TO: Interested Parties

FROM: Rachael Veregge, Assistant Director Licensure & Certification

DATE: July 31, 2017

RE: Public Comment Period

Attached is the Federal Fiscal Year 2018-2019 Combined Substance Abuse and Mental Health Block Grant Behavioral Health Assessment and Plan application for the Division of Behavioral Health Services.

The public comment period for this grant application is August 1, 2017-August 30, 2017.

Copies of the application can be found on our website: http://humanservices.arkansas.gov/dbhs/Pages/dbhs_docs.aspx

Please forward all comments regarding this application to Rachael Veregge via email to Rachael.Veregge@dhs.arkansas.gov
Arkansas

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

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

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 08/01/2017 10.09.29 AM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

Plan Year
Start Year  2018
End Year  2019

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  Pamela
Last Name  Dodson
Agency Name  Arkansas Department of Human Services, Division of Behavioral Health Services
Mailing Address  305 South Palm Street
City  Little Rock
Zip Code  72205
Telephone  501-686-9411
Fax  501-686-9182
Email Address  pamela.dodson@dhs.arkansas.gov

State CMHS DUNS Number
Number  1119988441
Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant
Agency Name  Department of Human Services
Organizational Unit  Division of Behavioral Health Services
Mailing Address  305 S Palm St
City  Little Rock
Zip Code  72205

II. Contact Person for the CMHS Grantee of the Block Grant
First Name  Pamela
Last Name  Dodson
Agency Name  Department of Human Services
Mailing Address  305 S Palm St
City: Little Rock
Zip Code: 72205
Telephone: 501-686-9411
Fax: 501-686-9182
Email Address: pamela.dodson@dhs.arkansas.gov

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

IV. Date Submitted
Submission Date
Revision Date

V. Contact Person Responsible for Application Submission
First Name: Rachael
Last Name: Veregge
Telephone: 501-320-6431
Fax: 501-686-9182
Email Address: racahel.veregge@dhs.arkansas.gov

Footnotes:
State Information

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

Fiscal Year 2018

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

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of 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 nondiscrimination 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.


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.); (a)


14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

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

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

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

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

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

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

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

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

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

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

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

Name of Chief Executive Officer (CEO) or Designee:

Signature of CEO or Designee¹: __________________________________________

Title: __________________________________________ Date Signed: ___________________________

mm/dd/yyyy

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

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

Fiscal Year 2018

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

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

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LIST of CERTIFICATIONS

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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.

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

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

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

Name of Chief Executive Officer (CEO) or Designee: ____________________________________________

Signature of CEO or Designee¹: ____________________________________________

Title: ____________________________________________ Date Signed: _________________________________

mm/dd/yyyy

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

### Disclosure of Lobbying Activities

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

**Standard Form LLL (click here)**

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<td>Jay Hill</td>
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<td>Division of Behavioral Health Services</td>
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Signature: ____________________________  Date: ____________

**Footnotes:**
Planning Steps

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

Narrative Question:

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

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

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

The provision of block grant funded substance abuse services is facilitated through eight contracts with treatment providers and thirteen prevention providers covering the state. The Division of Behavioral Health Services fulfills its responsibility for the provision of public mental health services by operating the 222 bed Arkansas State Hospital (ASH) and the 290 bed Arkansas Health Center (AHC) skilled nursing facility, by contracting with thirteen local, private, nonprofit Community Mental Health Centers (CMHCs), and certifying two private, nonprofit specialty Community Mental Health Clinics. Each provider of behavioral health services are expected to assess the diversity of their region and population served. Based on this assessment, providers are expected to assure that staff are trained on the specific treatment needs, cultural and ethnic differences, and disparities.

Substance Abuse Treatment DBHS is responsible for administering a comprehensive and coordinated program for the prevention and treatment of alcohol and drug abuse in Arkansas. As the Single State Authority, DBHS distributes federal funds from the Substance Abuse Prevention and Treatment (SAPT) Block Grant. DBHS provides oversight for 144 treatment providers, with eight of those funded by DBHS to provide substance use disorder prevention, treatment, and recovery services throughout the State. Substance abuse treatment services span a continuum that includes detoxification, residential treatment, outpatient treatment, and education. Current specialized programs include those for methadone maintenance and treatment for women with children.

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

The current substance abuse treatment catchment areas are as follows:
1. Benton, Carroll, Washington, Madison counties
2. Boone, Marion, Baxter, Newton, Searcy, Fulton, Izard, Sharp, Stone, Independence, Van Buren, Cleburne, Jackson, White, Woodruff counties
3. Randolph, Clay, Lawrence, Greene, Craighead, Mississippi, Poinsett, Cross, Crittenden, St. Francis, Lee, Monroe, Phillips counties
4. Crawford, Franklin, Sebastian, Logan, Scott, Polk counties
5. Johnson, Pope, Conway, Yell, Perry, Faulkner, Montgomery, Garland, Hot Spring, Pike, Clark counties
6. Arkansas, 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

The Drug and Alcohol Safety Education Program (DASEP), was established to implement those portions of the law requiring pre-screening, assessment reports, and alcohol/safety education courses of those who have received a Driving While Intoxicated (DWI) charge. The Division of Behavioral Health Services
(DBHS) provided the funding and provides oversight of the Program. DASEP was designed to assist the court by recommending drug and alcohol safety education or substance abuse treatment for Driving while Intoxicated (DWI)/Driving Under the Influence (DUI) offenders. There are a total of eight (8) that providers conduct assessment and provide treatment referral services within the 75 counties in Arkansas.

There are 12 funded juvenile drug courts across the state. Drug courts refer clients to local substance abuse providers to provide outpatient services, tobacco cessation, and drug screens. Funded providers work with the JDC to provide substance abuse treatment, which includes outpatient and residential services.

The Arkansas Prevention System currently consists of thirteen (13) Regional Prevention Providers (RPP). The system serves as a statewide infrastructure for providing resource support necessary to promote capacity development at the local level. The RPP represents the Division of Behavioral Health Services (DBHS) in forming a statewide infrastructure to develop knowledge, skills and abilities within communities to address behavioral health prevention needs. The RPP representatives must make progress towards the accomplishment of the state prevention plan and support the requirements of the federal funding source. The primary focus for the RPP will be to build substance abuse prevention capacity within the region and communities to address their own issues and to address the National Outcome Measure (NOMS). The secondary focus will be to assist with the statewide prevention infrastructure for promoting and increasing behavioral health prevention across the lifespan. The capacity will be built through raising community awareness and promoting media campaigns, conducting public presentations, information dissemination, prevention education/training, alternative activities, community-based process, environmental approaches, problem identification and referral, and the use of the Strategic Prevention Framework 5 step planning process.

There are thirteen (13) Community Mental Health Centers (CMHCs) covering the state of Arkansas. The CMHCs are responsible for providing behavioral health services to indigent individuals in their respective catchment area. The CMHCs also serve as the Single Point of Entry (SPOE) for adults in to the public mental health system. Created by Act 861 of 1989, each CMHC has a contractual obligation to perform initial SPOE screenings for individuals who live in their respective catchment areas to determine if the individual meets the criteria for admission to inpatient programs of the State Mental Health System, to determine if appropriate alternatives to inpatient treatment are clinically appropriate and available, and arrange for the provision of alternative outpatient services if inpatient or crisis residential services are not recommended.

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

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

DBHS maintains the certification policies for Outpatient Behavioral Health Services which includes compliance and outcome monitoring of providers. Providers may either be Individually Licensed Practitioners or Behavioral Health Agencies. To be an eligible OBHS provider, the provider must offer an array of outpatient treatment services outlined in the Outpatient Behavioral Health Services Medicaid Manual and be eligible to bill the Arkansas Medical Assistance Program (Medicaid) for reimbursable services. The Outpatient Behavioral Health Services provider must follow an application process and become certified by the DBHS prior to applying for Medicaid provider enrollment. DBHS manages the application process and compliance standards for all Outpatient Behavioral Health Services 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.

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 to successfully treat children and youth, family and community involvement is key. To support this belief, the Department of Human Services (DHS) has increased department wide efforts to create and build a System of Care (SOC) that is a coordinated network providing an array of services, of which mental health is a part. To improve the mental health service delivery system for children with severe to moderate behavioral health care needs and their families, DHS SOC Wraparound Demonstration Projects sites are developing methods that are becoming standards of practices based on Wraparound principles. Financial support for the behavioral health system comes from a variety of funding sources including Arkansas state general revenue, federal grants, Medicaid, and private insurance.

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

**Identified Strengths**

- DBHS is currently in process of adopting an evidence-based peer support curriculum. This is being accomplished through a local workgroup that is working with federal guidance from a awarded Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) grant.

- The Arkansas Behavioral Health Planning Advisory Council received a SAMHSA State TA Project Advocacy technical assistance grant to assist the Council to continue efforts to integrate mental health and substance abuse issues into its work; while developing strategies to strengthen and
sustain the planning council through the Technical Assistance Center at Advocates for Human Potential, Inc.

- Youth M.O.V.E. Arkansas is a statewide youth-led organization devoted to improving services and supports provided to children and youth in the State of Arkansas since 2010. 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 MOVE has a state office and a project director with staff that are funded through state general revenue. They currently have 14 local chapters across the state and provide two family and youth conferences each year. More than 316 people attended the 7th Annual Arkansas Youth and Family Empowerment Conference in June of this year with 30 workshops offered.

- All contracted substance abuse providers in Arkansas are nationally accredited. This is a requirement of the contract and of the licensure standards.

- All mental health providers certified to provide mental health services through the Outpatient Behavioral Health Services program in Medicaid are nationally accredited.

- The State of Arkansas had a unique opportunity to plan the implementation of a statewide System of Care (SOC). This project took 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 was supported by a SAMHSA grant and included technical assistance from Georgetown University to assist in this initiative. Upon the completion of this implementation grant, another SAMHSA grant (SOC Expansion Implementation Cooperative Agreement) was awarded to Arkansas in October 2014 through September 2019.

- All the Community Mental Health Centers have Consumer Councils which are in place to allow consumers to develop a strong and unified voice to influence and improve State policy decisions, further develop the consumer-led initiatives, impact local service development, and forge productive alliances with community resources.

- During 2012, eight Family Support Partners (FSPs) served and supported 142 families within nine service areas encompassing 50 counties in the state. FSPs are peer counselors who model recovery and resiliency in overcoming obstacles common to those who live with children or youth with behavioral health care needs. Legacy Families, those that have had multiple experiences with the mental health and broader social service system, are recruited to serve as FSPs. In this role, FSPs are charged to work alongside Community Care Directors (CCDs) and Wraparound Specialists (WAS) to help engage and support local families in the Wraparound process. In 2016, each Wraparound site employed at least one FSP totaling 15. FSP support was offered to over 900 families with many families choosing to receive this service.
Identified Needs

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

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

Narrative Question:

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

The state’s priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state’s unique data system (including community-level data), as well as SAMHSA’s data sets including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD 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 M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

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

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

Through the Healthy People Initiative1 HHS has identified a broad set of indicators and goals to track and improve the nation’s health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

Footnotes:

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

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

– Medicaid does not currently fund care coordination for individuals with serious mental illness or children with serious emotional disturbances.

– The current Medicaid program supporting substance abuse treatments services has been historically underutilized. This is due to the limited population eligible for the services, the professional requirements for providing services, and other procedural complications. Beginning July 1, 2017, outpatient substance abuse services are available for eligible beneficiaries through the Outpatient Behavioral Health Services Medicaid Program. Eligibility is determined by an independent assessment.

– The Medicaid programs supporting individuals with serious mental illness or children with serious emotional disturbances are not recovery oriented. Beginning July 1, 2017, recovery oriented services are available for eligible beneficiaries through the Outpatient Behavioral Health Services Medicaid Program. Eligibility is determined by an independent assessment.

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

Addressing the gaps within the Medicaid system is essential to moving the entire behavioral health system. This is due to the discrepancy in funding in Medicaid versus contracted services. For example, in SFY2016 Medicaid reimbursed providers statewide for approximately $550 million for mental health services, while the Community Mental Health Centers received approximately $27 million for contracted services during SFY 2017.
Planning Steps

Quality and Data Collection Readiness

Narrative Question:

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

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

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

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

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

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

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

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

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

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

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

Footnotes:
Quality and Data Collection Readiness

1. Briefly describe the state’s data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).

The Division of Behavioral Health Services (DBHS) collects client level data for all clients treated for substance use disorder from treatment providers receiving federal block grant monies. The Division also receives similar data from non-funded substance abuse treatment providers. The data reporting system provides aggregate data at the program, provider, and state level. Within the data system, there are a number of individual level data elements collected, including measures under SAMHSA’s National Outcomes Measures (NOMs) domains.

In addition, DBHS collects client level data for all clients receiving mental health services from Community Mental Health Centers receiving federal block grant funding. This client level encounter data is gathered on more than 70,000 adult and children receiving mental health services from 16 Community Mental Health Centers, which include 13 certified Community Mental Health Centers (CMHCs), 2 certified Community Mental Health Clinics, 1 Affiliate, and the Arkansas State Hospital.

More specifically, DBHS collects data via the following statewide data systems:

- 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).

- The DBHS Service Process Quality Management Data Mart (SPQM) collects client level data and provides reports based on various aspects (consumer satisfaction survey reporting, acute care reporting, for example) of the Community Mental Health Centers (CMHCs) and the Arkansas State Hospital (ASH). The primary purposes of the SPQM Data Mart is to 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 SPQM data mart captures mental health service data across the State’s 17 service provider entities, which include 13 certified Community Mental Health Centers (CMHCs), 2 certified Community Mental Health Clinics, 1 Affiliate, and the Arkansas State Hospital. Raw transaction data is transformed to produce specialty reporting cubes as 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.

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

- The Arkansas Department of Human Services (DHS) data warehouse is a centralized data repository consisting of disparate contributing source systems from both within and external to DHS. The data warehouse provides 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 governed by the contributing source data owner. DBHS is one of the contributors of data to the system and uses the capabilities of the data warehouse to complete state level data and policy analysis.

Beyond the data systems operated by the state, DBHS obtains and analyses data from several other data sources and systems administered on behalf of the state by subcontractors:

- The Web Infrastructure for Treatment Services (WITS) is a data repository that helps maintain plans, goals, objectives and activities related to substance abuse prevention and early intervention services. The system has a report system that is capable of tracking NOMS and block grant related data.
- The Arkansas Prevention Needs Assessment Student Survey (APNA) is an annual survey of grades 6, 8, 10 and 12 school students in Arkansas. The majority of 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 at various levels including state, county, school districts and schools. This survey has been conducted since 2002. Currently, over 200 school districts respond to the survey.
- 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 16 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.

2. Is the state’s current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what purposes (e.g., Medicaid, child welfare, etc.).

DBHS has multiple data collection systems (see question #1) which are all stand-alone systems. The primary system that collects data on Substance Abuse treatment is the Alcohol Drug
Management Information System (ADMIS). The primary system that collects data on Mental Health services is Service Process Quality Management Data Mart (SPQM). A separate state Medicaid administrative and billing data collects claims related data for substance abuse and/or mental health services. Through the state’s data warehouse, data from these three separate data systems may be cross-referenced and analyzed to inform policy decisions.

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client identifying information)?

DBHS’s primary Substance Use Disorder treatment and Mental Health services data systems are capable of collecting data at the client level. DBHS’s Substance Use Disorder treatment data system is also capable of reporting measures at the individual client level. The state is also able to collect and report claims data on Medicaid eligible services at the client level.

4. If not, what changes will the state need to make to be able to collect and report on these measures?

n/a

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

DBHS would like to move to an integrated data platform for all data collection purposes. Technical assistance from SAMHSA to achieve this would be appreciated.
### Table 1 Priority Areas and Annual Performance Indicators

<table>
<thead>
<tr>
<th>Priority #</th>
<th>1</th>
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</thead>
<tbody>
<tr>
<td>Priority Area</td>
<td>Substance Abuse Treatment</td>
</tr>
<tr>
<td>Priority Type</td>
<td>SAT</td>
</tr>
<tr>
<td>Population(s)</td>
<td>PWWDC, PP, PWID</td>
</tr>
</tbody>
</table>

**Goal of the priority area:**

- Maintain and expand access to substance abuse services for the indigent and/or court involved population

**Objective:**

- Ensure statewide access to substance abuse treatment
- Ensure individuals without a payer source in need of substance abuse treatment have access to needed care
- Place an emphasis on individuals who are intravenous drug users, women who are pregnant and/or parenting, military, and adolescents.

**Strategies to attain the objective:**

- Contract with community based providers to provide services to the indigent populations. These contracts prioritize individuals who are intravenous drug users, women who are pregnant and/or parenting, military, and adolescents.
- Provide detoxification, outpatient services, partial day treatment, residential services, and Specialized Women Services.

### Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
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<tbody>
<tr>
<td>Indicator:</td>
<td>Number of unduplicated individuals served</td>
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<tr>
<td>Baseline Measurement:</td>
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<tr>
<td>First-year target/outcome measurement:</td>
<td>A 1.5% increase from baseline.</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>A 3% increase from baseline.</td>
</tr>
</tbody>
</table>

**Data Source:**

Client specific treatment data reported from the state's substance use disorder treatment data system (Alcohol/Drug Management Information System: ADMIS).

**Description of Data:**

The Baseline Measurement is the number of unduplicated individuals served from July 1, 2015 to June 30, 2016 (SFY 2016). The first-year target will include data from SFY 2017. The second-year target will include SFY 2018.

**Data issues/caveats that affect outcome measures:**

The most current data available for establishing a baseline measurement is from SFY 2016. The first and second years data will be SFY 2017 and 2018, respectively.
Client specific treatment data reported from the state’s substance use disorder treatment data system (Alcohol/Drug Management Information System: ADMIS).

Description of Data:
The Baseline Measurement is the number of unduplicated individuals served from July 1, 2015 to June 30, 2016 (SFY 2016). The first-year target will include data from SFY 2017. The second-year target will include SFY 2018.

Data issues/caveats that affect outcome measures:
The most current data available for establishing a baseline measurement is from SFY 2016. The first and second years data will be SFY 2017 and 2018, respectively.

Priority #: 2
Priority Area: Mental Health Treatment
Priority Type: MHS
Population(s): SMI, SED

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

Objective:
Continue to support the statewide Forensics Outpatient Restoration Program. Continue to support the First Episode of Psychosis requirement.

Strategies to attain the objective:
Improve contracts with community based providers to provide mental health treatment to adults with serious mental illness and children with severe emotional disturbance.

Priority #: 3
Priority Area: Behavioral Health Medicaid transformation
Priority Type: SAT, MHS
Population(s): SMI, SED, Other (Adolescents w/SA and/or MH, Children/Youth at Risk for BH Disorder)

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

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

* 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 Care Coordination through Medicaid

Strategies to attain the objective:
Continue to meet with stakeholders to garner feedback and support.

Priority #: 4
Priority Area: Children's System of Care
Priority Type: MHS
Population(s): SED

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

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

Strategies to attain the objective:

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

Annual Performance Indicators to measure goal success

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Number of Support Groups Held (Through NAMI AR)</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>19</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>60</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>80</td>
</tr>
</tbody>
</table>

Data Source:
NAMI AR

Description of Data:
NAMI Support groups are funded by the Children’s System of Care grant. DBHS has a sub grant with NAMI Arkansas to provide funds for these groups. Arkansas would like to have one group meet monthly in each of 14 sites.

