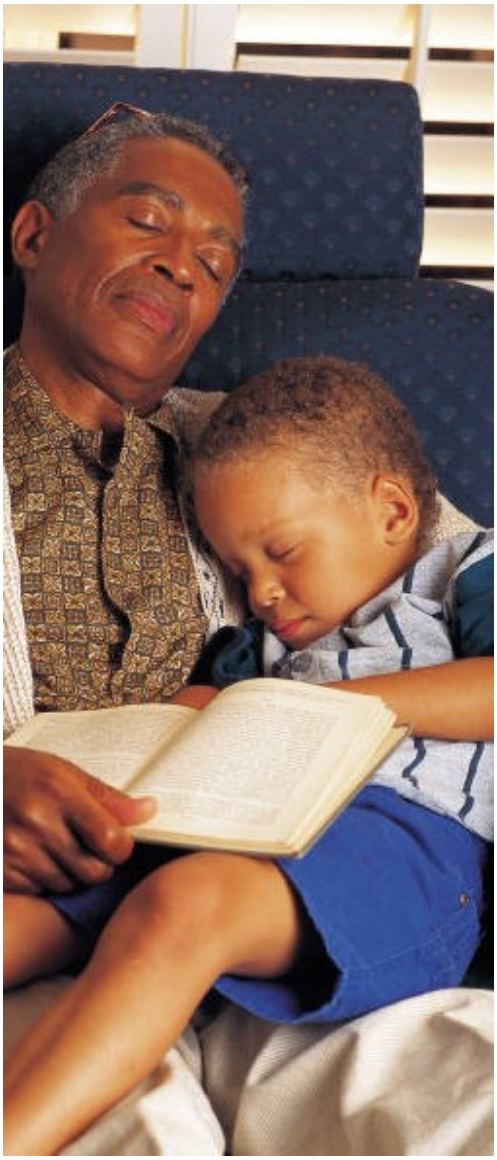
- A twelve-month period of services to treat ADHD including all needed physician visits, therapies, and medications
- Treatment provided by a designated Principle Accountable Provider
- Services provided to patients 6 – 17 years of age without co-occurring behavioral health conditions
- Treatment Options:
  - Level 1 – treatment for new patients positively responding to medication and first-line treatment interventions
  - Level 2 – treatment for patients with inadequate responses to medication and first-line treatment interventions.
- Approved treatment in compliance with clinical guidelines and in accordance with designated ADHD quality and utilization performance thresholds

July 1, 2012 marked the beginning of the preparatory period for the ADHD episode, which included training providers on provider portal access and offering a data entry period for providers to input patient information. October 1, 2012 marked the beginning of the reporting period for the ADHD episode quarter. As of January 2013, ADHD Principal Accountable Providers were given performance reports detailing components of quality, costs, and utilization to allow them to apply the findings to their care management practices for children with ADHD.



Oppositional Defiant Disorder (ODD)

In keeping with episode-based care delivery, this episode is being designed to enable better identification and treatment of individuals with ODD. The currently proposed ODD episode design includes the following elements:



- A single severity level for clients 6 – 17 years of age without co-occurring behavioral health conditions
- Treatment provided by a designated Principle Accountable Provider.
- A treatment period consisting of a single 3-month evidenced-based psychotherapy program and parent/teacher administered behavioral support (averages 1-2 therapy sessions per week)
- Treatment services include all office visits and psychotherapy
- Treatment excludes assessment from threshold calculations to encourage thorough assessment for appropriate diagnosis
- Medication as long-term treatment for ODD without co-occurring behavioral health condition is excluded
- Recertification of continued treatment after 3-month period, if inadequate response during initial treatment period

The anticipated preparatory period for designing the ODD episode is expected to end April 1, 2013. Additionally, ADHD and ODD often present as comorbid conditions and planning efforts have begun to develop a co-morbid episode.

Patient Centered Medical Homes and Health Homes

Arkansas Medicaid claims data for 2011 show that approximately 110,000 individuals received behavioral health services. In an effort to provide care coordination needed by individuals with the higher levels of need within the behavioral health system, patient center medical homes (PCMH) and health homes (HH) are being designed to meet these needs. The goals and associated care coordination responsibilities of each initiative are summarized as follows:

	Patient Centered Medical Home	Health Home
Target Population	Services to individuals receiving primary care services	Services to Medicaid beneficiaries with specific chronic conditions or serious and persistent mental health conditions
Typical Providers	Typically defined as primary care providers	Varies, but may consist of designated providers and include multidisciplinary team members (i.e. community mental health organizations, behavioral health providers, addiction treatment providers, etc.)
Care Delivery Approach	Team-based, whole-person approach with specific focus on primary care and coordination of health needs across multiple systems.	Team-based, whole-person orientation with specific focus on the integration and coordination of behavioral healthcare and primary care. May include individual and family support services

Behavioral Health Payment Improvement Initiative

While other models coordinate specific services and supports, Health Homes integrate and coordinate all primary, acute, behavioral health, and long term services and supports to address the needs in a "whole person" approach across the lifespan and service continuum.

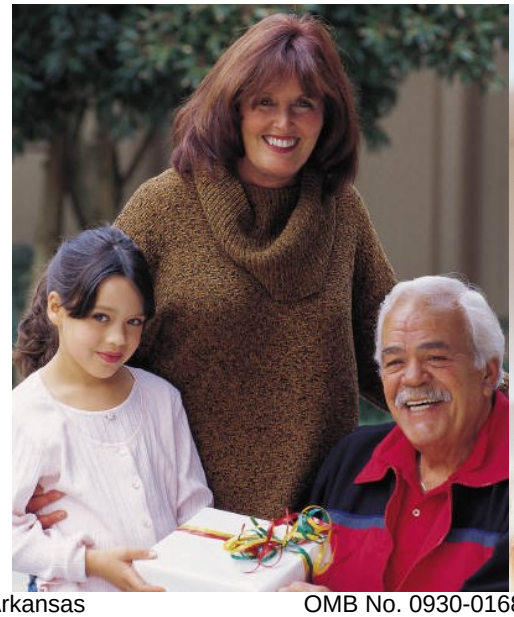
The specific goals of the behavioral Health Home are:

- To provide clients with integrated care coordination within and across behavioral health, physical health, long term services and supports, and other systems; and,
- To manage behavioral health core care delivery to ensure the effective treatment of behavioral health conditions, including monitoring medication compliance and complications.

Future Arkansas Behavioral System of Care

As episode and population-based models are being delivered, additional efforts are underway to address practice innovation, policy development, and systems planning to transform the current behavioral health care system and focus on prevention, early intervention, screening/assessment, treatment, and recovery/resilience. The envisioned Arkansas Behavioral Health System of Care will:

- Facilitate and provide access to behavioral health services at the appropriate level of care and in the appropriate setting of care;
- Provide care coordination based on level of need;
- Incentivize behavioral health organizations to provide services that are quality-driven and based on clinical guidelines; and
- Empower individuals and families to take an active role in the delivery of their behavioral health care services.



Atypical Antipsychotics Project

Since inception in 2008, the primary goal of the Atypical Antipsychotics work group has been to address clinical practice standards for children with serious emotional disturbances (SED) with the goal of ensuring child safety. The new policies that were established to address the safe use of psychopharmacological medication in children and youth, requiring consent and follow up labs, has raised the awareness among of providers and parents. This attention to safe psychopharmacological practices and engagement with providers regarding alternative non-pharmaceutical therapeutic procedures will lead to better health for children with SED.

The informed consent and lab monitoring policies were initiated for all new patients in November 2011 and for established patients in June 2012. This was in response to concerns that prescribers were not obtaining informed consent forms when prescribing antipsychotic medications and monitoring for metabolic changes once children began these medications. After implementation, the overall medication utilization results show that there has been a decrease in use of the antipsychotic medications in all age groups of children (under 6 years, 6 to 12 years, and 13 to 17 years of age) without any significant shift or increase to other psychotropic medications. Graphs depicting the change in utilization patterns are included on pages 38-40.

The policy changes resulted in a $1.5 million cost savings from reductions in antipsychotic prescriptions. To further support this effort, DHS also added two additional psychiatrists to the team responsible for reviewing utilization of antipsychotic medications in children and working with providers on alternative non-pharmaceutical procedures.

In partnership with the DHS Division of Behavioral Health Services (DBHS), the DHS Division of Medical Services (DMS) Pharmacy Program plans to continue with this focus on best practices for use of antipsychotics in treating children. Current work is focused on reviewing the use of combinations of antipsychotics and stimulants. Additionally, DMS will continue to review prior authorization requests for age exceptions, dose exceptions, and therapeutic duplication requests, as well as, monitor the utilization of psychotropic agents in children. This includes contacting prescribers of psychotropic medications that are outliers (for example, abnormally high prescribing rates) for consultation and/or education. The work group will continue these efforts, while also identifying new opportunities to improve children's health and safety.

Antipsychotic Medication for Foster Children

In 2011, Congress enacted the Fostering Innovations and Improvement in Child Welfare Act which directed the states to develop policies for oversight of psychotropic medications for foster children. To support this effort, the Administration for Children and Families (ACF), and Substance Abuse and Mental Health Services Administration (SAMHSA), in partnership with the Centers for Medicaid and Medicare Services (CMS) coordinated a national effort to address oversight and monitoring protocols to ensure the appropriate use of psychotropic medications for children in foster care. The organizations hosted a two-day summit to form collaboration across complex systems including representatives from across the country from state Medicaid, mental health services, and child welfare to bring attention to the important topic.

In August 2012, Department of Human Services (DHS) staff attended the *Summit on Psychotropic Medication Use with Children in Foster Care* to obtain information from experts and other states on additional ways to improve the Arkansas plan for oversight and monitoring. The Arkansas team included two staff members from the DHS Divisions of Children and Family Services (DCFS), Behavioral Health (DBHS) and Medical Services (DMS).

Following the summit, DHS formed a steering committee to continue to develop monitoring plans, recommend policy changes, and provide a forum for information and data sharing regarding this issue. The steering committee meets quarterly and prepares Medicaid pharmacy reports that are shared with DCFS and DBHS. Graphs depicting the change in utilization patterns are included on pages 38-40. Beginning January 2013, DMS will provide reports containing the following data for the previous 3 month time period:

- Number of foster children on any psychotropic medication
- Number of foster children on antipsychotic medications
- Number of foster children on stimulant medications
- Number of foster children on five or more psychotropic medications
- Number of foster children on a combination of Clonidine and Guanfacine

Each report will compare medication usage for children that are Medicaid beneficiaries in foster care with children that are not in foster care to identify differences in prescribing trends and presented by age groups: less than 6 years, 6 to 13 years, and 13 to 18 years of age. Data will be reviewed quarterly and action plans initiated, as deemed necessary to improve the care of children in foster care. Additional report content may be added based on the need to monitor other aspects of medication utilization.

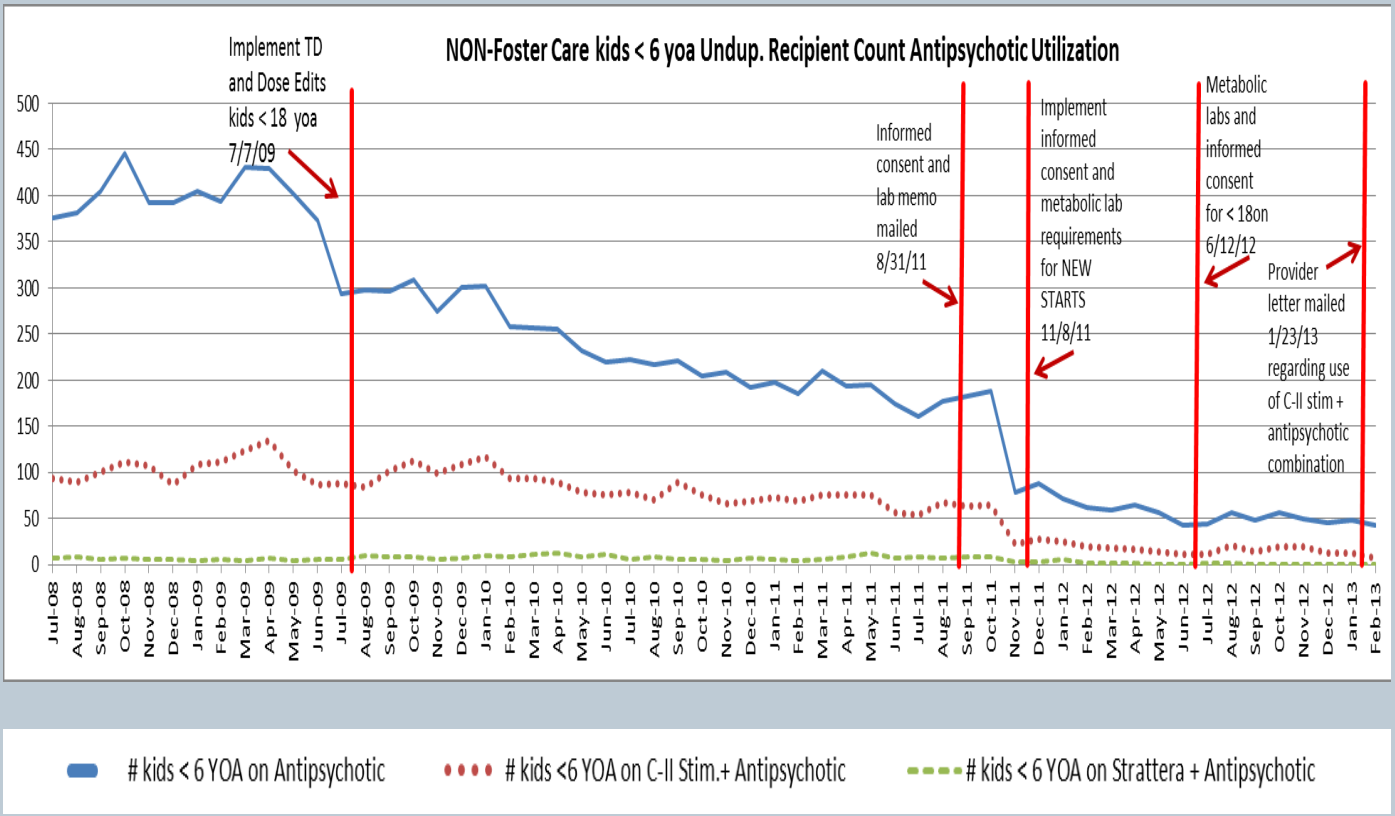
Arkansas submitted a plan to the U.S. Department of Health and Human Services Administration for Children and Families in June 2012, and an oversight committee was established in September 2012 to monitor the plan, set priorities, and determine target dates for implementation.

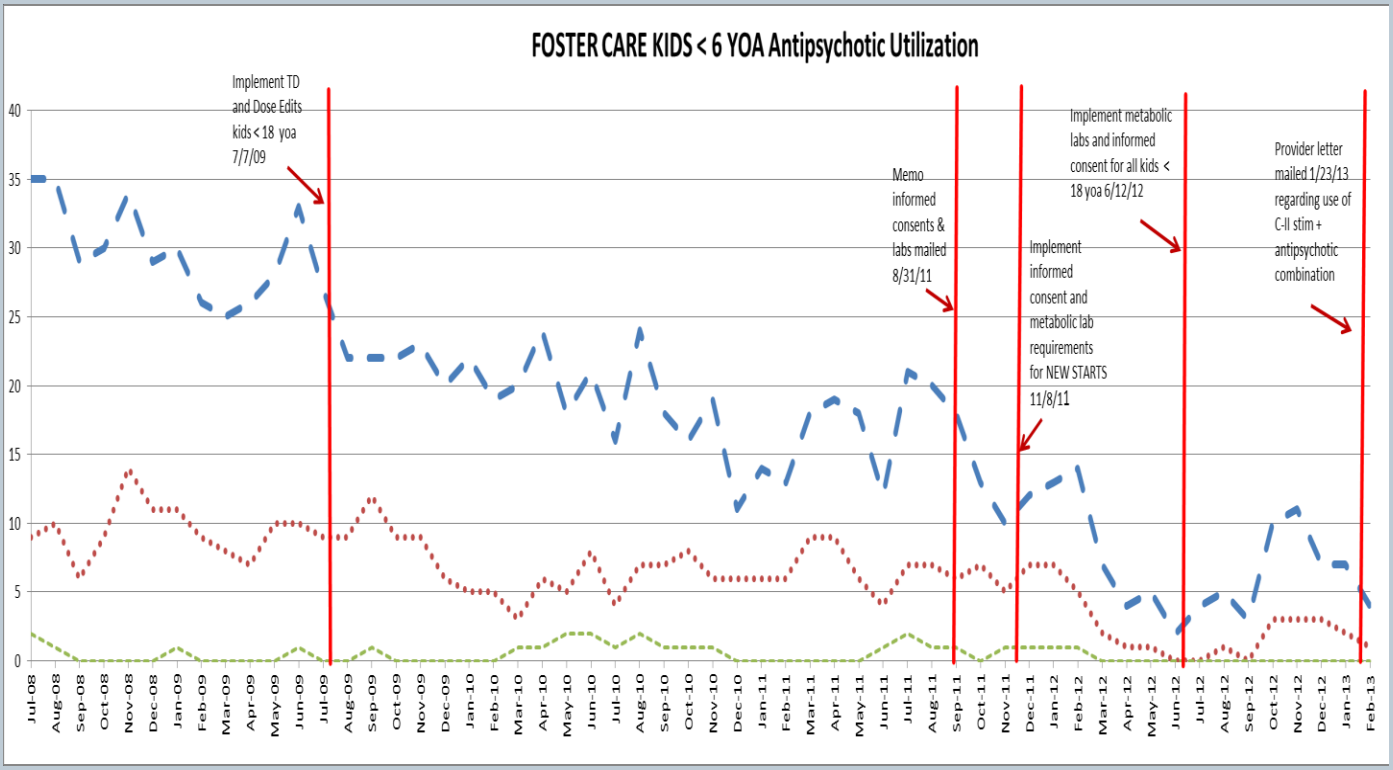
Antipsychotic Medication for Foster Children

Antipsychotic Medication and Children in Foster Care Plan

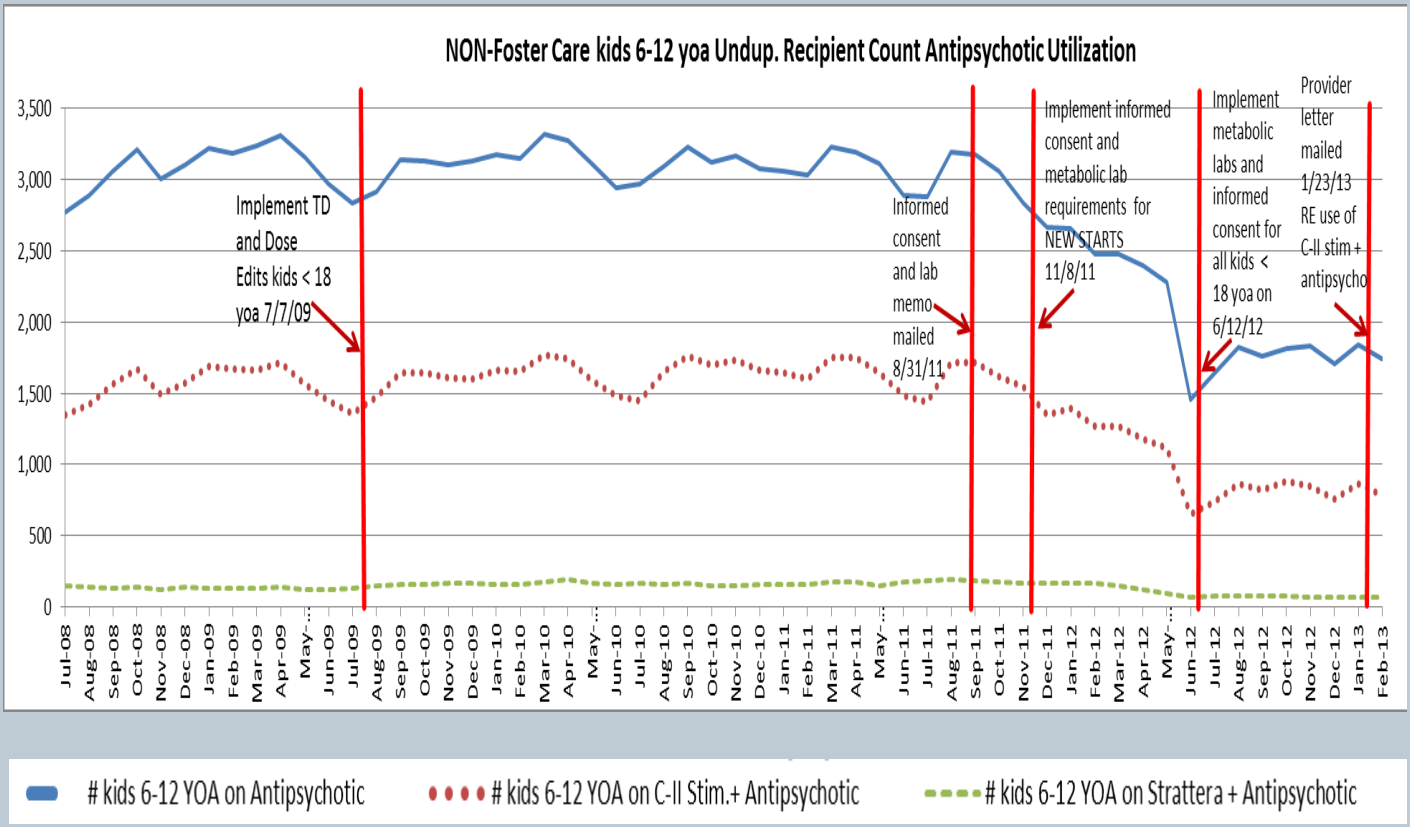
Plan Elements
Comprehensive and coordinated screening, assessment, and treatment planning mechanisms to identify children's mental health and trauma-treatment needs (including a psychiatric evaluation, as necessary, to identify needs for psychotropic medication).
Informed and shared decision-making and methods for on-going communication between the prescriber, the child, his/her caregivers, other healthcare providers, and the child welfare worker.
Effective medication monitoring at client and agency level.
Availability of mental health expertise and consultation regarding both consent and monitoring issues by a board-certified or board-eligible child and adolescent psychiatrist (agency and individual case level).
Mechanisms for accessing and sharing accurate and up-to-date information and educational materials related to mental health and trauma-related interventions to clinicians, child welfare staff and consumers.

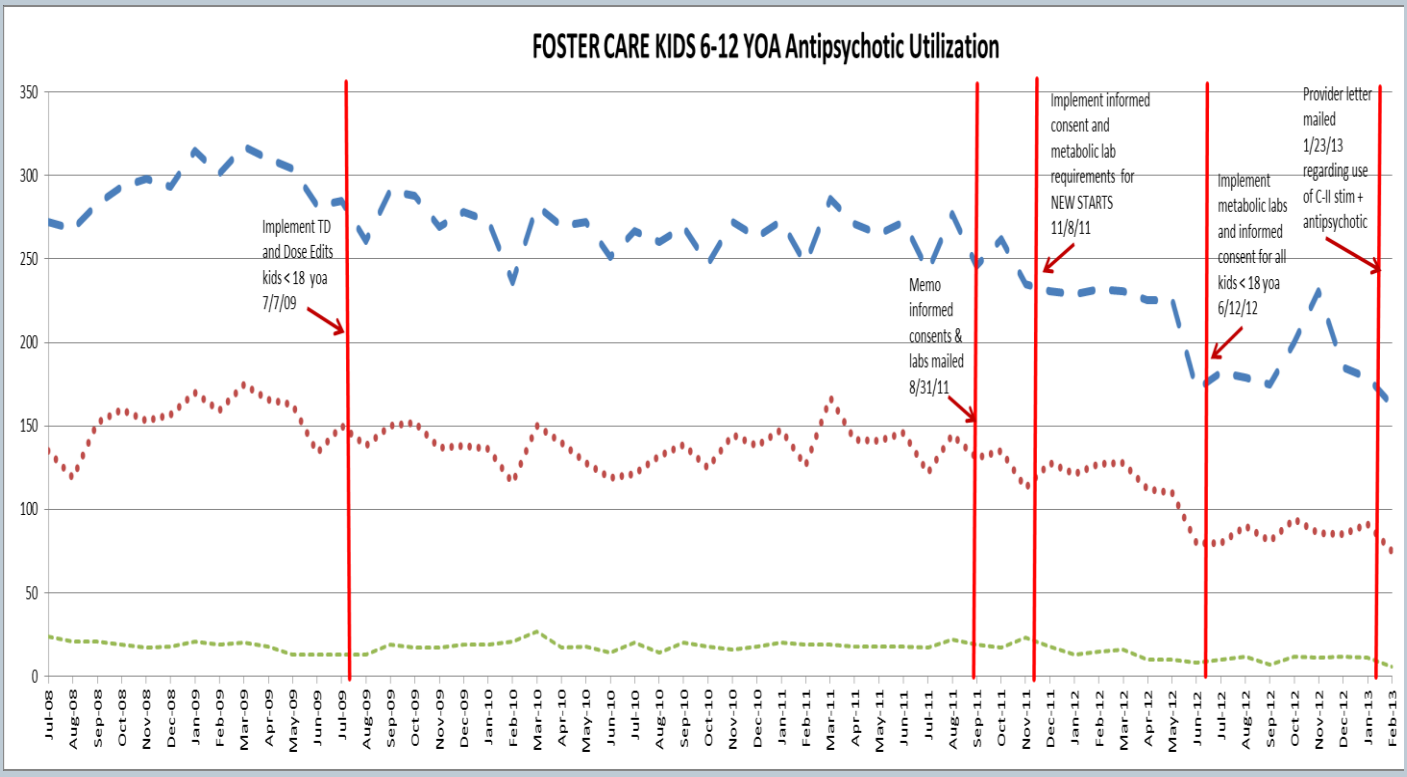
Antipsychotic Utilization among Kids <6 Years of Age