Data issues/caveats that affect outcome measures:
The challenge has been in finding individuals who are consistently able to lead support groups as the leaders must be legacy family members who complete the NAMI support group trainings and be unpaid volunteers.

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Number of Individuals Trained by UALR/MidSOUTH</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>426</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>356</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>2000</td>
</tr>
</tbody>
</table>

Data Source:
UALR/MidSOUTH

Description of Data:
Each year the Children’s System of Care grant trainings have been made available to mental health staff and families. During SFY 2016, an exceptionally large number of family members were trained in Team Up for Your Child. Each year different subjects directly related to the grant are chosen and specific groups are targeted for the trainings.

**Data issues/caveats that affect outcome measures:**
During the final years of the grant, less funds are available to be used for training.

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Number of Youth and Family Affiliate Liaisons Hired</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>9 Youth and 5 Family Liaisons Hired</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>11 youth and 11 family liaisons hired</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>14 youth and 14 family liaisons hired</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Mid-South Health Systems</td>
</tr>
<tr>
<td>Description of Data:</td>
<td>Family and youth liaisons work within their community in the area of social marketing to inform families and youth about System of Care and encourage their participation in System of Care activities.</td>
</tr>
<tr>
<td>Data issues/caveats that affect outcome measures:</td>
<td>All liaisons must have lived experiences and a desire to help others with similar backgrounds.</td>
</tr>
</tbody>
</table>

**Priority #:** 5
**Priority Area:** Consumer Affairs
**Priority Type:** SAT, MHS
**Population(s):** SMI, SED, PWIDC, PP, PWID, Other (Adolescents w/SA and/or MH, LGBTQ, Rural, Criminal/Juvenile Justice, Persons with Disabilities, Homeless)

**Goal of the priority area:**
Develop and build Division of Behavioral Health Service’s Office of Consumer Affairs to meet the needs of the identified populations throughout the state of Arkansas.

**Objective:**
Facilitate consumer and family voice in policy and program development.

**Strategies to attain the objective:**

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

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

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

* DBHS will work with organizations representing consumers and families to meet this goal.

* DBHS will work with Consumer Councils in the CMHCs.

**Priority #:** 6
**Priority Area:** Alcohol Use Among Youth, Adults and the Military
Priority Type: SAP
Population(s): PP, Other (Adolescents w/SA and/or MH, Military Families)

Goal of the priority area:
Reduce use of alcohol drinking among persons under 21, adults and the military.

Objective:
Lower reported 30-day alcohol usage by 2%

Strategies to attain the objective:

• Increase utilization of the Center for Substance Abuse Prevention (CSAP) strategies: information dissemination, education/training community-based, problem identification and referral

• Coordinate services for veterans, families, and other impacted by combat to determine and fill gaps based on issues, geography, age, and gender.

• 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 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.

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**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Number of students surveyed who reported that they had drank alcohol in the past 30 days.</td>
</tr>
<tr>
<td>Baseline Measurement</td>
<td>12%</td>
</tr>
<tr>
<td>First-year target/outcome measurement</td>
<td>Lower reported 30-day alcohol usage by 2%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement</td>
<td>Lower reported 30-day alcohol usage by 3%</td>
</tr>
</tbody>
</table>

**Data Source:**
Arkansas Prevention Needs Assessment Survey (APNA), State Epidemiological Outcome Workgroup (SEOW), Completed on-line training certificates, Arkansas Prevention WITS System

**Description of Data:**
The Arkansas Prevention Needs Assessment (APNA) Survey measures the current student use of alcohol, tobacco, and other drugs (ATOD) for students in grades 6th, 8th, 10th & 12th. APNA Survey is grounded in the risk and protective factor model of substance abuse prevention.

Enhance or expand data being collected by veteran serving organization for ATOD usage such as completed on-line training certificates.

State Epidemiological Outcome Workgroup: This report provides an overview of substance 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.

Arkansas Prevention WITS provides full functionality for tracking all prevention activities within the state and its regions or service areas. WITS contain a multi-dimensional Prevention Plan and allow contracted agencies to implement appropriate interventions/activities according to the plan. Implementation data is collected based on the workflow of the users, allowing for rapid but thorough collection of data required by the Block Grant, PFS and other required reporting mechanisms. All data collected can be used for subsequent evaluation, assessment and planning activities.

**Data issues/caveats that affect outcome measures:**
Arkansas uses the WITS reporting system – a web-based application designed to meet the growing need to capture substance abuse, mental health and treatment data. WITS satisfies mandatory government reporting requirements for planning, administration and monitoring of prevention programs. The system captures demographic information, number of individuals served, ethnicity, risk and protective factors along with the CSAP strategies.
Indicator #: 2
Indicator: The population served and reported in the Arkansas Prevention WITS by CSAP Strategies
Baseline Measurement: 1,122,046
First-year target/outcome measurement: Increase number of population served by 2%
Second-year target/outcome measurement: Increase number of population served by 3%

Data Source:
Arkansas Prevention Needs Assessment Survey (APNA), State Epidemiological Outcome Workgroup (SEOW), Completed on-line training certificates, Arkansas Prevention WITS System

Description of Data:
The Arkansas Prevention Needs Assessment (APNA) Survey measures the current student use of alcohol, tobacco, and other drugs (ATOD) for students in grades 6th, 8th, 10th & 12th. APNA Survey is grounded in the risk and protective factor model of substance abuse prevention.

Enhance or expand data being collected by veteran serving organization for ATOD usage such as completed on-line training certificates.

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Data issues/caveats that affect outcome measures:
Arkansas uses the WITS reporting system – a web-based application designed to meet the growing need to capture substance abuse, mental health and treatment data. WITS satisfies mandatory government reporting requirements for planning, administration and monitoring of prevention programs. The system captures demographic information, number of individuals served, ethnicity, risk and protective factors along with the CSAP strategies.

Indicator #: 3
Indicator: Number of completed on-line trainings for Center for Prevention and Training for Military
Baseline Measurement: 0
First-year target/outcome measurement: Increase number of completed on-line trainings by 2%
Second-year target/outcome measurement: Increase number of completed on-line trainings by 3%

Data Source:
State Epidemiological Outcome Workgroup (SEOW), Completed on-line training certificates, Arkansas Prevention WITS System

Description of Data:
Enhance or expand data being collected by veteran serving organization for ATOD usage such as completed on-line training certificates.

State Epidemiological Outcome Workgroup: This report provides an overview of substance 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.

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Data issues/caveats that affect outcome measures:
Arkansas uses the WITS reporting system – a web-based application designed to meet the growing need to capture substance abuse, mental health and treatment data. WITS satisfies mandatory government reporting requirements for planning, administration and monitoring of prevention programs. The system captures demographic information, number of individuals served, ethnicity, risk and protective factors along with the CSAP strategies.

Priority #: 7
Priority Area: Tobacco Use among the Youth, Adults and the Military
Priority Type: SAP
Population(s): PP, Other (Adolescents w/SA and/or MH, Military Families)

Goal of the priority area:
Reduction of cigarette use among the youth, Adults and the Military.

Objective:
Lower reported 30-day tobacco usage by 2%

Strategies to attain the objective:
• Increase utilization of the Center for Substance Abuse Prevention (CSAP) strategies to promote information dissemination, education/training, alternatives, environmental, community-based, problem identification and referral
• Coordinate services for veterans, families, and other impacted by combat to determine and fill gaps based on issues, geography, age, and gender.
• 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.

Annual Performance Indicators to measure goal success

Indicator #:

Indicator: Number of students surveyed in APNA 2014 who reported smoking cigarettes in the past 30 days.

Baseline Measurement: 6%

First-year target/outcome measurement: Lower reported 30-day tobacco usage by 2%

Second-year target/outcome measurement: Lower reported 30-day tobacco usage by 3%

Data Source:
Arkansas Prevention Needs Assessment Survey (APNA), State Epidemiological Outcome Workgroup (SEOW), Completed on-line training certificates, Arkansas Prevention WITS System

Description of Data:
The Arkansas Prevention Needs Assessment (APNA) Survey measures the current student use of alcohol, tobacco, and other drugs (ATOD) for students in grades 6th 8th, 10th, and 12th. APNA Survey is grounded in the risk and protective factor model of substance abuse prevention.

Enhance or expand data being collected by veteran serving organization for ATOD usage such as completed on-line training certificates.

State Epidemiological Outcome Workgroup: This report provides an overview of substance 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.

Prevention WITS directly supports efforts by State agencies, Tribal organizations, Providers and US territories to implement SAMHSA’s Strategic Prevention Framework (SPF).

Arkansas Prevention WITS provides full functionality for tracking all prevention activities within the state and its regions or service areas. WITS contain a multi-dimensional Prevention Plan and allow contracted agencies to implement appropriate...
Interventions/activities according to the plan. Implementation data is collected based on the workflow of the users, allowing for rapid but thorough collection of data required by the Block Grant, PFS and other required reporting mechanisms. All data collected can be used for subsequent evaluation, assessment and planning activities.

Data issues/caveats that affect outcome measures:

Arkansas uses the WITS reporting system – a web-based application designed to meet the growing need to capture substance abuse, mental health and treatment data. WITS satisfies mandatory government reporting requirements for planning, administration and monitoring of prevention programs. The system captures demographic information, number of individuals served, ethnicity, risk and protective factors along with the CSAP strategies.

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>The population served and reported in the WITS data system by CSAP Strategies.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>1,122,046</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Lower reported 30-day tobacco usage by 2%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Lower reported 30-day tobacco usage by 3%</td>
</tr>
</tbody>
</table>

Data Source: Arkansas Prevention Needs Assessment (APNA), State Epidemiological Outcome Workgroup (SEOW), Completed on-line training certificates, Arkansas Prevention WITS System

Description of Data:

The Arkansas Prevention Needs Assessment (APNA) Survey measures the current student use of alcohol, tobacco, and other drugs (ATOD) for students in grades 6th, 8th, 10th & 12th. APNA Survey is grounded in the risk and protective factor model of substance abuse prevention.

Enhance or expand data being collected by veteran serving organization for ATOD usage such as completed on-line training certificates.

State Epidemiological Outcome Workgroup: This report provides an overview of substance 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.

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Data issues/caveats that affect outcome measures:

Arkansas uses the WITS reporting system – a web-based application designed to meet the growing need to capture substance abuse, mental health and treatment data. WITS satisfies mandatory government reporting requirements for planning, administration and monitoring of prevention programs. The system captures demographic information, number of individuals served, ethnicity, risk and protective factors along with the CSAP strategies.

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>Number of completed on-line training for Center for Prevention and Training for Military</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>0</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Increase number of on-line trainings completed by 2%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Increase number of on-line trainings completed by 3%</td>
</tr>
</tbody>
</table>

Data Source: State Epidemiological Outcome Workgroup (SEOW), Completed on-line training certificates, Arkansas Prevention WITS System
**Priority #:** 8

**Priority Area:** Lower the Usage Rate for Prescription Drug Usage

**Priority Type:** SAP

**Population(s):** PP, Other (Adolescents w/SA and/or MH, Military Families)

**Goal of the priority area:**
Reduce use of prescription drugs among Youth, Adults and the Military.

**Objective:**
Lower reported 30-day prescription drug usage by 2%

**Strategies to attain the objective:**
- Increase utilization of the Center for Substance Abuse Prevention (CSAP) strategies to promote information dissemination, education/training, alternatives, environmental, community-based, problem identification and referral
- Coordinate services for veterans, families, and other impacted by combat to determine and fill gaps based on issues, geography, age, and gender.
- 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.

**Annual Performance Indicators to measure goal success**

<table>
<thead>
<tr>
<th>Indicator #</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator:</strong></td>
<td>Number of students surveyed in APNA 2014 who reported using prescription drugs use in the past 30 days.</td>
</tr>
<tr>
<td><strong>Baseline Measurement:</strong></td>
<td>3.2%</td>
</tr>
<tr>
<td><strong>First-year target/outcome measurement:</strong></td>
<td>Lower reported 30-day prescription drug usage by 2%</td>
</tr>
<tr>
<td><strong>Second-year target/outcome measurement:</strong></td>
<td>Lower reported 30-day prescription drug usage by 3%</td>
</tr>
</tbody>
</table>

**Data Source:**
Arkansas Prevention Needs Assessment Survey (APNA), State Epidemiological Outcome Workgroup (SEOW), Completed on-line training certificates, Arkansas Prevention WITS System

**Description of Data:**
Enhance or expand data being collected by veteran serving organization for ATOD usage such as completed on-line training certificates.

State Epidemiological Outcome Workgroup: This report provides an overview of substance 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.

Prevention WITS directly supports efforts by State agencies, Tribal organizations, Providers and US territories to implement SAMHSA’s Strategic Prevention Framework (SPF).

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**Data issues/caveats that affect outcome measures:**
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The Arkansas Prevention Needs Assessment (APNA) Survey measures the current student use of alcohol, tobacco, and other drugs (ATOD) for students in grades 6th, 8th, 10th & 12th. APNA Survey is grounded in the risk and protective factor model of substance abuse prevention.

Enhance or expand data being collected by veteran serving organization for ATOD usage such as completed on-line training certificates.

State Epidemiological Outcome Workgroup: This report provides an overview of substance 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.

Arkansas Prevention WITS provides full functionality for tracking all prevention activities within the state and its regions or service areas. WITS contain a multi-dimensional Prevention Plan and allow contracted agencies to implement appropriate interventions/activities according to the plan. Implementation data is collected based on the workflow of the users, allowing for rapid but thorough collection of data required by the Block Grant, PFS and other required reporting mechanisms. All data collected can be used for subsequent evaluation, assessment and planning activities.

Data issues/caveats that affect outcome measures:

Arkansas uses the WITS reporting system – a web-based application designed to meet the growing need to capture substance abuse, mental health and treatment data. WITS satisfies mandatory government reporting requirements for planning, administration and monitoring of prevention programs. The system captures demographic information, number of individuals served, ethnicity, risk and protective factors along with the CSAP strategies.

<table>
<thead>
<tr>
<th>Indicator #:</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator:</td>
<td>The population served and reported in the Arkansas Prevention WITS System by CSAP Strategies.</td>
</tr>
<tr>
<td>Baseline Measurement:</td>
<td>1,122,046</td>
</tr>
<tr>
<td>First-year target/outcome measurement:</td>
<td>Increase the population served by 2%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement:</td>
<td>Increase the population served by 3%</td>
</tr>
<tr>
<td>Data Source:</td>
<td>Arkansas Prevention Needs Assessment Survey (APNA), State Epidemiological Outcome Workgroup (SEOW), Completed on-line training certificates, Arkansas Prevention WITS System</td>
</tr>
<tr>
<td>Description of Data:</td>
<td>The Arkansas Prevention Needs Assessment (APNA) Survey measures the current student use of alcohol, tobacco, and other drugs (ATOD) for students in grades 6th, 8th, 10th &amp; 12th. APNA Survey is grounded in the risk and protective factor model of substance abuse prevention. Enhance or expand data being collected by veteran serving organization for ATOD usage such as completed on-line training certificates. State Epidemiological Outcome Workgroup: This report provides an overview of substance 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. Arkansas Prevention WITS provides full functionality for tracking all prevention activities within the state and its regions or service areas. WITS contain a multi-dimensional Prevention Plan and allow contracted agencies to implement appropriate interventions/activities according to the plan. Implementation data is collected based on the workflow of the users, allowing for rapid but thorough collection of data required by the Block Grant, PFS and other required reporting mechanisms. All data collected can be used for subsequent evaluation, assessment and planning activities</td>
</tr>
</tbody>
</table>

Data issues/caveats that affect outcome measures:
<table>
<thead>
<tr>
<th>Indicator #: 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator: Number of completed on-line training for Center for Prevention and Training for Military</td>
</tr>
<tr>
<td>Baseline Measurement: 0%</td>
</tr>
<tr>
<td>First-year target/outcome measurement: Increase the number of completed online trainings by 2%</td>
</tr>
<tr>
<td>Second-year target/outcome measurement: Increase the number of completed online trainings by 3%</td>
</tr>
</tbody>
</table>

**Data Source:**
State Epidemiological Outcome Workgroup (SEOW), Completed on-line training certificates, Arkansas Prevention WITS System

**Description of Data:**
Enhance or expand data being collected by veteran serving organization for ATOD usage such as completed on-line training certificates.

State Epidemiological Outcome Workgroup: This report provides an overview of substance 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.

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**Data issues/caveats that affect outcome measures:**
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**Footnotes:**
### Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2017   Planning Period End Date: 6/30/2019

<table>
<thead>
<tr>
<th>Activity (See instructions for using Row 1.)</th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention* and Treatment</td>
<td>$20,248,062</td>
<td>$0</td>
<td>$0</td>
<td>$2,980,072</td>
<td>$0</td>
<td>$17,212,176</td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children**</td>
<td>$2,338,724</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$17,212,176</td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td>$17,909,338</td>
<td>$0</td>
<td>$0</td>
<td>$2,980,072</td>
<td>$0</td>
<td>$17,212,176</td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$5,399,484</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td>$5,399,484</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
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<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>5. Early Intervention Services for HIV</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
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<tr>
<td>7. Other 24 Hour Care</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)</td>
<td>$1,349,871</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>10. SubTotal (1,2,3,4,9)</td>
<td>$21,597,933</td>
<td>$0</td>
<td>$0</td>
<td>$2,980,072</td>
<td>$0</td>
<td>$17,212,176</td>
<td></td>
</tr>
<tr>
<td>11. SubTotal (5,6,7,8)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>12. Total</td>
<td>$26,997,417</td>
<td>$0</td>
<td>$0</td>
<td>$2,980,072</td>
<td>$0</td>
<td>$17,212,176</td>
<td></td>
</tr>
</tbody>
</table>

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.
**Footnotes:**

Line 10 SubTotal (1,2,3,4,9) does not include line 2a, Primary Prevention. The total on line 12 is correct.
### Activity (See instructions for using Row 1.)

<table>
<thead>
<tr>
<th></th>
<th>A. Substance Abuse Block Grant</th>
<th>B. Mental Health Block Grant</th>
<th>C. Medicaid (Federal, State, and Local)</th>
<th>D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare), SAMHSA, etc.)</th>
<th>E. State Funds</th>
<th>F. Local Funds (excluding local Medicaid)</th>
<th>G. Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Pregnant Women and Women with Dependent Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. All Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Primary Prevention</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>a. Substance Abuse Primary Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Mental Health Primary*</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>3. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**</td>
<td>$962,890</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Early Intervention Services for HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. State Hospital</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>7. Other 24 Hour Care</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$13,734,068</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>8. Ambulatory/Community Non-24 Hour Care</td>
<td>$5,966,772</td>
<td>$0</td>
<td>$2,015,962</td>
<td>$49,805,062</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>9. Administration (Excluding Program and Provider Level)</td>
<td>$177,822</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>10. SubTotal (1,2,3,4,9)</td>
<td>$0</td>
<td>$177,822</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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</tr>
<tr>
<td>11. SubTotal (5,6,7,8)</td>
<td>$0</td>
<td>$6,929,662</td>
<td>$0</td>
<td>$2,015,962</td>
<td>$63,539,130</td>
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<td>$0</td>
</tr>
<tr>
<td>12. Total</td>
<td>$0</td>
<td>$7,107,484</td>
<td>$0</td>
<td>$2,015,962</td>
<td>$63,539,130</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMH or children with SED
** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside
Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

<table>
<thead>
<tr>
<th>Category</th>
<th>Aggregate Number Estimated In Need</th>
<th>Aggregate Number In Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant Women</td>
<td>98</td>
<td>186</td>
</tr>
<tr>
<td>Women with Dependent Children</td>
<td>2808</td>
<td>1780</td>
</tr>
<tr>
<td>Individuals with a co-occurring M/SUD</td>
<td>2664</td>
<td>4216</td>
</tr>
<tr>
<td>Persons who inject drugs</td>
<td>562</td>
<td>2876</td>
</tr>
<tr>
<td>Persons experiencing homelessness</td>
<td>1576</td>
<td>1167</td>
</tr>
</tbody>
</table>

Please provide an explanation for any data cells for which the stats does not have a data source.

*For the following categories, pregnant women, women with dependent children, individuals with a co-occurring M/SUD, and persons who inject drugs, the estimated in need value is defined by individuals that indicated a need for treatment in the past 12 months applied to the known sub-population. It is calculated by the rate of NSDUH survey respondents who indicated a need for treatment applied to the known sub-populations.

*Values for Pregnant Women, Co-occurring M/SUD and Persons who inject drugs were calculated using cross tabulation analysis of weighted data.

Footnotes:
## Planning Tables

### Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017   Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Expenditure Category</th>
<th>FFY 2018 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Substance Abuse Prevention and Treatment</td>
<td>$20,248,062</td>
</tr>
<tr>
<td>2. Primary Substance Abuse Prevention</td>
<td>$5,399,484</td>
</tr>
<tr>
<td>3. Early Intervention Services for HIV*</td>
<td></td>
</tr>
<tr>
<td>4. Tuberculosis Services</td>
<td></td>
</tr>
<tr>
<td>5. Administration (SSA Level Only)</td>
<td>$1,349,871</td>
</tr>
<tr>
<td><strong>6. Total</strong></td>
<td><strong>$26,997,417</strong></td>
</tr>
</tbody>
</table>

* For the purpose of determining the states and jurisdictions that are considered “designated states” as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to
do so.

Footnotes:
# Planning Tables

## Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017   Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Strategy</th>
<th>IOM Target</th>
<th>FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>SA Block Grant Award</strong></td>
</tr>
<tr>
<td><strong>Information Dissemination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$257,143</td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td>$142,857</td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td>$43,429</td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$443,429</strong></td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$537,143</td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td>$228,571</td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td>$40,000</td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$805,714</strong></td>
</tr>
<tr>
<td><strong>Alternatives</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$211,429</td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td>$17,143</td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td>$4,000</td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$232,572</strong></td>
</tr>
<tr>
<td><strong>Problem Identification and Referral</strong></td>
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<td></td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$154,286</td>
</tr>
<tr>
<td>Selective</td>
<td></td>
<td>$1,371</td>
</tr>
<tr>
<td>Indicated</td>
<td></td>
<td>$1,371</td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$157,028</strong></td>
</tr>
<tr>
<td>Category</td>
<td>Universal</td>
<td>Selective</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Community-Based Process</td>
<td>$753,677</td>
<td>$62,857</td>
</tr>
<tr>
<td>Environmental</td>
<td>$588,571</td>
<td>$25,142</td>
</tr>
<tr>
<td>Section 1926 Tobacco</td>
<td>$482,714</td>
<td>$0</td>
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<tr>
<td>Other</td>
<td>$1,787,207</td>
<td>$28,571</td>
</tr>
<tr>
<td><strong>Total Prevention Expenditures</strong></td>
<td><strong>$5,399,484</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong>*</td>
<td><strong>$26,997,417</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Planned Primary Prevention Percentage** 20.00 %

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

**Footnotes:**
# Planning Tables

**Table 5b SABG Primary Prevention Planned Expenditures by IOM Category**

Planning Period Start Date: 10/1/2017   Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Activity</th>
<th>FY 2018 SA Block Grant Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universal Direct</td>
<td>$3,421,556</td>
</tr>
<tr>
<td>Universal Indirect</td>
<td>$1,350,614</td>
</tr>
<tr>
<td>Selective</td>
<td>$506,512</td>
</tr>
<tr>
<td>Indicated</td>
<td>$120,802</td>
</tr>
<tr>
<td><strong>Column Total</strong></td>
<td><strong>$5,399,484</strong></td>
</tr>
<tr>
<td><strong>Total SABG Award</strong></td>
<td><strong>$26,997,417</strong></td>
</tr>
<tr>
<td><strong>Planned Primary Prevention Percentage</strong></td>
<td><strong>20.00 %</strong></td>
</tr>
</tbody>
</table>

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

**Footnotes:**
## Planning Tables

### Table 5c SABG Planned Primary Prevention Targeted Priorities

<table>
<thead>
<tr>
<th>Targeted Substances</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>b</td>
</tr>
<tr>
<td>Tobacco</td>
<td>b</td>
</tr>
<tr>
<td>Marijuana</td>
<td>b</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>b</td>
</tr>
<tr>
<td>Cocaine</td>
<td>b</td>
</tr>
<tr>
<td>Heroin</td>
<td>b</td>
</tr>
<tr>
<td>Inhalants</td>
<td>e</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>b</td>
</tr>
<tr>
<td>Synthetic Drugs (i.e. Bath salts, Spice, K2)</td>
<td>b</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Targeted Populations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Students in College</td>
<td>b</td>
</tr>
<tr>
<td>Military Families</td>
<td>b</td>
</tr>
<tr>
<td>LGBT</td>
<td>b</td>
</tr>
<tr>
<td>American Indians/Alaska Natives</td>
<td>e</td>
</tr>
<tr>
<td>African American</td>
<td>b</td>
</tr>
<tr>
<td>Hispanic</td>
<td>b</td>
</tr>
<tr>
<td>Homeless</td>
<td>e</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islanders</td>
<td>e</td>
</tr>
<tr>
<td>Asian</td>
<td>b</td>
</tr>
<tr>
<td>Rural</td>
<td>b</td>
</tr>
<tr>
<td>Underserved Racial and Ethnic Minorities</td>
<td>b</td>
</tr>
</tbody>
</table>
# Planning Tables

## Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017  
Planning Period End Date: 9/30/2019

<table>
<thead>
<tr>
<th>Activity</th>
<th>A. MHBG</th>
<th>B. SABG Treatment</th>
<th>C. SABG Prevention</th>
<th>D. SABG Combined*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information Systems</td>
<td>$290,000</td>
<td></td>
<td>$290,000</td>
<td></td>
</tr>
<tr>
<td>2. Infrastructure Support</td>
<td></td>
<td>$340,324</td>
<td></td>
<td>$340,324</td>
</tr>
<tr>
<td>3. Partnerships, community outreach, and needs assessment</td>
<td></td>
<td>$320,206</td>
<td>$280,000</td>
<td>$600,206</td>
</tr>
<tr>
<td>4. Planning Council Activities (MHBG required, SABG optional)</td>
<td>$177,822</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Quality Assurance and Improvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Research and Evaluation</td>
<td></td>
<td></td>
<td>$110,000</td>
<td>$110,000</td>
</tr>
<tr>
<td>7. Training and Education</td>
<td></td>
<td></td>
<td>$1,000,112</td>
<td>$1,000,112</td>
</tr>
<tr>
<td><strong>8. Total</strong></td>
<td><strong>$177,822</strong></td>
<td><strong>$320,206</strong></td>
<td><strong>$2,020,436</strong></td>
<td><strong>$2,340,642</strong></td>
</tr>
</tbody>
</table>

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

**Footnotes:**
Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions. Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease. It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders. SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity. For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care. SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders. The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care. Use of EHRs - in full compliance with applicable legal requirements? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes and ACOs may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs may also work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations. Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.

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

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

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

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA’s National Behavioral Health Quality Framework includes core measures that may be used by providers and payers. SAMHSA recognizes that certain jurisdictions receiving block grant funds including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs. However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.


29 http://www.samhsa.gov/health-disparities/strategic-initiatives


Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community-based mental and substance use disorders settings.

   Beginning July 1, 2017, Arkansas’s Medicaid Program is being transformed. A part of the transformation is that Medicaid will pay for outpatient Substance Abuse Treatment for all Medicaid recipients. Therefore, Medicaid providers will be providing not only Mental Health Services but will also provide Substance Abuse Treatment Services. Substance Abuse Providers will now have the opportunity to become Medicaid Providers through a couple of different avenues and thus will be able to provide Mental Health Services as well. Also, the new system allows for an Independently Licensed Clinician to co-locate with primary care physicians. This will assist with an integrated system of care for individuals that have mental health and/or substance abuse disorders. The PCP office is now an allowable place of service in the new Outpatient Behavioral Health system.

2. Describe how the state provides services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

   In addition to the information listed in question one, Arkansas is currently in the process of developing a Provider Led Managed Care Model. Here, the total cost of care for each Medicaid Recipient with Behavioral Health issues will be managed through a care coordination model for appropriate treatment of all medically needed services.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

   Yes No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

   Yes No

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?

   Yes No
6. Do the behavioral health providers screen and refer for:

a) Prevention and wellness education

b) Health risks such as
   i) heart disease
   ii) hypertension
   viii) high cholesterol
   ix) diabetes

c) Recovery supports

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?
   At this time, there are no issues or problems to report.

10. Does the state have any activities related to this section that you would like to highlight?
   The Provider-led Arkansas Shared Savings Entities (PASSE) is a new model of organized care that will address the needs of certain Medicaid recipients who have complex behavioral health and intellectual and developmental disabilities service needs. Under this unique organized care model, providers of specialty and medical services will enter into new partnerships with experienced organizations that perform the administrative functions of managed care. Together, these groups of providers and their managed care partners will form a new business organization called a PASSE. This organized care model will be designed to achieve savings over a five-year period in the overall effort to “bend the cost curve” of Medicaid and help the program to become sustainable. DHS will construct a financial baseline to reflect the five-year cost of covering the targeted population. Individuals served by this new coordinated care delivery system must meet the Medicaid income, resources, and functional needs assessment qualifications. In addition, they must meet the Tier II or Tier III level of care defined by DBHS and DDS. Individuals will be required to have an Independent Assessment (IA) for a Tier II or III determination while individuals who need Tier I or crisis services will be able to access them directly from certified providers.

   The PASSE model will include two phases. The first phase will begin October 1, 2017, at which time the PASSE will assume responsibility for the case management and care coordination for each of their members. Each PASSE will receive payment for case management and care coordination for each enrolled member. DHS will continue to pay for services on a fee-for-service basis.

   Phase 2 will begin January 1, 2019 at which time DHS will make an actuarially-sound “global payment” for to the PASSE for each enrollee to cover the administration costs and benefits for each patient, while ensuring a level of savings for the state. The Global Payment will include a percentage reduction to be determined off the projected baseline trend to achieve a guaranteed level of savings for the state and the federal government. The Global Payment will be made to each PASSE on a per-member per-month (PMPM) basis.

   Please indicate areas of technical assistance needed related to this section

Footnotes:
Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

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

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

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

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

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SM; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

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48 http://www.thinkculturalhealth.hhs.gov
51 http://www.whitehouse.gov/omb/fedreg_race-ethnicity
Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?
   a) Race
   b) Ethnicity
   c) Gender
   d) Sexual orientation
   e) Gender identity
   f) Age

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2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) standard?

6. Does the state have a budget item allocated to identifying and remedying disparities in behavioral health care?

7. Does the state have any activities related to this section that you would like to highlight?
   No

   Please indicate areas of technical assistance needed related to this section
   None

Footnotes:
Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

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

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities, NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

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

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA’s Treatment Improvement Protocol Series (TIPS) are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

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

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

56 http://psychiatryonline.org/
57 http://store.samhsa.gov
58 http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  [ ] Yes  [ ] No

2. Which value based purchasing strategies do you use in your state (check all that apply):
   a)  [ ] Leadership support, including investment of human and financial resources.
   b)  [ ] Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
   c)  [ ] Use of financial and non-financial incentives for providers or consumers.
   d)  [ ] Provider involvement in planning value-based purchasing.
   e)  [ ] Use of accurate and reliable measures of quality in payment arrangements.
   f)  [ ] Quality measures focus on consumer outcomes rather than care processes.
   g)  [ ] Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
   h)  [ ] The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

Arkansas is in the process of implementing a major transformation of its Medicaid outpatient behavioral health services program. In the first phase of this transformation, Medicaid will begin paying for several evidence-based practices it has not paid for in the past. For example, supported employment, supported housing, peer support, etc. It is anticipated that with this new payer source being in place, these evidence-based practices will become much more available to Arkansas consumers. In the second phased of the transformation, a hybrid-managed care system will be implemented. This provider owned and led entity will receive global payments and be at full risk for providing outpatient behavioral health services. A feature of this second phase will include provisions for providers to share in the potential cost savings based on producing quality outcomes for consumers.

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

Footnotes:
Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question
Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP (the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?

   If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

   Arkansas has implemented components of the Coordinated Specialty Care Model with the Community Mental Health Centers across the state. Individuals that experience a first episode of psychosis are able to receive the following components of the EBP model – Individual Therapy; Family Psycho-education and Low Dose Medications.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

   The state promotes the use of evidence-based for individual with ESMI on an ongoing basis. Providers are able to access both technical assistance and various training modalities.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI?

5. Does the state collect data specifically related to ESMI?

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

   The state implements components of the Coordinated Specialty Care Model. Those components are Cognitive Behavioral therapy for Psychosis; Individual Resiliency Training; Family Psychoeducation and Lower Dosages of Medication.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

   The state will continue to promote the use of Coordinated Specialty Care Model within the Community Mental Health Centers.
will provide training on the Supported Education/Employment to assist the providers with implementation. Providers will be required to improve the capacity of the CSC team to address and monitor suicidal behavior. Data reporting will include additional information regarding the improvement of symptoms and individual functioning.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.
   The state collects data from providers on a monthly basis. The current data form is being revised to include functional domains along with procedures to capture suicidal behavior and symptom reduction.

10. Please list the diagnostic categories identified for your state's ESMI programs.
    Schizophrenia; Bipolar Disorder; Schizo-affective Disorder; Psychosis NOS; Schizoid

    Does the state have any activities related to this section that you would like to highlight?
    No

    Please indicate areas of technical assistance needed related to this section.
    None

Footnotes:
Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question
States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person’s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person’s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person’s needs and desires.

1. Does your state have policies related to person centered planning?  
   - Yes  
   - No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

   Per contract, providers of MHBG funded services are required to have national accreditation (CARF, TJC or COA) and to follow “Standards for Community Mental Health Centers and Clinics in the State of Arkansas. These national and state standards require PCP on the part of accredited providers. The state also provides financial and other support to NAMI-Arkansas and to the Arkansas Behavioral Health Planning and Advisory Council. Both of these organizations promote consumer and caregiver involvement in health care decisions.

4. Describe the person-centered planning process in your state.

   As notes above, PCP is required of all providers receiving MHBG funds. This PCP takes place as part of the routine ongoing treatment planning process. At both the initial treatment plan and updates to this plan (typically at least every 90 days) consumer preferences, strengths and desired outcomes are assessed based on input from the consumer and/or caregiver and these are then incorporated into the consumer’s treatment plan.

   Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:
Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question
In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds, the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction?  j  Yes  j  No
2. Are there any concretely planned initiatives in our state specific to self-direction?  j  Yes  j  No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

a) How is this initiative financed:
   State General Revenue

b) What are the eligibility criteria?
   Currently this service is limited to children and youth and is provided through Wraparound services. Wraparound is for families involved with multiple service agencies (juvenile justice, child welfare, schools, mental health, etc.) who need help keeping their children or youth in the home, school or community.

c) How are budgets set, and what is the scope of the budget?
   The specific budget is based on the amount of SGR that is available for the Team's area. The Team members work to ensure funds are effectively used but are judicious with amounts per individual to ensure the money is available to as many children as possible. Although every Wraparound is different, every Wraparound must have four separate and unique phases:

   Engagement: The family and the Wraparound facilitator get to know one another and the family chooses the members of their Wraparound team.

   Planning: The Wraparound facilitator, family and team create a Wraparound plan. The plan is based on strengths and needs of the family. The Wraparound plan uses services and supports that are traditional along with those that are creative and non-traditional such as respite, mentoring, tutoring, community activities, parent training and more.

   Implementation: The Wraparound team follows the Wraparound plan and meets regularly to review the progress and to update the Wraparound plan.

   Transition: The family is empowered and is able to get the services and supports they need in their community, school, and home.
d) What role, if any, do peers with lived experience of the mental health system play in the initiative?
On some occasions, members of WRAP teams include those with lived-experience. However, the Peer Support initiative is still in the early stages of implementation in Arkansas.

e) What, if any, research and evaluation activities are connected to the initiative?
Wraparound is a nationally researched and recognized approach to providing family centered services, as referenced by nwi.pdx.edu.

f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.
NA

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.
Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SM1 and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SM1 and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?  
   - Yes  
   - No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard?  
   - Yes  
   - No

   Does the state have any activities related to this section that you would like to highlight?

   The state only contracts for the expenditure of MHBG funds with providers that are enrolled as Medicaid providers. The state actively encourages and supports provider efforts to ensure that all eligible clients are enrolled in Medicaid, including especially in “traditional” Medicaid (which offers the widest array of services needed by individuals with SM1 or SED) or, if not eligible for traditional Medicaid, are enrolled in the state’s Medicaid expansion program.

   Please indicate areas of technical assistance needed to this section

Footnotes:
Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation⁵⁹ to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

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

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state’s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.


Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

   Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed to this section

Footnotes:
Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. 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 use disorder 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 requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- **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;

- **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;

- **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;

- **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;

- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

- **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.