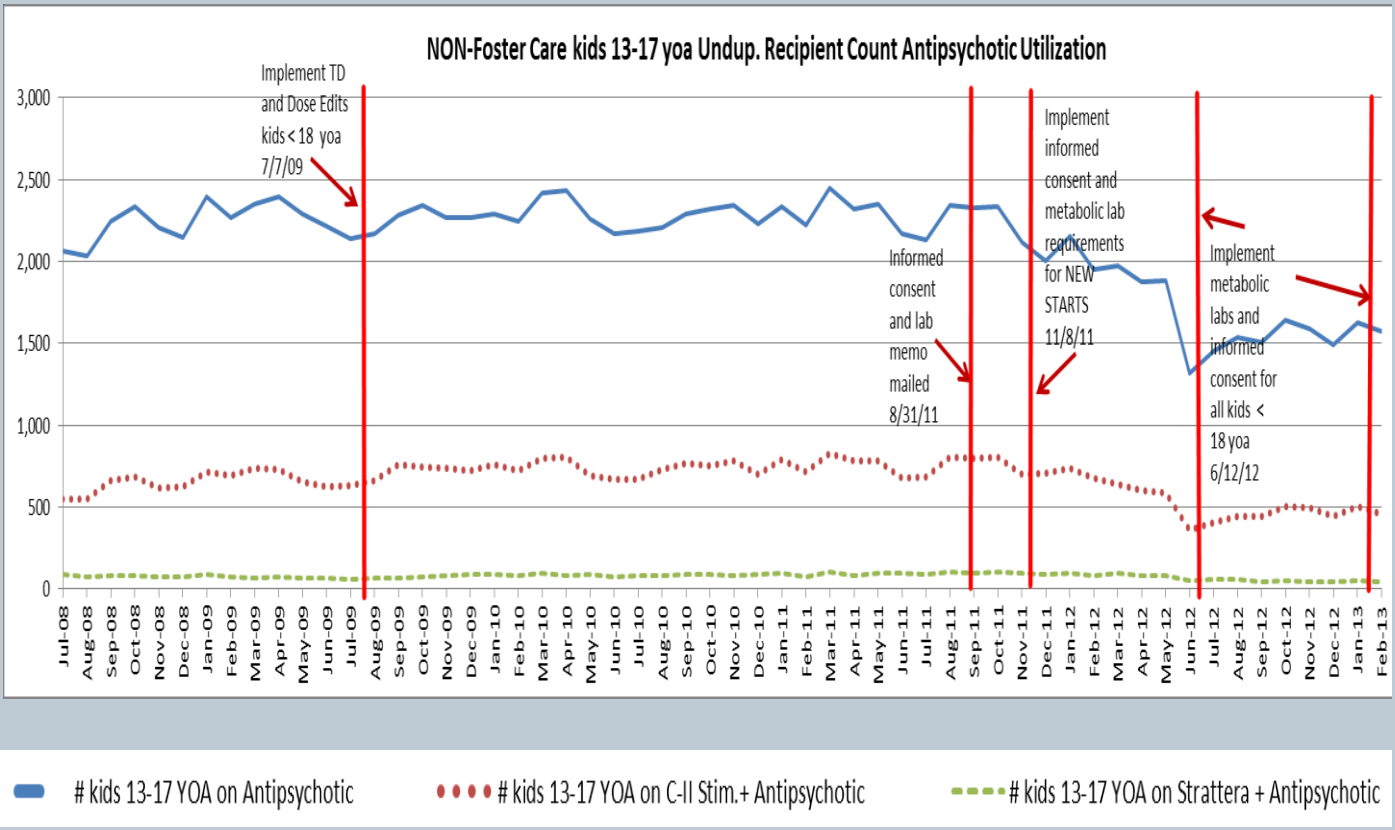


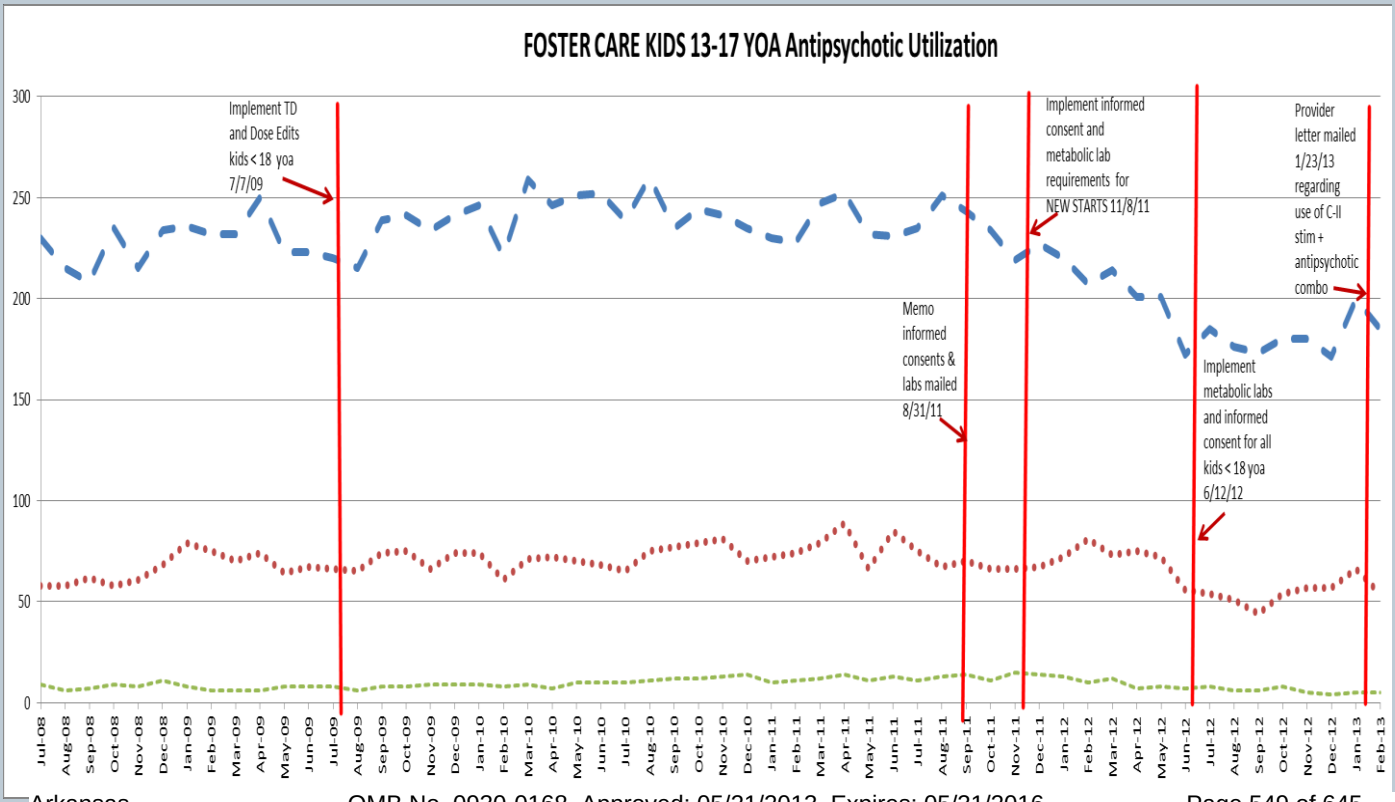
Antipsychotic Utilization among Kids 6 to 12 Years of Age





Antipsychotic Utilization among Kids 13 to 17 Years of Age





The Arkansas Children's Behavioral Health Care Commission 2012

Commissioner:	Representing:
Kim Arnold	Arkansas National Alliance on Mental Illness
Dr. Jim Aukstuolis	Arkansas Behavioral Health Care
Dr. Steven Domon	Arkansas State Hospital
Jonathan Dunkley	Arkansas Department of Human Services , TYS Grants Manager
Jennifer Gallaher*	Division of Behavioral Health Services
Adella Gray	Former School Counselor
Consevella James	Treatment Homes, Inc.
Georgia Rucker	Family Advocate
Dr. Tom Kimbrell	Arkansas Department of Education
Dr. Teresa Kramer	University of Arkansas for Medical Sciences
Carol Amundson Lee	Tri Region Programs of Community Development Institute
Karen Massey	Southwest Arkansas Educational Cooperative
Carol Moore	Dayspring Behavioral Health
Dr. Benjamin Nimmo	Pediatrician
Clarence Perkins	Southeast Arkansas Behavioral Health
Dr. Tommy Roebuck	Former Legislator and Dentist
Rhonda Sanders	Arkansas Children's Hospital
Joyce Soularie	Arkansas' Family Support Partner Coordinator
Honorable Joyce Williams Warren	Sixth Judicial Circuit Court Judge
Dr. Gary Wheeler	University of Arkansas for Medical Sciences

* A special thanks goes out to Jennifer Gallaher for her service to the Arkansas Children's Behavioral Health Commission. This position is currently vacant.

The following Commissioners are not pictured: Jonathan Dunkley, Tom Kimbrell, Teresa Kramer, Clarence Perkins, Georgia Rucker, Rhonda

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which should indicate how concerns of the tribes were addressed in the State Block Grant plan(s). States shall not require any tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for tribal members on tribal lands. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

P. Consultation with Tribes

The state of Arkansas does not have any federally recognized tribes.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

Q. Data Information Technology

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 2013, DBHS received client level substance abuse data, which indicated providers treated 12,099 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. Minimum Data Set (MDS) is maintained by Kit Solutions and SSA employees. The stakeholders for prevention enter their services that were provided in the communities.

- Web Infrastructure for Treatment Services (WITS) is maintained by FEi, and is operated for the Access to Recovery (ATR) program. Client level data is collected by participation from Access to Recovery episodes.

- 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 Youth Outcomes Questionnaire (Y-OQ®), implemented statewide for all Medicaid funded Rehabilitative Services for Persons with Mental Illness (RSPMI) providers, is a standardized instrument to track the progress of children and youth while they are in treatment and facilitate the State's ability to track treatment effectiveness. Client-level demographic and Y-OQ® overall and six subscale scores are available to DBHS. This data is used to assess provider instrument utilization compliance and treatment outcomes as measured by intake and discharge Y-OQ® scores.

- 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 2012 86,424 students from 216 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. DBHS is planning to extend to the survey to mental health clients served by all the private providers.

- DBHS created and maintains an Excel data base to capture various aspects of the state System of Care (SOC) program for 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. DBHS is developing a web-based data infrastructure application that will automate data capture from the 17 providers of the SOC program. The application will collect demographic and treatment outcomes 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. Currently, the YOQ data is being migrated to the system. In the near future the substance abuse treatment data from ADMIS will be migrated into the EDW system.

DBHS is currently exploring the possibility of acquiring an integrated web-based data based system similar to the functionalities of the WITS system. During recent reorganization of the division, an office of Quality Assurance was formed with Dr. Kazi Ahmed as its director. The Division recently also hired a new Director of Data Management. The office of Quality Assurance is upgrading 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.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

R. Quality Improvement Plan

The Division of Behavioral Health Services (DBHS) Continuous Quality Improvement (CQI) strategies involve commitment to ensure that quality substance abuse and mental health services are provided to those who are in need. DBHS strives to ensure that the services are appropriate to each consumer's need, easily accessible, consumer focused, evidence-based, and of high quality. DBHS strives to encourage consumers and families to participate in its CQI efforts.

Following are the primary actions steps implemented by DBHS to ensure continuous quality improvement:

- All licensed substance providers are being monitored by their daily and monthly data submissions by admissions and discharges in key performance measurements. Each quarter all funded substance abuse providers are given their performance indicators by their averages that are compared to the state averages with a colored dashboard that indicates equal to the state, area to target, and exceeds the state. Furthermore, at the end of the state fiscal year, they are given their performance measurements to indicate their measurements for the state fiscal year. The measures are using the national outcome measures. This data is used to establish the baseline for future expectations. These are sent by e-mail to each provider for their feedback, and then discussed at quarterly meetings for the licensed providers with DBHS.
- All substance abuse and mental health providers give clients a satisfaction survey to measure the outcomes of their facilities. If the client has a compliant or grievance, an ombudsman investigates and addresses the complaints of maladministration or violation of rights.
- All mental health stakeholders are given a Mental Health Customer Satisfaction Survey. Related questions were combined to form domains of various aspects of client satisfaction. Both the adult and child/adolescent surveys measure the domains of satisfaction with access, outcomes, participation in treatment planning, and overall satisfaction with services, as well as social connectedness and improved functioning.
- DBHS has a Policy and Procedures that govern the providers for support, services, emergencies, critical incidents, complaints, and grievances.
- A Senior Auditor at the Department of Human Services (DHS) Division of Medical Services (DMS), the Arkansas Medicaid agency conducts programmatic, operational/performance compliance, and financial-related audits of the stakeholders. DMS reviews the financial information to ensure compliance with established criteria, policy, and regulations.
- A DBHS Auditor confirms the providers' compliance of their programs, financial, policy and procedures and their services.
- Future plans to improve quality of administrative and services delivery include the full implementation of the National Outcomes Measures (NOMS) and other quality measures into an integrated data infrastructure system.

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans available on the SAMHSA website at here.

Footnotes:

S. Suicide Prevention

Arkansas has had several suicide taskforces, initiatives, stakeholder meetings, and attempts to combat suicide throughout the state of Arkansas. However, the lack of funding, a committed and sustained effort for coordination, and an organized network of key stakeholders have lagged the momentum.

Arkansas has been unsuccessful in its attempts to secure specific funding the Garrett Lee Smith Memorial Grant through SAMHSA. It was cited as the lack of infrastructure and evidence of need as the reason for not rewarding.

According to the Arkansas Department of Health (2010) Arkansas is ranked #15 among all other states with the highest rates of completed suicide. Almost 1,700 Arkansans were hospitalized from attempted suicide and almost 450 Arkansans died from completed suicide. Arkansas suicide rate was almost 30% higher than the national rate.

The Division of Behavioral Health Services (DBHS) recognizes that suicide and attempted suicide is a public health issue in Arkansas. Administrators assigned staff to look at model programs in other states, research existing resources in the state, and assess what needed to happen to start the process of a coordinated state effort. DBHS created and designated a full-time staff position of a Statewide Suicide Prevention Coordinator to implement, facilitate, and maintain suicide prevention efforts for the state. The planning of a Suicide Prevention Resource Center is on-going.

The creation of the Statewide Suicide Prevention Initiative (SSPI) is following the Strategic Prevention Framework Model of Assessing to identify the programs, efforts, and initiatives currently ongoing in Arkansas. Capacity building occurred through inviting key stakeholders that are working in the suicide prevention, intervention, and treatment field to be a part of the SSPI. Arkansas will be using a collaborative approach to combating suicide, recognizing that not one agency can work alone and that strength and ingenuity comes from having all partners at the table.

The planning phase is on-going, but has thus far consisted of a kick-off meeting for the SSPI held on February 1, 2013. Over 60 key stakeholders from all over the state, representing numerous agencies, organizations, foundations, and programs participated in the process of updating the State Suicide Prevention Plan to be congruent with the National Strategies for Suicide Prevention and setting goals. A second meeting occurred in May 2013 where a work plan was created using the State Plan and tasks were assigned. Memorandums of Understanding will be signed to solidify these tasks and relationships. The Statewide Suicide Prevention Coordinator from DBHS will be responsible for making sure that the plan, goals, and objectives are followed, implemented, and reported.

The SSPI is a welcomed leader in suicide prevention with the state stakeholders. Positive feedback has been given that there is a designated position to coordinate and sustain the momentum. The top three goals from the first SSPI meeting are: 1) Organize the statewide infrastructure, 2) Start the process of collecting reliable data, and 3) Investigate additional funding opportunities.

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.

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans to work with organizations such as FQHCs, hospitals, community-based organizations, and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

T. Use of Technology

Currently Arkansas' Division of Behavioral Health Services (DBHS) does not deploy Interactive Communication Technology (ICT). However, in 2007, DBHS successfully negotiated with SAMHSA to allow the use of its Co-Occurring State Incentive Grants (COSIG) fund to set up a behavioral health teleconferencing network. DBHS collaborated with the University of Arkansas for Medical Sciences (UAMS) to implement this technology. The technology linked community mental health centers and substance abuse providers through a COSIG-funded T1-lines (High Speed and Broad Internet Connection) and teleconferencing equipment. As an interactive communication technology, the initiative has improved access to prevention, treatment, and recovery services throughout the state, especially in rural areas with limited services. The initiative also extended the providers' ability to offer services across their catchment areas more efficiently. Many providers used the teleconferencing network to conduct training, provide consultation, join statewide meetings, and connect to several service locations. DBHS has not been successful in sustaining the teleconferencing program. The program ended in 2011 when grant funding ended. DBHS will seek future funding to revive this teleconferencing technology.

The following are some possible applications of ICTs the State will consider exploring and implementing:

- Through re-establishing full teleconferencing capabilities, DBHS could hold 'distance' Learning Communities, an approach that fosters shared understandings and collaborative working relationships, both hallmarks of Recovery-Oriented Systems. Establishing facilitated, structured Learning Communities that specifically target addictions and mental health shared awareness of both similar and divergent approaches regarding what is and is not successful. This tactic helps align concepts, such as how recovery is conceptualized and implemented.

- ICT can serve as a clearinghouse or resource list that provides a diverse menu of services and supports that promote choice and individualized approaches. Along with the list of resources, the ICT can offer linkages with community supports and services that are being seen as essential to sustaining recovery, for mental health, addictions, co-occurring disorders and trauma. ICT would be fostering recovery orientation based on community integration and inclusion principles.

- ICT can provide linkages to national recovery-based web-sites, such as Faces and Voices of Recovery for Additions and the National Coalition for Mental Health Recovery. Both are nationally recognized organization representing people in recovery from addictions and mental health problems, serve as clearinghouses, lobbying activities in Washington, D.C., and advocating for behavioral health. Many states have their own chapter. This use of ICT addresses grassroots mobilization of peers, family members and other allies who understand that the entire community has a role to play. Including this information may foster development of such organizations within Arkansas.

- ICT can serve as a clearinghouse to support various agencies, people with lived experience, supporters, and providers and other stakeholders, to alert of changing regulatory/physical environment, policies and procedures, enlisting community support.

This would bring about more alignment supporting recovery-oriented services and supports. One example could be information about what kinds of clinical practice changes support integration of peer-based support services – what they cover, the who, what, when, where and how of the practice, etc.

- ICT can provide some on-line approaches and information about some conditions such as trauma, with the Trauma-Self-Help Workbook, completing Psychiatric Advanced Directives. Such an approach helps shift from a culture of care-taking to empowerment and self-direction.

- ICT could make available, and offer Technical Assistance, for practice guidelines and resource toolkits developed to support providers with successful implementation.

- Social media, such as Facebook, Blogs, Twitter, etc. are especially popular with younger people. ICT could be utilized to take advantage of this type of media to disseminate information.

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. The state should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

Arkansas Department of Human Services Division of Behavioral Health Services Technical Assistance Plan
Developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) State Technical Assistance Project

Prioritized TA from the 2012 Technical Review	TA Objectives	TA Strategies and Tasks	Responsible Party
1. Update State's ability to plan for and allocate services	Develop a strategic planning process	Provide the State up to 15 days of on- and offsite TA to help the State develop a strategic plan that would allow all DBHS staff and various external stakeholders to define the organization's direction and the direction of behavioral health care in the State of Arkansas. Staff and stakeholder involvement will help put everyone on the same page, allowing DBHS to cohesively integrate services, improve quality or care, and uphold federal requirements.	Julie Meyer (to coordinate)
2. Increase capacity to measure service outcomes	Identify outcome measures	Provide the State up to 7 days of on- and offsite TA to identify specific outcomes the agency will focus on and to develop a plan for how the collected outcomes will inform which services the State purchases in the future.	Kazi Ahmed
3. Transition to a recovery oriented system of care (ROSC)	Develop plan to move from acute services to ROSC model	Provide the State up to 12 days of on- and offsite TA to help develop a plan to move from acute services to a recovery oriented system of care model that considers Department of Human Services' (DHS) Medicaid budget shortfalls, upcoming Medicaid Expansion, DHS' Payment Improvement Initiative, and DHS' transition to the health home model.	Frank Vega and Paula Stone
4. Increase responsiveness to client concerns	Develop protocol for handling and tracking client concerns	Provide the State up to 5 days of on- and offsite TA to develop a protocol for handling and tracking concerns regarding behavioral health care in Arkansas and to develop a consistent, system-wide complaint process to ensure DBHS involvement, when necessary, and to use complaints to facilitate systems improvements and a higher quality of care. The State will develop a policy to ensure an appropriate investigation of these events.	Linda Northern

5. Strengthen workforce of State staff	Develop training/curriculum plan	Provide the State up to 10 days of on- and offsite TA to develop a training/curriculum plan for internal DBHS staff and staff at behavioral health facilities. Cultural competency and the treatment of individuals with comorbid conditions are among the training priorities.	Julie Meyer
6. Standardize and update service definitions	Assess and research uniform service definitions	Provide the State up to 7 days of on- and offsite TA to help standardize and update service definitions. Specifically, the State is asking to help with assessing and researching service definitions that it can use across the behavioral health system. The definitions will need to be inclusive of recovery oriented services. The TA might include an evaluation of Arkansas' array of current service definitions and an evaluation of service definitions nationwide.	Frank Vega and Paula Stone
7. Improve provider accountability to service and fiscal requirements	Assess/address how providers' rules of practices might be updated	Provide the State up to 10 days of on- and offsite TA to develop a plan to assess and address how contracts and substance abuse providers' rules of practice might be updated, including outcome measures collection, adherence to Federal block grant fiscal requirements, and the treatment of comorbid conditions.	Frank Vega

Arkansas Division of Behavioral Health Services Strategy

Developed for the

Arkansas Department of Human Services

Division of Behavioral Health Services

AR-30

June 2013

Prepared under the

Substance Abuse and Mental Health Services Administration
State Technical Assistance Project

Contract No. HHSS283201200002I/HHSS28342001T

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I. Introduction

A. Purpose of the Technical Assistance

In May 2013, the Substance Abuse and Mental Health Services Administration (SAMHSA) State Technical Assistance Project (State TA Project) finalized a comprehensive TA plan for the State of Arkansas. The plan was based on the state's Center for Substance Abuse Treatment Technical Review. This report reflects TA delivered under the State TA Project in accordance with the TA plan. Specifically, the State TA Project provided TA to the Arkansas Department of Human Services' (DHS) Division of Behavioral Health Services (DBHS, or "Division") regarding initial steps in a strategic plan to guide the Division in several critical policy and program management issues confronting the behavioral health system. The TA was provided under the State TA Project. JBS International, Inc. (JBS) is the State TA Project contractor. JBS is a health and human services consulting firm based in North Bethesda, MD. David Wanser, Ph.D., of JBS and Michael Hogan, Ph.D., of Hogan Health Solutions LLC delivered the TA.

Arkansas is proceeding with Medicaid expansion as permitted under the Affordable Care Act (ACA) by utilizing a private insurance model approved by the Centers for Medicare and Medicaid Services. There are also planning efforts underway concerning the use of other waiver options and State Plan Amendments (SPAs) to the Arkansas Medicaid plan. The major shifts in Medicaid organization and financing will have a significant impact on the publicly funded behavioral health system. Presently, there is a significant level of complexity in the identified provider system, with distinct funding and oversight activities for substance abuse providers, community mental health centers, and certified private providers of psychosocial rehabilitation services.

The Division has experienced considerable senior management turnover over the past few years and was anticipating the appointment of a new Director within a few weeks of the TA. Against this backdrop is the need to work toward policy and administrative consolidation across mental health and substance abuse services offices within the Division, including efforts to reform contracting, data collection, and payment practices. The convergence of changes being contemplated by the Division, Medicaid structural and financing changes, and a desire to strengthen the use of evidence-based practices has contributed to the desire to develop a planning framework that can assist leadership and stakeholders in shaping the future of the behavioral health system in order to provide optimum service and supports for individuals in need of behavioral health services. This will entail the creation of new or modified financing models, planning for how to administer SAMHSA Block Grant funding, and movement toward integrated service provider networks.

During the May 16–17, 2013, visit, Drs. Wanser and Hogan met with the DBHS Senior Management Team and with staff from Adult and Recovery Services, Prevention and Children's Services, Block Grant Planning, Behavioral Health Planning and Advisory Council, and Data Management. They also met with DHS Medicaid leadership.

B. Consultants' Background

Michael Hogan, Ph.D., served successfully as Commissioner/Director of Mental Health in the States of Connecticut, Ohio, and New York before leaving public service in late 2011 to form Hogan Health Solutions LLC. Dr. Hogan chaired the President's New Freedom Commission on Mental Health in 2002 and 2003. He served on the National Institute of Mental Health's National Advisory Mental Health Council from 1994 to 1998, as Board President of the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. from 1999 to 2001, and as President of NASMHPD from 2003 to 2005. He was appointed the first representative of the behavioral health field on the board of The Joint Commission in 2007.

Dave Wanser, Ph.D., became the Technical Expert Lead for Health Information Technology at JBS International in August 2012. He most recently served as Senior Clinical Consultant for Intellica, a public

sector focused health information technology company and as a consultant with a private practice focusing on behavioral health, health reform, and healthcare technology. He was a Visiting Fellow at the Lyndon B. Johnson School of Public Affairs at the University of Texas at Austin from 2007 until 2010, and he was a lecturer in the Health Information Technology Program within the College of Natural Sciences. Dr. Wanser was Executive Director of the National Data Infrastructure Improvement Consortium (NDIIC) from 2007 until 2010. He served as the Deputy Commissioner for Behavioral and Community Health at the Texas Department of State Health Services, the consolidated department for mental health, substance abuse and public health, during the first 3 years after its creation in 2004. He was appointed Executive Director of the Texas Commission on Alcohol and Drug Abuse in 2001 and served in that role for 3 years. For 15 years before that, he was the Director of Behavioral Health Services and the Director of the NorthSTAR Managed Behavioral Health Program among other management positions within the Texas Department of Mental Health and Mental Retardation.

Dr. Wanser is past president of the Board of Directors of the National Association of State Alcohol and Drug Abuse Directors, past president of the Board of Directors of NDIIC, and past chairperson of the Adult Services Division of the National Association of State Mental Health Program Directors. He has served on advisory boards for several other national and federally sponsored organizations, including advisory boards for the Department of HHS Health Information Technology Policy Committee Privacy Workgroup and the Certification Commission for Health Information Technology Behavioral Health Workgroup. He was a member of the Texas Health Services Authority Workgroup on Electronic Health Record Adoption and Consumer Engagement, a member of the Workgroup on Privacy and Security, and on the Board of Directors of the Austin, TX chapter of the Health Information and Managements Systems Society. Dr. Wanser received a Ph.D. in psychology from the University of Oklahoma, where he was recognized as a distinguished alumnus in 2005.

II. Technical Assistance Summary

A. Methodology

A structured and sequential Scope of Work was developed for the TA and entailed the following objectives:

1. Gaining a comprehensive picture of the current policy and financing drivers and constraints across the behavioral health and Medicaid components of the state government and existing provider system.

2. Assisting the Division's leadership team in developing an organizing framework to inform and structure both short-term and longterm planning efforts.

3. Developing a work plan to structure and guide stakeholder input into a comprehensive strategic planning effort.

4. Summarizing next steps and providing guidance for the Division and its stakeholders a report that includes recommended action steps in the following areas: organization of the system of care, data strategies, policy needs, and communication and collaboration strategies.

B. Observations

Arkansas has a thoughtful and aggressive plan to transform the state's behavioral health system. The core of this plan is reform of Medicaid funded behavioral health services that have emphasized poorly directed Medicaid Rehabilitation Option services, with little integration of health, mental health, and substance abuse services. There are high levels of Medicaid-paid residential treatment services for children and youth. Diversion alternatives to inpatient and residential services are limited. There is low use of evidence-based and resilience- and recovery-oriented services in Medicaid.

The core of the state's transformational approach in Medicaid is the development of (behavioral) Health Homes under an SPA that will also use the 1915(i) option as both a pathway to allow matching consumers to appropriate levels of care and as a vehicle to ensure person-centered planning for people receiving Health Home services. The intention is to use System of Care principles to guide development of child/adolescent Health Home services and to reconfigure Block Grant services to support and complement Medicaid services.

The global strategy is commendable. It has been developed under strong collaboration between Medicaid and DBHS. But the challenges Arkansas faces are substantial:

- There has been great instability in the Division's top leadership, with six Directors/Acting Directors in the past few years. Proceeding with rapid and complex change during a leadership transition is challenging. The DBHS Senior Leadership Team is dedicated and coherent, but the team will have to welcome and adjust to a new Director. Achieving a successful transition to new leadership while moving the Division-defined initiatives and keeping pace with the Medicaid policy initiatives will require management support and a well-executed plan.

- The scope and pace of change will be unprecedented for Arkansas providers and consumers, and all issues, concerns, and challenges will affect or become the responsibility of DBHS staff. Contingencies to develop provider readiness and anticipate and handle implementation issues and challenges should be considered. A concerted communication strategy to assist providers with readiness is critical, as they have historically been successful in delaying or derailing Division initiatives with which they have disagreed.

- Data management capabilities in DBHS have been focused on Block Grant and state General Fund programs; they will need to be re-oriented and retooled to address system transformation in

a Medicaid environment and to anticipate data requirements under Meaningful Use and Continuity of Care expectations. Development of a data strategy to inform planning in this area is critical.

- Key aspects of progressive behavioral health care (e.g., System of Care principles, wraparound services, prevention efforts) have been supported through SAMHSA grants. The challenge now is to install these principles and practices across a much larger Medicaid behavioral health system. Related to this, planning and executing the best approach to use Block Grant resources in the context of system/Medicaid transformation needs continued attention.

- Although the collaboration between Arkansas' DBHS and Medicaid offices has been excellent, issues remain in the design and implementation of dramatically changed Medicaid services. For example, approaches to treating substance abuse for consumers who will be enrolled in Health Homes need continued attention. DBHS has been integrated administratively, but service integration is far more complicated. In addition, the design for the Health Homes has not been tested and is only in the design stage. Successful implementation will require a much more concerted and collaborative effort between the Division, Medicaid, and providers.

- Assuring that additional TA is well integrated and staged with system transformation activities, and that TA activities are well coordinated and driven by the priorities of DBHS leadership, is essential.

- Quality of care challenges at the Arkansas State Hospital (located in Little Rock next door to the DBHS offices) remain, although the hospital has emerged from the worst stages of quality problems. The director of the hospital reports directly to the DBHS Director; given the intensity of managing quality crises, further issues could be an immense burden and a distraction or could impede system transformation.

C. Recommendations

DBHS might consider the following actions:

- Convene an offsite leadership session or retreat with the new Director to cement relationships, accelerate good working relationships, and refine the aggressive transformation plan to the new Director's expectations.

- Develop plans and contingencies to facilitate implementation of reform activities. Plans to accomplish this could be initiated in the work session described above. A good deal of attention has gone into reform design; less has been paid to implementation and maintenance strategies and to identification and mediation of risks.

- Provide discrete attention to creating a data strategy that can support transformation, with a particular focus on moving into a Medicaid environment and to the data requirements that will support reform expectations under the ACA. Provider readiness in the areas of access to electronic health records, ability to interact with health information exchanges, streamlining data collection, and producing credible decision support tools requires significant attention.

- Refine proposals for TA in the context of these changes to ensure TA is goal-focused, builds capacity, and aligns with emerging expectations under leadership succession.

- Continue close collaboration with Medicaid staff. Behavioral health issues are rightly seen as central to successful reform; this is a major strength of Arkansas' efforts. However, designing deep and rapid change across Division lines is challenging. DBHS staff should use assistance as needed to ensure behavioral health approaches are appropriately integrated and attended to in reform. A focused effort across the Division and Medicaid should be made to anticipate the types

of information needed for managing the successful implementation of these initiatives and ensuring the availability of timely and accurate data to support decisionmaking.

- Support efforts to improve integration of substance abuse services into the Health Homes and other health-reform-related initiatives. Assist providers in making needed changes to make this possible.

D. Outcomes

Arkansas has a broad, aggressive, and appropriate agenda for reform that “bakes” behavioral health issues into its recipe for Medicaid reform. The agenda defines behavioral health as integral to overall health and intends to transform existing mental health services and integrate them. Core behavioral health values and approaches (e.g., resilience, recovery, integral roles for peer and family support, trauma-informed care) can help transform the larger health system.

These system transformation efforts will have a profound impact on the existing provider system. Communication efforts with providers should be initiated and should include Division and Medicaid leadership; such efforts need to impress upon providers the importance of business and clinical practice realignment as an essential ingredient for their continued ability to participate in the transformed system.

The direction is sound. However, not only is the scope of change dramatic, it is occurring during a leadership change period that follows substantial leadership flux. The central objective of TA is to help Arkansas achieve what it desires:

- Move behavioral health into the healthcare mainstream while changing virtually every aspect of service delivery.
- Expand behavioral health values and approaches from a few grant-funded programs to the entire system.
- Stage reform so it does not stall or crash.
- Create a data strategy that can inform change.
- Efficiently manage on an ongoing basis.

The end result of TA will be fused with the end results of transformation itself.

Short-Term Action Plan

Task	Timeline	Intended result
Plan and conduct executive retreat, and formalize action steps with new Director	Prior to August 1, 2013	A specific set of priorities and action steps identified, lead staff identified, and intended results defined in measureable terms
Align TA plan with action plan above, and initiate these efforts	Prior to August 20, 2013	TA needs will be prioritized and agreed upon, responsible parties will be identified as needed
Develop Health Homes readiness and decision support tools to assist providers and state leadership	Prior to October 15, 2013	Increase likelihood of project success by assisting all participants with access to information intended to improve client outcomes
Assist substance abuse treatment providers in making needed changes to ensure continued viability and inclusion of substance abuse services in Medicaid benefit packages	Prior to October 15, 2013	Seek alignment across Division and Medicaid on strategies to improve health and behavioral health outcomes by addressing substance use issues with covered populations. Increase ability of provider system to participate in Health Home efforts.

Substance Abuse and Mental Health Services Administration

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U. Technical Assistance Needs

The Division of Behavioral Health Services (DBHS) currently has an open and ongoing Technical Assistance Plan through the Substance Abuse and Mental Health Services Administration (SAMHSA) State Technical Assistance Project. The DBHS Technical Assistance Plan allows for technical assistance in the following areas:

- Update State's ability to plan for and allocate services
- Increase capacity to measure service outcomes
- Transition to a recovery oriented system of care (ROSC)
- Increase responsiveness to client concerns
- Strengthen workforce of State staff
- Standardize and update service definitions
- Improve provider accountability to service and fiscal requirements

DBHS is currently pursuing the first area of technical assistance and is currently in the midst of developing a strategic plan through provided technical assistance.

In addition to the SAMHSA Technical Assistance Project, DBHS is 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..

DBHS is also currently in the midst of a BRSS TACS Policy Academy. The Division and a diverse workgroup are working with SAMHSA technical assistants to develop a comprehensive Action Plan for Workforce Development for Medicaid Reimbursable Certified Peer Specialists. This will include implementation that brings recovery supports to scale in the context of the application of the Affordable Care Act.

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.

Technical assistance for state staff would be most beneficial in the following areas:

- Cross discipline (mental health and substance abuse) training to progress the integration of behavioral health services in the agency and state, and to ensure state staff is prepared to assist providers in the integration services;
- Cultural competence training to ensure state staff are equipped to implement services applicable and sensitive to special populations; and
- Contracting with providers to supplement the Affordable Care Act.

In addition, as the behavioral health providers prepare for the implementation of Medicaid Expansion through the Private Option, the Insurance Exchanges, and Medicaid Transformation,

the providers must adjust their business model and practices. The providers would most benefit from technical assistance in adjusting their business model to new billing mechanisms, different performing provider qualifications, eligibility and enrollment, and the usage of Health Information Technology. In addition, assistance in preparing providers to employ and work with peers would be beneficial to the system and consumers.

IV: Narrative Plan

V. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. In addition, the state should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the state education authority(ies), the State Medicaid Agency, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan.[45] This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The state justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

45 SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

V. 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.

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 Drug Court Advisory Council.

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.

Arkansas Foundation
for Medical Care℠
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July 30, 2013

Ms. Joy Figarsky
Director, Arkansas Division of Behavioral Health Services
305 South Palm Street
Little Rock, AR 72205

RE: Support for a data informed system of care and prevention in Arkansas

Dear Ms. Figarsky:

I am happy to write a letter of support and recommendation for the implementation of the Arkansas plan to move further toward a comprehensive data informed system of care and prevention. We are pleased to partner with the Arkansas Division of Behavioral Health Services (DBHS), and have worked closely with your division since 2005 on annual surveys on behalf of the DBHS and the Division of Medical Services (DMS). The partnership between AFMC and the Arkansas Department of Human Services goes back more than 20 years in various analytic, review and survey activities and leveraging this relationship, we will be able to maximize the impact of this grant in Arkansas by appropriately investing in infrastructure that will benefit our state.

Working collaboratively, we have made great strides in many accomplishments including but not limited to:

1. Developing an epidemiological workgroup with a substance abuse prevention focus;
2. Working toward identifying data needs/gaps and develop a set of key indicators (across the life-span) for use in products that inform prevention planning;
3. Collecting , analyzing, and profiling these data to create informative products including epidemiological profiles, dissemination products, etc;
4. Assisting the State and its communities to use these data/products to inform prevention planning; and
5. Building and enhancing a substance abuse monitoring system to track emerging priorities and assess progress.
6. Deploying a comprehensive website to assist with dissemination efforts of the State Epidemiological Outcomes Workgroup.

Medicaid Managed Care Services (MMCS) ■ 1020 West 4th Street, Suite 210 ■ Little Rock, AR 72201 ■ 501-375-1200 ■ Fax: 501-375-1201

We look forward to a timely and effective implementation upon award and are eager to strengthen our partnership to continuously improve care and prevention in Arkansas by promoting data driven decision making. Please feel free to contact us with any questions.

Sincerely yours,

Jason Scheel, MBA
Director, Analytics
Arkansas Foundation for Medical Care
1020 West 4th Street, Ste. 210
Little Rock, AR 72201
Phone: 501-212-8666
Fax: 501-375-1201
jscheel@afmc.org
www.afmc.org

ADMINISTRATIVE OFFICE OF THE COURTS
SUPREME COURT OF ARKANSAS
KARI E. POWERS, STATE DRUG COURT COORDINATOR

JUSTICE BUILDING
625 MARSHALL STREET
SUITE 1100
LITTLE ROCK, AR 72201-1020

TEL: 501-410-1944
FAX: 501-682-9410
TDD: 501-682-9412
EMAIL: kari.powers@arkansas.gov

July 31st, 2013

Ms. Joy Figarsky
Director, Arkansas Division of Behavioral Health Services
305 South Palm Street
Little Rock, AR 72205

RE: Support for a SAMHSA block grant application

Dear Ms. Figarsky:

I am happy to write a letter of support and recommendation for the Department of Behavioral Health Services application for block grants that provide funding for community based substance abuse and mental health treatment and prevention.

The Administrative Office of the Courts and Division of Drug Court Programs fully support the DBHS in their efforts to provide access to substance abuse and mental health treatment services to thousands of Arkansans. The AOC and DBHS work together to bring these services to the juvenile and adult drug court programs. For instance, the DBHS is an active voice on our state Drug Court Advisory Board since board inception in 2007. The advisory board, through statutory authority, was established to promote collaboration and provide recommendations on issues involving drug courts. The committee may provide advice and review on issues such as data collection, evaluation and program development.

The partnership between the Division of Drug Court Programs and the DBHS has been developed through their mutual efforts to ensure that the treatment needs of justice involved individuals within the juvenile and adult drug court are met. Treatment services are a necessary component of drug courts and must be available to adequately ensure that participants gain the full benefits of the program. Through this agency collaboration, both are able to continue a commitment to the drug court model, evidence based practices and support of community providers.

The Administrative Office of the Courts, Drug Court Division, wholeheartedly supports the goals set forth in this application.

Sincerely,

Kari E. Powers, MLA
State Drug Court Coordinator

Mental Health Council of Arkansas

Birch Tree Communities, Inc.
PO Box 1589
Benton, AR 72018-1589

Centers for Youth & Families
PO Box 251970
Little Rock, AR 72225-1970

Community Counseling, Inc.
125 Dons Way
Hot Springs, AR 71913

Counseling Associates, Inc.
350 Salem Rd., Suite 1
Conway, AR 72032

Counseling Clinic, Inc.
307 East Sevier Street
Benton, AR 72015

Delta Counseling Associates, Inc.
790 Roberts Drive
Monticello, AR 71657

Health Resources of Arkansas, Inc.
PO Box 2578
Batesville, AR 72503

Little Rock Community Mental Health Center, Inc.
PO Box 250337
Little Rock, AR 72225

Mid-South Health Systems
2707 Browns Lane
Jonesboro, AR 72401

Ozark Guidance Center
PO Box 6430
Springdale, AR 72766

Professional Counseling Associates, Inc.
PO Box 24210
Little Rock, AR 72211

South Arkansas Regional Health Center, Inc.
715 North College Ave.
El Dorado, AR 71730

Southeast Arkansas Behavioral Healthcare System, Inc.
PO Box 1019
Pine Bluff, AR 71613

Southwest Arkansas Counseling & Mental Health Center
PO Box 1987
Texarkana, AR 75504

Western Arkansas Guidance Counseling & Guidance Center, Inc.
PO Box 11818
Fort Smith, AR 72917-1818

August 16, 2013

Ms. Joy Figarsky
Director, Arkansas Division of Behavioral Health Services
305 South Palm St.
Little Rock, AR 72205
RE: Support for Block Grant Application

Dear Ms. Figarsky:

We are very pleased to write this letter of support and recommendation for the Department of Behavioral Health Services (DBHS) application for block grants that provide funding for community based mental health and substance abuse treatment and prevention.

The Mental Health Council of Arkansas, the State Association representing all the Community Mental Health Centers for the entire state of Arkansas, fully supports the DBHS in its efforts to provide access to mental health and substance abuse treatment services for thousands of Arkansans each year. The Council and DBHS work together to bring these services to individuals and families who may be uninsured or who cannot afford to pay full fee for these services. The Council and DBHS team members meet every month, and in particular, are focused on making sure mental health services are available to the most vulnerable – adults and juveniles in jails, adults on conditional release, adults with serious mental illnesses and children with severe emotional disturbances.

The collaboration between the Council and DBHS has been developed through their mutual efforts to ensure that the most vulnerable individuals with multiple needs have access to critically needed mental health services. These treatment services are vital to the recovery of individuals with serious mental illnesses and to their ultimate mental wellness.

The Mental Health Council of Arkansas wholeheartedly supports the DBHS application for block grants.

Sincerely yours,

Tom Petrizzo

Tom Petrizzo, President
Mental Health Council of Arkansas

Pam Christie

Pam Christie, Executive Director
Mental Health Council of Arkansas

501 Woodlane, Suite 136S, Little Rock, AR 72201
Phone: (501) 372-7062 Fax: (501) 372-8039
Email: mhca@mhca.org Website: www.mhca.org

ARKANSAS DEPARTMENT OF HUMAN SERVICES

Division of Medical Services
Medicaid Director's Office

P.O. Box 1437, Slot S401 · Little Rock, AR 72203-1437
501-682-8292 · Fax: 501-682-1197

July 29, 2013

Joy Figarsky, Director
Division of Behavioral Health Services
305 S. Palm
Little Rock, AR 72205

Dear Ms. Figarsky:

I am writing to confirm our commitment to continue partnering with you in support of building health homes for individuals with chronic behavioral health conditions and consultation on the benefits available to the expanded Medicaid population.

The goals of these projects are consistent with the goals of both Arkansas Medicaid and the Arkansas Division of Behavioral Health Services to promote use of quality, evidence-based behavioral health treatment services. We are interested in seeing high quality services available the citizens of Arkansas in keeping with the Arkansas Department of Human Services mission that together we improve the quality of life of all Arkansans by protecting the vulnerable, fostering independence, and promoting better health.

Sincerely,

Andy Allison

Andy Allison Ph.D
Medicaid Director

AA/AC/jm

August 21, 2013

Ms. Joy Figarsky, Director
Arkansas Division of Behavioral Health Services
305 South Palm Street
Little Rock, AR 72205

RE: FY 2014-2015 SABG/MHBG Behavioral Health Assessment and Plan

Dear Ms. Figarsky,

At the most recent meeting of the Arkansas Alcohol and Drug Abuse Coordinating Council (AADACC), the review of the above referenced plan was conducted and approved. The AADACC supports the efforts outlined that will provide critical and much needed substance abuse and mental health services to the citizens of Arkansas. The plan sets forth a comprehensive and coordinated program that supports the philosophy of effective community-based and community-supported services.

AADACC and the Office of the Drug Director urges SAMHSA to fully fund and to allow the implementation of the SABG/MHBG Behavioral Health and Assessment and Plan for FY 2014-2015.

Sincerely,

Fran Flener
State Drug Director

#1 State Police Plaza, Little Rock, Arkansas 72209. Ph: (501) 816- 8690 Fax: (501) 816-8841

ARKANSAS BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

August 16, 2013

The Arkansas Behavioral Health Planning and Advisory Council (ABHPAC) continues to enjoy a strong, consultative relationship with the leadership team within the Division of Behavioral Health Services (DBHS) in Arkansas. As the primary author of the Mental Health Block Grant state plan, DBHS supports ABHPAC and the ABHPAC Block Grant subcommittee by providing meeting facilities, travel expenses for volunteer members, and administrative support during the review and recommendation process. ABHPAC was not actively involved in establishing the state's block grant priorities for this application. This was due primarily to changes in personnel and responsibilities at DBHS resulting from natural attrition and role integration at the state level of substance abuse and mental health. The planning process for this block grant application was further complicated with the timing of implementation of the Affordable Care Act. The council had record participation (up to 17 individuals actively engaged and 40 hours of group meetings during the review and recommendation process, for a total of 450 hours of group work in addition to personal time given by members) involving stakeholders from both the substance abuse and mental health arenas. ABHPAC has provided multiple recommendations for this application which are included in the Appendix of this application. Given the unanticipated timing of external factors, we are confident the role of the planning council will deepen and extend to the priorities phase with future applications. The priorities included in the application are strong reflections of the state's activities and also the commitment to progress towards a vision of behavioral health recovery in Arkansas and the acknowledged value of individuals with personal behavioral health experiences as well as their family members.

It is important to note that ABHPAC enjoys unfettered access to both the Policy Director who leads the Block Grant application team and also the Director of the Division of Behavioral Health. These individuals set the direction and focus of not only Arkansas' block grant efforts but behavioral health as a whole for the state. ABHPAC's executive team has participated in leadership training with key DBHS personnel, has a diverse group from DBHS engaged at the council's annual retreat, and met with key individuals at DBHS to review and make recommendations in person for this application.

ABHPAC sees many opportunities for progress in Arkansas through the goals included in the Block Grant application. For example, the council is poised to play an instrumental role in monitoring, reviewing and evaluating the adequacy of behavioral health services in Arkansas. Instruction and review of a monitoring tool was included in the council's annual retreat (August, 2013) and we are eager to take the next step. This year, the council has made additional progress towards an integrated council with new members joining from key stakeholder groups in the substance abuse and recovery community.

The members of ABHPAC take the responsibility to the block grant process as a primary concern and have shown a tremendous commitment to the process as it has emerged this year in our joint application. We had active and considerable participation in reviewing the application from mental health and substance abuse treatment stakeholders, including providers and individuals with lived experience. One of the challenges facing DBHS to integrate the Block Grant process is Arkansas Statue 20-64-1003 which creates and empowers the Arkansas Alcohol and Drug Abuse Coordinating Council. Part A states that the 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.* ABHPAC is actively seeking engagement with the leadership of the Council to further efforts to collaborate in recovery efforts throughout the state.

In closing, it is an exciting time in Arkansas in behavioral health. This Block Grant application appears to be the jumping off point for a very dynamic vision of recovery, recovery support, and person driven engaged behavioral health transformation for Arkansas. ABHPAC itself is an example of this beginning. We have informed and committed voices on our council from the intellectual disability community, the Disability Rights Center of Arkansas' Protection and Advocacy for Individuals with Mental Illness (PAIMI), the Arkansas Alcohol and Drug Abuse Coordinating Council, the consumer councils with community mental health providers, provider organizations in both mental health and substance abuse, and stakeholders within state government including vocational rehabilitation, behavioral health, and Medicaid. The executive leadership of ABHPAC consists of individuals and family members of lived experience and recovery in mental health and substance abuse. We look forward to continuing our work with behavioral health stakeholders throughout the state as we navigate the opportunities that lay before us.

Sincerely,

Loretta F. Cochran, Ph.D.
Chairperson

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:

ARKANSAS ALCOHOL AND DRUG ABUSE COORDINATING COUNCIL

Category	Member	Contact Information
Arkansas Drug Director	**Fran Flener, Council Chair**	#1 State Police Plaza Drive Little Rock, AR 72209 O: (501) 618-8690 C: (501) 554-9357 F: (501) 618-8841 E-mail: **frances.flener@arkansas.gov**
Director, Alcohol and Drug Abuse Prevention	**Frank Vega**	305 South Palm Street Little Rock, AR 72205 O: (501) 686-9875 F: (501) 686-9396 Email: **frank.vega@arkansas.gov**
Director, Arkansas State Police	**Colonel Stan Witt**	#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 F: (501) 618-8859 E-mail: **stuart.woodward@asp.arkansas.gov**
Director, Department of Education	**Dr. Tom Kimbrell**	#4 Capitol Mall, Room 202A Little Rock, AR 72201-1071 Main: (501) 682-4475 **Alternate: Don Kaminar** O: (501) 683-4905 F: (501) 682-7963 E-mail: **john.kaminar@arkansas.gov**
Director, Highway and Transportation Department	**Scott Bennett**	10324 Interstate 30 Little Rock, AR 72209 **Alternate: Ronald Burks, Chief** AR Highway Police P. O. Box 2779 Little Rock, AR 72203-2779 O: (501) 569-2421 F: (501) 569-2963 E-mail: **ron.burks@arkansashighways.com**
Director, Department of Correction	**Ray Hobbs**	P. O. Box 8707 Pine Bluff, AR 71611 **Alternate: Robert A. Parker** O: (870) 267-6325 F: (870) 267-6327 E-mail: **bob.parker@arkansas.gov**
Director, Department of Finance & Administration	**Richard Weiss**	1509 West 7th Street Little Rock, AR 72201 **Alternate: Doris Smith** O: (501) 682-5242 F: (501) 683-2598 E-mail: **doris.smith@dfa.arkansas.gov**

Adjutant General Arkansas National Guard	**Major General William D. Wofford**	Camp Joe T. Robinson, Box 16 North Little Rock, AR 72199-9600 O: (501) 212-5001 F: (501) 212-5009 **Alternate: COL Marcus Hatley** Camp Joe T. Robinson CD-DOMS Building #16412 North Little Rock, AR 72199 O: (501) 212-5494 E-mail: **marcus.r.hatley.mil@mail.mil**
Attorney General	**Dustin McDaniel**	323 Center Street, Suite 200 Little Rock, AR 72201 O: (501) 682-2007 F: (501) 682-8084 F: (501) 682-2591 **Alternate: Jake Jones** O: (501) 682-8131 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 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	**David Eberhard**	Two Union National Plaza, 2nd Floor Little Rock, AR 72201 O: (501) 682-9566 F: (501) 682-9539 E-mail: **david.eberhard@arkansas.gov** **Alternate: Dan Roberts** E-mail: **dan.roberts@arkansas.gov**
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 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 F: (870) 382-5667 E-mail: **ecox901@yahoo.com**
County Sheriff	**Sheriff Marty Moss**	Cleburne County Sheriff's Office 914 South 9th Street Heber Springs, AR 72543 O: (501) 362-8143 F: (501) 362-7386 E-mail: **ccso1@suddenlinkmail.com**
Drug Court Judge	**Judge Joe Griffin**	Eighth South Judicial Circuit Miller County Courthouse 410 Laurel, Suite 207 Texarkana, AR 71854 O: (870) 774-2421 F: (870) 772-4680 E-mail: **joeegriffin@cableone.net**
Prosecuting Attorney	**Larry Jegley**	224 S. Spring Street Little Rock, AR 72201 O: (501) 340-8000 E-mail: **larryj@dist6pa.org** **Alternate: Jason Ables** O: (501) 340-8000 E-mail: **Jasona@pulaskipa.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: **rwcovington@cox.net**
Director of a Publicly-Funded Alcohol and Drug Abuse Treatment Program	**George Weaver**	4601 W. 7th St. Little Rock Arkansas 72076 O: (501) 686-9380 F: (501) 686-9581 C: (501) 413-7843 E-mail: **georgeweaver@sbcglobal.net**
School Drug Counselor	**vacant**	
Director of a Drug Abuse Prevention Program	**Dennis Emerson**	P.O. Box 209 Poyen, AR 72128 O: 501-332-2939 C: 870-917-8976 F: 501-332-7809 E-mail: **emerson.dennis@poyenschool.com**

Director of a DWI Program	**Paul Dottley**	Delta Counseling, Inc. P.0. Box 175 Monticello, AR 71657 O: (870) 723-2555 E-mail: **p.dottley@deltacounseling.org**
-Health Professional	**Charlotte Denton**	2718 Bradley 16 Banks, AR 71656 O: (870) 460-1369 C: (870) 820-1422 F: (870) 460-1969 E-mail: **denton@uamont.edu**
Four members from the state at large, two of which shall be recovering persons	**Teresa Belew**	2123 Arkansas Valley Drive Little Rock, AR 72212 O: (501)671-1563 F: (501) 280-4729 C: (501)258-6037 E-mail: **teresabelew@yahoo.com**
	Norith Ellison	7001 West 41st Street Little Rock, AR 72204 O: (501)-568-3236 E-mail: **norithspks@sbcglobal.net**
	Erin Gildner	1619 Waldron CV Bryant, AR 72022 O: (501) 280-4030 C: (501) 920-1432 F: (501) 661-2388 E-mail: **erin.gildner@att.net**
	vacant	

REVISED 6/28/2013

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.

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 past 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.

State Chair, Arkansas Behavioral Health Planning Advisory Council

APPROVED:
This 15th day of February, 2012.

Director of the Division of Behavioral Health Services

W. State Behavioral Health Advisory Council

The state of Arkansas has a 27 member council, the Arkansas Alcohol and Drug Abuse Coordinating Council (AADACC), which 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) was not directly involved in the development of the block grant, the ABHPAC Block Grant committee (made up of 12 ABHPAC members and invited guest of those 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.

The integration of substance abuse prevention and treatment of ABHPAC is ongoing. In 2013, ABHPAC has succeeded in recruiting two substance abuse treatment. Also, the two consumer/family representatives from the Arkansas Alcohol and Drug Abuse Coordinating Council have become members of ABHPAC. ABHPAC and DBHS recognize that the Planning Council has a way to go to successfully integrate, but are encouraged by the strides the Planning Council has made. Important to note, the newly elected ABHPAC Chair, Loretta Cochran, has been in recovery for 20 years and also receives treatment for a mental health disorder.

The ABHPAC Bylaws and the AADACC Rules of Procedure are included in this applicationbelow to better illustrate the roles and responsibilities of both councils.

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*** Legislation is current through the 2012 Fiscal Session and updates ***
*** 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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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.

Arkansas Behavioral Health

Planning Advisory Council

FY14 – FY15 Joint SAMHSA Block Grant

Recommendations and Comments

The Arkansas Behavioral Health Planning and Advisory Council (ABHPAC) block grant committee began their process in October 2012. The committee worked to follow the guidelines set out in the application for insuring broad involvement from stakeholders. The ABHPAC block grant committee has more consumers and families than providers in attendance but the SWOT exercise was completed at a state meeting that had providers and professionals in attendance.

SAMHSA instructions in the application list priorities concerning the Health Care Reform for state authorities to focus on as they plan for the FY14 – 15 joint application is planned and prepared. Those priorities are:

- Funding priority treatment and support services for individuals without insurance or for those with loss of coverage for short periods of time.
- Funding those priority treatment and support services (that demonstrate success in improving outcomes and/or supporting recovery) not covered by Medicaid, Medicare or private insurance for low income individuals.
- Funding primary prevention (universal, selective & indicated) for persons not yet identified as needing treatment.
- Collect performance & outcome data to determine effectiveness of behavioral health promotion, treatment and recovery support services & to plan implementation of new services.

The application went on to say that state authorities should make every effort to ensure that 'the right recipient is receiving the right service at the right time for the right reason'. Historically, Arkansas' SMHA hasn't been able to follow SAMHSA Block Grant dollars out into the state and determine exactly what is being purchased. ABHPAC recommends that DBHS staff

work with providers receiving block grant dollars to develop a process where these dollars can be tracked to the service recipient level.

Medicaid Expansion

ABHPAC has come to a consensus that the expansion of Medicaid is a positive thing for Arkansans. Medicaid Expansion benefits not only the population without insurance coverage, but will also benefit the hospitals that are already treating a segment of this population in their emergency rooms with little or no monetary reimbursement.

In Arkansas, the proposed Medicaid Expansion (17% of FPL – 133% of FPL), that could provide coverage for about 250,000 individuals in Arkansas, who otherwise will not be financial eligible to purchase on the Arkansas Insurance Exchange. The National Alliance on Mental Illness (NAMI) estimates that 1 out of 4 Americans will need mental health treatment in any given year. For Arkansas and the estimated 250,000 Arkansans who will be positively affected by Medicaid Expansion, 62,500 will have a behavioral health need.

Prevention dollars and behavioral health risk and protective factors: This is a brand new concept for ABHPAC this year. There has been much conversation about prevention, behavioral health treatment and the risk and protective factors effecting the population DBHS serves. The recent tragedy in Connecticut caused the block grant committee to again discuss risk and protective factors, especially for young children. After reviewing the Information Sheet #8 from the Substance Abuse Prevention Skills Training (SAPST) used by the AR Prevention Centers the conversation became more targeted. As we went through the risk factors we realized the children, youth and families of Arkansas are at an inherent risk just by being Arkansans. The following risk factors were highlighted by the committee:

- Parental drug/alcohol use
- Poor academic performance in school (ACTAAP scores)
- Specific traumatic experiences
- Inadequate supervision (36.2% of Arkansans are single parents)
- Extreme poverty (18.4% of Arkansans live below FPL)
- Harsh discipline
- Stressful community events
- Not college bound
- Societal/community permissive norms about drugs and alcohol

- Low expectations from parents – '48% of adults in Arkansas read below a 5th grade level' excerpt from an Arkansas Legislative committee.

Additionally, in 2002, the National Technical Assistance Center [NTAC] a branch of the National Association of State Mental Health Program Directors [NASMHPD] funded a national research project to identify what helps and what hinders for adults in mental health recovery. It is important to note that the majority of the research project principle investigators were people with lived experiences. "Mental Health Recovery: What Helps and What Hinders? A National Research Project for the Development of Recovery Facilitating System Performance Indicators" retrieved 2/11/13 from: http://
nasmhpd.org/docs/publications/archiveDocs/2002/AppendixD.pdf
Throughout the 30 page document delineating protective and risk factors, some of the major risk factors are:

- A sense of hopelessness
- Income at or below poverty level
- Gross inequities in the societal distribution of resources for mental and general health
- Lack of informal supports/lack of natural support network
- Trauma and abuse experiences
- Lack of information and knowledge regarding choices

- Formal services that have bio-medical orientation and paternalism
- Lack of peer support/self-help services

Currently, Arkansas is looking into supporting services for adults that have not been available. Again, referring to the "Mental Health Recovery: What Helps and What Hinders?" document, the following are a few identified factors that help an adult person with a successful recovery.

- Responsibility/Making own decisions
- A livable income
- Affordable housing
- Restoring or gaining a sense of hope
- Community integration/Using community resources/Social acceptance
- Peer Support/Self-help
- Peer-provided/Consumer-run services

Currently Arkansas is beginning to develop plans for:

Certified Peer Specialists

At this point in time, Arkansas is exploring the possibility of developing:

Consumer-operated Service Programs, an Evidence-based Practice

Then we moved into exploring the protective factors that if in place in a child's family and community could prevent a child/youth from ever experimenting with alcohol and drugs and potentially could prevent/delay the onset of a mental illness or possible decrease the severity of symptoms

of an illness over a lifetime. The ones that were highlighted and discussed by the committee include:

- A families ability to provide adequate nutrition, child care, safe housing and healthcare
- Families implementing language based discipline
- Extended family support
- Parental resources (including positive personal efficacy, adaptive coping, self-views high on potency and life satisfaction)
- Opportunities to belong
- Positive social norms
- Integration of family, school and community efforts
- Positive physical, intellectual, psychological, emotional, and social development as a child develops into young adulthood.

Also discussed were adult protective factors and trauma issues….

The ABHPAC Block Grant committee members have huge concerns about the protective factors and the children of Arkansas. We have a third of our families being headed up by a single parent who are trying to earn a living wage and effectively parent their children. Adding that data to the statistic that almost 20% of our families live at or below poverty level caused the block grant committee further concern. Working from the SAPST curriculum on risk and protective factors the committee realized that Arkansas has on a small scale begun to address the identified risk factors with the following Evidenced Based Practice (EBP):

Conscious Discipline (CD) implemented with fidelity in preschool settings (Headstart, CADC/ABC programs, Development Day Treatment Programs, Children's Health and Medical Centers and daycares) and early elementary schools across Arkansas would help very young children begin to develop needed skills to be more successful in learning the academics introduced in higher grades and begin to understand what is appropriate conduct, how to initiate interactions, understanding of self-emotions and of others emotions.

Implementing Positive Behavioral Interventions and Supports (PBIS) has already shown in three communities across Arkansas that attendance improves, behaviors improve and grades improve. It also has the potential to create positive regard for school and teachers, since the interactions for children and youth are based on what is working well to

address what is not working well. There is also Positive Behavioral Supports (PBS) in some Arkansas school districts, but the committee members are not as familiar with that program and it's outcomes.

The **Lead and Seed** program is newer to Arkansas, training youth leaders (and the adult partners) in schools and communities to 'lead' the other students in making positive changes for their community.

Wraparound is currently being implemented by 14 System of Care sites in Arkansas. Wraparound in Arkansas is for those families of children/youth involved with multiple service agencies (juvenile justice, child welfare, schools, mental health, etc.) and who need help keeping their children/youth in the home, school or community.

SMART and STAR are EBP that are implemented for the dually diagnosed population in school settings typically in self-contained classrooms.

Using Prevention dollars to support these EBP's curriculums expansion across the state, to every community and school district would be a 'universal' strategy for behavioral health prevention. The individualized, strength based approach to implementing these EBP's also would move these EBP's into indicated and selective strategies. There may be other EBP being implemented that the committee members are not aware of.

If Arkansas' State Legislators vote to expand the income eligibility for Medicaid recipients, ABHPAC has the following recommendations for the mental health block grant dollars:

- Budget dollars to fund, execute and implement a training and education program designed to provide training to consumers and families in all aspects of planning and decision making (at the local and state level) on policy development, service design, outcome development and evaluation of behavioral health care services and system.
- Dedicated dollars to fund the development a process of training and certification of Peer Specialists to be employed by CMHC's. Ensure that the Medicaid reimbursement rate is set at a level that these individuals can make a living wage. If Medicaid (by waiver or healthcare reform) doesn't reimburse for these services and supports Block Grant funds should support these positions.

As an adequate workforce of peer specialists are developed, begin planning for and implementing:

- **Certified Peer Specialists** An individual, with self-identified lived experience with the behavioral health system, that has successfully completed a standardized training curriculum that is grounded in the values and beliefs of the Consumer/Survivor Movement, to provide specific care to other individuals that choose to work with a certified peer specialist (p. 6, SAMHSA EBP ToolKIT for COSPs, http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-Kit/SMA11-4633CD-DVD)
- Recovery Support Coaching – Typically originates from Substance Abuse/Use; a one-on-one relationship in which a peer in which a peer leader with more recovery experience than the person served encourages, motivates, and supports a peer who is seeking to establish or strengthen his or her recovery …. Assist peers with tasks such as setting recovery goals, developing recovery action plans, and solving problems directly related to recovery, including finding sober housing, making new friends, finding new uses of spare time, and improving one's job skills. (SAMHSA "What Are Peer Recovery Support Services?" p. 3)
- Recovery Support Center Services – Typically originates from Substance Abuse/Use; four major types of recovery support services emerging in RCSP projects: 1.) peer mentoring, 2.) recovery resource connecting, 3.) facilitating and leading recovery groups, 4.) building community. (SAMHSA "What Are Peer Recovery Support Services?"

  p. 3)

- Consumer Operated Service Programs (COSP) using the SAMHSA EBP Toolkit for COSP's. [added to list] Typically originates from Mental Health 1.) mutual support, 2.) community building, 3.) providing services (drop-in centers, peer counseling, assistance with basic needs or benefits, help with housing, employment or education); linkage to services or resources, social and recreational opportunities; arts and expression; structures educational or support groups, crisis response and respite; information and education, and outreach to community and institutions. (p. 3, SAMHSA EBP ToolKIT for COSPs, http://store.samhsa.gov/product/Consumer-Operated-Services-Evidence-Based-Practices-EBP-Kit/SMA11-4633CD-DVD

- Warm lines answered by trained peers – Phone lines answered by peer workers who are there to offer general support and/or resource information. Warmlines typically offer hours during the evenings and weekends (when other services are often closed) and are available to individuals who are bored, lonely, isolated, sad, anxious, struggling or just want to talk to someone.
- Consumer run/led organizations across the state for alternatives to or enhancements to traditional behavioral health services.
- Dedicated funding for the training and implementation of a Person Centered Model for the adult behavioral health service system.
- Dedicated funding for a Statewide Consumer Network to organize and support the CMHC's Consumer Councils and other consumer organizations.
- Continue to develop and ensure fidelity in delivering the Wraparound model Consumer Operated Service Programs (COSP) using the SAMHSA BBP Toolkit for COSP's.
- Warm lines answered by trained peers
- Consumer run/led organizations across the state for alternatives to or enhancements to traditional behavioral health services.
- Dedicated funding for the training, education and implementation of a Person Centered Model for the adult behavioral health service system that includes community integration (services for care/support).
- Dedicated funding for a Statewide Consumer Network to organize and support the CMHC's Consumer Councils and other consumer organizations.
- Ensure adequate attention is paid to transition age youth in the above areas.

As DBHS continues to move forward with implementing and expanding capacity SOC in the children's system ABHPAC recommends:

- Continue to develop and ensure fidelity in delivering the Wraparound model in Arkansas for those children/youth involved in multiple systems.
- Sustaining and expanding the existing progress on Family Support Partners. If Medicaid, by healthcare reform doesn't allow for reimbursement of these services/supports block grant funds should be used to support these positions across the state.
- Ensure adequate attention is paid to transition age youth in the above areas.

(Note): The services and supports provided by peer specialist and family support partners are not meant to be a substitute for work with clinicians but are to be an enhancement or an expansion of professional services.

If the legislature votes not to expand the financial requirements for Medicaid eligibility then behavioral health block grant funds must be used to cover 1) individuals who will not be financially eligible to purchase insurance through the Exchanges and 2) those that have insurance policies that do not cover behavioral health services. Ensuring that those individuals have a comprehensive array of community based services and supports easily accessible across the state. This will enable us to ensure that the 'right service, for the right person, at the right time' is being purchased. ABHPAC recommends that this array of services and supports should have parity with Arkansas Medicaid (adults, children and youth) under the healthcare reform.

Healthcare Reform

The Department of Human Services (DHS) has shared the evolving documents on Behavioral Health Homes, Medical Model Homes and Episodes of Care with ABHPAC. The ability to comment on these documents is much appreciated, but it is insufficient. Following SAMHSA language the inclusion of an adequate number of trained educated and informed consumers, family members and youth on those committees developing the documents would help model for providers across the state the importance of the inclusion of those individuals at the planning table. ABHPAC members will continue to be as involved as we are allowed as Healthcare Reform continues to move forward. ABHPAC members are a resource for Arkansas and are underutilized by DBHS.

Around the Behavioral Health Homes work the independent assessment (including a functional assessment) will be an important issue. ABHPAC recommends that this assessment must screen for trauma issues.

Co-occurring Services (substance abuse and mental health)

While co-occurring services are known to the ABHPAC block grant committee members, actually looking at the data collected from substance abuse providers was a new element this year for the committee members. Medicaid does allow for selected services for some special populations to receive treatment for substance use or addiction. The majority of those

service providers depend on block grant funds to provide those services to the broader population. We did discover, in reviewing the data and asking questions, that the block grant funds are only used for inpatient treatment. Once an individual finishes those 5 – 6 weeks of inpatient treatment, they are referred for outpatient only or possibly moving into transition housing to continue treatment. Block grant funds are not used for testing individuals for illegal drug use – clients and/or their families are responsible for covering those cost. It has been the experience of several ABHPAC members that ensuring co-occurring treatment (collaboration of services between mental health treatment and substance abuse treatment) for Arkansans is extremely hard to achieve across the state. For those individuals without insurance coverage many roadblocks and barriers (including funds to pay for such services) occur and must be eliminated for adequate access to happen.

ABHPAC recommends that to truly support individuals in recovery funding must be allocated to cover housing, transportation, medication and testing for use of illegal drugs for those individuals as they move from inpatient treatment to either the community or transition housing.

Dually Diagnosed Services (Behavioral Health and Intellectual Disabilities)

Several of our block grant members have family members that fall into this population. There is much concern from this group on the future of the Tax Equity and Fiscal Responsibility Act (TEFRA) in Arkansas. ABHPAC recommends that DHS insure that TEFRA continues to stay a viable program in Arkansas until all Community First Choice Option (CFCO) work is completed, implemented and the TEFRA cases can be moved into a CFCO.

Also of concern to this group are issues around episodes of care. Many family members who have been receiving services from CMHC's and other RSPMI providers have been dismissed from treatment because of Autism or other Intellectual Delay diagnosis. Apparently many providers have been providing therapy and wraparound services to these families, their children and youth, once episodes of care begin to be implemented last April those same families are being discharged from care. Thus far the Developmental Delayed Services (DDS) services haven't begun to deal with this lack of services in the system. ABHPAC recommends that DDS provide community

based services and supports for these families and their children and youth until CFCO is ready to be implemented.

Recovery

SAMHSA, continuing its position of encouraging states to develop and implement recovery support services rolled out **BRSS TACS – Bringing Recovery Supports to Scale Technical Assistance Center Strategy.** Arkansas was recipient of one of the BRSS-TACS grants. DBHS wrote a letter of support for the project for Linda Donovan, who wrote the grant and was the project manager. As a part of her role at DBHS Linda has traveled to several CMHC's educating staff and consumers on different values and beliefs between various recovery communities.

Lynn Kell in her role as the Recovery Coordinator and Linda Donovan worked with a couple of stakeholders groups on vetting the definition and values/principles. Lynn Kell recommended to the DBHS Executive Team that SAMHSA 2012 "Working Definition of Recovery" be adopted by DBHS. No decision has been made by the Executive Committee.

ABHPAC recommends that a broad group of stakeholders (including consumer/survivors, family members, youth, professionals and providers) be brought together to discuss, develop and implement the values and beliefs of a recovery based system of care for adults and transition age youth with identified behavioral health needs.

Office of Consumer Affairs

It was exciting for ABHPAC members to hear from DBHS staff that Arkansas was going to have an Office of Consumer Affairs (OCA) at DBHS. We were very disappointed when the February 2013 Organizational Chart was passed out. First, the OCA director (when hired) will not be a part of the Executive Team. All relevant literature points this out as a must. According to literature from SAMHSA and NAC/SMHA the OCA office should be an agent of change for the behavioral health system as well as, for the DBHS executive team decision making processes. Also included in the organizational chart was many areas thrown under the heading of the OCA. With all the other areas of focus listed on the organizational chart listed as 'duties' of the OCA ABHPAC members feels that this design doesn't support this area being

called an OCA. There is much literature from other states that have an OCA in their states some for over two decades.

The Consumer Services Advocate (CSA) position is vacant again. When this position was developed 7 years ago by DBHS the ideal for this position came from the block grant committee. Historically this position has been an extra help, part time position. ABHPAC hopes that as conversations continue around the OCA, conversations will also include discussions about making the CSA position a full time employee of DBHS. Sustaining this valuable position as DBHS moves forward as a full time slot will help in successfully filling this position with a qualified applicant and help to increase the perceived value that DBHS has for this consumer and family voice in the system.

DBHS State Priorities for FY14 & 15

ABHPAC's top 3 priorities for FY14 &FY15:

- The lack of peer specialists and the need for statewide training and certification.
- Integrated treatment for those individuals identified as dually diagnosed and co-occurring.
- The need to develop statewide the expertise for the LGBTQ2-S.

We see healthcare reform as a window of opportunity to make sure that in various stages of development ABHPAC priorities are discussed and hopefully included in the planning process.

These priorities were determined by a vote of all ABHPAC members present at the end of our SWOT exercise.

DBHS has selected 7 priorities to address in the joint application. There is concern that the process implemented by the DBHS block grant team has lacked for involvement from a broad group of stakeholders. There also seems to have been little, if any planning for how healthcare reform work will actually affect the purchasing power of block grant dollars in FY14 & FY15.

ABHPAC is excited about the opportunities that a joint block grant has brought to our discussions and we look forward to working with DBHS staff as the development of this block grant continues.

ARKANSAS BEHAVIORAL HEALTH PLANNING & ADVISORY COUNCIL

August 16, 2013

The Arkansas Behavioral Health Planning and Advisory Council (ABHPAC) continues to enjoy a strong, consultative relationship with the leadership team within the Division of Behavioral Health Services (DBHS) in Arkansas. As the primary author of the Mental Health Block Grant state plan, DBHS supports ABHPAC and the ABHPAC Block Grant subcommittee by providing meeting facilities, travel expenses for volunteer members, and administrative support during the review and recommendation process. ABHPAC was not actively involved in establishing the state's block grant priorities for this application. This was due primarily to changes in personnel and responsibilities at DBHS resulting from natural attrition and role integration at the state level of substance abuse and mental health. The planning process for this block grant application was further complicated with the timing of implementation of the Affordable Care Act. The council had record participation (up to 17 individuals actively engaged and 40 hours of group meetings during the review and recommendation process, for a total of 450 hours of group work in addition to personal time given by members) involving stakeholders from both the substance abuse and mental health arenas. ABHPAC has provided multiple recommendations for this application which are included in the Appendix of this application. Given the unanticipated timing of external factors, we are confident the role of the planning council will deepen and extend to the priorities phase with future applications. The priorities included in the application are strong reflections of the state's activities and also the commitment to progress towards a vision of behavioral health recovery in Arkansas and the acknowledged value of individuals with personal behavioral health experiences as well as their family members.

It is important to note that ABHPAC enjoys unfettered access to both the Policy Director who leads the Block Grant application team and also the Director of the Division of Behavioral Health. These individuals set the direction and focus of not only Arkansas' block grant efforts but behavioral health as a whole for the state. ABHPAC's executive team has participated in leadership training with key DBHS personnel, has a diverse group from DBHS engaged at the council's annual retreat, and met with key individuals at DBHS to review and make recommendations in person for this application.

ABHPAC sees many opportunities for progress in Arkansas through the goals included in the Block Grant application. For example, the council is poised to play an instrumental role in monitoring, reviewing and evaluating the adequacy of behavioral health services in Arkansas. Instruction and review of a monitoring tool was included in the council's annual retreat (August, 2013) and we are eager to take the next step. This year, the council has made additional progress towards an integrated council with new members joining from key stakeholder groups in the substance abuse and recovery community.

The members of ABHPAC take the responsibility to the block grant process as a primary concern and have shown a tremendous commitment to the process as it has emerged this year in our joint application. We had active and considerable participation in reviewing the application from mental health and substance abuse treatment stakeholders, including providers and individuals with lived experience. One of the challenges facing DBHS to integrate the Block Grant process is Arkansas Statue 20-64-1003 which creates and empowers the Arkansas Alcohol and Drug Abuse Coordinating Council. Part A states that the 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.* ABHPAC is actively seeking engagement with the leadership of the Council to further efforts to collaborate in recovery efforts throughout the state.

In closing, it is an exciting time in Arkansas in behavioral health. This Block Grant application appears to be the jumping off point for a very dynamic vision of recovery, recovery support, and person driven engaged behavioral health transformation for Arkansas. ABHPAC itself is an example of this beginning. We have informed and committed voices on our council from the intellectual disability community, the Disability Rights Center of Arkansas' Protection and Advocacy for Individuals with Mental Illness (PAIMI), the Arkansas Alcohol and Drug Abuse Coordinating Council, the consumer councils with community mental health providers, provider organizations in both mental health and substance abuse, and stakeholders within state government including vocational rehabilitation, behavioral health, and Medicaid. The executive leadership of ABHPAC consists of individuals and family members of lived experience and recovery in mental health and substance abuse. We look forward to continuing our work with behavioral health stakeholders throughout the state as we navigate the opportunities that lay before us.

Sincerely,

Loretta F. Cochran, Ph.D.
Chairperson

August 21, 2013

Ms. Joy Figarsky, Director
Arkansas Division of Behavioral Health Services
305 South Palm Street
Little Rock, AR 72205

RE: FY 2014-2015 SABG/MHBG Behavioral Health Assessment and Plan

Dear Ms. Figarsky,

At the most recent meeting of the Arkansas Alcohol and Drug Abuse Coordinating Council (AADACC), the review of the above referenced plan was conducted and approved. The AADACC supports the efforts outlined that will provide critical and much needed substance abuse and mental health services to the citizens of Arkansas. The plan sets forth a comprehensive and coordinated program that supports the philosophy of effective community-based and community-supported services.

AADACC and the Office of the Drug Director urges SAMHSA to fully fund and to allow the implementation of the SABG/MHBG Behavioral Health and Assessment and Plan for FY 2014-2015.

Sincerely,

Fran Flener
State Drug Director

#1 State Police Plaza, Little Rock, Arkansas 72209. Ph: (501) 816- 8690 Fax: (501) 816-8841

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year: 2014

End Year: 2015

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Melanie Rae Allen	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1108 Citizen, Apt 4 Jonesboro, AR 72401 PH: 870-203-0000	
Besty Lee Barnes	State Employees	DHS/Division of Aging and Adult Services	FAX: 501-682-8155	betsy.barnes@arkansas.gov
Cherokee T Bradley	State Employees	Arkansas Department Of Health	1912 Green Mountain Drive 284 Little Rock, AR 72212 PH: 501-660-6817	cherokeebradley@yahoo.com
Scott Burcham	Others (Not State employees or providers)	University of Tenn., Dept. of Social Work		rburcham@utk.edu
Pam Christie	Others (Not State employees or providers)	Mental Health Council of Arkansas	501 S. Woodlane, Ste 104 Little Rock, AR 72201 PH: 501-372-7062	pchristie@mhca.org
Loretta Ferguson Cochran	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Behavioral Health Advisory Council -State Chair	264 West Cedar Street Pottsville, AR 72585 PH: 479-890-3908	lfcochran@gmail.com
Mary Jean Crook	Parents of children with SED		7107 Valley Drive Little Rock, AR 72209 PH: 501-570-8563	mary.crook@med.va.gov
Junie "Sissy" Cumblidge	Family Members of Individuals in Recovery (to include family members of adults with SMI)		11001 Donnie Drive Shannon Hills, AR 72103 PH: 501-455-2174	tomandsissy777@msn.com
Winston L DaBell	Family Members of Individuals in Recovery (to include family members of adults with SMI)		P.O. Box 22014 Hot Springs, AR 71903 PH: 501-520-2324	winston.dabell@arkansas.gov
Georgia Rucker	Family Members of Individuals in Recovery (to include family members of adults with SMI)		P.O. Box 45402 Little Rock, AR 72214 PH: 501-223-2714	mgrucker@sbcglobal.net
Kenneth E Lake	Family Members of Individuals in Recovery (to include family members of adults with SMI)		5329 Lee Avenue Little Rock, AR 72205 PH: 501-661-9278	zoro72080@yahoo.com
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	angi.lassiter@ymail.com
Jim Moreland	State Employees	Vocational Rehabilitation		jim.moreland@arkansas.gov

Bob Parker	State Employees	Criminal Justice - Ark Dept of Corrections		bob.parker@arkansas.gov
Ramona Sanford	Family Members of Individuals in Recovery (to include family members of adults with SMI)		1700 Stedham Rd Jefferson, AR 72079 PH: 501-818-9608	jeffersonmona@aol.com
Jo Ann Sullivan	Family Members of Individuals in Recovery (to include family members of adults with SMI)		19 Purdue Circle Little Rock, AR 72204 PH: 501-562-5284	
Angela Taylor	Family Members of Individuals in Recovery (to include family members of adults with SMI)		3472 East Kiehl, Apt. #7203 Sherwood, AR 72120 PH: 501-843-8480	princessangi@juno.com
Rebecca Webber	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		305 S. Palm St. Little Rock, AR 72205 PH: 501-259-0371	aubie1952@yahoo.com
Betty Ruth Welch	State Employees	AR Department of Education	1401 W. Capitol Avenue, Suite 450 Little Rock, AR 72201	betty.welch@arkansas.gov
Kim Weser	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1175 Hopper Rd Redfield, AR 72132 PH: 501-397-2430	kjsmadonna@yahoo.com
Chappell Leigh Mosby	Family Members of Individuals in Recovery (to include family members of adults with SMI)		8217 Pine Summit Ct Little Rock, AR 72204 PH: 501-379-8479	chappellmosby@yahoo.com
Kim Arnold	Others (Not State employees or providers)	NAMI-Arkansas	1012 Autumn Rd Ste. 1 Little Rock, AR 72211 PH: 501-661-1548	karnold@nami.org
Felicia Michelle Betts	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Youth Consumer	7107 Valley Drive Little rock, AR 72209 PH: 501-246-5373	Betts_Felicia@yahoo.com
Steve Clark	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1175 Hoper Road Redfield, AR 72132 PH: 479-301-3107	willdoabrew@yahoo.com
Michele R Clemons	Parents of children with SED		94 Ellen Lane Higden, AR 72067 PH: 501-691-2354	
Jannie Cotton	Providers		P.O. Drawer 24210 Little Rock, AR 72211 PH: 501-221-1843	jannie.cotton@pca-ar.org
Linda Donovan	State Employees	DHS/Division of Behavioral Health	PH: 501-683-0387	linda.donovan@arkansas.gov
Elizabeth Emerson	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Youth Consumer	341 Babcock Apt #10 Malvern, AR 72104 PH: 501-605-2554	
Arvin C Marlowe	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1600 S. Elm St. apt 37 Little Rock, AR 72204 PH: 501-680-7678	carnell1963@yahoo.com
	Individuals in Recovery (to include		811 N. Spruce St.	

William "Bill" Shumaker	adults with SMI who are receiving, or have received, mental health services)	Behavioral Health Advisory Council-Parliamentarian	Little Rock, AR 72205 PH: 501-666-0371	rockshoe501@yahoo.com
Rosemary Uwabor	Family Members of Individuals in Recovery (to include family members of adults with SMI)		15000 Chenal Parkway Apt. #F101 Little Rock, AR 72211 PH: 501-221-6779	Rosemary.uwabor@yahoo.com
Kellie Frances Van Curen	Parents of children with SED		P.O. Box 650 Springdale, AR 72765 PH: 479-530-9254	KFVCR69@hotmail.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
Freda Tobias	Others (Not State employees or providers)	Little Rock Housing Authority	9 Redleaf Circle Little Rock, AR 72210 PH: 501-416-2767	fredagillispie@yahoo.com
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
Paula Stone	State Employees	DHS/Division of Behavioral Health Services-Children Services	305 South Palm Street Little Rock, AR 72205 PH: 501-686-9106 FAX: 501-686-9182	paula.stone@arkansas.gov
Tenesah Barnes	State Employees	AR Division of Medicaid Services	2100 Main Street Little Rock, AR 72203 PH: 501-683-1900	tenesah.barnes@arkansas.gov
Alexanderia Richey	Parents of children with SED	Youth Consumer	P.O. Box 650 Springdale, CA 72765 PH: 479-530-9254	alexanderia96@yahoo.com
Ann Gevock	Family Members of Individuals in Recovery (to include family members of adults with SMI)		P.O. Box 1437, Slot W102 Little Rock, AR 72203 PH: 501-686-0162 FAX: 501-371-8050	agevock@gmail.com
LaKesia Spencer	Parents of children with SED		517 East 15th Street Little Rock, AR 72202 PH: 501-296-9356	lakesia.spencer@yahoo.com
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)		1400 Cumberland Street #401 Little Rock, CA 72202 PH: 501-398-2154	coconigeria29@yahoo.com
Melissa Burns	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		12307 Bear Creek Lane Des Arc, AR 72040 PH: 870-946-5547	k9cop7022000@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
Melody Kouchehbagh	Providers		614 East Emma, Suite 213 Springdale, AR 72764 PH: 479-756-1995	mk@arcrisis.org
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
Shirley Clark	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1502 Green Mountain Drive Little Rock, AR 72211 PH: 501-612-6115	shirley_morris49@yahoo.com
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
Fran Flener	State Employees	State Drug Office	Little Rock, AR 72201 PH: 501-618-8690	
Tammy Alexander	Providers		29 Rosewood Dr. Beebe, AR 72012 PH: 501-288-7208	Tammy.Alexander2@va.gov

Footnotes:

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year: 2014

End Year: 2015

Type of Membership	Number	Percentage
Total Membership	51	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	11	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	14	
Parents of children with SED*	5	
Vacancies (Individuals and Family Members)		
Others (Not State employees or providers)	4	
Total Individuals in Recovery, Family Members & Others	34	66.67%
State Employees	14	
Providers	3	
Federally Recognized Tribe Representatives	0	
Vacancies		
Total State Employees & Providers	17	33.33%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations		
Providers from Diverse Racial, Ethnic, and LGBTQ Populations		
Persons in recovery from or providing treatment for or advocating for substance abuse services		

* 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:

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

X. Enrollment and provider business practices, including Billing Systems

The Division of Behavioral Health Services (DBHS) is currently awaiting finalized decisions regarding the Qualified Health Plans (QHPs) and provider qualifications from the Arkansas Insurance Department. Once this information is shared, DBHS will have a more complete picture of the workforce development and training needs of the state. The Division has begun initial research on the current workforce capacity.

In 2012, DBHS contracted with a consulting group to assist the 25 funded substance abuse providers become nationally accredited. Currently, all funded substance abuse providers are nationally accredited. This service was provided to help prepare substance abuse providers for not only billing Medicaid, but also private insurance.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

Y. Comment on the State Block Grant Plan

The FY2014-2015 Combined SABG/MHBG Behavioral Health Block Grant Application was made available on the Division of Behavioral Health Services (DBHS) website at http://humanservices.arkansas.gov/dbhs/Pages/dbhs_docs.aspx on August 1, 2013. The public was asked to provide all comments to the Director of Policy and Research at DBHS by August 23, 2013.

A notification was placed in the Arkansas Democrat Gazette from Wednesday, July 31, 2013 through Friday, August 2, 2013 to alert the public that the block grant application was available online and at DBHS for public comment.

The Arkansas Behavioral Health Planning and Advisory Council (ABHPAC), the Arkansas Alcohol and Drug Abuse Coordinating Council (AADACC), and all behavioral health providers were emailed a notification that the block grant was posted online and available for comment.

After submission of the Block Grant on September 2, 2013, the finalized Block Grant Application will be posted on the DBHS website.