Please respond to the following items

**Assessment**

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?
   - Yes
   - No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)
   - Data on consequences of substance using behaviors
   - Substance-using behaviors
   - Intervening variables (including risk and protective factors)
   - Others (please list)

   The types of data collected by the SEOW includes:
   * Alcohol, tobacco, and other drug use indicators for youth and adults
   * Consequences including developmental, physiological, psychological, and community indicators
   * Contributing factors related to individuals, family, peers, school settings, and the community
   * Treatment admissions

3. Does your state collect needs assessment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
   - Children (under age 12)
   - Youth (ages 12-17)
   - Young adults/college age (ages 18-26)
   - Adults (ages 27-54)
   - Older adults (age 55 and above)
Cultural/ethnic minorities
Sexual/gender minorities
Rural communities
Others (please list)

Minorities

4. Does your state use data from the following sources in its Primary prevention needs assessment? (check all that apply)

- Archival indicators (Please list)
- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

American Lung Association, Estimated Prevalence and Incidence of Lung Disease report
Arkansas Alcoholic Beverage Control (ABC)
Arkansas Community Mental Health Center (CMHC) client satisfaction surveys
Arkansas Crime Information Center (ACIC)
Arkansas Department of Education (ADE)
Arkansas Department of Finance and Administration
Arkansas Department of Health (ADH)
Arkansas Department of Human Services (DHS) Division of Behavioral Health Services (DBHS) Alcohol and Drug Information System (ADMIS)
Arkansas Prevention Needs Assessment student survey (APNA)
Arkansas State Police, Highway Safety Office
Arkansas Synar Reports
Arkansas Tobacco Control Board (ATCB)
Centers for Disease Control and Prevention (CDC) WISQARS Injury Mortality Reports
Core Alcohol and Drug Survey
County Health Rankings and Roadmaps, Robert Wood John Foundation
National Adult Tobacco Survey (NATS)
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
Pregnancy Risk Assessment Monitoring System (PRAMS)
SAMHSA Centers for Mental Health Services (CMHS) Uniform Reporting System output tables (URS)
SAMHSA Treatment Episode Data Set (TEDS)
University of Arkansas at Little Rock (UA Little Rock) Survey Research Center
US Census Bureau
US Department of Justice, US Drug Enforcement Agency
US Department of Labor
Youth Tobacco Survey (YTS – active survey through 2010)

5. Does your state use needs assessment data to make decisions about the allocation SABG primary prevention funds?

| Yes | No |

If yes, (please explain)

The Arkansas Prevention Needs Assessment Survey (APNA) collects data on health risk behaviors, such as violence and alcohol, tobacco and other drug use that could result in injury and/or impede positive development among youth. The survey also assesses risk and protective factors, which include attitudes and opinions that have been shown through research to predict involvement in health risk behaviors. Public school districts are offered the opportunity for all students enrolled in grades 6, 8, 10, and 12 to be surveyed.

By comparing the results of the previous surveys, changes in ATOD (alcohol, tobacco and other drugs) use, rates of ASB (antisocial behavior) and levels of risk and protective factors can be determined for a specific grade. Although the target populations for the substance abuse prevention efforts are across the lifespan and not children only, it is a requirement that all of the substance abuse prevention providers’ efforts are all data-driven and the Arkansas Prevention Needs Assessment Survey is a key component of the primary prevention data.
The APNA Survey was first administered in the fall of 2002 and has been administered in the Fall of each school year since then.

If no, (please explain) how SABG funds are allocated:

Does the state have any activities related to this section that you would like to highlight?

Demographic Scope of the 2015-16 APNA Survey

Participating Students – 82,984
Valid Students – 75,027
184 Districts
511 Schools

Publications from Arkansas Foundation for Medical Care (AFMC):

Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas
Arkansas State Epidemiological Outcomes Workgroup: State Profile of Substance Use

Please indicate areas of technical assistance needed related to this section
Narrative Question

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### Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?  
   - Yes  
   - No

   If yes, please describe
   
   Arkansas Prevention Certification Board- the Arkansas Prevention Certification Board (APCB) oversees and evaluates the certification process for the state of Arkansas. APCB believes all individuals working in the field of prevention have a responsibility to the general public, their clientele, their employers and themselves to be positive role models. APCB is a member of the International Certification and Reciprocity Consortium (IC & RC).

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?  
   - Yes  
   - No

   If yes, please describe mechanism used
   
   University of Arkansas Little Rock MidSOUTH Center for Prevention and Training is the workforce development initiative that provides technical assistance and training on a variety of prevention topics reflecting the most current, science-based approaches to prevention professionals in their efforts to plan, implement, and evaluate science-based programming around the prevention of substance abuse, violence, and other high-risk behaviors. University of Arkansas Little Rock MidSOUTH Center has five training locations across the state.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?  
   - Yes  
   - No

   If yes, please describe mechanism used
   
   The state will implement the Strategic Prevention Framework (SPF) process (Assessment, Capacity, Planning, Implementation, and Evaluation). One of the components within the step of Assessment is community readiness. To determine the stage of community readiness, we will implement the Tri-Ethnic Center Community Readiness model, which identifies nine (9) stages of readiness.

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Does the state have any activities related to this section that you would like to highlight?

**Trainings and Conferences Provided**

- Substance Abuse Prevention Skills Training (SAPST) & TOT
- UA Little Rock Prevention Summit – 3 days
- UA Little Rock Youth Leadership Conference – 3 days
Regional Lead and Seed Trainings
Prescription Drug Abuse Summit
MidSOUTH Summer School: 45 Years of Navigating the Future
MidSOUTH – Various ATOD/SPF trainings, including capacity building

Please indicate areas of technical assistance needed related to this section
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**Planning**

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  
   - Yes  
   - No

   If yes, please attach the plan in BGAS by going to the Attachments Page and upload the plan.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)  
   - Yes  
   - No  
   - N/A

3. Does your state’s prevention strategic plan include the following components? (check all that apply):
   - a) b Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds  
   - b) b Timelines  
   - c) b Roles and responsibilities  
   - d) b Process indicators  
   - e) b Outcome indicators  
   - f) b Cultural competence component  
   - g) b Sustainability component  
   - h) e Other (please list):  
   - i) e Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?  
   - Yes  
   - No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?  
   - Yes  
   - No

   If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence-based.

Arkansas State Epidemiological Outcomes Workgroup (AR-SEOW) - The primary focus of the programs, practices, and strategies funded through the SABG prevention set-aside is to assist with building the capacity within communities, implement evidence-based prevention programs, and strategies within the communities and to promote understanding of the Strategic Prevention Framework. DBHS intends to...
fund an array of statewide, regional and community based primary prevention services, including:

13 Regional Prevention Providers (RPPs): RPPs provide prevention capacity development within regions and communities they serve to support statewide prevention efforts and programming. RPPs use the Strategic Prevention Framework to plan, develop, implement, and sustain effective prevention initiatives.

University of Arkansas Little Rock MidSOUTH Center for Prevention and Training: is a workforce development initiative that provides technical assistance and training on a variety of prevention topics reflecting the most current, science-based approaches to prevention and strives to assist prevention professionals in their efforts to plan, implement, and evaluate science-based programming around the prevention of substance abuse, violence, and other high-risk behaviors.

The Arkansas Prevention Certification Board (APCB): This body oversees and evaluates the certification process for the state of Arkansas. APCB is a member of the International Certification and Reciprocity Consortium (IC&RC).

Arkansas Prevention Network (APNet): APNet establishes and facilitates a statewide network of prevention professionals and stakeholders to share information about evidence-based and emerging programs, practices and policies, and the resources to develop and implement these strategies. APNet also advocates for the prevention practitioners by working to promote, establish, and maintain a support system for them.

Arkansas State Epidemiological Outcomes Workgroup (AR-SEOW): The AR-SEOW 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 SEOW compiles the Statewide Epidemiological Profile from various national and state agencies to integrate information about the causes and consequences of the use of alcohol, tobacco, and other drugs in both adults and children.

The state supports development and implementation of a wide array of primary prevention interventions to meet community needs and gaps in prevention services. Strategies based on assessment of needs, resources, and readiness are used to ensure funded prevention interventions to reduce risks and enhance protective factors.

SABG dollars set aside for primary prevention services not funded through other means are through prevention initiatives such as Fetal Alcohol Spectrum Disorders (FASD) Initiative, Arkansas Drug and Alcohol Safety Education Program (DASEP), Suicide Prevention and Early Intervention Programs, Gambling Prevention Initiative, Screening Brief Intervention, and early Referral to Treatment Initiative.

Does the state have any activities related to this section that you would like to highlight?

Through the SEOW Workgroup, Arkansas Foundation for Medical Care has developed a variety of prevention tools/materials that are available for no cost at PreventionWorksAR.org.

Does the state have any activities related to this section that you would like to highlight?

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

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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.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

   a) SSA staff directly implements primary prevention programs and strategies.
   b) The SSA has statewide contracts (e.g., statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
   c) The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
   d) The SSA funds regional entities that provide training and technical assistance.
   e) The SSA funds regional entities to provide prevention services.
   f) The SSA funds county, city, or tribal governments to provide prevention services.
   g) The SSA funds community coalitions to provide prevention services.
   h) The SSA funds individual programs that are not part of a larger community effort.
   i) The SSA directly funds other state agency prevention programs.
   j) Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

   a) **Information Dissemination:**

   This strategy provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two.

   Examples: clearinghouse/information resource centers, media campaigns, speaking engagements, and health fairs.

   *Promoted Great American Smokeout; National Impaired Driving Prevention Month; Drugged, Drunk, Driving Month, Prescription Drug Awareness Month, Prescription Drug Take Back Events, Fetal Alcohol Syndrome Disorder, Children of Alcoholics Awareness Month, National Kick Butts Day, and Reducing Sales to Minors Awareness through stakeholder emails, flyers, newsletters, billboards, radio public service announcements, and television commercials.*
*Distributed clearing house materials to community coalitions, schools/colleges, health departments, health care clinics, hospitals, pregnancy resource centers, youth serving agencies, mental health care facilities, recovery/treatment centers, faith-based organizations, Partnership for Success grantees, and DFC partners.

*Hosted ATOD booths at resource/health fairs across the state.

*Conducted presentations on various topics, including medical marijuana, SPF, dangers of ATOD.

*Hosted Conversation Cafes about monthly ATOD promotion topics.

b) Education:
This strategy builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem-solving, interpersonal communication, and systematic and judgmental abilities. Organizational infrastructure, planning, and evaluation skills are part of capacity development education. There is more interaction between facilitators and participants than in the information strategy.

Examples: Coalition training and peer leader/helper programs.

*Conducted youth presentations on: choices & consequences, underage drinking, marijuana dangers, tobacco effects, tobacco cessation, current drug trends, prescription drug abuse, suicide, cyberbullying & internet safety, and overcoming life's challenges: refusal skills, children of alcoholics, adolescent brain development, and principles of SPF Model.

*Conducted Lead and Seed Trainings with youths and adults

*Conducted various community trainings: APCB Exam Prep, Basic Prevention Techniques for Teens & Adolescents, Coalition Building & Sustainability, Evidence-Based Model Programs and Data Driven Decision Making, Cultural Competency and Sustainability, Mental Health First Aid, Suicide, and others.

*SAPST training.

c) Alternatives:
This strategy provides participation in activities that exclude alcohol and other drugs. The purpose is to meet the needs filled by alcohol and other drugs with healthy activities and to discourage the use of alcohol and other drugs.

Examples: Recreation activities, drug-free dances and parties, and community service activities.

d) Problem Identification and Referral:
This strategy aims at identification of those who have indulged in illegal/age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity to determine if a person is in need of treatment.

Examples: Employee Assistance programs, student assistance programs, and DWI/DUI education programs.

e) Community-Based Processes:
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.

*Partnered with PFS and DFC grantees in prevention efforts.

*Assisted/educated community coalitions with systematic planning/logic models utilizing the SPF process.

*Provided technical assistance to multi-agencies and coalitions.

*Partnered with youth organizations to host Teen Summits.

*Assessed community needs/gaps.

f) Environmental:
This strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing alcohol and other drug use by the general population.

Examples: Modifying alcohol and tobacco advertising practices, product pricing strategies, and promoting the establishment of review of alcohol, tobacco, and drug use policies.
*Conducted SYNAR tobacco compliance checks.

*Purchased MedReturn Drug Boxes for regional prescription drug collection efforts.

*Worked with law enforcement to reduce holiday drinking and educate offenders.

*Implemented Social Norming Campaigns.

*Hosted Tobacco Merchant Trainings.

*Educated Tobacco Merchants with Stop Tobacco Addiction and Break the Chain tool kits

*Participated in Prescription Drug Take Back Events

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?  

   Yes  No

If yes, please describe

No state allocation is set aside dollars for primary prevention services. The only other funding available is the SAMHSA approved Partnership for Success (PFS). To assist in reducing the number of overdose deaths related to prescription drug and other opioid drugs in our state, the Arkansas Department of Human Services, Division of Behavioral Health Services (DBHS), was awarded a Prescription Drug/Opioid Overdose-Related Deaths (PDO) prevention grant by the Substance Abuse Mental Health Service Administration (SAMHSA) in September 2016.

The purpose of this five-year program is to reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone to first responders.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.
SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. 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 use disorder 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 requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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- **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;

- **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and

- **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.

### Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?  
   - **Yes**  
   - **No**

   If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):  
   a) Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks  
   b) Includes evaluation information from sub-recipients  
   c) Includes SAMHSA National Outcome Measurement (NOMs) requirements  
   d) Establishes a process for providing timely evaluation information to stakeholders  
   e) Formalizes processes for incorporating evaluation findings into resource allocation and decision-making  
   f) Other (please list:)  
   g) Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

   a) Numbers served  
   b) Implementation fidelity  
   c) Participant satisfaction  
   d) Number of evidence based programs/practices/policies implemented  
   e) Attendance  
   f) Demographic information  
   g) Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

   a) 30-day use of alcohol, tobacco, prescription drugs, etc
b) Heavy use
b) Binge use
b) Perception of harm
c) b) Disapproval of use
d) b) Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
e) b) Other (please describe):

DBHS has currently acquired the WITS reporting system - a web-based application designed to meet the growing need to capture substance abuse, mental health & treatment data. WITS satisfy mandatory government reporting requirements for the planning, administration, and monitoring of prevention programs. The system captures demographic information, number of individuals served, ethnicity, risk and protective factors, along with the CSAP strategies.

The Arkansas Prevention Needs Assessment Student Survey will collect the outcome data of 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use, age of first use of ATOD, average age of first arrests, average age of first attacked to harm, lifetime use, and average age of first use and antisocial behavior.
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 diagnosis). 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.
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](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
3. Restructuring of the technical assistance system at the regional/community level
4. Comprehensive data management system
5. Need for more behavioral health training and certification capacity
6. Need for more prevention services staff at the state and local levels.
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:

<table>
<thead>
<tr>
<th># of Respondents</th>
<th>Training Needs Identified</th>
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<tbody>
<tr>
<td>1. 320</td>
<td>Conducting a community assessment</td>
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<td>2. 310</td>
<td>Creating and maintaining coalitions and partnerships</td>
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<td>3. 308</td>
<td>Using Institute of Medicine categories to select the appropriate strategy</td>
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<tr>
<td>4. 147</td>
<td>Writing grant applications for funding</td>
</tr>
<tr>
<td>5. 120</td>
<td>Assessing community needs and resources</td>
</tr>
<tr>
<td>6. 116</td>
<td>Developing interventions</td>
</tr>
<tr>
<td>7. 108</td>
<td>Describing the process of addiction</td>
</tr>
<tr>
<td>8. 108</td>
<td>Knowledge of current trends in drug use patterns</td>
</tr>
<tr>
<td>9. 106</td>
<td>Creating a sustainability plan</td>
</tr>
<tr>
<td>10. 106</td>
<td>Maintaining proficiency in technology, facilitation and presentation skills</td>
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See appendix VIII for MidSOUTH Prevention Institute 2011 Training Survey and statewide reports.
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 to 25) 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 brain 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 lifelong 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.
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.

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>ADH</td>
<td>Arkansas Department of Health</td>
</tr>
<tr>
<td>AFMC</td>
<td>Arkansas Foundations for Medical Care</td>
</tr>
<tr>
<td>AG</td>
<td>Attorney General’s Office</td>
</tr>
<tr>
<td>AOS</td>
<td>Army One Source</td>
</tr>
<tr>
<td>APCB</td>
<td>Arkansas Prevention Certification Board</td>
</tr>
<tr>
<td>APNA</td>
<td>Arkansas Prevention Needs Assessment</td>
</tr>
<tr>
<td>CAR</td>
<td>Center for Artistic Revolution</td>
</tr>
<tr>
<td>CHC</td>
<td>Community Health Center</td>
</tr>
<tr>
<td>CSOC</td>
<td>Children’s System of Care</td>
</tr>
<tr>
<td>DASEP</td>
<td>Drug and Alcohol Safety Education Program</td>
</tr>
<tr>
<td>DBHS</td>
<td>Division of Behavioral Health Services</td>
</tr>
<tr>
<td>DCFS</td>
<td>Division of Children and Family Services</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>DHS IT</td>
<td>Department of Human Services Information Technology</td>
</tr>
<tr>
<td>DOE</td>
<td>Department of Education</td>
</tr>
<tr>
<td>DYS</td>
<td>Division of Youth Services</td>
</tr>
<tr>
<td>EBP</td>
<td>Evidence-based Programs and Practices</td>
</tr>
<tr>
<td>ISA</td>
<td>International Survey Associates</td>
</tr>
<tr>
<td>LGBTQ</td>
<td>Lesbian, Gay, Bi-sexual, Transgender, and Questioning</td>
</tr>
<tr>
<td>MISGRO</td>
<td>Minority Initiative Sub Grant Recipient Office</td>
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<tr>
<td>MSPI</td>
<td>MidSouth Prevention Institute</td>
</tr>
<tr>
<td>MSSS</td>
<td>MidSouth Summer School</td>
</tr>
<tr>
<td>NG</td>
<td>National Guard</td>
</tr>
<tr>
<td>PRC</td>
<td>Prevention Resource Centers</td>
</tr>
<tr>
<td>RTI</td>
<td>Research Triangle Institute</td>
</tr>
<tr>
<td>SDDO</td>
<td>State Drug Director’s Office</td>
</tr>
<tr>
<td>SEOW</td>
<td>State Epidemiological Outcome Workgroup</td>
</tr>
<tr>
<td>TPCP</td>
<td>Tobacco Prevention and Cessation Program</td>
</tr>
<tr>
<td>UALR</td>
<td>University of Arkansas at Little Rock</td>
</tr>
<tr>
<td>UAMS</td>
<td>University of Arkansas Medical Sciences</td>
</tr>
<tr>
<td>UAPB</td>
<td>University of Arkansas at Pine Bluff</td>
</tr>
<tr>
<td>UDTF</td>
<td>Underage Drinking Task Force</td>
</tr>
<tr>
<td>YTS</td>
<td>Youth Tobacco Survey</td>
</tr>
</tbody>
</table>
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 |

<p>| 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. |</p>
<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Entity</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey State Policy Consortium for data collected by represented agencies.</td>
<td>DBHS, RTI</td>
<td>Jan. 2013</td>
</tr>
<tr>
<td>Conduct meetings with identified state agencies to assess available data.</td>
<td>DBHS</td>
<td>Apr. 2013</td>
</tr>
</tbody>
</table>

**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.

<table>
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<tr>
<th>Action Steps</th>
<th>Responsible Entity</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>Determine materials for the website.</td>
<td>DBHS, AFMC</td>
<td>Oct. 2012</td>
</tr>
<tr>
<td>Purchase domain and create website.</td>
<td>DBHS, AFMC</td>
<td>Oct. 2012</td>
</tr>
</tbody>
</table>

**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.

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<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Entity</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>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.</td>
<td>DBHS, DHS</td>
<td>Jun. 2013</td>
</tr>
<tr>
<td>Review and recommend contract oversight and language to insure data “ownership” and rights remain with DBHS.</td>
<td>DBHS, DHS</td>
<td>Dec. 2012</td>
</tr>
</tbody>
</table>

**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.
## 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.

<table>
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<tr>
<th>Action Steps</th>
<th>Responsible Entity</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>Collaborate with DBHS data section, state hospital, mental health section, treatment and recovery to provide input on development of dashboard.</td>
<td>All DBHS sections</td>
<td>TBD</td>
</tr>
<tr>
<td>Develop a Crosswalk between SAMHSA’s National Outcome Measure Domains (NOMS) and existing DBHS Prevention Databases</td>
<td>DBHS</td>
<td>TBD</td>
</tr>
<tr>
<td>Identify gaps in NOMS that are not in the existing Prevention Databases</td>
<td>DBHS</td>
<td>TBD</td>
</tr>
<tr>
<td>Determine procedures to capture the remaining NOMS Data sets</td>
<td>DBHS</td>
<td>TBD</td>
</tr>
<tr>
<td>Dedicate a staff member to maintain the Dashboard and update NOMS on a regular basis</td>
<td>DBHS</td>
<td>TBD</td>
</tr>
</tbody>
</table>
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.

<table>
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<tr>
<th>Action Steps</th>
<th>Responsible Entity</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>Identify existing partnerships.</td>
<td>DBHS, UALR, UAMS, UAPB, AHD (TPCP and Injury Prevention), C.A.R, SDDO</td>
<td>Jan. 2013</td>
</tr>
<tr>
<td>Identify and enhance relationships with additional partners.</td>
<td>DBHS, DYS, DCFS, HIV, DOE, AG, Drug Courts, CSOC, CHC</td>
<td>Jan. 2013</td>
</tr>
<tr>
<td>Review and identify opportunities for leveraging resources and funding.</td>
<td>DBHS, Partner agencies</td>
<td>Jan. 2013</td>
</tr>
</tbody>
</table>

**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.

<table>
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<tr>
<th>Action Steps</th>
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<th>Timeline</th>
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<tbody>
<tr>
<td>Facilitate community meetings to discuss collaborative efforts and leveraging of resources.</td>
<td>DBHS, PRCs</td>
<td>Apr. 2013</td>
</tr>
<tr>
<td>Review results of coalition leadership and consortium</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**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.

<table>
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<tr>
<th>Action Steps</th>
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<th>Timeline</th>
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<tbody>
<tr>
<td>Conduct meetings with established networks of DBHS funded providers.</td>
<td>DBHS, PRCs, DASEP, Treatment providers</td>
<td>Mar. 2013</td>
</tr>
<tr>
<td>Solicit partnerships through engaging other coalitions and stakeholders</td>
<td>DBHS, Statewide Providers, Primary Care Networks and TBD</td>
<td>Feb. 2013</td>
</tr>
<tr>
<td>Re-establish the Underage Drinking Task Force.</td>
<td>DBHS, UDTF</td>
<td>Mar. 2013</td>
</tr>
<tr>
<td>Revitalize Suicide Prevention Task Force.</td>
<td>DBHS, Suicide Prevention Task Force</td>
<td>Jul. 2013</td>
</tr>
</tbody>
</table>

**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.

<table>
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<tr>
<th>Action Steps</th>
<th>Responsible Entity</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine criteria to select best fit evidence-based programs and strategies for Arkansas communities.</td>
<td>DBHS, EBP Workgroup</td>
<td>Jul. 2012</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
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<th>Responsible Entity</th>
<th>Timeline</th>
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<tbody>
<tr>
<td>Assess prevention training needs among DBHS staff and develop training module.</td>
<td>DBHS</td>
<td>Jan. 2013</td>
</tr>
<tr>
<td>Develop standardized prevention training to establish a common prevention knowledge base and shared interests across sectors and disciplines.</td>
<td>DBHS, MSPI</td>
<td>Jul. 2013</td>
</tr>
<tr>
<td>Develop a basic Prevention Model System guide and toolkit with additional modules for specific community sectors to meet their unique training needs.</td>
<td>DBHS, MSPI</td>
<td>Jul. 2013</td>
</tr>
<tr>
<td>Develop a marketing plan to increase training opportunities both online and onsite for prevention providers and other stakeholders.</td>
<td>DBHS, MSPI, APCB, MSSS</td>
<td>May 2013</td>
</tr>
<tr>
<td>Increase greater variety and access to onsite and online training offerings to community coalitions, providers and stakeholders.</td>
<td>DBHS, SWCAPT, MSPI, APCB</td>
<td>Jan. 2013</td>
</tr>
<tr>
<td>Explore ways to expand the use of technology to support training through the existing prevention contractor.</td>
<td>DBHS, MSPI</td>
<td>Jan. 2013</td>
</tr>
<tr>
<td>Provide more opportunities for Training of Trainers</td>
<td>DBHS, MSPI</td>
<td>Jul. 2013</td>
</tr>
</tbody>
</table>
(TOT) for current prevention providers.

Revise orientation and training manuals for DBHS prevention staff.

<table>
<thead>
<tr>
<th>Goal 2: Restructure current TA and Training programs for behavioral health, prevention, and special populations.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy:</strong> Review the TA and Training system infrastructure to assess current training opportunities for commonalities in goals and identify any gaps.</td>
</tr>
<tr>
<td><strong>Action Steps</strong></td>
</tr>
<tr>
<td>Review current training programs to identify gaps.</td>
</tr>
<tr>
<td>Review annual workforce survey for most requested training topics.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 3: Create training systems that include TA that are responsive to the needs of the communities, special populations, and paid workforce.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy:</strong> Identify additional trainings needed at the community level, for licensure, and for special populations such as LGBTQ and military families that are evidenced-based.</td>
</tr>
<tr>
<td><strong>Action Steps</strong></td>
</tr>
<tr>
<td>Conduct community level focus groups to assess training needs specific to special populations.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>Meet with certification and workforce training system to establish a sequential core curriculum for licensure.</td>
</tr>
<tr>
<td>Review current TA system and explore feasibility of developing an on-line/electronic technical assistance system.</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Goal 1: Review process and outcome measures as utilized in the Strategic Prevention Framework (SPF), to foster more responsive and interactive state prevention systems.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy:</strong> Assess data collection and reporting methods for inclusion of process evaluation and comparison of process to outcome.</td>
</tr>
<tr>
<td><strong>Action Steps</strong></td>
</tr>
<tr>
<td>Evaluate minimum Data Set process for additional data to be collected.</td>
</tr>
<tr>
<td>Compare number of services provided per county to consumption and consequence data from Arkansas Prevention Needs Assessment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy:</strong> Meet with evaluation of efforts contractor to review current performance management and evaluation methods with a focus on enhancing the system.</td>
</tr>
<tr>
<td><strong>Action Steps</strong></td>
</tr>
<tr>
<td>Provide technical assistance on use of data for formative assessment for effectiveness of program and use of data for summative outcomes of behavioral changes.</td>
</tr>
<tr>
<td>Determine specific evaluation methods which can be replicated consistently.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 3: Create a structure whereby process and outcome measures can be integrated into</th>
</tr>
</thead>
</table>
program development.

**Strategy:** Develop a structure to ensure consistency in the implementation of programs.

<table>
<thead>
<tr>
<th>Action Steps</th>
<th>Responsible Entity</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review fidelity checklists associated with evidence-based programs.</td>
<td>DBHS</td>
<td>Jul. 2013</td>
</tr>
<tr>
<td>Develop standardized evaluation forms.</td>
<td>DBHS, PRCs, RTI</td>
<td>Jul. 2013</td>
</tr>
<tr>
<td>Provide technical assistance on use of outcome measures.</td>
<td>DBHS, MSPI, RTI</td>
<td>Jul. 2013</td>
</tr>
</tbody>
</table>
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)**

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Re-establish Underage Drinking Task Force</td>
<td>Establish MOU’s with partner agencies</td>
<td>Develop leveraged funding opportunities</td>
<td>Develop common funding applications</td>
<td></td>
</tr>
<tr>
<td>Develop LGBTQ consortium</td>
<td>Expand ACDEC program</td>
<td>Develop LGBTQ and Veteran’s surveys</td>
<td>Combine APNA and YTS</td>
<td></td>
</tr>
<tr>
<td>Restructure TA system</td>
<td>Develop community training curriculums and conduct TOTs</td>
<td>Train partner sectors about addiction</td>
<td>Standardize process and outcome measure collection process</td>
<td></td>
</tr>
<tr>
<td>Conduct TOTs for parenting curriculums</td>
<td>Restructure workforce training</td>
<td>Train community providers about suicide</td>
<td>Outreach to Beverage Retailer on social host campaign</td>
<td></td>
</tr>
<tr>
<td>Outreach to additional partner agencies</td>
<td>Coordinate Veteran’s services</td>
<td></td>
<td>Coordinate suicide data sources</td>
<td></td>
</tr>
<tr>
<td>Coordinated merchant education</td>
<td></td>
<td>Coordinate merchant training</td>
<td></td>
<td></td>
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</tbody>
</table>

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.

  o 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

<table>
<thead>
<tr>
<th>Category</th>
<th>Appointee</th>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arkansas Drug Director</td>
<td>Fran Flener</td>
<td>Governor’s Office Office of Alcohol and Drug Abuse Prevention</td>
</tr>
<tr>
<td>Alcohol and Drug Abuse Prevention</td>
<td>Ann Brown</td>
<td></td>
</tr>
<tr>
<td>Statewide Law Enforcement</td>
<td>Colonel Winford Phillips</td>
<td>Arkansas State Police</td>
</tr>
<tr>
<td>Alternate: Lt. Jerry Digman</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>Dr. Tom Kimbrell</td>
<td>Department of Education</td>
</tr>
<tr>
<td>Alternate: Tammy Harrell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highway Safety</td>
<td>Dan Flowers</td>
<td>AR Highway and Transportation Department</td>
</tr>
<tr>
<td>Alternate: Ronald Burks, Chief</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prison System</td>
<td>Ray Hobbs</td>
<td>Department of Corrections</td>
</tr>
<tr>
<td>Finance</td>
<td>Robert A. Parker</td>
<td></td>
</tr>
<tr>
<td>Alternate: Ann Purvis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Military</td>
<td>Major General William D. Wofford</td>
<td>National Guard</td>
</tr>
<tr>
<td>Alternate: LTC Marcus Hatley</td>
<td></td>
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</tr>
<tr>
<td>Attorney General</td>
<td>Dustin McDaniel</td>
<td>Attorney General</td>
</tr>
<tr>
<td>Alternate: Laura Shue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>State Crime Laboratory</td>
<td>Kermit Channell</td>
<td>State Crime Laboratory</td>
</tr>
<tr>
<td>Alternate: Richard Gallagher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Alcohol Levels</td>
<td>Laura Bailey</td>
<td>Blood Alcohol Testing Program, Department of Health</td>
</tr>
<tr>
<td>Alternate: Kent Williams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Probation</td>
<td>David Eberhard</td>
<td>Department of Community Correction</td>
</tr>
<tr>
<td>Court System</td>
<td>J. D. Gingerich</td>
<td>Administrative Office of the Courts</td>
</tr>
<tr>
<td>Police Chief</td>
<td>Chief Everett Cox</td>
<td>Tillar Police Department</td>
</tr>
<tr>
<td>County Sheriff</td>
<td>Sheriff Marty Moss</td>
<td>Cleburne County Sheriff Department</td>
</tr>
<tr>
<td>Cleburne County</td>
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<tr>
<td>Drug Court Judge</td>
<td>Judge Joe Griffin</td>
<td>Drug Court</td>
</tr>
<tr>
<td>Miller County</td>
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</tr>
<tr>
<td>Prosecuting Attorney</td>
<td>Larry Jegley</td>
<td>Pulaski County Prosecuting Attorney</td>
</tr>
<tr>
<td>Alternate: Jonathan Ross</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private citizen not employed by the State or Federal government</td>
<td>Dennis Emerson</td>
<td>Poyen School District</td>
</tr>
<tr>
<td>Director of a publicly funded alcohol and drug abuse treatment program</td>
<td>Dr. Rob Covington</td>
<td>Horizon Adolescent Treatment</td>
</tr>
<tr>
<td>School drug counselor</td>
<td>Katrina Cavaness</td>
<td>Monticello Public Schools</td>
</tr>
<tr>
<td>Director of a drug abuse prevention program</td>
<td>Reverend Edna Morgan</td>
<td>Healing Place Ministries</td>
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<tr>
<td>DWI program</td>
<td>Jim Allen</td>
<td>Family Service Agency, Inc.</td>
</tr>
<tr>
<td>Health Professional</td>
<td>Charlotte Denton</td>
<td>University of Arkansas at Monticello</td>
</tr>
<tr>
<td>At Large Members</td>
<td>Teresa Belew</td>
<td>Private Citizen</td>
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<tr>
<td>John Wiles</td>
<td>Person in Recovery</td>
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<tr>
<td>Vivian Ozura</td>
<td>Private Citizen</td>
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<tr>
<td>North Elliott</td>
<td>Narcotics Anonymous</td>
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## Appendix VI

### Recommended Evidence-based Programs and Strategies

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<tr>
<th>Evidence-Based Program Summary</th>
<th>Target Population and Setting</th>
<th>Substance Use</th>
<th>Mental Health Promotion and Externalizing Disorders</th>
<th>Bullying, Violence and Suicide Prevention</th>
<th>Cost of Curriculum and Training</th>
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<tr>
<td><strong>Al's Pals: Kids Making Healthy Choices.</strong> 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): <a href="http://www.wingspanworks.com/educational_programs">http://www.wingspanworks.com/educational_programs</a></td>
<td>Ages 0 to 12. Black or African American; Hispanic or Latino; White. School; other community settings.</td>
<td>↓ Alcohol use ↓ Tobacco use ↓ Other drug use</td>
<td>↑ social-emotional skills ↑ Problem-solving ↑ Healthy decision making ↑ Social competence ↑ Prosocial behaviors ↓ Antisocial behavior ↓ Aggressive behaviors</td>
<td>↓ Bullying Behavior ↓ Violence</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Big Brothers Big Sisters Mentoring Program.</strong> Designed to help participating youth ages 6-18 (&quot;Littles&quot;) reach their potential through supported matches with adult volunteer mentors ages 18 and older (&quot;Bigs&quot;). 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): <a href="http://www.bigbrothersbigsisters.org">http://www.bigbrothersbigsisters.org</a></td>
<td>Ages 6 to 17. Black or African American; Hispanic or Latino; White; American Indian or Alaska Native. Other community settings</td>
<td>↓ Initiation of drug use</td>
<td>↓ Aggressive behaviors ↑ Social competence ↑ Social achievement ↑ Family relationships ↓ Skipping school ↑ Complete homework</td>
<td>↓ Violence</td>
<td>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</td>
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<td><strong>Brief Alcohol Screening &amp; Intervention in College Students (BASICS).</strong> 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): <a href="http://depts.washington.edu/abr/c/basics.htm">http://depts.washington.edu/abr/c/basics.htm</a></td>
<td>Ages 18 to 25. Asian; Hispanic or Latino; White; American Indian or Alaska Native. Schools</td>
<td>↓ Frequency of alcohol use ↓ Quantity of alcohol use ↓ College Binge Drinking</td>
<td></td>
<td>$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.</td>
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<tr>
<td><strong>Caring School Community (NREPP).</strong> Universal elementary school program designed to create a caring school environment, supportive relationships, and collaboration among students, staff, and parents. Web Site(s): <a href="http://www.devstu.org/csc/videos/index.shtml">http://www.devstu.org/csc/videos/index.shtml</a></td>
<td>Ages 6 to 12. Asian; Black or African American; Hispanic or Latino; White School</td>
<td>↓ Alcohol use ↓ Marijuana use</td>
<td>↑ Social achievement ↑ Academic achievement ↑ Concern for others ↓ Disciplinary referrals</td>
<td>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.</td>
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<tr>
<td><strong>Community Trials Intervention To Reduce High-Risk Drinking.</strong> 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): <a href="http://www.pire.org/communitytrials/index.htm">http://www.pire.org/communitytrials/index.htm</a></td>
<td>Ages 13 and older Black or African American Hispanic or Latino Other community settings</td>
<td>↓ Alcohol use patterns and related problems ↓ Alcohol-related traffic crashes ↓ Alcohol-related assaults</td>
<td>↓ Violence</td>
<td>$0–$10,000 Costs will vary by community. Implementation materials, training, technical assistance/consultation, and quality assurance materials Contact the developer</td>
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<td><strong>Families and Schools Together (FAST).</strong> 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): <a href="http://familiesandschools.org">http://familiesandschools.org</a> <a href="http://cfsproject.wceruw.org/fastprogram.html">http://cfsproject.wceruw.org/fastprogram.html</a></td>
<td>Ages 0 to 12. Black or African American; Hispanic or Latino; White. School; other community settings.</td>
<td>↓ Substance abuse</td>
<td>↓ Child problem behaviors ↑ Child social skills ↑ Academic competencies ↑ Family relationships ↑ Social functioning</td>
<td>↓ Violence</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Guiding Good Choices (GGC).</strong> 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): <a href="http://www.channing-bete.com/ggc">http://www.channing-bete.com/ggc</a></td>
<td>Ages 6 and older White. School</td>
<td>↓ Lifetime marijuana use ↓ Lifetime alcohol use ↓ Tobacco ↓ Other drugs use</td>
<td>↓ Rate of depression ↓ Delinquent activities ↑ Family relationships ↑ Social functioning</td>
<td></td>
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</tr>
<tr>
<td><strong>Lead and Seed.</strong> A youth empowered, environmental approach to preventing and reducing alcohol, tobacco and drugs in a community <a href="https://www.alutiiq.com/capabilities/lead-seed/">https://www.alutiiq.com/capabilities/lead-seed/</a></td>
<td>Elementary and High school School</td>
<td>↑ human, technical and financial capacities ↑ advocacy skills ↑ leadership, efficacy and environmental skills</td>
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<tr>
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<td><strong>Life Skills Training.</strong> 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): <a href="http://www.lifeskillstraining.com">http://www.lifeskillstraining.com</a></td>
<td>Ages 13 to 17. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White. School</td>
<td>↓ Alcohol use ↓ Cigarettes ↓ Marijuana use ↓ Inhalants</td>
<td>↓ Delinquency ↓ Fighting ↓ Aggression</td>
<td>↓ Violence</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Lion’s Quest (NREPP).</strong> 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): <a href="http://www.lions-quest.org">http://www.lions-quest.org</a></td>
<td>Ages 6 to 17. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White. School</td>
<td>↓ Past month alcohol use ↓ Past month chewing tobacco ↓ Lifetime marijuana use</td>
<td>↑ Academic performance ↑ Handling peer conflicts ↓ Misconduct ↑ Social functioning</td>
<td>↓ Violence</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Olweus Bullying Prevention Program.</strong> The Olweus Bullying Prevention Program is designed to improve peer relations and make schools safer, more positive places for students to learn and develop.</td>
<td>Ages 5 to 15. School</td>
<td>↓ Existing bullying problems ↓ New bullying problems ↑ Peer relations at school</td>
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<td><strong>Parenting Wisely.</strong> 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): <a href="http://www.familyworksinc.com">http://www.familyworksinc.com</a></td>
<td>Ages 0 to 17. Black or African American; White; Non-U.S. population; Other community settings</td>
<td>↓ Substance abuse</td>
<td>↓ Child problem behaviors ↑ Parental sense of competence ↑ Family relationships ↑ Social functioning</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Project ALERT.</strong> 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): <a href="http://www.projectalert.com">http://www.projectalert.com</a></td>
<td>Ages 13 to 17. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White. School</td>
<td>↓ Alcohol use ↓ Tobacco use ↓ Marijuana use</td>
<td>↑ Family relationships ↑ Mental health promotion</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Project Northland.</strong> 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): <a href="http://www.hazelden.org/web/go/projectnorthland">http://www.hazelden.org/web/go/projectnorthland</a></td>
<td>Ages 6 to 17. American Indian or Alaska Native; White. School</td>
<td>↓ 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</td>
<td>↑ Family relationships</td>
<td></td>
<td>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.</td>
</tr>
<tr>
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<td><strong>Second Step.</strong> 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): <a href="http://www.cfchildren.org">http://www.cfchildren.org</a></td>
<td>Ages 6 to 12. American Indian or Alaska Native; Asian; Black or African American; Hispanic or Latino; White. School.</td>
<td>↓ Substance abuse</td>
<td>↑ Social competence  ↑ Prosocial behavior  ↓ Incidence of negative behaviors  ↓ Aggressive behaviors  ↓ Antisocial behaviors</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Strengthening Families.</strong> 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): <a href="http://www.strengtheningfamiliesprogram.org">http://www.strengtheningfamiliesprogram.org</a></td>
<td>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</td>
<td>↓ Substance abuse</td>
<td>↑ Family relationships  ↑ Mental health Promotion  ↑ Social functioning</td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Strengthening Families Program: For Parents and Youth 10-14.</strong> 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): <a href="http://www.extension.iastate.edu/sfp">http://www.extension.iastate.edu/sfp</a></td>
<td>Ages 6 to 12; 26 to 55. White. School.</td>
<td>↓ Lifetime alcohol use  ↓ Lifetime smoking  ↓ Lifetime marijuana use  ↓ Lifetime drunkenness  ↓ Using alcohol without parent permission</td>
<td>↓ Aggressive behavior</td>
<td></td>
<td>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.</td>
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<tr>
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<td>Team Awareness. Customizable worksite prevention training program that addresses behavioral risks associated with substance abuse among employees, their coworkers, and, indirectly, their families.</td>
<td>↓ Drinking ↓ Job-related hangovers</td>
<td>↑ Spiritual health ↑ Willingness to seek help</td>
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Sources:

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

- Lack of training
- Not getting help (effective)
- Causes division in community
- Fear
- Dogma
- Need to have something to believe in
- Addiction to God

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
  - High risk behaviors
  - Stigma
  - Lack of communication
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 resource that was identified as inadequate in this region is 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.
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.
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 their 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.
Response #19

TRANSPORTATION: ACCESS TO RESOURCES

- Lack of jobs
- Travel for groceries counseling
- Accommodate late schedule
- Travel for jobs
- No public transportation
- No cell phones & cars
- Sparse and spread out
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/Plsurvey2011.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/Plsurvey2011.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.
<table>
<thead>
<tr>
<th>Core Competencies</th>
<th>Check if you need training</th>
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<tbody>
<tr>
<td><strong>Assessment:</strong></td>
<td></td>
</tr>
<tr>
<td>Creating and maintaining coalitions and partnerships</td>
<td></td>
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<tr>
<td><strong>Assessing community needs and resources</strong></td>
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<tr>
<td>Analyzing problems and goals</td>
<td></td>
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<tr>
<td>Developing a framework or model of change</td>
<td></td>
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<tr>
<td><strong>Capacity:</strong></td>
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<tr>
<td>Building coalition leadership</td>
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<tr>
<td>Increasing coalition participation</td>
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<tr>
<td>Enhancing cultural competence</td>
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<tr>
<td>Improving organizational management and development</td>
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<tr>
<td><strong>Planning:</strong></td>
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<tr>
<td>Developing strategic and action plans</td>
<td></td>
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<tr>
<td><strong>Implementation:</strong></td>
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<tr>
<td>Developing interventions</td>
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<tr>
<td>Advocating for change</td>
<td></td>
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<tr>
<td>Influencing policy development</td>
<td></td>
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<tr>
<td>Writing grant applications for funding</td>
<td></td>
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<tr>
<td><strong>Evaluation:</strong></td>
<td></td>
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<tr>
<td>Evaluating initiatives</td>
<td></td>
</tr>
<tr>
<td>Sustaining projects and initiatives</td>
<td></td>
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</table>

**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 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:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Training Need</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>320</td>
<td>Conducting a community assessment</td>
</tr>
<tr>
<td>2</td>
<td>310</td>
<td>Creating and maintaining coalitions and partnerships</td>
</tr>
<tr>
<td>3</td>
<td>308</td>
<td>Using Institute of Medicine categories to select the appropriate strategy</td>
</tr>
<tr>
<td>4</td>
<td>147</td>
<td>Writing grant applications for funding</td>
</tr>
<tr>
<td>5</td>
<td>120</td>
<td>Assessing community needs and resources</td>
</tr>
<tr>
<td>6</td>
<td>116</td>
<td>Developing interventions</td>
</tr>
<tr>
<td>7</td>
<td>108</td>
<td>Describing the process of addiction</td>
</tr>
<tr>
<td>8</td>
<td>108</td>
<td>Knowledge of current trends in drug use patterns</td>
</tr>
<tr>
<td>9</td>
<td>106</td>
<td>Creating a sustainability plan</td>
</tr>
<tr>
<td>10</td>
<td>106</td>
<td>Maintaining proficiency in technology, facilitation and presentation skills</td>
</tr>
</tbody>
</table>
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 years 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
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 BRFSS 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 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.monitoringthefuture.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**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADAP</td>
<td>Arkansas Office of Alcohol and Drug Abuse Prevention</td>
</tr>
<tr>
<td>AOD</td>
<td>Alcohol and Other Drugs</td>
</tr>
<tr>
<td>APNA</td>
<td>Arkansas Prevention Needs Assessment Survey</td>
</tr>
<tr>
<td>ARF</td>
<td>Risk Factors for Adolescent Drug and Alcohol Abuse in Arkansas</td>
</tr>
<tr>
<td>ATOD</td>
<td>Alcohol Tobacco and Other Drugs</td>
</tr>
<tr>
<td>BRFSS</td>
<td>Behavioral Risk Factor Surveillance System</td>
</tr>
<tr>
<td>CADCA</td>
<td>Community Anti-Drug Coalitions of America</td>
</tr>
<tr>
<td>CAPT</td>
<td>Center for the Application of Prevention Technologies</td>
</tr>
<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention</td>
</tr>
<tr>
<td>CSAP</td>
<td>Center for Substance Abuse Prevention</td>
</tr>
<tr>
<td>DBHS</td>
<td>Arkansas Division of Behavioral Health Services</td>
</tr>
<tr>
<td>DEA</td>
<td>Drug Enforcement Administration</td>
</tr>
<tr>
<td>DFSCA</td>
<td>Drug-Free Schools and Communities Act</td>
</tr>
<tr>
<td>DHHS</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>DOE</td>
<td>Department of Education</td>
</tr>
<tr>
<td>GPRA</td>
<td>Government Performance and Results Act</td>
</tr>
<tr>
<td>GIS</td>
<td>Geographic Information System</td>
</tr>
<tr>
<td>ICRC</td>
<td>International Certification Reciprocity Consortium</td>
</tr>
<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
</tr>
<tr>
<td>MDS</td>
<td>Minimum Data Set System</td>
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<tr>
<td>MADD</td>
<td>Mothers Against Drunk Drivers</td>
</tr>
<tr>
<td>MTF</td>
<td>Monitoring the Future</td>
</tr>
<tr>
<td>NASADAD</td>
<td>National Association of State Alcohol and Drug Abuse Directors</td>
</tr>
<tr>
<td>NCADI</td>
<td>CSAP's National Clearinghouse for Alcohol and Drug Information</td>
</tr>
<tr>
<td>NIDA</td>
<td>National Institute on Drug Abuse (institute within NIH)</td>
</tr>
<tr>
<td>NIH</td>
<td>National Institute of Health</td>
</tr>
<tr>
<td>NPN</td>
<td>National Prevention Network</td>
</tr>
<tr>
<td>NREPP</td>
<td>National Registry of Evidence-based Programs and Practices</td>
</tr>
<tr>
<td>NSDUH</td>
<td>National Survey on Drug Use and Health</td>
</tr>
</tbody>
</table>
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
Prevention for a Healthy Arkansas

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
Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

**Criterion 1**

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

   DBHS ensures mental and behavioral health care is available to children, youth and adults 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, youth, and their family community involvement is vital. Over the last seven years, the Department of Human Services (DHS)/DBHS has developed a System of Care (SOC) that is a community collaboration of families and agencies creating a coordinated network of services, supports, and social opportunities aimed at keeping children and youth with severe emotional and/or behavioral health needs in their homes and out of psychiatric hospitals, psychiatric residential facilities, child welfare and juvenile justice systems. A major tenet of SOC and the Wraparound Program is to ensure that whenever viable, child and youth live at home, in their community and attend school in their community. Families are included in all aspects of their child/youth’s services, and are also included in community activities that strengthen families’ natural support systems and provide a sense of social connections and inclusion in the community. Community collaboration for and by families and youth is a core strategy for ensuring the support necessary to keep children/youth in the least restrictive, most effective services that lead to better behavioral health outcomes. Services for adults include: psychiatric and psychological evaluation and diagnosis, individual, marital, family and group therapy; psychosocial rehabilitative day services, including illness self-management and family psycho-education; medication management; case management; outreach to the homeless and those involved with the criminal justice system; assertive community treatment; supported employment and housing; crisis intervention services (see detail in 4 below) and Integrated Treatment for those with co-occurring disorders. Arkansas is currently in process of transforming its current Medicaid System. It is enhancing its community based services which includes Peer Support, Employment Support, and Housing Support Services as well as Substance Abuse Treatment for all Medicaid recipients.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

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<table>
<thead>
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<tbody>
<tr>
<td>a) Physical Health</td>
<td>Yes</td>
</tr>
<tr>
<td>b) Mental Health</td>
<td>Yes</td>
</tr>
<tr>
<td>c) Rehabilitation services</td>
<td>Yes</td>
</tr>
<tr>
<td>d) Employment services</td>
<td>Yes</td>
</tr>
<tr>
<td>e) Housing services</td>
<td>Yes</td>
</tr>
<tr>
<td>f) Educational Services</td>
<td>Yes</td>
</tr>
<tr>
<td>g) Substance misuse prevention and SUD treatment services</td>
<td>Yes</td>
</tr>
<tr>
<td>h) Medical and dental services</td>
<td>Yes</td>
</tr>
<tr>
<td>i) Support services</td>
<td>Yes</td>
</tr>
<tr>
<td>j) Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)</td>
<td>Yes</td>
</tr>
<tr>
<td>k) Services for persons with co-occurring M/SUDs</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Please describe as needed (for example, best practices, service needs, concerns, etc)
3. Describe your state's case management services

Arkansas provides care coordination to children, youth and their families in the form of Wraparound services. Through the principles of Wraparound, these services are family driven and youth guided. The care coordinator assists the family and youth in building a support team of professionals and natural supports. This team includes mental health therapists, teachers and other school personnel, child welfare, juvenile justice and other individuals working together in the best interest of the youth in an effort to assist the youth to remain in their home and in their community. Under the new Medicaid program that has been adopted by the state, Medicaid eligible individuals with intensive behavioral health needs will be assigned a care coordinator to assist the individual in obtaining the best array of services to meet their needs. This new system will be available to both children and adults. Currently adults with serious mental illness receive case management services through the state's CMHC providers. Case managers assist clients in accessing needed benefits and community services, and in coordinating their care across service systems.

4. Describe activities intended to reduce hospitalizations and hospital stays.

As stated above, Arkansas provides care coordination to children, youth and their families in the form of Wraparound services. Working together in the best interest of the youth a team of individuals chosen by the family and the youth and in an effort to assist the youth provide both traditional and nontraditional services so that the youth is able to remain in their home and in their community. For adults, the state operates a Single-Point-Of-Access (SPOA) system for those in crisis and for whom hospitalization is being considered. These individuals are evaluated face-to-face by a mental health professional who seeks to divert the individual from hospitalization if this can be done safely and effectively. Currently over 50% of those served in the SPOA system are successfully diverted from hospitalization. For those who are hospitalized, the vast majority are hospitalized in a community hospital rather than the State Hospital. The CMHCs are financially incentivized to provide utilization management of these hospital stays and to move the person to community care as soon as this can be done safely. Currently this system of utilization management results in an average length of stay in community hospitals of 4.2 days.
In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state’s behavioral health system.

<table>
<thead>
<tr>
<th>Target Population (A)</th>
<th>Statewide prevalence (B)</th>
<th>Statewide incidence (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults with SMI</td>
<td>115,000</td>
<td>30,393</td>
</tr>
<tr>
<td>2. Children with SED</td>
<td>91,984</td>
<td>13,175</td>
</tr>
</tbody>
</table>

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Arkansas collects mental service data at the client level data for all adults with SMI (ages 18 and older) and children with SED (ages 0-17). To calculate the presented incidence data, the state totaled the counts of unique individuals identified as SMI/SED that received services through the state’s public mental health system in SFY2017.

To calculate prevalence of Adults with SMI, the state uses prevalence data from the state-level National Survey on Drug Use and Health (NSDUH) as described in the Arkansas Behavioral Health Barometer Report (https://www.samhsa.gov/data/sites/default/files/2015_Arkansas_BHBarometer.pdf).

To calculate prevalence of Children with SED, the state uses the Centers for Disease Control and Prevention’s (CDC) mean estimate of a prevalence rate of 16.5% for children (range of 13% to 20%) the resultant SED population need is Arkansas is estimated at 91,984.

The state uses both prevalence and incidence rates in planning for statewide service delivery. For example, the state disaggregates incidence data by regional areas and uses this information along with per capita data to help identify geographical areas of high need where access is particularly vital.
Narrative Question

Criterion 3: Children’s Services
Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

**Criterion 3**

Does your state integrate the following services into a comprehensive system of care?

<table>
<thead>
<tr>
<th></th>
<th>Social Services</th>
<th>Educational services, including services provided under IDEA</th>
<th>Juvenile justice services</th>
<th>Substance misuse prevention and SUD treatment services</th>
<th>Health and mental health services</th>
<th>Establishes defined geographic area for the provision of services of such system</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>b)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>c)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>d)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<td>e)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
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<tr>
<td>f)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
Describe your state's targeted services to rural and homeless populations and to older adults

Arkansas annually receives approximately $302,000 in Projects to Assist Transition from Homelessness (PATH) grant. This money is sub-granted to four community mental health centers as part of a competitive application process. The sub-grantees are tasked with providing outreach, assessment, housing match and assistance to obtain housing, and assistance with receiving social security income through the SOAR process. In 2016, the funds were used to assist 270 individuals in obtaining housing and mental health services. Of these, 97 were diagnosed with co-occurring substance misuse and mental health disorders.
**Narrative Question**

**Criterion 5: Management Systems**

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

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**Criterion 5**

Describe your state's management systems.

All Medicaid Providers and Community Mental Health Centers are required to have and advertise an emergency number made available 24-7 to individuals who have a behavioral health emergency. Also, certified Providers are required to ensure that staff have training to provide behavioral health crisis services.
Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Narrative Question
Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

   a) A full continuum of services

      i) Screening
      ii) Education
      iii) Brief Intervention
      iv) Assessment
      v) Detox (inpatient/social)
      vi) Outpatient
      vii) Intensive Outpatient
      viii) Inpatient/Residential
      ix) Aftercare; Recovery support

   b) Are you considering any of the following:

      Targeted services for veterans
      Expansion of services for:
      (1) Adolescents
      (2) Other Adults
      (3) Medication-Assisted Treatment (MAT)
Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

**Criterion 2**
Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?

   - Yes
   - No

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services?

   - Yes
   - No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?

   - Yes
   - No

4. Does your state have an arrangement for ensuring the provision of required supportive services?

   - Yes
   - No

5. Are you considering any of the following:

   a) Open assessment and intake scheduling

      - Yes
      - No

   b) Establishment of an electronic system to identify available treatment slots

      - Yes
      - No

   c) Expanded community network for supportive services and healthcare

      - Yes
      - No

   d) Inclusion of recovery support services

      - Yes
      - No

   e) Health navigators to assist clients with community linkages

      - Yes
      - No

   f) Expanded capability for family services, relationship restoration, custody issue

      - Yes
      - No

   g) Providing employment assistance

      - Yes
      - No

   h) Providing transportation to and from services

      - Yes
      - No

   i) Educational assistance

      - Yes
      - No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   The contractor must comply with service provision for priority populations and comply with required timeframes as identified by SAMSHA and in the most current version of the DBHS Rules of Practice and Procedure Contractors will establish policies and procedures to prioritize the Pregnant intravenous drug users must receive services within forty-eight (48) hours Pregnant Women must receive services within forty-eight (48) hours. For Pregnant women, Interim Services must also include counseling on the effects of alcohol and drug use on the fetus. A referral for prenatal care must be made within twenty-four (24) hours of the request for admission services. DBHS must be notified immediately if a priority population client cannot be admitted to the Contractor’s program within the required timeframes. DBHS will assist will locating a clinically appropriate placement.

   DHS/DBHS does quarterly site visits to all the Specialized Women Programs in the state. The auditors make sure that the licensure standards for the Specialized Women’s Services for families are being followed and they are in compliance with licensure and certification standards. Specialized Women’s Services have specific standards that must be met and maintained. If an auditor finds discrepancies, a written and verbal notification must be submitted to DHS. DBHS immediately. A written explanation as to how the Contractor will ensure all required services will be provided must be provided to DHS/DBHS within forty—eight (48) hours.
**Narrative Question**

**Criterion 4, 5 and 6: Persons Who inject Drugs (PWID), Tuberculosis (TB), Human Immunodeficiency Virus (HIV), Hypodermic Needle Prohibition, and Syringe Services Program**

**Criterion 4,5& 6**

**Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
   
   a) 90 percent capacity reporting requirement
   b) 14-120 day performance requirement with provision of interim services
   c) Outreach activities
   d) Syringe services programs
   e) Monitoring requirements as outlined in the authorizing statute and implementing regulation

2. Are you considering any of the following:
   
   a) Electronic system with alert when 90 percent capacity is reached
   b) Automatic reminder system associated with 14-120 day performance requirement
   c) Use of peer recovery supports to maintain contact and support
   d) Service expansion to specific populations (military families, veterans, adolescents, older adults)

3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   The contractor must comply with service provision for priority populations and comply with required timeframes as identified by SAMSHA and the most current version of the DBHS Rules of Practice and Procedure. Intravenous drug users must receive services within fourteen (14) days. Priority populations placed on waiting list must receive interim Services as identified and within timeframes established in the most current version of the DBHS Rules of Practice and Procedure. Interim Services must include counseling and education about the risks of HIV, TB, the risks of needle-sharing, risks of transmission to sexual partners and infants, steps to endure transmission doesn’t occur, and referral for HIV or TB services if necessary.

   DHS/DBHS does quarterly site visits to all Programs in the state. The auditors make sure that the licensure standards for the treatment services are being followed and they are in compliance with licensure and certification standards. If an auditor finds discrepancies, a written and verbal notification must be submitted to DHS/DBHS immediately. A written explanation as to how the Contractor will ensure all required services will be provided must be provided to DHS/DBHS within forty—eight (48) hours.

**Tuberculosis (TB)**

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?

2. Are you considering any of the following:
   
   a) Business agreement/MOU with primary healthcare providers
   b) Cooperative agreement/MOU with public health entity for testing and treatment
   c) Established co-located SUD professionals within FQHCs

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

   Each of our funded providers are responsible for maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery.

**Early Intervention Services for HIV (for “Designated States” Only)**

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery?
2. Are you considering any of the following:

<table>
<thead>
<tr>
<th>a) Establishment of EIS-HIV service hubs in rural areas</th>
<th>jn Yes jn No</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) Establishment or expansion of tele-health and social media support services</td>
<td>jn Yes jn No</td>
</tr>
<tr>
<td>c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS</td>
<td>jn Yes jn No</td>
</tr>
</tbody>
</table>

**Syringe Service Programs**

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes (42 U.S.C§ 300x-31(a)(1)F)?

   | jn Yes jn No |

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?

   | jn Yes jn No |

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?

   | jn Yes jn No |

If yes, please provide a brief description of the elements and the arrangement
**Criterion 8,9&10**

**Syringe System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement?

2. Are you considering any of the following:
   a) Workforce development efforts to expand service access
   b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services
   c) Establish a peer recovery support network to assist in filling the gaps
   d) Incorporate input from special populations (military families, service memberes, veterans, tribal entities, older adults, sexual and gender minorities)
   e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations
   f) Explore expansion of service for:
      i) MAT
      ii) Tele-Health
      iii) Social Media Outreach

**Service Coordination**

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?

2. Are you considering any of the following:
   a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services
   b) Establish a program to provide trauma-informed care
   c) Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education

**Charitable Choice**

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)

2. Are you considering any of the following:
   a) Notice to Program Beneficiaries
   b) Develop an organized referral system to identify alternative providers
   a) Develop a system to maintain a list of referrals made by religious organizations

**Referrals**

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?

2. Are you considering any of the following:
   a) Review and update of screening and assessment instruments
   b) Review of current levels of care to determine changes or additions
c) Identify workforce needs to expand service capabilities

j n Yes j n No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background

j n Yes j n No

Patient Records

1. Does your state have an agreement to ensure the protection of client records?

j n Yes j n No

2. Are you considering any of the following:

   a) Training staff and community partners on confidentiality requirements

      j n Yes j n No

   b) Training on responding to requests asking for acknowledgement of the presence of clients

      j n Yes j n No

   c) Updating written procedures which regulate and control access to records

      j n Yes j n No

   d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure

      j n Yes j n No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?

j n Yes j n No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

   Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

   4

3. Are you considering any of the following:

   a) Development of a quality improvement plan

      j n Yes j n No

   b) Establishment of policies and procedures related to independent peer review

      j n Yes j n No

   c) Develop long-term planning for service revision and expansion to meet the needs of specific populations

      j n Yes j n No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?

j n Yes j n No

If YES, please identify the accreditation organization(s)

   i) Commission on the Accreditation of Rehabilitation Facilities

   ii) The Joint Commission

   iii) Other (please specify)

Council on Accreditation
Criterion 7 & 11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  
   - Yes  
   - No

2. Are you considering any of the following:
   a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  
      - Yes  
      - No
   b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  
      - Yes  
      - No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
   a) Recent trends in substance use disorders in the state  
      - Yes  
      - No
   b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  
      - Yes  
      - No
   c) Performance-based accountability  
      - Yes  
      - No
   d) Data collection and reporting requirements  
      - Yes  
      - No

2. Are you considering any of the following:
   a) A comprehensive review of the current training schedule and identification of additional training needs  
      - Yes  
      - No
   b) Addition of training sessions designed to increase employee understanding of recovery support services  
      - Yes  
      - No
   c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services  
      - Yes  
      - No
   d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  
      - Yes  
      - No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:
   a) Allocations regarding women  
      - Yes  
      - No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
   a) Tuberculosis  
      - Yes  
      - No
   b) Early Intervention Services Regarding HIV  
      - Yes  
      - No

3. Additional Agreements
   a) Improvement of Process for Appropriate Referrals for Treatment  
      - Yes  
      - No
   b) Professional Development  
      - Yes  
      - No
   c) Coordination of Various Activities and Services  
      - Yes  
      - No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.
Environmental Factors and Plan

12. Quality Improvement Plan- Requested

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017?
   - Yes
   - No

   Does the state have any activities related to this section that you would like to highlight?
   - No

   Please indicate areas of technical assistance needed related to this section.
   - None

Footnotes:
Environmental Factors and Plan

**13. Trauma - Requested**

**Narrative Question**

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

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource-poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma paper.

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

61 Ibid

**Please respond to the following items**

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues?  
   - Yes  
   - No

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers?  
   - Yes  
   - No

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care?  
   - Yes  
   - No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?  
   - Yes  
   - No

5. Does the state have any activities related to this section that you would like to highlight?

Arkansas Federation for Medical Care in conjunction with the Department of Health has a continuous workgroup to explore Adverse Childhood Experience (ACEs) in order to address the high incidence of trauma in the state. The Division of Children and Family (DCFS) in conjunction with UAMS and DBHS continues on-going planning of training sessions across the state on Trauma Informed Treatment and Services. These trainings are being made available to all behavioral health providers who contract either with the DBHS or DCFS divisions.

Recently, AR Medicaid has included a new Medicaid reimbursable service that will be provided by certified infant mental health clinicians. DBHS in conjunction with University of AR Little Rock is in the process of developing curriculum for training in infant mental health as well as a certification process. UAMS continues to train and certified clinicians across the state in Trauma Focused Cognitive Behavioral Therapy.
Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.62

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.63

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid 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.

The MHBG and SABG 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.


Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services?  

   Yes

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?  

   Yes

3. Does the state provide cross-trainings 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?  

   Yes

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances?  

   Yes

5. Does the state have any activities related to this section that you would like to highlight?  

   Juvenile Justice
Department of Human Services Systems of Care has a pilot project in which they are working with the Division of Youth Services (DYS) targeting youth who have a Family In Need of Services (FINS) or are on probation. They are also including the Division of Youth Services community based providers. Evidenced-based trainings are provided to improve outcomes of treatment to lessen involvement with the juvenile justice system and improve overall functioning. Trainings consisted of Collaborative Problem Solving and Cultural and Linguistic Competency. Trauma Focused Cognitive Behavioral Therapy certification is on-going as well as Team Up for Your Child-Road Map to Services. System of Care Wrap-Around training is also offered to all DYS contracted providers; and Trust-Based Relational training intervention was provided to all DYS facilities.

   Juvenile Drug Court
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. Services are available in ten different judicial districts. Services are provided by contracted licensed substance abuse providers. These contracts are awarded via bid process. Juveniles admitted to the Juvenile Drug Court program are provided a number of services including outpatient therapy, case management, and urine analysis. The Arkansas Supreme Court Commission on Children, Youth and Families adopted Core Principles for Reducing Recidivism and Improving Outcomes for Youth in Juvenile Justice System. The Division of Behavioral Health Services has partnered with the Administrative Office of the Courts to support this initiative.

Adult Criminal Justice

Arkansas utilizes a Forensic Outpatient Restoration Program (FORP) when there is concern that an individual is unfit to proceed within the legal system due to a possible mental health deficit. The individual is referred to the court where a judge orders a forensic evaluation. The evaluation is completed by a Psychologist trained in Forensics. If the individual is determined to be "unfit to proceed," a report is presented to the court with this information and the individual is then ordered to proceed into FORP. The time frame for the restoration is ten (10) months and the individual is referred to a local community mental health center for a maximum duration of six months in order to complete the restoration process. The individual, to be restored, may either be in the county jail or out on bond during the outpatient restoration process. Approximately sixty-percent of individuals reside in jail while approximately forty-percent are on bond. At any point, the process can be terminated for one of two reasons. Either the individual is restored by a passing score of 70% or higher on an educational exam or the individual is considered non-restorable due to malingering, lack of cooperation or the individual's mental health condition has elevated to the point that inpatient services are necessary. In either case, the individual is referred to the Arkansas State Hospital (ASH) where he/she is re-evaluated. This evaluation is utilized to determine if the individual needs further inpatient restoration in a more structured environment or to determine if the individual is ready to proceed through the legal system. If found not restored, but capable of being restored, the individual may be referred back to the CMHC for continuation of FORP services. If the time-line is close to the sixth month window, the individual will, in most cases remain at ASH, for continued inpatient restoration services until the completion of the tenth month duration. The end result is that a report is sent to the courts declaring the individual as being: competent/responsible, competent/not responsible or incompetent (unfit to proceed) as determined by the evaluator. The implementation of FORP has drastically reduced the waitlist at the state hospital and has allowed for treatment to be provided in the least restrictive setting and in a more expedient timeframe.

There has been training for law enforcement within the state, such as Mental Health First AID. More importantly, this is a continued goal of outside organizations such as the Sheriff’s Association, County Associations, and the Community Mental Health Centers. Further, the Arkansas Community Corrections Department now has 35 trainers to provide Mental Health First Aid statewide training to their staff. Also, Community Corrections is assisting parolees with signing up for insurance benefits once released. They report this has been successful with assisting in reducing recidivism due to access of behavioral health and medical treatment. According to an Arkansas Community Correction report, there are 53,000 parolees and probationers at any given time for oversight. Approximately 80 percent of them suffer substance abuse issues; and of those 42,000 people, another 20 to 30 percent also have mental health needs.

Specialty Courts

Act 895 amended the statute outlining the drug court system in the state. The amendment expanded the definition of specialty court to include other specialty courts, such as HOPE court, Veterans Court, juvenile drug court, and etc. All specialty court programs operated by a circuit court or district court must be approved by the Supreme Court in the administrative plan submitted under Supreme Court Administrative Order No.14. The Administrative Office of the Courts shall evaluate and make finding with respect to all specialty court programs operated by a circuit court or district court in this state and refer the findings to the Supreme Court. An evaluation under this section shall reflect nationally recognized and peer-reviewed standards for each particular type of specialty court program. The office shall also establish, implement, and operate a uniform specialty court program evaluation process to ensure specialty court program resources are uniformly directed to high-risk and medium-risk offenders; and that specialty court programs provide effective and proven practices that reduce recidivism, as well as other factors such as substance dependency, among participants. They should also establish an evaluation process that ensures that any new and existing specialty court program that is a drug court meets standards for drug court operation and promulgate rules to be approved by the Supreme Court to carry out the evaluation process under this section. A specialty court program shall be evaluated under the following schedule. (1) A specialty court program application submitted on or after the effective date of this act shall require evaluation of the specialty court program based on the proposed specialty court program plan; (2) A specialty court program established on or after the effective date of this act shall be evaluated after its second year of funded operation; (3) A specialty court program in existence on the effective date of this act shall be evaluated under the requirements of this section prior to expending resources budgeted for fiscal year 2017; and (4) A specialty court program shall be reevaluated every two years after the initial evaluation. All of these “specialty courts” are utilized the asses, screen and provide services to individuals with both mental health and/or substance abuse use disorders prior to adjudication.

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. 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.

Affordable Care Act
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.

Foot note: Does the state have any activities related to this section that you would like to highlight

Another DBHS initiative that began in 2016 and will continue through 2018 with a contract is partnering with the Division of Youth Services and four community mental health centers (CMHC) to provide outpatient therapy services to youth currently in the custody of DYS and residing in DYS residential facilities. Outpatient therapy sessions include: individual therapy, family therapy, psychotherapy group, psycho-education groups, care coordination and weekly staffing with DYS staff. Once center provides specialized sexual offender treatment to designated youth up to the age of 21 years.

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

Footnotes:
Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question
There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient’s needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA’s activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  
   Yes No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly, pregnant women?  
   Yes No

3. Does the state purchase any of the following medication with block grant funds?  
   Yes No
   a) Methadone
   b) Buprenorphine, Buprenorphine/naloxone
   c) Disulfiram
   d) Acamprosate
   e) Naltexone (oral, IM)
   f) Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA approved medications for treatment of substance abuse use disorders are used appropriately?  
   Yes No

5. Does the state have any activities related to this section that you would like to highlight?
Currently substance use providers are not required to provide MAT through their program, with the exception of the five (5) Licensed Opioid Treatment Programs. However, with the receipt of the STR grant, funded providers are being trained and encouraged to partner with a local DATA 2000 waivered physician to make this part of their treatment curriculum, to include psychosocial interventions.

Please indicate areas of technical assistance needed to this section.

*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.

Footnotes:
16. Crisis Services - Requested

Narrative Question

In the ongoing development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful. SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA’s publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises,

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

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

Please respond to the following items:

1. Crisis Prevention and Early Intervention
   a) b Wellness Recovery Action Plan (WRAP) Crisis Planning
   b) b Psychiatric Advance Directives
   c) b Family Engagement
   d) b Safety Planning
   e) e Peer-Operated Warm Lines
   f) e Peer-Run Crisis Respite Programs
   g) b Suicide Prevention

2. Crisis Intervention/Stabilization
   a) e Assessment/Triage (Living Room Model)
   b) e Open Dialogue
   c) b Crisis Residential/Respite
   d) b Crisis Intervention Team/Law Enforcement
   e) b Mobile Crisis Outreach
   f) b Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support
   a) b WRAP Post-Crisis
   b) b Peer Support/Peer Bridges
Follow-up Outreach and Support
Family to Family Engagement
Connection to care coordination and follow-up clinical care for individuals in crisis
Follow-up crisis engagement with families and involved community members
Recovery community coaches/peer recovery coaches
Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Arkansas is in the process of implementing Crisis Stabilization Units which will interface with law enforcement per ACT 423 which was passed this year in the Legislative Session. Also, the Medicaid system in being transformed with the addition of community support services as well as Acute Crisis Units and Therapeutic Communities. Substance Use Disorder treatment will be available for all Medicaid recipients as well. Though Arkansas has certified Family Support Partners for several years, the recent behavioral health transformations in our Medicaid system allows for reimbursement for Family Support Partners, Peer Support Specialists, and Youth Support Specialists. Approved behavioral health agencies with appropriate credentialed staff will soon be able to provide this new service to Arkansans as a way to promote recovery. Additionally, Arkansas is in process of creating new Performance Deliverables for community mental health centers to expand the current crisis services and to up-date the current Public Mental Health System.

Please indicate areas of technical assistance needed to this section.

Footnotes:
Environmental Factors and Plan

17. Recovery - Required

Narrative Question
The implementation of recovery supports and services is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making.

The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual’s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

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

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

In addition, SAMHSA identified 10 guiding principles of recovery:

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

Please see [SAMHSA’s Working Definition of Recovery from Mental Disorders and Substance Use Disorders](https://www.samhsa.gov/). States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery...
Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders. Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

   a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? [ ] Yes [ ] No

   b) Required peer accreditation or certification? [ ] Yes [ ] No

   c) Block grant funding of recovery support services. [ ] Yes [ ] No

   d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state’s M/SUD system? [ ] Yes [ ] No

   The Arkansas Behavioral Health Planning and Advisory Council is a group composed of individuals in recovery, family members, and professionals in the behavioral health field. This group reviews the block grant and its outcomes each year. It provides input on concerns and planning of behavioral health administration and service gaps.

   Individuals also have input to the system through local consumer councils. These organizations are operated by community mental health centers but come together as an umbrella of the Arkansas Mental Health Council.

   The system of care includes community stakeholder councils comprised of youth and family members accessing the system. While serving as a method for the families to connect and provide recovery support to each other, the councils also give them opportunities to provide input and address concerns. In a similar vein, the 15 chapters of YouthMove, a national organization, allows youth to have say in planning.

   Limited technical assistance and encouragement is given to the statewide Personal Empowerment Recovery Coalition, a body originally convened under a BRSS ATC grant awarded to the state. This group has developed the ability to function on its own and receives much of its technical advice from the National Empowerment Center. Members of PERC sit on the Behavioral Health Planning and Advisory Council.

2. Does the state measure the impact of your consumer and recovery community outreach activity? [ ] Yes [ ] No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

   Through the PATH grant, housing placement and recovery supports are provided to those individuals experiencing both SMI and homelessness.

   With recent changes to Medicaid reimbursable categories, individuals at Tier 2 and 3 will be eligible for peer support specialists. Tier 2 and 3 are the individuals with the most disruption to functioning. The certification and training are in development through technical assistance provided by BRSS TACS. That work is scheduled to be complete by end of August 2017. A group of both providers, trainers, and peers has been convened to assure that all voices are heard in the process.

   Family support partners (FSP) have been in place for several years to assist families whose children are diagnosed with SED. The FSPs are individuals who have navigated the system of care for children with their own family members. An association of these families is forming as a coalition. The group is led by certified family support partners.

   Youth support partners (YSP) training is in development to train youth who have navigated the system to assist their peers in reaching recovery.

   Patients at the Arkansas State Hospital have access to a peer support partner during their hospitalization. Training on Wellness Recovery Action Planning has begun with staff members and support groups of patients meet regularly to work on their individual plans.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

   Funding with the STR grant will be utilized to place peer specialists in each of our 8 block-granted funded treatment providers.

   The credentialing and training program are in development as part of the discussion and technical assistance through BRSS TAC. That work is scheduled to be complete by end of August 2017. A group of both providers, trainers, and peers has been convened to assure that all voices are heard in the process.

   Family support partners (FSP) have been in place for several years to assist families whose children are diagnosed with SED. The FSPs are individuals who have navigated the system of care for children with their own family members. An association of these families is forming as a coalition. The group is led by certified family support partners.

   Youth support partners (YSP) training is in development to train youth who have navigated the system to assist their peers in reaching recovery.

5. Does the state have any activities that it would like to highlight?

   Please indicate areas of technical assistance needed related to this section.
Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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

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

Please respond to the following items

1. Does the state's Olmstead plan include:
   - housing services provided.
   - home and community based services.
   - peer support services.
   - employment services.

2. Does the state have a plan to transition individuals from hospital to community settings?

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

    As part of the Pre-Admission Screening Resident Review (PASRR) process, individuals with serious mental illnesses who make application for care in Medicaid-eligible nursing facilities are reviewed by a staff member from the Division of Behavioral Health Services to assure that placement is in the least restrictive environment. Alternative placement is recommended should nursing facility be found to be too restrictive.

    At this time, complete data about congregate versus integrated housing is not available. Given the rural nature of the state, many individuals live within the community at large but the precise number is not known at this time. The same can be said about competitive wage earners.

    Starting July 1, 2017 new behavioral health standards for Medicaid became effective which will allow for additional community supports, and that workforce is in development.

    Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:
Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children’s needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

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

According to data from the 2015 Report to Congress on systems of care, services:

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

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and
68The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

Please respond to the following items:

1. Does the state utilize a system of care approach to support:
   a) The recovery and resilience of children and youth with SED?  
   b) The recovery and resilience of children and youth with SUD?
   
2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:
   a) Child welfare?
   b) Juvenile justice?
   c) Education?

3. Does the state monitor its progress and effectiveness, around:
   a) Service utilization?
   b) Costs?
   c) Outcomes for children and youth services?

4. Does the state provide training in evidence-based:
   a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?
   b) Mental health treatment and recovery services for children/adolescents and their families?

5. Does the state have plans for transitioning children and youth receiving services:
   a) to the adult behavioral health system?
   b) for youth in foster care?

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

DBHS ensures mental and behavioral health services are available to children and youth throughout the state. Currently, outpatient services receive Medicaid funds under the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program for under 21 population. There are 53 providers and 302 RSPMI certified sites across the state. There are approximately 65,000 children and youth being served through this program each year. Therapy services can be provided in a clinic, home or school setting. Over 5,000 children and youth per year are provided services in a residential treatment setting. Youth MOVE Arkansas is a statewide youth-led organization with a state office and project director paid for with state general revenue. During 2017 at the Youth MOVE Empowerment Conference, over 315 youth and families attended. This conference has grown every year. Youth MOVE has 14 chapters.

Beginning in the state fiscal year 2017, DBHS moved from six years of subgrants to contracts with our fourteen SOC Wraparound sites across Arkansas. Over 940 children and youth were served in the Wraparound Program this year. For 2018, we have continued to contract with all fourteen sites to fulfill the state goals for the Wraparound Program. Financial support comes from a variety of funding sources including Medicaid, state general revenue, mental health block grant, SAMHSA grant(s) and private insurance. Children and youth behavioral health services are thoroughly integrated with social services, child welfare, juvenile
justice, substance abuse and educational services through the Wraparound Program as well as many of the initiatives listed below. Juvenile Drug Court services are available in 10 judicial districts as well as the Substance Abuse Treatment Services Program that provides services to children and youth up to 21 years of age.

Does the state have any activities related to this section that you would like to highlight?

During 2017, the Wraparound Program provided wraparound services to over 940 children and youth. Over 225 family & youth attended community based activities held across the state with 2,432 family members, 1,237 youth and 1,206 children attending these events. DBHS established a pilot project in late 2016 designed to work with the Division of Children & Family Service’s foster care children/youth that are in congregant care facilities and are hard to place due to severe behavioral health issues. Five community mental health centers with therapeutic foster care programs agreed to place these children/youth into their TFC programs with a Behavior Assistant trained in Trust-Based Relational Intervention. Behavior Assistants may spend up to 40 hours per week shadowing the child/youth in the home, community &/or school. Each child/youth also has a wraparound plan & receives intensive outpatient mental health services. This goal is to stabilize them into a home-like setting.

Eighty-nine foster care children were identified in July of 2016 & 36 remain in congregant care settings. DBHS clinical staff attend an "interdivisional staffing" weekly with other child services divisions discuss placement options for challenging foster care cases. Another DBHS initiative is partnering with the Division of Youth Services & four community mental health centers to provide outpatient therapy services to 220 youth currently in DYS custody and residing in DYS residential facilities. DBHS was awarded a SAMHSA grant in 2014 for four years. Here is a list of a few of the successes we continue to address: 1) Family/Parent Support Partner curriculum, training & certification, 2) Youth Support Partner curriculum, training & certification process, 3) Infant & Early Childhood curriculum & certification process, 4) Steering committee established to develop a family-run organization, and 5) Coordination with DCFS to train DCFS providers in trauma informed care.

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

Footnotes:
Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question
Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? 
   - Yes
   - No

2. Describe activities intended to reduce incidents of suicide in your state.
   2. Arkansas has established the Arkansas Suicide Prevention Council. The council serves as a central body on suicide prevention efforts across the state. A representative from the Division of Behavioral Health Services is member of the council and works collaboratively to set priorities for statewide, evidenced based suicide prevention in Arkansas. The Arkansas Department of Health Injury and Violence Prevention Section implements several evidence-based programs address the need for suicide prevention and intervention for youth 10-24 in the state. The Division of Behavioral Health Services is also working collaboratively with ADH to facilitate the development of systems to enhance the state's Suicide Prevention Hotline.

3. Have you incorporated any strategies supportive of Zero Suicide? 
   - Yes
   - No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? 
   - Yes
   - No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? 
   - Yes
   - No

   If so, please describe the population targeted.

   Does the state have any activities related to this section that you would like to highlight?
   - No

   Please indicate areas of technical assistance needed related to this section.
   - None

Footnotes:
Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question
The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD 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 factors for mental and substance use disorders, and, for those youth with at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  
   Yes  No

2. Has your state identified the need to develop new partnerships that you did not have in place?  
   Yes  No

If yes, with whom?

The Division of Behavioral Health (DBHS) is currently in process of partnering with county entities, which have not yet been identified, in 3 different areas within the state for the development of Crisis Stabilization Units as defined in ACT 423. These entities will partner with stakeholders, such as law enforcement and behavioral health providers, within their communities to assist with better management of individuals presenting with behavioral health issues within their communities. These individuals, where possible, will be diverted from incarceration and triaged to the appropriate level of care to best address their behavioral health needs. Also, ACT 423 has allowed for the Division to be partnered with the Criminal Justice Institute (CJI) of Arkansas. Through this partnership, CJI will provide Crisis Intervention Training (CIT) to law enforcement throughout the state of Arkansas. This will better equip law enforcement with knowledge and skills to deal with individuals that present with behavioral health issues within their communities.

The Division is also partnered with the Arkansas Community Corrections which is working to implement the evidenced-based Oxford House model within its reentry program. This will assist individuals with placement within the community, support for employment, and overall recovery support which will assist with preventing recidivism.

The Division is working with the Department of Human Services, Division of Youth Services (DYS) to ensure that adolescents residing within the DYS facilities are receiving treatment for their Behavioral Health issues. This includes but is not limited to treatment of Mental Health and Substance Use disorders, participating in team meetings, and discharge planning.

With the Opioid Crisis sweeping the Nation, the Division of Behavioral Health is partnering with Medicaid, the University of Arkansas.
Arkansas at Little Rock, the Criminal Justice Institute, and the University of Medical Science to work to combat this problem in Arkansas.

The Department of Health is in process of creating a state-wide Suicide Line and the Division is offering support to the Department. Currently the calls are answered through a call center in Memphis Tennessee. Moving forward, the calls will be answered by a call center in Little Rock.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Arkansas is currently in process of transforming the current Medicaid system. The focus of the transformation is to enhance services within the community, including recovery support services, as well as to ensure that individuals are receiving the appropriate level of care. An Independent Assessment has been adopted and will be administered to determine whether an individual needs intensive outpatient services within the community or residential services. Also, Crisis Units, Peer Support, Family Support, Employment and Housing Support services have been added to assist with improving functioning within the community to divert from acute and residential settings.

Also, Arkansas is currently in the process of up-dating its public mental health system through changes in the manner in which it procures services from community mental health centers. This will allow for enhancement of community and crisis systems and improve upon relationships within the community for the best treatment and appropriate placement of individuals with behavioral health issues.

With regards to services provided in local school systems, schools can provide services to Medicaid Beneficiaries under the School Based Mental Health program. In addition, schools can make referrals to enrolled Medicaid provider agencies and school is an allowable location of service. Therefore, most students receive services through the Medicaid program. These providers can also provide services through private insurance as well. The Schools enter into agreements through Memorandum of Understandings with provider agencies which fulfills the needed services regardless of payer source that have been identified by schools under IDEA.

Does the state have any activities related to this section that you would like to highlight?

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

Footnotes:
Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council’s comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.  

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)
   a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?
      The Arkansas Behavioral Health Planning and Advisory Council (ABHPAC) were not directly involved in the development of the block grant. However, the ABHPAC Block Grant committee 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. The state of Arkansas has 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 members of the AADACC are appointed by the Governor. The meetings are held quarterly. 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.

      A representative from ABHPAC attends the AADACC council planning meetings which provides opportunities for the consumer voice to be heard with regards to how funds will be allocated for Arkansans receiving substance abuse, treatment, and prevention services.

   b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguist, rural, suburban, urban, older adults, families of young children)?
   j n Yes j n No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.
   The ABHPAC Council is comprised of consumers, youth, family members, providers, and representatives of state and private agencies. The council is federally mandated through PL 102-321 to review the state plans for the block grant and provide recommendations to the State; to serve as an advocate for adults with SMI, children with SED and other individuals with mental illness and emotional problems along with individuals in recovery dealing with substance use and treatment issues; and to monitor, review and evaluate the allocation and adequacy of behavioral health services in the State. The council has bi-monthly meetings.
In addition, the Alcohol and Drug Abuse 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.

Does the state have any activities related to this section that you would like to highlight?
The ABHPAC Council has conducted several awareness education and training events this past year. Some of these events include: the Recovery Jam, Mental Health Awareness events which included the NAMI Smarts trainings; and a Candlelight vigil Event to honor individuals and families dealing with behavioral health issues as well as raise awareness and educate the public about behavioral health issues affecting Arkansans.

In addition, the council had a learning academy to educate council members and the public about the role of ABHPAC and the collaborative partnership between the Division of Behavioral Health. The council has been working with the community mental health centers to build relationships with the consumer councils in the state by providing education and raising awareness about the mission and goals of the planning council. The council attends community awareness events to provide resources to the public about the council.

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

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.\(^\text{71}\)

\(^{71}\) There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.
## Environmental Factors and Plan

### Behavioral Health Advisory Council Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Type of Membership</th>
<th>Agency or Organization Represented</th>
<th>Address, Phone, and Fax</th>
<th>Email (if available)</th>
</tr>
</thead>
<tbody>
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<td><a href="mailto:knoble@aoinc.org">knoble@aoinc.org</a></td>
</tr>
<tr>
<td>Bob Parker</td>
<td>State Employees</td>
<td>Criminal Justice - Ark Dept of Corrections</td>
<td>3301 Dartmouth Ct. Little Rock AR, 72204</td>
<td><a href="mailto:bob.parker@arkansas.gov">bob.parker@arkansas.gov</a></td>
</tr>
<tr>
<td>Miriam Pearsall</td>
<td>Individuals in Recovery</td>
<td>Arkansas Behavioral Health Planning and Advisory Council</td>
<td>111 S. Glenstone, Ste 300 Springfield MO, 65804, PH: 417-869-8911</td>
<td><a href="mailto:mlpearsa@gmail.com">mlpearsa@gmail.com</a></td>
</tr>
<tr>
<td>Dena Perry</td>
<td>State Employees</td>
<td>DHS/Division of Behavioral Health</td>
<td>2000 cherry crossing benton AR, 72015, PH: 501-317-0165</td>
<td><a href="mailto:dena.perry@dhs.arkansas.gov">dena.perry@dhs.arkansas.gov</a></td>
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<tr>
<td>Melissa Pettus</td>
<td>Family Members of Individuals in Recovery</td>
<td>Arkansas Behavioral Health Planning and Advisory Council</td>
<td>811 N. Spruce St. Little Rock AR, 72205, PH: 501-412-9460</td>
<td><a href="mailto:mpettus@counselingclinic.org">mpettus@counselingclinic.org</a></td>
</tr>
<tr>
<td>Kay Procop</td>
<td>Family Members of Individuals in Recovery</td>
<td>Arkansas Behavioral Health Planning and Advisory Council</td>
<td>P.O. Box 45402 Little Rock AR, 72214, PH: 501-681-5186</td>
<td><a href="mailto:kayprocop@yahoo.com">kayprocop@yahoo.com</a></td>
</tr>
<tr>
<td>Randall Rainwater</td>
<td>Individuals in Recovery</td>
<td>Arkansas Behavioral Health Planning and Advisory Council</td>
<td>3301 Dartmouth Ct. Little Rock AR, 72204</td>
<td><a href="mailto:rainwattrandal@gmail.com">rainwattrandal@gmail.com</a></td>
</tr>
<tr>
<td>Georgia Rucker</td>
<td>Individuals in Recovery</td>
<td>Arkansas Behavioral Health Planning and Advisory Council</td>
<td>811 N. Spruce St. Little Rock AR, 72205, PH: 501-412-9460</td>
<td><a href="mailto:mgrucker@sbcglobal.net">mgrucker@sbcglobal.net</a></td>
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<tr>
<td>William Shumaker</td>
<td>Individuals in Recovery</td>
<td>Arkansas Behavioral Health Planning and Advisory Council</td>
<td>7296 Geona Rd Texarkana AR, 71854, PH: 903-490-7004</td>
<td><a href="mailto:williamshumaker@gmail.com">williamshumaker@gmail.com</a></td>
</tr>
<tr>
<td>Diane Skaggs</td>
<td>Others (Not State employees or providers)</td>
<td>Mental Health Council of Arkansas</td>
<td></td>
<td><a href="mailto:dskaggs@mhca.org">dskaggs@mhca.org</a></td>
</tr>
<tr>
<td>Name</td>
<td>Role</td>
<td>Organization</td>
<td>Address</td>
<td>Contact Information</td>
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<tr>
<td>-------------------</td>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------</td>
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<tr>
<td>Eddie Smith</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Arkansas Department Of Veterans Affairs</td>
<td>21 Dellwood Drive, Little Rock AR, 72209</td>
<td>PH: 501-541-4087 <a href="mailto:eddie.smith2@va.gov">eddie.smith2@va.gov</a></td>
</tr>
<tr>
<td>Angela Smith</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>PERC</td>
<td>21 Dellwood Dr, Little Rock AR, 72209</td>
<td>PH: 501-541-4087 <a href="mailto:aysmith1972@gmail.com">aysmith1972@gmail.com</a></td>
</tr>
<tr>
<td>Sherry Smith</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Arkansas Behavioral Health Planning and Advisory Council</td>
<td>302 Shadow Oaks Drive Sherwood AR, 72120</td>
<td>PH: 501-553-7677 <a href="mailto:msssherry00@gmail.com">msssherry00@gmail.com</a></td>
</tr>
<tr>
<td>Lakesia Smith</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>Arkansas Behavioral Health Planning and Advisory Council</td>
<td>517 East 15th Little Rock AR, 72202</td>
<td>PH: 501-519-6176 <a href="mailto:lakesia.spencer@yahoo.com">lakesia.spencer@yahoo.com</a></td>
</tr>
<tr>
<td>Joyce Soulderie</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Arkansas Behavioral Health Planning and Advisory Council</td>
<td>40 Collins Road, Jacksonville AR, 72076</td>
<td>PH: 501-773-0040 <a href="mailto:jlsoularie2017@outlook.com">jlsoularie2017@outlook.com</a></td>
</tr>
<tr>
<td>Ben Udachi</td>
<td>State Employees</td>
<td>Arkansas Department of Community Corrections</td>
<td>105 West Capital, Little Rock AR, 72201</td>
<td>PH: 501-837-9506 <a href="mailto:ben.udachi@arkansas.gov">ben.udachi@arkansas.gov</a></td>
</tr>
<tr>
<td>Kellie Van Curen</td>
<td>Parents of children with SED</td>
<td>Arkansas Behavioral Health Planning and Advisory Council</td>
<td>P.O.Box 650, Springdale AR, 72765</td>
<td>PH: 479-530-9254 <a href="mailto:kfvcr69@hotmail.com">kfvcr69@hotmail.com</a></td>
</tr>
<tr>
<td>Pat Warner</td>
<td>Parents of children with SED</td>
<td>YouthMOVE</td>
<td>1409 E. Moore St, Searcy AR, 72143</td>
<td>PH: 501-230-1793 <a href="mailto:patwarner1@yahoo.com">patwarner1@yahoo.com</a></td>
</tr>
<tr>
<td>Ray Warner</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
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<td>1409 East Moore Searcy AR, 72143</td>
<td>PH: 501-230-8533 <a href="mailto:RayDog1322@gmail.com">RayDog1322@gmail.com</a></td>
</tr>
<tr>
<td>Kwashunda Watson</td>
<td>Family Members of Individuals in Recovery (to include family members of adults with SMI)</td>
<td>Veteran Affairs-Arkansas</td>
<td>5615 Green Valley Ave North Little Rock AR, 72118</td>
<td>PH: 501-831-7127 <a href="mailto:kwashunda.watson@va.gov">kwashunda.watson@va.gov</a></td>
</tr>
<tr>
<td>Anne Wells</td>
<td>State Employees</td>
<td>AR Division of Children and Family Services - Social Services Representative</td>
<td>P.O. Box 1437 Little Rock AR, 72203 -1437</td>
<td>PH: 501-682-8771 <a href="mailto:anne.wells@dhs.arkansas.gov">anne.wells@dhs.arkansas.gov</a></td>
</tr>
<tr>
<td>Kim Weser</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Arkansas Behavioral Health Planning and Advisory Council</td>
<td>1175 Hooper Rd, Redfield AR, 72132</td>
<td>PH: 501-200-0170 <a href="mailto:kjsmadonna@yahoo.com">kjsmadonna@yahoo.com</a></td>
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<tr>
<td>Daronda Elaine Williams</td>
<td>Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)</td>
<td>Arkansas Behavioral Health Planning and Advisory Council</td>
<td>425 E Walnut Street, Prescott AR, 71857</td>
<td>PH: 870-299-3325 <a href="mailto:ewrecyc@centurytel.net">ewrecyc@centurytel.net</a></td>
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<tr>
<td>Derek Wright</td>
<td>State Employees</td>
<td>Springdale Police Department</td>
<td>201 Spring St, Springdale AR, 72764</td>
<td>PH: 479-750-8158 <a href="mailto:dewright@springdalear.gov">dewright@springdalear.gov</a></td>
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Footnotes:
# Environmental Factors and Plan

## Behavioral Health Council Composition by Member Type

Start Year: 2018  
End Year: 2019

<table>
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<tr>
<th>Type of Membership</th>
<th>Number</th>
<th>Percentage</th>
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<tbody>
<tr>
<td><strong>Total Membership</strong></td>
<td>59</td>
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<tr>
<td>Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)</td>
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<tr>
<td>Family Members of Individuals in Recovery* (to include family members of adults with SMI)</td>
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<td>Parents of children with SED*</td>
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<td>Vacancies (Individuals and Family Members)</td>
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<tr>
<td>Others (Not State employees or providers)</td>
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<tr>
<td><strong>Total Individuals in Recovery, Family Members &amp; Others</strong></td>
<td>46</td>
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<td>State Employees</td>
<td>7</td>
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<tr>
<td>Providers</td>
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<td>Federally Recognized Tribe Representatives</td>
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<tr>
<td>Vacancies</td>
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<tr>
<td><strong>Total State Employees &amp; Providers</strong></td>
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<tr>
<td>Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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<td>Providers from Diverse Racial, Ethnic, and LGBTQ Populations</td>
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<tr>
<td><strong>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</strong></td>
<td>0</td>
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<tr>
<td>Persons in recovery from or providing treatment for or advocating for substance abuse services</td>
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</table>

* 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:**
Environmental Factors and Plan

23. Public Comment on the State Plan - Required

Narrative Question

**Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51)** requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

**Please respond to the following items:**

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
   a) Public meetings or hearings?
   b) Posting of the plan on the web for public comment?
   c) Other (e.g. public service announcements, print media)

   If yes, provide URL: http://humanservices.arkansas.gov/dbhs/Pages/dbhs_docs.aspx

Footnotes: